# MEDICAL INSURANCE

A Revenue Cycle Process Approach





# Medical Insurance

# A Revenue Cycle Process Approach

**Eighth Edition** 

Joanne D. Valerius, RHIA, MPH Oregon Health & Science University

Nenna L. Bayes, AAS, BBA, M.Ed., CPC Ashland Community and Technical College, Retired

Cynthia Newby, CPC, CPC-P

Amy L. Blochowiak, MBA, ACS, AIAA, AIRC, ARA, FLHC, FLMI, HCSA, HIA, HIPAA, MHP, PCS, SILA-F

Northeast Wisconsin Technical College









#### MEDICAL INSURANCE

Published by McGraw-Hill Education, 2 Penn Plaza, New York, NY 10121. Copyright ©2020 by McGraw-Hill Education. All rights reserved. Printed in the United States of America. No part of this publication may be reproduced or distributed in any form or by any means, or stored in a database or retrieval system, without the prior written consent of McGraw-Hill Education, including, but not limited to, in any network or other electronic storage or transmission, or broadcast for distance learning.

Some ancillaries, including electronic and print components, may not be available to customers outside the United States.

This book is printed on acid-free paper.

1 2 3 4 5 6 7 8 9 QVS 21 20 19

ISBN 978-1-260-56620-8 MHID 1-260-56620-X

Cover Image: ©Devon Ford and Michael Glascott

All credits appearing on page or at the end of the book are considered to be an extension of the copyright page.

The Internet addresses listed in the text were accurate at the time of publication. The inclusion of a website does not indicate an endorsement by the authors or McGraw-Hill Education, and McGraw-Hill Education does not guarantee the accuracy of the information presented at these sites.



# **Brief Contents**



<b>D</b>	
Preface	IX
I I CIUCC	1/

Part 1	WORKING WITH MEDICAL INSURANCE AND BILLING 1
Chapter 1	Introduction to the Revenue Cycle 2
Chapter 2	Electronic Health Records, HIPAA, and HITECH: Sharing and Protecting Patients' Health Information 33
Chapter 3	Patient Encounters and Billing Information 71
Part 2	CLAIM CODING 105
Chapter 4	Diagnostic Coding: ICD-10-CM 106
Chapter 5	Procedural Coding: CPT and HCPCS 137
Chapter 6	Visit Charges and Compliant Billing 189
Part 3	CLAIMS 217
Chapter 7	Healthcare Claim Preparation and Transmission 218
Chapter 8	Private Payers/ACA Plans 259
Chapter 9	Medicare 302
Chapter 10	Medicaid 338
Chapter 11	TRICARE and CHAMPVA 360
Chapter 12	Workers' Compensation and Disability/Automotive Insurance 377
Part 4	CLAIM FOLLOW-UP AND PAYMENT PROCESSING 401
Chapter 13	Payments (RAs), Appeals, and Secondary Claims 402
Chapter 14	Patient Billing and Collections 434
Chapter 15	Primary Case Studies 458
Chapter 16	RA/Secondary Case Studies 495





# Part 5

## HOSPITAL SERVICES 509

### **Chapter 17**

Hospital Billing and Reimbursement 510

Appendix A: Place of Service Codes A-1

**Appendix B: Professional Websites** B-1

**Appendix C: Forms** C-1

**Abbreviations** AB-1

**Glossary** GL-1

Index IN-1



# **Contents**

**Preface** ix

Part 1

# WORKING WITH MEDICAL INSURANCE AND BILLING

### **Chapter 1**

### Introduction to the Revenue Cycle 2

- 1.1 Working in the Medical Insurance Field 3
- 1.2 Medical Insurance Basics 6
- 1.3 Healthcare Plans 8
- 1.4 Health Maintenance Organizations 11
- 1.5 Preferred Provider Organizations 15
- 1.6 Consumer-Driven Health Plans 15
- 1.7 Medical Insurance Payers 16
- 1.8 The Revenue Cycle 18
- 1.9 Achieving Success 23
- 1.10 Moving Ahead 26

Chapter Review 27

## Chapter 2

Electronic Health Records, HIPAA, and HITECH: Sharing and Protecting Patients' Health Information 33

- 2.1 Medical Record Documentation: Electronic Health Records 34
- 2.2 Healthcare Regulation: HIPAA, HITECH, and ACA 40
- 2.3 Covered Entities and Business Associates 43
- 2.4 HIPAA Privacy Rule 45
- 2.5 HIPAA Security Rule 53
- 2.6 HITECH Breach Notification Rule 54
- 2.7 HIPAA Electronic Health Care Transactions and Code Sets 56
- 2.8 Omnibus Rule and Enforcement 58
- 2.9 Fraud and Abuse Regulations 60
- 2.10 Compliance Plans 61

Chapter Review 63

### Chapter 3

# Patient Encounters and Billing Information 71

- 3.1 New Versus Established Patients 72
- 3.2 Information for New Patients 72
- 3.3 Information for Established Patients 81
- 3.4 Verifying Patient Eligibility for Insurance Benefits 83
- 3.5 Determining Preauthorization and Referral Requirements 86
- 3.6 Determining the Primary Insurance 89
- 3.7 Working with Encounter Forms 91



3.8 Understanding Time-of-Service (TOS) Payments 93

3.9 Calculating TOS Payments 95

Chapter Review 99

# Part 2 CLAIM CODING

105

C	ha	'n	te	r	4
	ПС	ıР	LC	7	7

Diagnostic Coding: ICD-10-CM 106

- 4.1 ICD-10-CM 107
- 4.2 Organization of ICD-10-CM 108
- 4.3 The Alphabetic Index 109
- 4.4 The Tabular List 112
- 4.5 ICD-10-CM Official Guidelines for Coding and Reporting 116
- 4.6 Overview of ICD-10-CM Chapters 123
- 4.7 Coding Steps 127
- 4.8 ICD-10-CM and ICD-9-CM 129

Chapter Review 131

### **Chapter 5**

### Procedural Coding: CPT and HCPCS 137

- 5.1 Current Procedural Terminology (CPT), Fourth Edition 138
- 5.2 Organization 140
- 5.3 Format and Symbols 144
- 5.4 CPT Modifiers 147
- 5.5 Coding Steps 150
- 5.6 Evaluation and Management Codes 152
- 5.7 Anesthesia Codes 165

- 5.8 Surgery Codes 167
- 5.9 Radiology Codes 171
- 5.10 Pathology and Laboratory Codes 173
- 5.11 Medicine Codes 174
- 5.12 Categories II and III Codes 175
- 5.13 HCPCS 176

Chapter Review 183

### **Chapter 6**

### Visit Charges and Compliant Billing 189

- 6.1 Compliant Billing 190
- 6.2 Knowledge of Billing Rules 190
- 6.3 Compliance Errors 194
- 6.4 Strategies for Compliance 195
- 6.5 Audits 198
- 6.6 Physician Fees 201
- 6.7 Payer Fee Schedules 202
- 6.8 Calculating RBRVS Payments 204
- 6.9 Fee-Based Payment Methods 205
- 6.10 Capitation 208
- 6.11 Collecting Time of Service (TOS) Payments and Checking Out Patients 209

Chapter Review 211





### **Chapter 7**

# Healthcare Claim Preparation and Transmission 218

- 7.1 Introduction to Healthcare Claims 219
- 7.2 Completing the CMS-1500 Claim: Patient Information Section 220
- 7.3 Types of Providers 227
- 7.4 Completing the CMS-1500 Claim: Physician/ Supplier Information Section 227
- 7.5 The HIPAA 837P Claim 240
- 7.6 Completing the HIPAA 837P Claim 243
- 7.7 Checking Claims Before Transmission 249
- 7.8 Clearinghouses and Claim Transmission 250 Chapter Review 252

### **Chapter 8**

### Private Payers/ACA Plans 259

- 8.1 Group Health Plans 260
- 8.2 Types of Private Payers 263
- 8.3 Consumer-Driven Health Plans 267
- 8.4 Major Private Payers and the BlueCross BlueShield Association 270
- 8.5 Affordable Care Act (ACA) Plans 273
- 8.6 Participation Contracts 275
- 8.7 Interpreting Compensation and Billing Guidelines 279
- 8.8 Private Payer Billing Management: Plan Summary Grids 285
- 8.9 Preparing Correct Claims 287
- 8.10 Capitation Management 293

Chapter Review 294

### **Chapter 9**

### Medicare 302

- 9.1 Eligibility for Medicare 303
- 9.2 The Medicare Program 303
- 9.3 Medicare Coverage and Benefits 305
- 9.4 Medicare Participating Providers 310
- 9.5 Nonparticipating Providers 316
- 9.6 Original Medicare Plan 319

- 9.7 Medicare Advantage Plans 320
- 9.8 Additional Coverage Options 322
- 9.9 Medicare Billing and Compliance 323
- 9.10 Preparing Primary Medicare Claims 328

Chapter Review 331

### **Chapter 10**

### Medicaid 338

- 10.1 The Medicaid Program 339
- 10.2 Eligibility 339
- 10.3 State Programs 342
- 10.4 Medicaid Enrollment Verification 345
- 10.5 Covered and Excluded Services 349
- 10.6 Plans and Payments 350
- 10.7 Third-Party Liability 352
- 10.8 Claim Filing and Completion Guidelines 352

Chapter Review 355

### **Chapter 11**

### TRICARE and CHAMPVA 360

- 11.1 The TRICARE Program 361
- 11.2 Provider Participation and Nonparticipation 361
- 11.3 TRICARE Prime 363
- 11.4 TRICARE Select 364
- 11.5 CHAMPVA 365
- 11.6 Filing Claims 367

Chapter Review 370

### **Chapter 12**

### Workers' Compensation and Disability/ Automotive Insurance 377

- 12.1 Federal Workers' Compensation Plans 378
- 12.2 State Workers' Compensation Plans 379
- 12.3 Workers' Compensation Terminology 381
- 12.4 Claim Process 383
- 12.5 Disability Compensation and Automotive Insurance Programs 389

Chapter Review 393



Part 4

# CLAIM FOLLOW-UP AND PAYMENT PROCESSING

401

### **Chapter 13**

Payments (RAs), Appeals, and Secondary Claims 402

- 13.1 Claim Adjudication 403
- 13.2 Monitoring Claim Status 406
- 13.3 The RA 410
- 13.4 Reviewing RAs 416
- 13.5 Procedures for Posting 417
- 13.6 Appeals 419
- 13.7 Postpayment Audits, Refunds, and Grievances 422
- 13.8 Billing Secondary Payers 423
- 13.9 The Medicare Secondary Payer (MSP) Program, Claims, and Payments 424

Chapter Review 429

### **Chapter 14**

Patient Billing and Collections 434

- 14.1 Patient Financial Responsibility 435
- 14.2 Working with Patients' Statements 438
- 14.3 The Billing Cycle 439
- 14.4 Organizing for Effective Collections 440

14.5 Collection Regulations and Procedures 442

14.6 Credit Arrangements and Payment Plans 447

14.7 Collection Agencies and Credit Reporting 449

14.8 Writing Off Uncollectible Accounts 452

14.9 Record Retention 454

Chapter Review 454

### **Chapter 15**

Primary Case Studies 458

15.1 Method of Claim Completion 459

15.2 About the Practice 459

15.3 Claim Case Studies 465

### **Chapter 16**

RA/Secondary Case Studies 495

16.1 Completing Secondary Claims 496

16.2 Handling Denied Claims 496

16.3 Processing Medicare RAs and Preparing Secondary Claims 498

16.4 Processing Commercial Payer RAs and Preparing Secondary Claims 500

16.5 Calculating Patients' Balances 502

### Part 5

### HOSPITAL SERVICES

509

### **Chapter 17**

Hospital Billing and Reimbursement 510

17.1 Healthcare Facilities: Inpatient Versus
Outpatient 511

17.2 Hospital Billing Cycle 512

17.3 Hospital Diagnosis Coding 521

17.4 Hospital Procedure Coding 523

17.5 Payers and Payment Methods 525

17.6 Claims and Follow-Up 530

Chapter Review 541

Appendix A: Place of Service Codes A-1

Appendix B: Professional Websites B-1

Appendix C: Forms C-1

**Abbreviations** AB-1

**Glossary** GL-1

Index IN-1



# Preface

# Follow the Money!

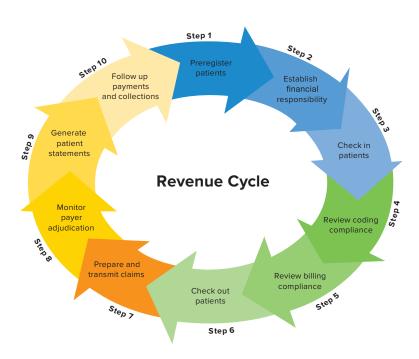
Medical insurance plays an important role in the financial well-being of every healthcare business. The regulatory environment of medical insurance is now evolving faster than ever. Changes due to healthcare reform require medical office professionals to acquire

and maintain an in-depth understanding of compliance, electronic health records, medical coding, and more.

The eighth edition of *Medical Insurance: A Revenue Cycle Process Approach* emphasizes the **revenue cycle**—ten steps that clearly identify all the components needed to successfully manage the medical insurance claims process. The cycle shows how administrative medical professionals "follow the money."

Medical insurance specialists must be familiar with the rules and guidelines of each health plan in order to submit proper documentation. This ensures that offices receive maximum, appropriate reimbursement for services provided. Without an effective administrative staff, a medical office would have no cash flow!

The following are some of the key skills covered for you and your students in *Medical Insurance*, 8e:



Skills	Coverage
Procedural	<b>Learning</b> administrative duties important in medical practices as well as how to bill both payers and patients
Communication	<b>Working</b> with physicians, patients, payers, and others using both written and oral communication
Health information management	<b>Using</b> practice management programs and electronic health records technology to manage both patient records and the billing/collections process, to electronically transmit claims, and to conduct research
Medical coding	<b>Understanding</b> the ICD-10, CPT, and HCPCS codes and their importance to correctly report patients' conditions on health insurance claims and encounter forms as well as the role medical coding plays in the claims submission process
HIPAA/HITECH	<b>Applying</b> the rules of HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health act) to ensure compliance, maximum reimbursement, and the electronic exchange of health information

Medical Insurance is available with McGraw-Hill Education's revolutionary adaptive learning technology, McGraw-Hill SmartBook®! You can study smarter, spending your valuable time on topics you don't know and less time on the topics you have already mastered. Succeed with SmartBook. . . . Join the learning revolution and achieve the success you deserve today!

# Organization of Medical Insurance, 8e

An overview of the book's parts, including how they relate to the steps of the revenue cycle, follows:

Part	Coverage
1: Working with Medical Insurance and Billing	Covers Steps 1 through 3 of the revenue cycle by introducing the major types of medical insurance, payers, and regulators, as well as the steps of the cycle. Also covers HIPAA/HITECH Privacy, Security, and Electronic Health Care Transactions/Code Sets/Breach Notification rules.
2: Claim Coding	Covers Steps 4 through 6 of the revenue cycle while building skills in correct coding procedures, using coding references, and complying with proper linkage guidelines.
3: Claims	Covers Step 7 of the revenue cycle by discussing the general procedures for calculating reimbursement, how to bill compliantly, and preparing and transmitting claims.
4: Claim Follow-Up and Payment Processing	Covers Steps 8 through 10 of the revenue cycle by describing the major third-party private and government-sponsored payers' procedures and regulations along with specific filing guidelines. Also explains how to handle payments from payers, follow up and appeal claims, and correctly bill and collect from patients. This part includes two case studies chapters that provide exercises to reinforce knowledge of completing primary/secondary claims, processing payments from payers, and handling patients' accounts. The case studies in Chapter 15 can be completed using Connect for simulated exercises. The case studies in Chapter 16 can be completed using the CMS-1500 form.
5: Hospital Services	Provides necessary background in hospital billing, coding, and payment methods.

# **New to the Eighth Edition**

Medical Insurance is designed around the revenue cycle with each part of the book dedicated to a section of the cycle followed by case studies to apply the skills discussed in each section. The revenue cycle now follows the overall medical documentation and revenue cycle used in practice management/electronic health records environments and applications.

Medical Insurance offers several options for completing the case studies at the end of Chapters 8-12 and throughout Chapter 15:

- Paper Claim Form: If you are gaining experience by completing a paper CMS-1500 claim form, use the blank form supplied to you (from the back of Medical Insurance) and follow the instructions in the text chapter that is appropriate for the particular payer to fill in the form by hand.
- · Connect Simulations: The ability to understand and to use Electronic Health Records (EHR) systems are critical job skills and competencies required for employment in a Medical Office or Hospital. In the past, teaching students the hows and whys of using an EHR has been challenging. Live software solutions require complex installation and support, and often don't translate well into the classroom. Simulated educational solutions often fall short in giving students the realistic experience of working in real world scenarios.

McGraw-Hill Education is proud to introduce EHRclinic, the educational EHR solution that provides the best of both worlds, both the experience of working in a



live, modern EHR application, along with the convenience and reliability of simulated educational solutions.

**EHRclinic** is integrated into **Connect**, **McGraw-Hill's** digital teaching and learning environment that saves students and instructors time while improving performance over a variety of critical outcomes.

For *Medical Insurance*, Connect provides simulated, auto-graded exercises in multiple modes to allow the student to use EHRclinic to complete the claims. If assigned this option, students should read the User Guide at www.mhhe.com/valerius as the first step, and then follow the instructions with each chapter's case studies. Note: some data may be prepopulated to allow students to focus on the key tasks of each exercise.

- Connect CMS-1500 Form Exercises: Another way to complete the claims exercises
  is by using the CMS-1500 form exercises in Connect if directed by your instructor.
  These exercises allow you to complete the necessary fields of the form in an autograded environment.
- Please note that starting with this edition, we will no longer be offering live Medisoft<sup>®</sup>
  or Medisoft simulations as part of the options.

### Key content features include the following.

#### Pedagogy

- Learning Outcomes reflect the range of difficulty levels to teach and assess critical thinking about medical insurance and coding concepts and continue to reflect the revised version of Bloom's Taxonomy.
- Objective end-of-chapter questions cover all Learning Outcomes.

### • HIPAA-Related Updates

- 2018 ICD-10-CM and CPT/HCPCS codes are included.
- The new Notice of Privacy Practices (NPP) that addresses disclosures in compliance with HITECH is illustrated.

### • Key Chapter Changes

- Chapter 1: New: Thinking It Through 1.7. Revised: Thinking It Through 1.2. Updated: statistics and data in Figures 1.1 and 1.4; Compliance Guideline on ICD-10-CM implementation.
- Chapter 2: New: two HIPAA/HITECH Tips on Texting and Plans Mandated; PHI on the cloud. Updated: four WWW features on HHS, Medical Notice of Privacy Practices, HHS Breach Notifications, and CMS HIPAA Enforcement. Deleted: old Figures 2.1, 2.2, and 2.6; information on the National Health Information Network.
- Chapter 3: Deleted: old Figure 3.7.
- Chapter 4: *Updated:* all ICD-10-CM codes and conventions for 2018; Figures 4.1 and 4.3; Case 4.1 in Applying Your Knowledge. *Deleted:* key term ICD-9-CM.
- Chapter 5: New: Billing Tips on Category III Code Sunsets and Revised Guidelines Coming; symbol for telemedicine. Updated: all CPT codes, conventions, and modifiers for 2018; WWW features on CPT Updates, AMA Vaccine Code Updates, and Category II and III Updates; all cases in Applying Your Knowledge; Tables 5.2, 5.3, and 5.6; structure of E/M section. Deleted: symbol for moderate sedation.
- Chapter 6: New: image for Figure 6.3. Revised: Figures 6.1 and 6.2. Updated: Case 6.1 in Applying Your Knowledge.
- Chapter 7: New: key terms 5010A1 version and Healthcare Provider Taxonomy Code (HPTC); text for 5010A1 Version and the CMS-1500. Revised: Figure 7.1; art in Cases 7.2, 7.3, and 7.4. Updated: all conventions for completing the CMS-1500 and all Item Numbers; WWW features on POS Codes, Current Taxonomy Code Set, and All Administrative Code Sets for HIPAA Transactions. Deleted: old Figures 7.2, 7.3, 7.4, 7.5, 7.6, and 7.8; old Table 7.1; Billing Tip on How Many Pointers?

- **Chapter 8:** *New:* item in Thinking It Through 8.9. *Revised:* Figures 8.5, 8.7, 8.9, and 8.10; Case 8.4 introduction and art. *Updated:* high-deductible health plan deductibles; out-of-pocket limits for metal plans in section 8.5.
- Chapter 9: New: key terms Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare Beneficiary Identifier (MBI), Quality Payment Program (QPP); Figure 9.1; WWW features on New Medicare Card Information and QPP; Medicare coverage text in section 9.3; Medicare incentives text in section 9.4. Revised: WWW feature on Beneficiary Preventive Services; Figures 9.7 and 9.9; Applying Your Knowledge introduction; Cases 9.1, 9.2, and 9.3. Updated: Billing Tips on Medicare Part A and Part B; WWW features on Medicare FFS Provider Web Pages Bookmark and Medicare Physician Fee Schedule; Thinking It Through 9.8. Deleted: key terms Medicare health insurance claim number (HICN), Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM); WWW feature on MPFS Online.
- Chapter 10: New: Thinking It Through 10.7. Revised: Figure 10.5; Applying Your Knowledge introduction; Cases 10.1 and 10.2. Updated: Medicaid info in intro; Medicaid changes in section 10.1; WWW feature on CHIP; websites in Table 10.1; covered services in section 10.5.
- Chapter 11: New: key terms Prime Service Area, TRICARE For Life, TRICARE Select; section 11.3 on TRICARE Prime; section 11.4 on TRICARE Select; Figure 11.1. Revised: Figure 11.2; Review Questions section; Applying Your Knowledge Introduction; Cases 11.1, 11.2, and 11.3. Updated: TRICARE regions in section 11.6. Deleted: key terms catchment area, nonavailability statement (NAS), TRICARE Extra, TRICARE Prime Remote, TRICARE Reserve Select, TRICARE Standard, TRICARE Young Adult (TYA); old Figures 11.1, 11.2, 11.3; Compliance Guideline on Preauthorization.
- Chapter 12: Revised: Figure 12.2; Applying Your Knowledge introduction; Cases 12.1 and 12.2.
- Chapter 13: Revised: Figures 13.1 and 13.8; Thinking It Through 13.3 and 13.5. Updated: key term claim adjustment group code (CAGC); Medicare appeals costs in section 13.6. Deleted: question D in Case 13.2.
- Chapter 14: Revised: chart in section 14.2; Thinking It Through 14.2; Figures 14.3 and 14.4. *Deleted:* old Figures 14.3a, 14.3b, and 14.3c; relating statements to the PMP section.
- Chapter 15: Updated: all CPT codes, conventions, and modifiers for 2018; Updated:
  Patient Account Number section so students no longer assign patient chart numbers; Updated: Dates for each case study.
- Chapter 16: Updated: Dates for each case study.
- Chapter 17: New: Figure 17.3; WWW feature on Medicare Secondary Payer Questionnaire; NUBC information on electronic claim submission. *Updated:* Compliance Guideline What Determines the Correct Code Set for Hospital Coding?

For a detailed transition guide between the seventh and eighth editions, visit the Instructor Resources in *Connect*.

### Workbook for Use with Medical Insurance: A Revenue Cycle Process Approach, Eighth Edition (1-260-48914-0, 978-1-260-48914-9)

The Workbook for Use with Medical Insurance has excellent material for reinforcing the text content, applying concepts, and extending understanding. It combines the best features of a workbook and a study guide. Each workbook chapter enhances the text's strong pedagogy through:

- · Assisted outlining-reinforces the chapter's key points
- Key terms-objective questions
- Critical thinking-questions that stimulate process understanding
- Guided web activities—exercises to build skill in locating and then evaluating information on the Internet
- Application of concepts—reinforcements and extensions for abstracting insurance information, calculating insurance math, and using insurance terms

The workbook matches the text chapter by chapter. It reinforces, applies, and extends the text to enhance the learning process.

# Medical Coding Workbook for Physician Practices and 2018–2019 Edition (1-259-63002-1, 978-1-259-63002-6)

The Medical Coding Workbook provides practice and instruction in coding and using compliance skills. Because medical insurance specialists verify diagnosis and procedure codes and use them to report physicians' services, a fundamental understanding of coding principles and guidelines is the basis for correct claims. The coding workbook reinforces and enhances skill development by applying the coding principles introduced in Medical Insurance, 8e, and extending knowledge through additional coding guidelines, examples, and compliance tips. It offers more than seventy-five case studies that simulate real-world application. Also included are inpatient scenarios for coding that require compliance with ICD-10-CM Official Guidelines for Coding and Reporting sequencing rule as explained in Chapter 17 of the text.

Students—study more efficiently, retain more and achieve better outcomes. Instructors—focus on what you love—teaching.

# SUCCESSFUL SEMESTERS INCLUDE CONNECT

# FOR INSTRUCTORS

### You're in the driver's seat.

Want to build your own course? No problem. Prefer to use our turnkey, prebuilt course? Easy. Want to make changes throughout the semester? Sure. And you'll save time with Connect's auto-grading too.

65%
Less Time

Grading

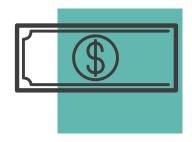


# They'll thank you for it.

Adaptive study resources like SmartBook® help your students be better prepared in less time. You can transform your class time from dull definitions to dynamic debates. Hear from your peers about the benefits of Connect at www.mheducation.com/highered/connect

# Make it simple, make it affordable.

Connect makes it easy with seamless integration using any of the major Learning Management Systems—Blackboard®, Canvas, and D2L, among others—to let you organize your course in one convenient location. Give your students access to digital materials at a discount with our inclusive access program. Ask your McGraw-Hill representative for more information.





# Solutions for your challenges.

A product isn't a solution. Real solutions are affordable, reliable, and come with training and ongoing support when you need it and how you want it. Our Customer Experience Group can also help you troubleshoot tech problems—although Connect's 99% uptime means you might not need to call them. See for yourself at **status.** 

mheducation.com

# FOR STUDENTS

# Effective, efficient studying.

Connect helps you be more productive with your study time and get better grades using tools like SmartBook, which highlights key concepts and creates a personalized study plan. Connect sets you up for success, so you walk into class with confidence and walk out with better grades.



©Shutterstock/wavebreakmedia

I really liked this app—it made it easy to study when you don't have your text-book in front of you.

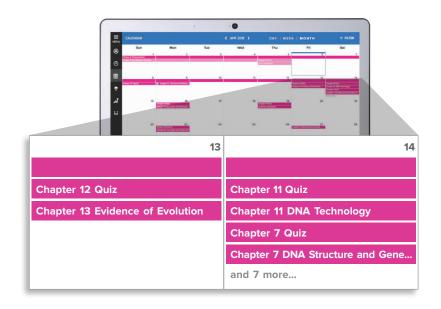
- Jordan Cunningham, Eastern Washington University

# Study anytime, anywhere.

Download the free ReadAnywhere app and access your online eBook when it's convenient, even if you're offline. And since the app automatically syncs with your eBook in Connect, all of your notes are available every time you open it. Find out more at www.mheducation.com/readanywhere

# No surprises.

The Connect Calendar and Reports tools keep you on track with the work you need to get done and your assignment scores. Life gets busy; Connect tools help you keep learning through it all.





# Learning for everyone.

McGraw-Hill works directly with Accessibility Services Departments and faculty to meet the learning needs of all students. Please contact your Accessibility Services office and ask them to email accessibility@mheducation.com, or visit www.mheducation.com/about/accessibility.html for more information.

# CONNECT FOR MEDICAL INSURANCE, 8E

McGraw-Hill Connect for Medical Insurance, 8e will include:

- All end-of-section questions
- · All end-of-chapter questions
- · Interactive exercises, such as matching, sequencing, and labeling activities
- Testbank questions
- Simulated CMS-1500 exercises for Chapters 8-12 and 15
- Simulated EHRclinic exercises for Chapters 8-12 and 15

### **INSTRUCTORS' RESOURCES**

You can rely on the following materials to help you and your students work through the material in the book; all are available in the Instructor Resources under the library tab in *Connect* (available only to instructors who are logged in to *Connect*).

Supplement	Features
Instructor's Manual (organized by Learning Outcomes)	Lesson Plans     Answer Keys for all exercises
PowerPoint Presentations (organized by Learning Outcomes)	<ul><li>Key Terms</li><li>Key Concepts</li><li>Accessible</li></ul>
Electronic Testbank	<ul> <li>Computerized and Connect</li> <li>Word Version</li> <li>Questions tagged for Learning Outcomes, Level of Difficulty, Level of Bloom's Taxonomy, Feedback, ABHES, CAAHEP, CAHIIM, and Estimated Time of Completion.</li> </ul>
Tools to Plan Course	<ul> <li>Correlations of the Learning Outcomes to Accrediting Bodies such as ABHES, CAAHEP, and CAHIIM</li> <li>Sample Syllabi</li> <li>Conversion Guide between seventh and eighth editions</li> <li>Asset Map—recap of the key instructor resources as well as information on the content available through Connect</li> </ul>
EHRclinic Simulated Exercises Resources	Implementation Guide     Technical Support Information     Steps for students completing the simulated exercises in Connect
CMS-1500 and UB-04 Forms	PDFs of both forms

Want to learn more about this product? Attend one of our online webinars. To learn more about them, please contact your McGraw-Hill sales representative. To find your McGraw-Hill representative, go to www.mheducation.com and click "Support & Contact," select "Higher Education," and then click on "Find Your Higher Ed Sales Rep."

Need Help? Contact the McGraw-Hill Education Customer Experience Group (CXG)

Visit the CXG website at www.mhhe.com/support. Browse our frequently asked questions (FAQs) and product documentation and/or contact a CXG representative.

# Acknowledgments

Suggestions have been received from faculty and students throughout the country. This is vital feedback that is relied on with each edition. Each person who has offered comments and suggestions has our thanks. The efforts of many people are needed to develop and improve a product. Among these people are the reviewers and consultants who point out areas of concern, cite areas of strength, and

# **Market Surveys**

make recommendations for change.

Multiple instructors participated in a survey to help guide the revision of the book and related materials and/or a survey on materials for Connect.

Marie A. Auclair, MSW, CCA, CPC

Springfield Technical Community College

Sharon Breeding, MAE

Bluegrass Community and Technical College

Angela M. Chisley, AHI, CMA, RMA

College of Southern Maryland

Regina B. Clawson, MBA

York Technical College

Toni L. Clough, MBA

Umpqua Community College

Denise Cross, BHSA, CMA (AAMA)

Jackson College

Laura A. Diggle, MS, CMA (AAMA)

Ivy Tech Community College

Mary Douglas, CPC

Jackson College

Savanna Garrity, CPC, MPA Madisonville Community

College

Dan Guerra

Community Business College

Sarah Jordan, AAS in Accounting, BSBA, MHA, CEHRS, CBCS, CMAA

South Piedmont Community College

Keita Kornegay, CMAA, CEHRS, CBCS

Wilson Community College

Julie Ledbetter, B.S., CMA (AAMA), CMRS, CPC

Sinclair Community College

Breanne Marshburn, MHA, CPhT

Randolph Community College

Michelle C. McCranie, AAS,

CPhT, CMA

Ogeechee Technical College

Jillian J. McDonald, BS, RMA (AMT), EMT (NREMT), CPT

(NPA)

Goodwin College

Tracey A. McKethan, MBA,

RHIA, CCA

Springfield Technical

Community College

Tanya Ocampo, RHIT

Meridian Community College

Paula Phelps, MBA, RMA

Cowley College

Karen S. Saba, CPC, CPC-I

Spokane Community College

Vicki L. Schuhmacher, BSM, CMA (AAMA)

Ivy Tech Community College

Janet Seggern, M.Ed.,

M.S., CCA

Lehigh Carbon Community College

Julia Steff, RHIA, CPHQ, CPHI,

CCS, CCS-P

Palm Beach State College

Rebecca L. Stimpson, MS

Carteret Community College

Ronnie Turnmire, BBA (HCM), CPC, CPB, CPPM, CPC-I

ATA College

Karen Warner, CPC

Carroll Community College

Kari Williams, RMA (AMT),

BS, DC

Front Range Community

College

Dana Woods, BS, CMA (AAMA)

 $Southwestern\ Illinois\ College$ 

Bettie Wright, MBA, CMA

(AAMA)

Umpqua Community College

Cindy Zumbrun, MEd, RHIT, CCS-P

Allegany College of Maryland

# **Technical Editing/Accuracy Panel**

A panel of instructors completed a technical edit and review of all content in the book and workbook page proofs to verify their accuracy.

Cherelle Aguigui, MS, RHIA American College for Medical Careers

Julie Alles-Grice, DHA, RHIA Grand Valley State University

Angela M. Chisley, AHI, CMA, RMA

Gwinnett College

Laura A. Diggle, MS, CMA (AAMA)

Ivy Tech Community College

Savanna Garrity, MPA, CPC Madisonville Community

College

Susan Holler, MSEd, CPC, CCS-P, CMRS

Bryant & Stratton College

Janis A. Klawitter, AS, CPC, CPB, CPC-I, Provider Audits/

Analytics

Bakersfield Family Medical Center

Beverly Marquez, M.S., RHIA State Fair Community

College

Jillian McDonald BS,

RMA(AMT), EMT, CPT(NPA)

Goodwin College

Janna Pacey, MSCTE, RHIA Grand Valley State University

Karen S. Saba, CPC, CPC-I Spokane Community College

Audrey J. Theisen, BS, RHIA,

MSCIS, PhD

Front Range Community College

Sharon Turner, MS, CMC, CMIS, CHI, CBS, CEHRS, CMAA

Brookhaven College

Erica Wilson, MS, MHA, RHIA,

CPC

Southern Regional Technical

College

# **Digital Products**

Several instructors helped author and review the digital content for Connect, SmartBook, and more!

Julie Alles-Grice, DHA, RHIA

Grand Valley State University

Tammy L. Burnette, PhD

Tyler Junior College

Phyllis A. Davis, BS, CCS,

CPC, CPCP, CPCO, CPCI Ultimate Medical Academy,

Rasmussen College

Denise DeDeaux, MBA

Fayetteville Technical

Community College

Laura A. Diggle, MS, CMA (AAMA)

Ivy Tech Community College

Mary Douglas, CPC

Jackson College

Amy L. Ensign, BHSA, CMA (AAMA), RMA (AMT)

Baker College of Clinton

Township

Savanna Garrity, MPA, CPC

Madisonville Community College

Larena Grieshaber, CPC Northeast State Community

College
Judith Hurtt, MEd

East Central Community College

Shalena Jarvis, RHIT, CCS

Janis A. Klawitter, AS, CPC, CPB, CPC-I, Provider Audits/

Analytics

Bakersfield Family Medical Center

Keita Kornegay, CMAA,

CEHRS, CBCS

Wilson Community College

Lynnae Lockett, RN, RMA (AMT), CMRS, MSN/Ed

(AWII), CWIKS, WISH/Lu

Bryant & Stratton College

Tracey A. McKethan, MBA,

RHIA, CCA

Springfield Technical Community College Janna Pacey, MSCTE, RHIA

Grand Valley State University

Shauna Phillips, RMA, AHI,

CCMA, CMAA, CPT PIMA Medical Institute

Patricia A. Saccone, MA, RHIA,

CDIP, CCS-P, CPB

Waubonsee Community

College

Audrey J. Theisen, BS, RHIA,

MSCIS, PhD

Front Range Community College

Sharon Turner, MS, CMC, CMIS,

CHI, CBS, CEHRS, CMAA

Brookhaven College

Erica Wilson, MS, MHA, RHIA,

CPC

Southern Regional Technical

College

# **Acknowledgments from the Authors**

To the students and instructors who use this book, your feedback and suggestions have made it a better learning tool for all.

Thank you to Amy Blochowiak for continuing to lead the charge on the digital offerings available with the book.

Hats off to the Customer Experience Group at McGraw-Hill for providing outstanding technical assistance to students and instructors. Thank you to Michelle Flomenhoft for her insistence on the best possible product. Thank you to Yvonne Lloyd for her help on the digital front. The content production staff was also outstanding, which Becca Gill, project manager, implemented through the production process. Thanks also to Egzon Shaqiri, designer, Sue Culbertson, buyer, and to Brent dela Cruz and Karen Jozefowicz, assessment and media project managers.

# Part 1

# WORKING WITH MEDICAL INSURANCE AND BILLING

### chapter 1

Introduction to the Revenue Cycle

### chapter 2

Electronic Health Records, HIPAA, and HITECH: Sharing and Protecting Patients' Health Information

### chapter 3

Patient Encounters and Billing Information



# INTRODUCTION TO THE REVENUE CYCLE

### KEY TERMS

accounts payable (AP)

accounts receivable (AR)

adjudication

benefits

capitation

cash flow

certification

coinsurance

compliance

consumer-driven health plan (CDHP)

copayment

covered services

deductible

diagnosis code

electronic health record (EHR)

ethics

etiquette

excluded services

fee-for-service

healthcare claim

health information technology (HIT)

health maintenance organization (HMO)

health plan

indemnity plan

managed care

managed care organization (MCO)

medical coder

medical insurance

medical insurance specialist

medical necessity

network

noncovered services

out-of-network

out-of-pocket

participation

patient ledger

payer

per member per month (PMPM)

PM/EHR

policyholder

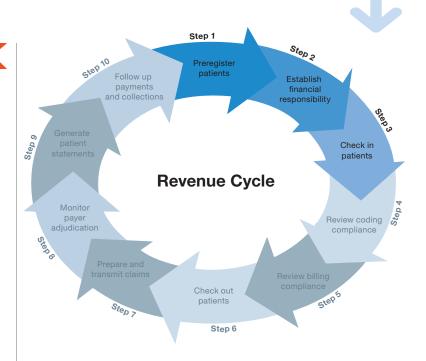
practice management program (PMP)

preauthorization

preferred provider organization (PPO)

premium

Continued



# Learning Outcomes

### After studying this chapter, you should be able to:

- **1.1** Identify three ways that medical insurance specialists help ensure the financial success of physician practices.
- **1.2** Differentiate between covered and noncovered services under medical insurance policies.
- **1.3** Compare indemnity and managed care approaches to health plan organization.
- **1.4** Discuss three examples of cost containment employed by health maintenance organizations.
- **1.5** Explain how a preferred provider organization works.
- 1.6 Describe the two elements that are combined in a consumerdriven health plan.
- **1.7** Define the three major types of medical insurance payers.
- **1.8** Explain the ten steps in the revenue cycle.
- 1.9 Analyze how professionalism, ethics, and etiquette contribute to career success.
- **1.10** Evaluate the importance of professional certification for career advancement.

preventive medical services primary care physician (PCP) procedure code

professionalism provider referral revenue cycle

schedule of benefits self-funded (self-insured) health plan third-party payer

Patients who come to physicians' practices for medical care are obligated to pay for the services they receive. Some patients pay these costs themselves, while others have medical insurance to help them cover medical expenses. Administrative staff members help collect the maximum appropriate payments by handling patients' financial arrangements, billing insurance companies, and processing payments to ensure both top-quality service and profitable operation.

# Working in the Medical Insurance Field

A major trend in the trillion-dollar healthcare industry is a shift of payment responsibility from employers and insurance companies to patients. To remain profitable, as this trend accelerates, physicians must carefully manage the business side of their practices. Knowledgeable medical office employees are in demand to help.

### **Administrative Complexity Increases Career Opportunities**

The healthcare industry offers many rewarding career paths for well-qualified employees. Providers must compete in a complex environment of various health plans, managed care contracts, and federal and state regulations. The average practice works with nearly twenty different health plans, and some with more than eighty of them. Employment in positions that help providers handle these demands is growing, as are opportunities for career development. According to The Physician's Advisory, a healthcare journal:

"... good, experienced billing/coding specialists are in short supply; to retain good workers in these very important positions, going up in salary is a bargain compared to risking their going to another employer . . . the work of insurance specialists is an increasingly complex job."

Figure 1.1 describes the rapidly growing employment possibilities in the healthcare administrative area.

### **Helping to Ensure Financial Success**

Medical insurance specialists' effective and efficient work is critical for the satisfaction of the patients—the physician's customers—and for the financial success of the practice. To maintain a regular cash flow-the movement of monies into or out of a businessspecific tasks must be completed on a regular schedule before, during, and after a patient visit. Managing cash flow means making sure that sufficient monies flow into the practice from patients and insurance companies paying for medical services, referred to as accounts receivable (AR), to pay the practice's operating expenses, such as for rent, salaries, supplies, and insurance-called accounts payable (AP).

Tracking AR and AP is an accounting job. Accounting, often referred to as "the language of business," is a financial information system that records, classifies, reports on, and interprets financial data. Its purpose is to analyze the financial condition of a business following generally accepted accounting principles (GAAP). The accountant of the practice sets up accounts such as AR, AP, and patient accounts for all aspects of running

cash flow movement of monies into or out of a business

accounts receivable (AR) monies owed to a medical practice

accounts payable (AP) a practice's operating expenses

# U.S. Department of Labor Bureau of Labor Statistics

### **Occupational Outlook Handbook**

#### **Medical Records and Health Information Technicians**

- Employment of medical records and health information technicians is projected to grow faster than the average for all occupations.
- Job prospects for those with a certification in health information will be best.
   As electronic health record (EHR) systems continue to become more common,
   technicians with computer skills will be needed to use them. Employment of
   medical records and health information technicians is expected to grow faster than
   the average for all occupations through 2026, due to an aging national population
   and rapid growth in the number of medical tests, treatments, and procedures
   that will be increasingly scrutinized by third-party payers, regulators, courts,
   and consumers.
- Most technicians will be employed in hospitals, but job growth will be faster in
  offices and clinics of physicians, nursing homes, and home health agencies.
  Technicians who achieve additional qualifications through professional
  organizations or who obtain a bachelor's or master's degree will be particularly
  successful.

#### **Medical Assistants**

- Employment of medical assistants is expected to grow much faster than the average for all occupations through 2026 as the health services industry expands due to technological advances in medicine and a growing and aging population. It is one of the fastest-growing occupations.
- Employment growth will be driven by the increase in the number of group practices, clinics, and other healthcare facilities that need a high proportion of support personnel, particularly the flexible medical assistant who can handle both administrative and clinical duties so that physicians can see more patients. Medical assistants work primarily in outpatient settings, where much faster than average growth is expected. As more and more physicians' practices switch to EHRs, medical assistants' job responsibilities will continue to change. They will need to become familiar with EHR computer software, including maintaining EHR security and analyzing electronic data, to improve healthcare information.
- Job prospects should be best for medical assistants with formal training or experience, particularly those with certification. The medical assistants who are expected to excel are those best fit to deal with the public through a courteous, pleasant manner and a professional demeanor.

### **Medical Administrative Support**

- Growth in the health services industry will spur faster than average employment growth for medical support staff.
- Medical administrative support employees may transcribe dictation, prepare
  correspondence, and assist physicians or medical scientists with reports,
  speeches, articles, and conference proceedings. They also record simple
  medical histories, arrange for patients to be hospitalized, and order supplies.
  Most medical administrative support staff need to be familiar with insurance
  rules, billing practices, the use of EHRs, and hospital or laboratory procedures.
- As with medical records and health information technicians and medical assistants, medical administrative support employees with advanced qualifications and degrees will excel.

### **FIGURE 1.1** Employment Opportunities

the practice and then prepares financial statements that show whether the cash flow is adequate. These statements are monitored regularly to see whether revenues are sufficient or need improving.

Having adequate cash flow is the purpose of managing the **revenue cycle**, which is made up of all administrative and clinical functions which ensure that sufficient monies flow

revenue cycle all administrative and clinical functions that help capture and collect patient into the practice from patients and insurance companies paying for medical services to pay the practice's bills.

Medical insurance specialists have an important role in revenue cycle management. They help to ensure financial success by (1) carefully following procedures, (2) communicating effectively, and (3) using health information technology—medical billing software and electronic health records-to improve efficiency and contribute to better health outcomes.

### Following Procedures

Medical billing requires a set of procedures. Some procedures involve administrative duties, such as entering data and updating patients' records. Other procedures are done to comply with government regulations, such as keeping computer files secure from unauthorized viewing. In most offices, policy and procedure manuals that describe how to perform major duties are available.

For most procedures, medical insurance specialists work in teams with both licensed medical professionals and other administrative staff members. Providers include physicians and nurses as well as physician assistants (PAs), nurse-practitioners (NPs), clinical social workers, physical therapists, occupational therapists, speech therapists, audiologists, and clinical psychologists. Administrative staff may be headed by an office manager, practice manager, or practice administrator to whom medical assistants, patient services representatives or receptionists, and billing, insurance, and collections specialists report.

### Communicating

Communication skills are as important as knowing about specific forms and regulations. A pleasant tone, a friendly attitude, and a helpful manner when gathering information increase patient satisfaction. Having interpersonal skills enhances the billing and reimbursement process by establishing professional, courteous relationships with people of different backgrounds and communication styles. Effective communicators have the skill of empathy; their actions convey that they understand the feelings of others.

Equally important are effective communications with physicians, other professional staff members, and all members of the administrative team. Conversations must be brief and to the point, showing that the speaker values the provider's time. People are more likely to listen when the speaker is smiling and has an interested expression, so speakers should be aware of their facial expressions and should maintain moderate eye contact. In addition, good listening skills are important.

### Using Health Information Technology

Medical insurance specialists use health information technology (HIT)—computer hardware and software information systems that record, store, and manage patient information-in almost all physician practices.

Practice Management Programs Practice management programs (PMPs), which are accounting software used in almost all medical offices for scheduling appointments, billing, and financial record keeping, are good examples of HIT. They streamline the process of creating and following up on healthcare claims sent to payers and on bills sent to patients.

Expertise in the use of practice management programs is an important skill in the medical practice. Medical insurance specialists use them to:

- Schedule patients
- Organize patient and insurance information
- ► Collect data on patients' diagnoses and services

health information technology (HIT) computer information

systems that record, store, and manage patient information

practice management program (PMP) accounting software used for scheduling appointments, billing, and financial record keeping

- Generate, transmit, and report on the status of healthcare claims
- ▶ Record payments from insurance companies
- Generate patients' statements, post payments, and update accounts
- Create financial and productivity reports

#### Electronic Health Records

Another HIT application is rapidly becoming critical in physician practices: electronic health records, or EHRs. While patients' financial records have been electronic for more than a decade, clinical records—the information about a patient's health entered by doctors, nurses, and other healthcare professionals—until recently, have been stored in paper charts. An electronic health record (EHR) is a computerized lifelong healthcare record for an individual that incorporates data from all sources that provide treatment for the individual. Note that EHRs are not the same as electronic medical records, or EMRs, which are a single provider's records of patients.

EHR systems are set up to gather patients' clinical information using the computer rather than paper. Most EHR systems are designed to exchange information with-to "talk" to—the PMP and to eliminate the need for many paper forms. Electronic health record systems are discussed further in the chapter on EHRs, Health Insurance Portability and Accountability Act (HIPAA), and Health Information Technology for Economic and Clinical Health (HITECH) Act.

**PM/EHRs** Some software programs combine both a PMP and an EHR in a single product called an integrated PM/EHR. Data entered in either the PMP or the EHR can be used in all applications, such as scheduling, billing, and clinical care. For example, if a receptionist enters basic information about a patient in the electronic health record during the patient's first visit to the practice, those data are available for the medical insurance specialist to use in the billing program. Facts such as the patient's identifying information, type of health insurance, and previous healthcare records must be entered only once rather than in both programs. PM/EHRs greatly improve administrative efficiency.

### A Note of Caution: What Health Information Technology Cannot Do

Although computers increase efficiency and reduce errors, they are not more accurate than the individual who is entering the data. If people make mistakes while entering data, the information the computer produces will be incorrect. Computers are very precise and very unforgiving. While the human brain knows that flu is short for influenza, the computer regards them as two distinct conditions. If a computer user accidentally enters a name as ORourke instead of O'Rourke, a human might know what is meant; the computer does not. It might respond with the message "No such patient exists in the database."

### THINKING IT THROUGH 1.1

1. In your opinion, will employment opportunities for medical insurance specialists in physician practices continue to grow?

electronic health record (EHR) computerized lifelong healthcare record for an individual that incorporates data from all sources

PM/EHR software program that combines both a PMP and an EHR into a single product

medical insurance a written policy stating the terms of an agreement between a policyholder and a health plan

policyholder person who buys an insurance plan

health plan individual or group plan that provides or pays for medical care



### 1.2 Medical Insurance Basics

Understanding how to work with the revenue cycle begins with medical insurance basics. Medical insurance, which is also known as health insurance, is a written policy that states the terms of an agreement between a policyholder-an individual-and a health plan—an insurance company. The policyholder (also called the insured, the member, or the subscriber) makes payments of a specified amount of money. In exchange, the health plan provides benefits-defined by the America's Health Insurance Plans (AHIP) as payments for covered medical services—for a specific period of time. Because they pay for medical expenses, health plans are often referred to as payers.

benefits health plan payments for covered medical services

payer health plan or program

### **BILLING TIP**

### **Third-Party Payers**

There are actually three participants in the medical insurance relationship. The patient (policyholder) is the first party, and the physician is the second party. Legally, a patient-physician contract is created when a physician agrees to treat a patient who is seeking medical services. Through this unwritten contract, the patient is legally responsible for paying for services. The patient may have a policy with a health plan, the third party, which agrees to carry some of the risk of paying for those services and therefore is called a **third-party payer**.

Health plans create a variety of insurance products that offer different levels of coverage for various prices. In each product, they must manage the risk that some individuals they insure will need very expensive medical services. They do that by spreading that risk among many policyholders.

third-party payer private or government organization that insures or pays for healthcare on behalf of beneficiaries

### **Healthcare Benefits**

The medical insurance policy contains a schedule of benefits that summarizes the payments that may be made for medically necessary medical services that policyholders receive. The payer's definition of medical necessity is the key to coverage and payment. A medically necessary service is reasonable and is consistent with generally accepted professional medical standards for the diagnosis or treatment of disease, illness, or injury.

Payers scrutinize the need for medical procedures, examining each bill to make sure that it meets their medical necessity guidelines. The provider of the service must also meet the payer's professional standards. Providers include physicians, nurse-practitioners, physician assistants, therapists, hospitals, laboratories, long-term care facilities, and suppliers such as pharmacies and medical supply companies.

#### Covered Services

Covered services are listed on the schedule of benefits. These services may include primary care, emergency care, medical specialists' services, and surgery. Coverage of some services is mandated by state or federal law; others are optional. Some policies provide benefits only for loss resulting from illnesses or diseases, while others also cover accidents or injuries. Many health plans also cover preventive medical services, such as annual physical examinations, pediatric and adolescent immunizations, prenatal care, and routine screening procedures such as mammograms.

Not all services that are covered have the same benefits. A policy may pay less of the charges for specialty care than for primary care, for example. Many services are also limited in frequency. A payer may cover just three physical therapy treatments for a condition or a certain screening test every five years, not every year.

### schedule of benefits list of medical expenses covered by a health plan

medical necessity payment criterion that requires medical treatments to be appropriate and provided in accordance with generally accepted standards

provider person or entity that supplies medical or health services and bills for, or is paid for, the services in the normal course of business

covered services medical procedures and treatments that are included as benefits in a health plan

preventive medical services care provided to keep patients healthy or prevent illness

### Noncovered Services

The medical insurance policy also describes noncovered services—those for which it does not pay. Such excluded services or exclusions may include any of the following:

- Most medical policies do not cover dental services, eye examinations or eyeglasses, employment-related injuries, cosmetic procedures, or experimental or investigational procedures.
- ▶ Policies may exclude specific items such as vocational rehabilitation or surgical treatment of obesity.
- Many policies do not have prescription drug benefits.

noncovered services medical procedures that are not included in a plan's benefits

excluded services services not covered in a medical insurance contract

### Group or Individual Medical Insurance Policies

Either groups or individuals may be insured. In general, policies that are written for groups cost policyholders less than those written for individuals. Group plans are bought by employers or organizations. The employer or the organization agrees to the contract and then offers the coverage to its group members. People who are not eligible for group insurance from employers-for example, independent contractors, temporary or part-time employees, or unemployed people-may purchase individual policies directly from health plans, either private, government, or state sponsored. In either a group or an individual plan, the policyholder's dependents, customarily the spouse and children, may sometimes also be covered for an additional cost.

### Disability and Automotive Insurance and Workers' Compensation

Other types of health-related insurance are available. A patient may have disability insurance that provides reimbursement for income lost because of the person's inability to work. Automotive insurance policies cover specific vehicle-related situations. Disability insurance is discussed in the chapter about workers' compensation.

Workers' compensation insurance is purchased by employers to pay benefits and provide medical care for employees who are injured in job-related accidents or develop illnesses from their jobs and to pay benefits to employees' dependents in the event of work-related death. State laws determine the coverage that is required.

### THINKING IT THROUGH 1.2

1. Describe the type of medical insurance coverage you have. If you are not insured, describe the policy held by someone you know, or access the website of the Medicare program (Medicare.gov) and click the tab "What Medicare Covers" before answering the following questions: According to the plan's policy information (often printed in a pamphlet that accompanies the policy itself or available online at the plan's website), what benefits does the policy cover? Are some services excluded from coverage? Are any preventive medical services included?

# 3 Healthcare Plans

Although there are many variations, all insurance plans are based on one of the two essential types of plans, indemnity and managed care.

### **BILLING TIP**

#### Filing Claims for Patients

The practice usually handles the process of billing the insurance company for patients; patients are generally more satisfied with their office visits when this is done for them, and the practice receives payment more quickly.

indemnity plan health plan that reimburses a policyholder for medical services under the terms of its schedule of benefits

healthcare claim electronic transaction or a paper document filed to receive benefits

### Indemnity

An indemnity is protection against loss. Under an indemnity plan, the payer indemnifies the policyholder against costs of medical services and procedures as listed on the benefits schedule. Patients choose the providers they wish to see. The physician usually sends the healthcare claim—a formal insurance claim in either electronic or hard copy format that reports data about the patient and the services provided by the physician-to the payer on behalf of the patient.

### Conditions for Payment

For each claim, four conditions must be met before the insurance company makes a payment:

- 1. The medical charge must be for medically necessary services and covered by the insured's health plan.
- 2. The insured's payment of the **premium**—the periodic payment the insured is required to make to keep the policy in effect-must be up-to-date. Unless the premium is current, the insured is not eligible for benefits and the insurance company will not make any payment.
- 3. If part of the policy, a deductible—the amount that the insured pays on covered services before benefits begin-must have been met (paid) by the insured. Deductibles range widely, usually from \$200 to thousands of dollars annually. Higher deductibles generally mean lower premiums.
- **4.** Any coinsurance—the percentage of each claim that the insured pays—must be taken into account. The coinsurance rate states the health plan's percentage of the charge, followed by the insured's percentage, such as 80-20. This means that the payer pays 80 percent of the covered amount and the patient pays 20 percent after the premiums and deductibles are paid.

The formula is as follows:

Charge – Deductible – Patient Coinsurance = Health Plan Payment.

premium money the insured pays to a health plan for a policy

deductible amount the insured must pay for healthcare services before a health plan's payment begins

coinsurance portion of charges an insured person must pay for covered healthcare services after the deductible

### Example

An indemnity policy states that the deductible is the first \$200 in covered annual medical fees and that the coinsurance rate is 80-20. A patient whose first covered medical charge of the year was \$2,000 would owe \$560:

Charge	\$2,000
Patient owes the deductible	\$ 200
Balance	\$1,800
Patient also owes coinsurance (20% of the balance)	\$ 360
Total balance due from patient	\$200 + \$360 - \$560

In this case, the patient must pay an out-of-pocket expense of \$560 this year before out-of-pocket expenses the benefits begin. The health plan will pay \$1,440, or 80 percent of the balance:

insured must pay prior to benefits

Charge	\$2,000
Patient payment	<u></u> \$560
Health plan payment	\$1,440

If the patient has already met the annual deductible, the patient's benefits apply to the charge, as in this example:

Charge	\$2,000
Patient coinsurance (20%)	\$ 400
Health plan payment (80%)	\$1,600 <b>&lt;</b>

### **BILLING TIP**

#### **Out-of-pocket Maximum**

Health plans state the out-of-pocket maximum for a given year. Premium payments do not count toward this figure.

fee-for-service payment method based on provider charges

managed care system combining the financing and delivery of healthcare services

managed care organization (MCO) organization offering a managed healthcare plan

### Fee-for-Service Payment Approach

Indemnity plans usually reimburse medical costs on a fee-for-service basis. The fee-for-service payment method is retroactive: The fee is paid after the patient receives services from the physician (see the following Figure 1.2).

### **Managed Care**

Managed care offers a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and other charges than traditional indemnity insurance. This approach to insurance combines the financing and management of healthcare with the delivery of services. Managed care organizations (MCOs) establish links between provider, patient, and payer. Instead of only the patient having a policy with the health plan, both the patient and the provider have agreements with the MCO. This arrangement gives the MCO more control over what services the provider performs and the fees for the services.

Managed care plans, first introduced in California in 1929, are now the predominant type of insurance. More than 90 percent of all insured employees are enrolled in some type of managed care plan, and thousands of different plans are offered. The basic types are:

- Health maintenance organizations
- Point-of-service plans
- Preferred provider organizations
- Consumer-driven health plans

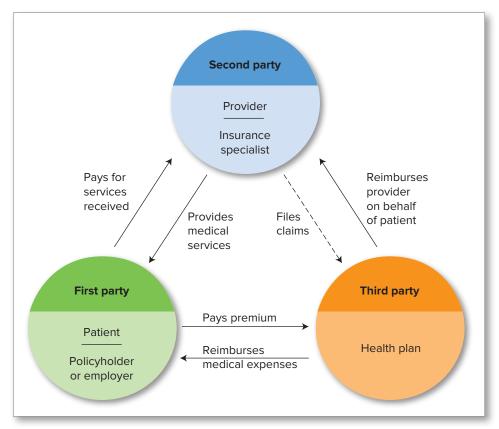


FIGURE 1.2 Payment Under Fee-for-Service

### **BILLING TIP**

### Participation as a Provider

Participation means that a provider has contracted with a health plan to provide services to the plan's beneficiaries. Being a participating (PAR) provider brings advantages, such as more patients, as well as contractual duties and, usually, reduced fees.

participation contractual agreement to provide medical services to a payer's policyholders

### THINKING IT THROUGH 1.3

1. Which types of health plans, indemnity or managed care, are likely to offer patients more selection in terms of which physicians patients can visit?



# **1.4** Health Maintenance Organizations

A health maintenance organization (HMO) combines coverage of medical costs and delivery of healthcare for a prepaid premium. The HMO creates a network of physicians, hospitals, and other providers by employing or negotiating contracts with them. The HMO then enrolls members in a health plan under which they use the services of those network providers. In most states, HMOs are licensed and are legally required to provide certain services to members and their dependents. Preventive care is often required as appropriate for each age group, such as immunizations and well-baby checkups for infants and screening mammograms for women.

health maintenance organization (HMO) managed healthcare system in which providers offer healthcare to members for fixed periodic payments

### Capitation in HMOs

Capitation (from capit, Latin for head) is a fixed prepayment to a medical provider for all necessary contracted services provided to each patient who is a plan member (see Figure 1.3). The capitated rate is a prospective payment—it is paid before the patient visit. It covers a specific period of time. The health plan makes the payment whether the patient receives many or no medical services during that specified period.

In capitation, the physician agrees to share the risk that an insured person will use more services than the fee covers. The physician also shares in the prospect that an insured person will use fewer services. In fee-for-service, the more patients the provider sees, the more charges the health plan reimburses. In capitation, the payment per patient remains the same, and the provider risks receiving lower per-visit revenue.

capitation a fixed prepayment covering provider's services for a plan member for a specified

### Example

A family physician has a contract for a capitated payment of \$30 a month for each of a hundred patients in a plan. This \$3,000 monthly fee ( $$30 \times 100$  patients = \$3,000) covers all office visits for all the patients. If half of the patients see the physician once during a given month, the provider in effect receives \$60 for each visit (\$3,000 divided by 50 visits). If, however, half of the patients see the physician four times in a month, the monthly fee is \$3,000 divided by 200 visits, or \$15 for each visit.

A patient is enrolled in a capitated health plan for a specific time period, such as a month, a quarter, or a year. The capitated rate, which is called **per member per month** (PMPM), is usually based on the health-related characteristics of the enrollees, such as age and gender. The health plan analyzes these factors and sets a rate based on its prediction of the amount of healthcare each person will need. The capitated rate of prepayment covers only services listed on the schedule of benefits for the plan. The provider may bill the patient for any other services.

per member per month (PMPM) periodic capitated prospective payment to a provider that covers only services listed on the schedule of benefits

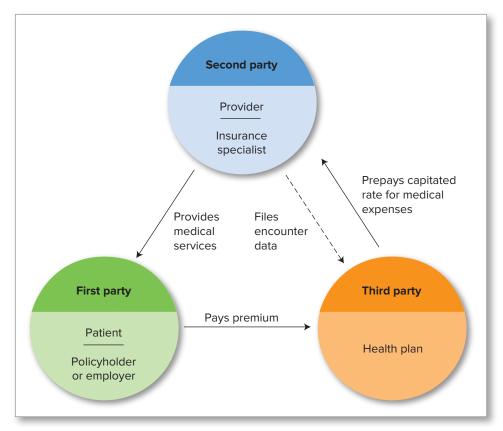


FIGURE 1.3 Payment Under Capitation

### Medical Management Practices in HMOs

Health maintenance organizations seek to control rising medical costs and at the same time improve healthcare.

**Cost Containment** An HMO uses the following cost-containment methods:

- Restricting patients' choice of providers: After enrolling in an HMO, members must receive services from the **network** of physicians, hospitals, and other providers who are employed by or under contract to the HMO. Visits to out-of-network providers are not covered except for emergency care or urgent health problems that arise when the member is temporarily away from the geographical service area.
- ▶ Requiring preauthorization for services: HMOs often require preauthorization (also called precertification or prior authorization) before the patient receives many types of services. The HMO may require a second opinion-the judgment of another provider that a planned procedure is necessary—before authorizing service. Services that are not preauthorized are not covered. Preauthorization is almost always needed for nonemergency hospital admission, and it is usually required within a certain number of days after an emergency admission.
- Controlling the use of services: HMOs develop medical necessity guidelines for the use of medical services. The HMO holds the provider accountable for any questionable service and may deny a patient's or provider's request for preauthorization.

For example, a patient who has a rotator cuff shoulder injury repair can receive a specific number of physical therapy sessions. More sessions will not be covered unless additional approval is obtained. Emergency care is particularly tightly controlled because it is generally the most costly way to deliver services. These guidelines are also applied to hospitals in the network, which, for instance, limit the number of days patients can remain in the hospital following particular surgeries.

network a group of healthcare providers, including physicians and hospitals, who sign a contract with a health plan to provide services to plan members

out-of-network provider who does not have a participation agreement with a plan

preauthorization prior authorization from a payer for services to be provided

- ► Controlling drug costs: Providers must prescribe drugs for patients only from the HMO's list of selected pharmaceuticals and approved dosages, called a formulary. Drugs that are not on the list require the patient to have preauthorization, which is often denied.
- Cost-sharing: At the time an HMO member sees a provider, he or she pays a specified charge called a copayment (or copay). A lower copayment may be charged for an office visit to the primary care physician, and a higher copayment may be required for a visit to the office of a specialist or for the use of emergency department services.
- ▶ Requiring referrals: HMOs may require a patient to select a primary care physician (PCP)—also called a gatekeeper—from the HMO's list of general or family practitioners, internists, and pediatricians. A PCP coordinates patients' overall care to ensure that all services are, in the PCP's judgment, necessary. In gatekeeper plans, an HMO member needs a medical referral from the PCP before seeing a specialist or a consultant and for hospital admission. Members who visit providers without a referral are directly responsible for the total cost of the service.

Historically, the first HMOs used all of these cost-containment methods and reduced operating costs. However, both physicians and patients became dissatisfied with the policies. Physicians working under managed care contracts complained that they were not allowed to order needed treatments and tests. Patients often reported that needed referrals were denied. In response, the medical management practices of HMOs increasingly emphasize the quality of healthcare as well as the cost of its delivery. Just as providers must demonstrate that their services are both effective and efficient, HMOs must demonstrate that they can offer these services at competitive prices while improving the quality of healthcare.

**Healthcare Quality Improvements** The quality improvements made by HMOs are illustrated by these features, which most plans contain:

- ▶ Disease and case management: Some patients face difficult treatments, such as for highrisk pregnancies, and others need chronic care for conditions such as congestive heart failure, diabetes, and asthma. HMOs often assign case managers to work with these patients. Some conditions require case managers who are healthcare professionals. Others are assigned to people who are familiar with the healthcare system, such as social workers. The goal of case managers is to make sure that patients have access to all needed treatments. For example, physician case managers coordinate appropriate referrals to consultants, specialists, hospitals, and other services. Other types of case managers provide patient education, special equipment such as a blood glucose meter for a diabetic, and ongoing contact to monitor a patient's condition.
- Preventive care: Preventive care, which seeks to prevent the occurrence of conditions through early detection of disease, is emphasized through provisions for annual checkups, screening procedures, and inoculations.
- ▶ Pay-for-performance (P4P): HMOs collect and analyze large amounts of data about patients' clinical treatments and their responses to treatment. In this way, the HMOs can establish the most effective protocols—detailed, precise treatment regimens that work best. HMOs use financial incentives to encourage their providers to follow these protocols.

### Point-of-Service Plans and Exclusive Provider **Organizations**

Many patients dislike HMO rules that restrict their access to physicians. In order to better compete for membership, a point-of-service (POS) plan, also called an open HMO, reduces restrictions and allows members to choose providers who are not in the HMO's network.

Members must pay additional fees that are set by the plan when they use out-ofnetwork providers. Typically, the patient must pay 20 to 30 percent of the charge for out-of-network service, and the deductible can be very high. The HMO pays out-ofnetwork providers on a fee-for-service basis.

copayment specified amount a beneficiary must pay at the time of a healthcare encounter

primary care physician (PCP) physician in a health maintenance organization who directs all aspects of a patient's care

referral transfer of patient care from one physician to another

An exclusive provider organization (EPO) plan is similar. EPOs generally do not cover care outside the plan's provider network. These plans, though, do not usually require referrals to specialists.

### THINKING IT THROUGH 1.4

- 1. Managed care organizations often require different payments for different services. Table 1.1 shows the copayments for an HMO health plan. Study this schedule and answer these questions:
  - A. Does this health plan cover diabetic supplies? Dental exams? Emergency services?
  - **B.** Is the copayment amount for a PCP visit higher or lower than the charge for specialty care?

able 1.1 Example of Benefits Under an H	IMO
	Copayments
Primary Care Physician Visits Office Hours	\$20
After Hours and Home Visits	\$20
Specialty Care Office Visits Diagnostic Outpatient Testing Phys, Occ, Speech Therapy	\$30 \$20 \$20
SPU Surgery	\$250
Hospitalization	\$250
Emergency Room (copay waived if admitted)	\$35
Maternity First OB Visit Hospital	\$30 \$250
Mental Health Inpatient Outpatient	\$250, 60 days \$30
Substance Abuse Detoxification Inpatient Rehab (combined with mental health coverage) Outpatient Rehabilitation	\$250 \$250 \$30
Preventive Care Routine Eye Exam Routine GYN Exam Pediatric Preventive Dental Exam	Not covered \$30 Not covered
Chiropractic Care (20 visits per condition)	\$20
Prescriptions  Contraceptives Diabetic Supplies 31–90 Day Supply	\$15/\$20/\$30 \$150 deductible/calendar year Covered Covered \$30/\$40/\$60
7 17 7	ψοσιψησιφού

# **1.5** Preferred Provider Organizations

A preferred provider organization (PPO) is another healthcare delivery system that manages care. PPOs are the most popular type of insurance plan. They create a network of physicians, hospitals, and other providers with whom they have negotiated discounts from the usual fees. For example, a PPO might sign a contract with a practice stating that the fee for a brief appointment will be \$60, although the practice's physicians usually charge \$80. In exchange for accepting lower fees, providers-in theory, at least—see more patients, thus making up the revenue that is lost through the reduced fees.

A PPO requires payment of a premium and often of a copayment for visits. It does not require a primary care physician to oversee patients' care. Referrals to specialists are also not required. Premiums and copayments, however, are higher than in HMO or POS plans. Members choose from many in-network generalists and specialists. PPO members also can use out-of-network providers, usually for higher copayments, increased deductibles, or both.

preferred provider organization (PPO) managed care organization in which a network of providers supplies discounted treatment for plan members

### Example

A PPO member using an in-network provider pays a \$20 copayment at the time of service (the visit), and the PPO pays the full balance of the visit charge. A member who sees an out-of-network provider usually pays a deductible and a coinsurance that is a higher percentage than in-network visits.

As managed care organizations, PPOs also control the cost of healthcare by:

- ▶ Directing patients' choices of providers: PPO members have financial incentives to receive services from the PPO's network of providers.
- ▶ Controlling use of services: PPOs have guidelines for appropriate and necessary medical care.
- ▶ Requiring preauthorization for services: PPOs may require preauthorization for nonemergency hospital admission and for some outpatient procedures.
- Requiring cost-sharing: PPO members are also required to pay copayments for general or specialist services.

### THINKING IT THROUGH 1.5

1. In your opinion, why are PPOs the most popular type of insurance plan?

# 1.6 Consumer-Driven Health Plans

Consumer-driven health plans (CDHPs), also known as high-deductible health plans, combine two elements. The first element is a health plan, usually a PPO, that has a high deductible (such as \$5,000) and low premiums. The second element is a special "savings account" that is used to pay medical bills before the deductible has been met. The savings account, similar to an individual retirement account (IRA), lets people put aside untaxed wages that they may use to cover their out-of-pocket medical expenses. Some employers contribute to employees' accounts as a benefit.

Cost containment in consumer-driven health plans begins with consumerism—the idea that patients who themselves pay for healthcare services become more careful consumers. Both insurance companies and employers believe that asking patients to pay a larger portion of medical expenses reduces costs. To this are added the other controls typical of a PPO, such as in-network savings and higher costs for out-of-network visits.

The major types of plans are summarized in Table 1.2.

consumer-driven health plan (CDHP) medical insurance that combines a high-deductible health plan with a medical savings plan

Table 1.2 Comparison of Health Plan Options					
Plan Ty	pe	Provider Options	Cost-Containment Methods	Features	
Indemnity	/ Plan	Any provider	Little or none     Preauthorization required for some procedures	<ul><li>Higher costs</li><li>Deductibles</li><li>Coinsurance</li><li>Preventive care coverage limited</li></ul>	
Health Maintena Organiza (HMO)		Only HMO network providers	<ul> <li>Primary care physician manages care; referral required</li> <li>No payment for out-of-network nonemergency services</li> <li>Preauthorization required</li> </ul>	<ul><li>Low copayment</li><li>Limited provider network</li><li>Covers preventive care</li></ul>	
Point-of-S (POS) and Exclusive Organiza (EPOs)	d Provider	Network providers or out-of-network providers	Within network, primary care physician manages care	<ul> <li>Lower copayments for network providers</li> <li>Higher costs for out-of-network providers</li> <li>Covers preventive care</li> </ul>	
	I Provider tion (PPO)	Network or out-of-network providers	<ul><li>Referral not required for specialists</li><li>Fees are discounted</li><li>Preauthorization for some procedures</li></ul>	<ul> <li>Higher cost for out-of-network providers</li> <li>Preventive care coverage varies</li> </ul>	
Consume Health PI (CDHP)		Usually similar to PPO	<ul><li>Increases patient awareness of healthcare costs</li><li>Patient pays directly until</li></ul>	High deductible/low premium     Savings account	

### THINKING IT THROUGH 1.6

1. What two elements are combined in a consumer-driven health plan?

high deductible is met

### **COMPLIANCE GUIDELINE**

### **Unpaid Healthcare**

Under the federal Emergency **Medical Treatment and Active** Labor Act, or EMTALA, hospital emergency departments must provide care for all patients in need of medical services, regardless of their ability to pay. More than \$100 billion in unpaid healthcare is provided annually for uninsured and underinsured patients.



# 1.7 Medical Insurance Payers

Based on the 2017 U.S. Census Bureau data, 91.2 percent of people in the United States have medical coverage through private payers, self-funded health plans, or government programs. Just over 28 million people that year had no insurance. See Figure 1.4 for a breakdown of the types of insurance held.

### **Private Payers**

A small number of large insurance companies dominate the national market and offer all types of health plans. There are also a number of nonprofit organizations, such as Kaiser Permanente, which is the largest nonprofit HMO. Some organizations, such as the Blue Cross and Blue Shield Association, have both for-profit and nonprofit parts.

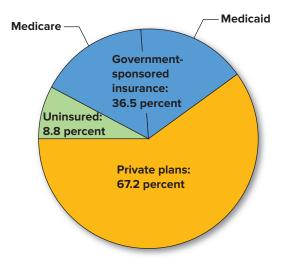


FIGURE 1.4 Types of Insurance Held

Source: U.S. Census Bureau, "Health Insurance Coverage: 2017," www.census.gov/hhes.

Private payers have contracts with businesses to provide benefits for their employees. These may be large-group or small-group healthcare plans. Payers may also offer individual insurance coverage.

### Self-Funded Health Plans

Most large employers that offer insurance have established themselves as self-funded (self-insured) health plans. Rather than paying premiums to an insurance carrier, the organization "insures itself." It assumes the risk of paying directly for medical services and sets up a fund from which it pays for claims. The organization establishes the benefit levels and the plan types it will offer. Self-funded health plans may set up their own provider networks or, more often, buy the use of existing networks from managed care organizations.

Most self-funded health plans are set up as PPOs; fewer than 10 percent are set up as HMOs. As discussed in the chapter about private payers, being self-insured changes the regulations under which a plan works, giving the employer some financial advantages over paying for coverage through a typical insurance company.

### **Government-Sponsored Healthcare Programs**

The four major government-sponsored healthcare programs offer benefits for which various groups in the population are eligible:

- 1. Medicare is a 100 percent federally funded health plan that covers people who are sixty-five and over and those who, regardless of age, are disabled or have permanent kidney failure (end-stage renal disease, or ESRD).
- 2. Medicaid, a federal program that is jointly funded by federal and state governments, covers low-income people who cannot afford medical care. Each state administers its own Medicaid program, determining the program's qualifications and benefits under broad federal guidelines.
- 3. TRICARE, a Department of Defense program, covers medical expenses for activeduty members of the uniformed services and their spouses, children, and other dependents; retired military personnel and their dependents; and family members of deceased active-duty personnel. (This program replaced CHAMPUS, the Civilian Health and Medical Program of the Uniformed Services, in 1998.)

self-funded (self-insured) health plan organization pays for health insurance directly and sets up a fund from which to pay 4. CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, covers the spouses and dependents of veterans with permanent service-related disabilities. It also covers surviving spouses and dependent children of veterans who died from service-related disabilities.

These government programs are covered in the chapters about Medicare, Medicaid, TRICARE, and CHAMPVA.

#### THINKING IT THROUGH 1.7

1. In your opinion, should having medical insurance be mandated? Is it fair to charge monetary penalties for people who do not have insurance?

medical insurance specialist staff member who handles billing, checks insurance, and processes payments

# 1.8 The Revenue Cycle

In this text, the job title medical insurance specialist encompasses all the tasks that are completed by administrative staff members during the revenue (medical billing) cycle. Typically, front office staff members handle duties such as reception (registration) and scheduling. Back office staff duties are related to billing, insurance, and collections. Job titles in common use are billing clerk, insurance specialist, reimbursement specialist, and claims specialist. The broad picture of the medical insurance specialist is presented in Medical Insurance, Eighth Edition, to provide the widest background for future employment.

The main job functions of medical insurance specialists are:

- ► To understand patients' responsibilities for paying for medical services
- ▶ To analyze charges and insurance coverage to prepare accurate, timely claims
- To collect payment for medical services from health plans and from patients

These functions entail:

- ▶ Verifying patient insurance information and eligibility before medical services are provided
- ► Collecting payments that are due, such as copayments, at the time of service
- Maintaining up-to-date information about health plans' billing guidelines
- ▶ Following federal, state, and local regulations on maintaining the confidentiality of information about patients
- ▶ Abstracting information from patients' records for accurate billing
- Billing health plans and patients, maintaining effective communication to avoid problems or delayed payments
- Assisting patients with insurance information and required documents
- Processing payments and requests for further information about claims and bills
- Maintaining financial records
- ▶ Updating the forms and computer systems that the practice uses for patient information and healthcare claims processing

To complete their duties and contribute to financial success, medical insurance specialists follow the series of steps in the revenue cycle that leads to maximum, appropriate, timely payment for patients' medical services (see Figure 1.5).

#### **BILLING TIP**

#### The Revenue Cycle

Study the revenue cycle in Figure 1.5 as you read the steps. Refer to the cycle as you read the text's chapters; it serves as your path toward expertise in medical insurance.

BEFORE THE ENCOUNTER	Step 1	Preregister patients
DURING THE ENCOUNTER	Step 2 Step 3 Step 4 Step 5 Step 6	Establish financial responsibility Check in patients Review coding compliance Review billing compliance Check out patients
AFTER THE ENCOUNTER	Step 7 Step 8 Step 9 Step 10	Prepare and transmit claims  Monitor payer adjudication  Generate patient statements  Follow up payments and collections

FIGURE 1.5 The Revenue Cycle

#### **Step 1 Preregister Patients**

The first step in the revenue cycle is to preregister patients. It involves two main tasks:

- Schedule and update appointments
- ► Collect preregistration demographic and insurance information

New patients who call for appointments provide basic personal and insurance information to the scheduler. Both new and returning patients are asked about the medical reason for the visit so appropriate visits can be scheduled for them.

# Step 2 Establish Financial Responsibility

The second step is very important: determine financial responsibility for visits. For insured patients, these questions must be answered:

- ▶ What services are covered under the plan? What medical conditions establish medical necessity for these services?
- What services are not covered?
- ▶ What are the billing rules of the plan?
- ▶ What is the patient responsible for paying?

Knowing the answers to these questions is essential to correctly bill payers for patients' covered services. This knowledge also helps medical insurance specialists ensure that patients will pay their bills when benefits do not apply.

To determine financial responsibility, these procedures are followed:

- ▶ Verify patients' eligibility for their health plan.
- ► Check the health plan's coverage.
- ▶ Determine the first payer if more than one health plan covers the patient (this is the payer to whom the first claim will be sent).
- Meet payers' conditions for payment, such as preauthorization, ensuring that the correct procedures are followed to meet them.

The practice's financial policy—which defines when bills have to be paid—is explained so that patients understand the revenue cycle. Patients are told that they are responsible for paying charges that are not covered under their health plans. Uninsured patients are informed of their responsibility for the entire charge. Payment options are presented if the bill will be large.

#### Step 3 Check In Patients

The third step is to check in individuals as patients of the practice. When new patients arrive for their appointments, detailed and complete demographic and medical information is collected at the front desk. Returning patients are asked to review the information that is on file for them, making sure that demographics and medical data are accurate and up-to-date. Their financial records are also checked to see whether balances are due from previous visits.

Both the front and back of insurance cards and other identification cards, such as driver's licenses, are scanned or photocopied and stored in the patient's record. If the health plan requires a copayment, the correct amount is noted for the patient. Copayments should always be collected at the time of service. Some practices collect copayments before the patient's encounter with the physician, others after the encounter.

A number of other important forms may need to be completed by patients. These forms are part of the process of recording administrative and clinical facts about patients. Often, they involve authorizing planned procedures and payments to the practice from the health plan.

During the office visit, a physician evaluates, treats, and documents a patient's condition. These notes include the procedures performed and treatments provided, as well as the physician's determination of the patient's complaint or condition.

Steps 1-3 are covered in later chapters of this text.

# **Step 4 Review Coding Compliance**

To bill for the visit, the medical diagnoses and procedures must be assigned medical codes. In some practices, physicians assign these codes; in others, a medical coder or a medical insurance specialist handles this task. The medical insurance specialist may verify the codes with data in the patient's medical record.

The patient's primary illness is assigned a diagnosis code from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (see the chapter about diagnostic coding).

#### **Example**

The ICD-10-CM code for Alzheimer's disease is G30.9.

The ICD-10-CM code for frostbite with tissue necrosis of the left wrist is T34.512A. ◀

Similarly, each procedure the physician performs is assigned a procedure code that stands for the particular service, treatment, or test. This code is selected from the Current Procedural Terminology (CPT) (see the chapter about procedural coding). A large group of codes covers the physician's evaluation and management of a patient's condition during office visits or visits at other locations, such as nursing homes. Other codes cover groups of specific procedures, such as surgery, pathology, and radiology. Another group of codes covers supplies and other services.

# Example

99460 is the CPT code for the physician's examination of a newborn infant. 27130 is the CPT code for a total hip replacement operation.

The physician identifies the patient's diagnoses and procedures. The medical insurance specialist uses this information after the encounter to update the patient's account in the PMP. The transactions for the visit, which include both the charges and any

#### **COMPLIANCE GUIDELINE**

#### ICD-9-CM versus ICD-10-CM

ICD-9-CM was required until October 1, 2015, after which ICD-10-CM must be used for medical coding.

medical coder staff member with specialized training who handles diagnostic and procedural coding

diagnosis code number assigned to a diagnosis

procedure code code that identifies medical treatment or diagnostic services

patient ledger record of a patient's financial transactions

payment the patient has made, are entered in the patient ledger (the record of a patient's financial transactions; also called the *patient account record* when stored in the PMP), and the patient's balance is updated. Following is an example of the account for one patient's recent series of visits:

Date/Procedure		Charge	Paym	Balance	
7/2/2029	OV	200.00		200.00	_
7/3/2029	OV	150.00			
7/4/2029	INS	_		_	150.00
7/13/2029	PMT		Insurance	120.00	30.00
7/25/2029	STM	_		_	30.00
7/30/2029	PMT		Patient	30.00	0.00

This formula is followed to calculate the current balance:

Previous Balance + Charge - Payment = Current Balance.

In this example, on 7/2, the patient's office visit (OV) resulted in a \$200 charge. The patient paid this bill, so there is no current balance. The patient's next office visit, 7/3, resulted in a charge of \$150. The medical insurance specialist sent a healthcare claim to the health plan (INS for insurance) the next day, and the payer paid \$120 (PMT) on 7/13. This payment is subtracted from the charge to equal the current balance of \$30.

As noted on the account, then a statement (STM) (a bill) was sent to the patient on 7/25 showing the current balance now owed. The patient sent a payment of \$30 (PMT) received on 7/30, which reduced the patient's current balance to zero.

At the time of the visit, patients may owe a previous balance, coinsurance, deductibles, and/or fees for noncovered services. Payments may be made by cash, check, or credit or debit card. When a payment is made, a receipt is given to the patient. Patients' follow-up visits are also scheduled.

#### **Coding Compliance**

Compliance means actions that satisfy official requirements. In the area of coding, compliance involves following official guidelines when codes are assigned. Also, after diagnosis and procedure codes are selected, they must be checked for errors. The diagnosis and the medical services that are documented in the patient's medical record should be logically connected (linked), so that the payer understands the medical necessity of the charges.

compliance actions that satisfy official requirements

# Step 5 Review Billing Compliance

Each charge, or fee, for a visit is related to a specific procedure code. The provider's fees for services are listed on the medical practice's fee schedule. Most medical practices have standard fee schedules listing their usual fees.

Although a separate fee is associated with each code, each code is not necessarily billable. Whether a code can be billed depends on the payer's rules. Following these rules when preparing claims results in billing compliance. Some payers combine certain physician work in the payment for another code. Medical insurance specialists apply their knowledge of payer guidelines to analyze what can be billed on healthcare claims.

# **Step 6 Check Out Patients**

Checkout is the last step that occurs while the patient is still in the office. The medical codes have been assigned and checked, and the amounts to be billed have also been verified according to payers' rules. The charges for the visit are calculated and discussed with the patient. Payment for these types of charges is usually collected at the time of service:

- Previous balances
- Copayments or coinsurance
- Noncovered services
- Charges of nonparticipating providers
- Charges for self-pay patients
- Deductibles

A receipt is prepared for the payments made by the patients, and follow-up work is scheduled as ordered by the physician.

Steps 4, 5, and 6 are covered in Chapters 4-6.

#### **Step 7 Prepare and Transmit Claims**

A major step in the revenue cycle is the preparation of accurate, timely healthcare claims. Most practices use the PMP to prepare claims for their patients and send them to the payer electronically. A claim communicates information about the diagnosis, procedures, and charges to a payer. A claim may be for reimbursement for services rendered or to report an encounter to an HMO. The practice has a schedule for transmitting claims, such as daily or every other day, which is followed.

General information on claims found in the chapters about healthcare claim preparation and transmission, private payers, and workers' compensation explains how to prepare correct claims for each major payer group:

- Private payers or Blue Cross and Blue Shield
- Medicare
- Medicaid
- TRICARE and CHAMPVA
- Workers' compensation and disability
- A related topic, hospital coding and billing, is covered in Chapter 17.

# **Step 8 Monitor Payer Adjudication**

Once healthcare claims have been sent to health plans, it is important to collect payments as soon as possible. The money due from the plans, as well as payments due from patients, adds up to the practice's accounts receivable (AR)—the money that is needed to run the practice.

Payers review claims by following a process known as adjudication. This term means that the payer puts the claim through a series of steps designed to judge whether it should be paid. What the payer decides about the claim—to pay it in full, to pay some of it, to pend it for further information to arrive, or to deny it—is explained on a report sent back to the provider with the payment. Common reasons that claims are not paid in full include factual errors and failure to satisfy the payer's medical necessity guidelines. When patients are covered by more than one health plan, the additional plans are then sent claims based on the amounts still due.

The amount of the payment depends on the practice's contract with the payer. Seldom do the practice's fee and the payer's fee match exactly. Most payers have their own fee schedules for providers with whom they have contractual arrangements. The medical insurance specialist compares each payment with the claim to check that:

- ▶ All procedures that were listed on the claim also appear on the payment transaction.
- Any unpaid charges are explained.
- ► The codes on the payment transactions match those on the claim.
- ▶ The payment listed for each procedure is correct according to the contract with the payer.

If discrepancies are found, an appeal process may be started. In this process, the medical insurance specialist follows payers' or state rules to seek full appropriate reimbursement for a claim.

adjudication health plan process of examining claims and determining benefits

When a patient is covered by more than one health plan, the second and any other plans must be sent claims.

Step 8 is covered in Chapter 13.

#### **Step 9 Generate Patient Statements**

Payers' payments are applied to the appropriate patients' accounts. In most cases, these payments do not fully pay the bills, and patients will be billed for the rest. The amount paid by all payers (the primary insurance and any other insurance) plus the amount to be billed to the patient should equal the expected fee. Bills that are mailed to patients list the dates and services provided, any payments made by the patient and the payer, and the balances now due.

#### Step 10 Follow Up Payments and Collections

Patient payments are regularly analyzed for overdue bills. A collection process is often started when patient payments are later than permitted under the practice's financial policy.

Patient medical records and financial records are stored and retained according to the medical practice's policy. Federal and state regulations govern what documents are kept and for how long.

Steps 9 and 10 are covered in Chapter 14.

#### THINKING IT THROUGH 1.8

- 1. In your opinion, is each of the following procedures likely to be considered medically necessary by a payer's healthcare claims examiner? Why?
  - A. Diagnosis: deviated septum
    - Procedure: nasal surgery
  - B. Diagnosis: mole on a female patient's cheek, questionable nature
    - Procedure: surgical removal and biopsy
  - C. Diagnosis: male syndrome hair loss
    - Procedure: implant hair plugs on scalp
  - D. Diagnosis: probable broken wrist
    - Procedure: comprehensive full-body examination, with complete set of lab tests, chest X-ray, and electrocardiography (ECG)

# 1.9 Achieving Success

In addition to working in physicians' practices, medical insurance specialists work in clinics, for hospitals or nursing homes, and in other healthcare settings such as in insurance companies as claims examiners, provider relations representatives, or benefits analysts. The majority of these employees work for small- to medium-sized practices that range from solo doctors to multi-physician practices. Positions are also available in government and public health agencies. Employment with companies that offer billing or consulting services to healthcare providers is an option, as is self-employment as a claims assistance professional who helps consumers with medical insurance problems or as a billing service for providers.

In small physician practices, medical insurance specialists handle a variety of billing and collections tasks. In larger medical practices, duties may be more specialized. Billing, insurance, and collections duties may be separated, or a medical insurance specialist may work exclusively with claims sent to just one of many payers, such as Medicare or workers' compensation. Practice size varies by specialty. Seventy-five percent of physicians professionalism acting for the good of the public and the medical practice

provide care in small settings, usually in practices with one to three physicians. Specialties that require a lot of technology, such as radiology, tend to have large single-specialty medical groups.

Regardless of the size of the practice, the most important characteristic that medical insurance specialists should evidence is **professionalism**, always acting for the good of the public and the medical practice they serve. Professional staff members act with honor and integrity to ensure a high quality of service. They are internally motivated to do their best. They aim for a professional image in their appearance, their actions, and their oral communications.

#### **Requirements for Success**

A number of skills and attributes are required for successful mastery of the tasks of a medical insurance specialist.

#### Skills

Knowledge of medical terminology, anatomy, physiology, and medical coding: Medical insurance specialists must analyze physicians' descriptions of patients' conditions and treatments and relate these descriptions to the systems of diagnosis and procedure codes used in the healthcare industry.

Communication skills: The job of a medical insurance specialist requires excellent oral and written communication skills. For example, patients often need explanations of insurance benefits or clarification of instructions such as referrals. Courteous, helpful answers to questions strongly influence patients' willingness to continue to use the practice's services. Memos, letters, telephone calls, and e-mails are used to research and follow up on changes in health plans' billing rules. Communication skills also are needed to create and send collection letters that are effective and claim attachments that explain special conditions or treatments so as to obtain maximum reimbursement.

Attention to detail. Many aspects of the job involve paying close attention to detail, such as correctly completing healthcare claims, filing patients' medical records, recording preauthorization numbers, calculating the correct payments, and posting payments for services.

Flexibility: Working in a changing environment requires the ability to adapt to new procedures, handle varying kinds of problems and interactions during a busy day, and work successfully with different types of people with various cultural backgrounds.

Health information technology (HIT) skills: Most medical practices use computers to handle billing and process claims. Many also use or plan to use computers to keep patients' medical records. General computer literacy is essential, including working knowledge of an operating system, a word-processing program, a medical billing program, Internet-based research, and use of social media. Data-entry skills are also necessary. Many human errors occur during data entry, such as pressing the wrong key on the keyboard. Other errors are a result of a lack of computer literacy-not knowing how to use a program to accomplish tasks. For this reason, proper training in data-entry techniques and in using computer programs are essential for medical insurance specialists.

Honesty and integrity: Medical insurance specialists work with patients' medical records and with finances. It is essential to maintain the confidentiality of patient information and communications as well as to act with integrity when handling these tasks.

Ability to work as a team member: Patient service is a team effort. To do their part, medical insurance specialists must be cooperative and must focus on the best interests of the patients and the practice.

#### BILLING TIP

#### **Keeping Up-to-Date: The** Internet

The Internet is frequently used for research about government requlations, payer billing updates, and code updates. Ignorance of new instructions, rules, or codes is not an excuse for incorrect billing. Experienced medical insurance specialists make it a habit to reqularly check the websites that are most important for their billing environment. Many are provided throughout this text and summarized in Appendix C.

#### **Attributes**

A number of attributes are also very important for success as a medical insurance specialist. Most have to do with the quality of professionalism, which is key to getting and keeping employment. These factors include the following:

Appearance: A neat, clean, professional appearance increases other people's confidence in your skills and abilities. When you are well groomed, with clean hair, nails, and clothing, patients and other staff members see your demeanor as businesslike. Many employers do not permit visible piercings or tattoos, and following their guidelines is critical for being hired and keeping the job.

Attendance: Being on time for work demonstrates that you are reliable and dependable.

Initiative: Being able to start a course of action and stay on task is an important quality to demonstrate.

Courtesy: Treating patients and fellow workers with dignity and respect helps build solid professional relationships at work.

#### Medical Ethics and Etiquette in the Practice

Licensed medical staff and other employees working in physicians' practices share responsibility for observing a code of ethics and for following correct etiquette.

#### **Ethics**

Medical ethics are standards of behavior requiring truthfulness, honesty, and integrity. Ethics guide the behavior of physicians, who have the training, the primary responsibility, and the legal right to diagnose and treat human illness and injury. All medical office employees and those working in health-related professions share responsibility for observing the ethical code.

Each professional organization has a code of ethics that is to be followed by its membership. In general, this code states that information about patients and other employees and confidential business matters should not be discussed with anyone not directly concerned with them. Behavior should be consistent with the values of the profession. For example, it is unethical for an employee to take money or gifts from a company in exchange for giving the company business.

#### **Etiquette**

Professional etiquette is also important for medical insurance specialists. Correct behavior in a medical practice is generally covered in the practice's employee policy and procedure manual. For example, guidelines establish which types of incoming calls must go immediately to a physician or to a nurse or assistant and which require a message to be taken. Of particular importance are guidelines about the respectful and courteous treatment of patients and all others who interact with the practice's staff.

THINKING IT THROUGH 1.9

- 1. Dorita McCallister, the office manager of Clark Clinic, ordered medical office supplies from her cousin, Gregory Hand. When the supplies arrived, Gregory came to the office to check on them and to take Dorita out to lunch. Is Dorita's purchase of supplies from her cousin ethical? Why?
- 2. George McGrew is a medical insurance specialist in the practice of Dr. Sylvia Grets. Over the past few weeks, Dr. Grets has consistently assigned procedure codes that stand for lengthy, complex appointments to visits that were actually for the administration of flu shots—a brief procedure. Is it ethical for George to report these codes on healthcare claims?

ethics standards of conduct based on moral principles

etiquette standards of professional behavior

# 1.10 Moving Ahead

Completion of a medical insurance specialist program, coding specialist program, or medical assisting or health information technology program at a postsecondary institution provides an excellent background for many types of positions in the medical insurance field. Another possibility is to earn an associate degree or a certificate of proficiency by completing a program in a curriculum area such as healthcare business services. Further baccalaureate and graduate study enables advancement to managerial positions.

Moving ahead in a career is often aided by membership in professional organizations that offer certification in various areas. Certification by a professional organization provides evidence to prospective employers that the applicant has demonstrated a superior level of skill on a national test. Certification is the process of earning a credential through a combination of education and experience followed by successful performance on a national examination.

#### certification recognition of a superior level of skill by an official organization

#### **CMA**

American Association of Medical Assistants (AAMA) 20 N. Wacker Drive, Suite 1575 Chicago, IL 60606-2903 312-899-1500 www.aama-ntl.org

#### RMA

American Medical Technologists (AMT) 10700 West Higgins Road, Suite 150 Rosemont, IL 60018 847-823-5169 www.AmericanMedTech.org

#### RHIT, RHIA, CCS, CCS-P, CCA

American Health Information Management Association (AHIMA) 233 N. Michigan Ave., 21st Floor Chicago, IL 60601-5809 800-335-5535 www.ahima.org

#### CPC, CIC, CPC-P, CPC-A

American Academy of Professional Coders (AAPC) 2233 S. Presidents Dr., Suite F Salt Lake City, Utah 84120 800-626-2633 www.aapc.com

#### Medical Assisting Certification

Two organizations offer tests in the professional area of medical assisting. After earning a diploma in medical assisting from an accredited program (or having five years' work experience [for the RMA only]), medical assistants may sit for the Certified Medical Assistant (CMA) title from the American Association of Medical Assistants or the Registered Medical Assistant (RMA) designation from the American Medical Technologists.

#### Health Information Certification

Students who are interested in the professional area of health information (also known as medical records) may complete an associate degree from an accredited college program and pass a credentialing test from the American Health Information Management Association (AHIMA) to be certified as a Registered Health Information Technician, or RHIT. An RHIT examines medical records for accuracy, reports patient data for reimbursement, and helps with information for medical research and statistical data.

Also offered is the Registered Health Information Administrator (RHIA), requiring a baccalaureate degree and national certification. RHIAs are skilled in the collection, interpretation, and analysis of patient data. Additionally, they receive the training necessary to assume managerial positions related to these functions. RHIAs interact with all levels of an organization-clinical, financial, and administrative-that employ patient data in decision making and everyday operations.

RHITs and RHIAs enjoy job placements in a broad range of settings that span the continuum of healthcare, including office-based physician practices, nursing homes, home health agencies, mental health facilities, and public health agencies. The growth of managed care has created additional job opportunities in HMOs, PPOs, and insurance companies. Prospects are especially strong in these settings for RHIAs who possess advanced degrees in business or health administration and informatics.

#### Coding Certification

Medical coders are expert in classifying medical data. They assign codes to physicians' descriptions of patients' conditions and treatments. For employment as a medical coder, employers typically prefer-or may require-certification. AHIMA offers three coding certifications: the Certified Coding Associate (CCA), intended as a starting point for entering a new career as a coder; the Certified Coding Specialist (CCS); and the Certified Coding Specialist-Physician-based (CCS-P). The American Academy of Professional Coders (AAPC) grants the Certified Professional Coder (CPC) and the CPC-A, an apprentice level for those who do not yet have medical coding work experience.

#### **BILLING TIP**

#### **Moving Ahead in Your Career**

Professional certification, additional study, and work experience contribute to advancement to positions such as medical billing manager and medical office manager. Billers may also advance through specialization in a field, such as radiology billing management. Some become medical coders or coding managers.

#### Advanced Professional Certification

Professional organizations such as AHIMA and AAPC also have professional certification that can be earned following work experience and additional education. For example, AHIMA offers the Certified Documentation Improvement Practitioner (CDIP) recognition, and AAPC offers the Certified Professional Medical Auditor (CPMA) certification.

#### **Continuing Education**

Most professional organizations require certified members to keep up-to-date by taking annual training courses to refresh or extend their knowledge. Continuing education sessions are assigned course credits by the credentialing organizations, and satisfactory completion of a test on the material is often required for credit. Employers often approve attendance at seminars that apply to the practice's goals and ask the person who attends to update other staff members.

#### THINKING IT THROUGH 1.10

1. Why is it important for administrative medical office employees to become certified in their area of expertise? At this point, what are your personal goals relating to certification?

Chanter 1 Summary

Chapter I Summary					
Learning Outcomes	Key Concepts/Examples				
<b>1.1</b> Identify three ways that medical insurance specialists help ensure the financial success of physician practices.	<ul> <li>Following all procedures carefully.</li> <li>Communicating effectively with patients and with those who work in the practice.</li> <li>Using health information technology skills to work with practice management programs and electronic health records.</li> </ul>				
<b>1.2</b> Differentiate between covered and noncovered services under medical insurance policies.	Covered services:  • May include primary care, emergency care, medical specialists' services, and surgery				
	<ul><li> Are eligible for members</li><li> Are listed under the schedule of benefits of an insurance policy</li></ul>				
	Noncovered services:				
	Are identified by the insurance policy as services for which it will not pay				

Learning Outcomes	Key Concepts/Examples
<b>1.3</b> Compare indemnity and managed care approaches to health plan organization.	<ul> <li>All insurance plans are based on one of the two essential types of plans, indemnity and managed care.</li> <li>Under an indemnity plan, the payer protects the member against loss from the costs of medical services and procedures.</li> <li>Managed care offers a more restricted choice of providers and treatments in exchange for lower premiums, deductibles, and other charges.</li> </ul>
<b>1.4</b> Discuss three examples of cost containment employed by health maintenance organizations.	Health maintenance organizations (HMOs) control healthcare costs by:  Creating a restricted number of physicians for members  Requiring preauthorization of services  Controlling the use of services  Controlling drug costs  Using cost-sharing methods
<b>1.5</b> Explain how a preferred provider organization works.	<ul> <li>Create a network of hospitals and other providers for members to use at negotiated, reduced fees.</li> <li>Are the most popular type of healthcare.</li> <li>Generally require the payment of premiums and copayments from patients.</li> </ul>
<b>1.6</b> Describe the two elements that are combined in a consumer-driven health plan.	• Consumer-driven health plans (CDHPs) combine a high-deductible, low-premium PPO with a pretax savings account to cover out-of-pocket medical expenses up to the amount of the deductible.
<b>1.7</b> Define the three major types of medical insurance payers.	<ul> <li>Private payers of health benefits are either insurance companies or self-insured employers.</li> <li>Most private health insurance is employer sponsored.</li> <li>Government-sponsored healthcare programs include Medicare, Medicaid, TRICARE, and CHAMPVA.</li> </ul>
<b>1.8</b> Explain the ten steps in the revenue cycle.	The ten steps in the revenue cycle are:  1. Preregister patients 2. Establish financial responsibility 3. Check in patients 4. Review coding compliance 5. Review billing compliance 6. Check out patients 7. Prepare and transmit claims 8. Monitor payer adjudication 9. Generate patient statements 10. Follow up payments and collections
<b>1.9</b> Analyze how professionalism, ethics, and etiquette contribute to career success.	<ul> <li>It is vitally important for all members of the medical office to possess these traits.</li> <li>Office members acquire the proper skills and develop the necessary attributes in order to perform their work successfully.</li> <li>Pair these characteristics with a strong code of ethics and correct etiquette.</li> </ul>
<b>1.10</b> Evaluate the importance of professional certification for career advancement.	<ul> <li>Medical staff personnel advance their careers through membership in a professional organization and by receiving a certification by that organization.</li> <li>Certifications are earned through a combination of education, experience, and an exam.</li> </ul>

### **Review Questions**

Match the key terms with their definitions.

- 1. **LO 1.4** health maintenance organization (HMO)
- 2. LO 1.9 etiquette
- 3. LO 1.2 schedule of benefits
- 4. LO 1.3 fee-for-service
- 5. LO 1.3 coinsurance
- **6. LO 1.10** certification
- 7. LO 1.4 copayment
- **8. LO 1.1** electronic health record (EHR)
- 9. LO 1.5 preferred provider organization (PPO)
- **10. LO 1.3** indemnity
- 11. LO 1.8 compliance
- 12. LO 1.6 consumer-driven health plan (CDHP)
- **13. LO 1.7** self-funded (self-insured) health plans

- A. A list of the medical services covered by an insurance policy
- B. A computerized lifelong healthcare record for an individual that incorporates data from all sources that provide treatment for the individual
- C. A managed care network of providers under contract to provide services at discounted fees
- D. An amount that an insured person pays at the time of a visit to a provider
- E. The percentage of each claim that an insured person must pay
- F. Standards of professional behavior
- **G.** Payment method based on provider's charges
- H. An organization that contracts with a network of providers for the delivery of healthcare for a prepaid premium
- I. Recognition of a superior level of skill by an official organization
- J. Health plan that protects beneficiaries against losses
- K. A method by which organizations pay for health insurance directly and set up a fund from which to pay
- L. Actions that are performed to satisfy official requirements
- M. Type of medical insurance combining a high-deductible health plan and a medical savings plan

Select the answer choice that best completes the statement or answers the question.

14. L(	<b>1.4</b>	In an HMO	with a	gatekeeper	system, a(n)	cooi	rdinates t	he patien	t's care an	ıd provide	s referrals
--------	------------	-----------	--------	------------	--------------	------	------------	-----------	-------------	------------	-------------

A. PPO

c. PCP

B. EPO

D. NPP

15. LO 1.6 Which of the following combines a health plan that has a high deductible and low premiums with a special "savings account" that is used to pay medical bills before the deductible has been met?

A. CDHP

c. PPO

B. HMO

- D. EHR
- **16.** LO **1.2** Health plans pay for \_\_\_\_\_ services.
  - **A.** indemnity

C. coded

B. covered

- **D.** out-of-network
- 17. LO 1.4 In an HMO, securing \_
- may be required before services are provided.
- **A.** preauthorization
- C. gatekeeper

**B.** utilization

- **D.** formulary
- 18. LO 1.7 A self-insured health plan may use its own
  - **A.** physician-employees
- C. gatekeepers

B. funds

- D. primary care physicians
- 19. LO 1.5 Unlike an HMO, a PPO permits its members to use \_ providers, but at a higher cost.
  - A. subcapitated

- C. nonphysician practitioner
- B. out-of-network
- D. primary care



Enhance your learning at http://connect.mheducation.com!

- · Practice Exercises
- Worksheets
- Activities
- SmartBook

20.	<ul> <li>LO 1.7 The major government-sponso</li> <li>A. TRICARE, CHAMPVA,     Medicare, and Medicaid</li> <li>B. HEDIS, Medicare,     Medicaid, and CHAMPUS</li> </ul>	c. Medicare and Medicaid  D. Medicare and TRICARE				
21.	<ul><li>LO 1.3 Coinsurance is calculated base</li><li>A. the number of policyholders in a plan</li><li>B. a fixed charge for each visit</li></ul>	c. a capitation rate  D. a percentage of a charge				
22.	LO 1.8 When a patient has insurance usually done A. before the encounter B. during the encounter	coverage for which the practice will create a claim, the patient bill is  C. after the encounter when the healthcare claim is transmitted D. after the encounter and after the payer's payment is posted				
23.	<ul><li>LO 1.8 If a patient's payment is later be started.</li><li>A. copayment process</li><li>B. appeal process</li></ul>	than permitted under the financial policy of the practice, the may  C. coding process D. collection process				
Con	nplete the following.					
24.	LO 1.8 List the ten steps in the reven	ue cycle.				
	Step 1					
	Step 2					
	Step 3					
	Step 4					
	Step 5					
	Step 6					
	Step 7					
	Step 8					
	Step 9					
	Step 10					
25.	. LO 1.8 List at least four important skills of medical insurance specialists.					
	A.					
	В.					
	C.					
	D.					

- Practice Exercises Activities
- WorksheetsSmartBook

# Applying Your Knowledge

#### Case 1.1 Abstracting Insurance Information

A patient shows the following insurance identification card to the medical insurance specialist:



#### Connecticut HealthPlan

I.D.#: 1002.9713

DANIEL ANTHONY Employee:

Group #: A0000323 Eff. date: 03/01/2029

Status: Dependent Coverage? F

In-network: \$10 Co-Pay

Out-of-network: \$250 Ded; 80%/20%

#### Front of card

#### IMPORTANT INFORMATION

**Notice to Members and Providers of Care** 

To avoid a reduction in your hospital benefits, you are responsible for obtaining certification for hospitalization and emergency admissions. The review is required regardless of the reason for hospital admission. For specified procedures, Second Surgical Opinions may be mandatory.

For certification, call Utilization Management Services at 800-837-8808:

- At least 7 days in advance of Scheduled Surgery of Hospital Admissions
- . Within 48 hours after Emergency Admissions or on the first business day following weekend or holiday Emergency Admissions

#### CONNECTICUT HEALTHPLAN C/O Robert S. Weiss

& Company Silver Hill Business Center 500 S. Broad Street P.O. Box 1034 Meriden, CT 06450 (800) 466-7900

THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT ESTABLISH ELIGIBILITY FOR COVERAGE BY CONNECTICUT HEALTH PLAN. Please refer to your insurance bookle

#### Back of card

- A. LO 1.4, 1.5 What copayment is due when the patient sees an in-network physician?
- B. LO 1.4, 1.5 What payment rules apply when the patient sees an out-of-network physician?
- **C.** LO 1.4, 1.5 What rules apply when the patient needs to be admitted to the hospital?

#### Case 1.2 Calculating Insurance Math

Calculate the payment(s) billed in each of the following situations:

- A. LO 1.3 The patient's health plan has a \$100 annual deductible. At the first visit of the year, the charges are \$95. What does the patient owe?
- B. LO 1.3 The patient's coinsurance percentage is stated as 75-25 in the insurance policy. The deductible for the year has been met. If the visit charges are \$1,000, what payment should the medical insurance specialist expect from the payer? What amount will the patient be billed?
- C. LO 1.3 The patient's coinsurance percentage is stated as 80-20 in the insurance policy. The deductible for the year has been met. If the visit charges are \$420, what payment should the medical insurance specialist expect from the payer? What amount will the patient be billed?

- **D. LO 1.4** The patient is enrolled in a capitated HMO with a \$10 copayment for primary care physician visits and no coinsurance requirements. After collecting \$10 from the patient, what amount can the medical insurance specialist bill the payer for an office visit?
- **E. LO 1.3, 1.8** The patient has a policy that requires a \$20 copayment for an in-network visit due at the time of service. The policy also requires 30 percent coinsurance from the patient. Today's visit charges total \$785. After subtracting the copayment collected from the patient, the medical insurance specialist expects a payment of what amount from the payer? What amount will the patient be billed?
- **F. LO 1.3** A patient's total surgery charges are \$1,278. The patient must pay the annual deductible of \$1,000, and the policy states a 80-20 coinsurance. What does the patient owe?
- **G. LO 1.3, 1.6** A patient has a high-deductible consumer-driven health plan. The annual deductible is \$2,500, of which \$300 has been paid. After a surgical procedure costing \$1,890, what does the patient owe? Can any amount be collected from a payer? Why?
- H. LO 1.3, 1.5, 1.6 A patient with a high-deductible consumer-driven health plan has met half of the \$1,000 annual deductible before requiring surgery to repair a broken ankle while visiting a neighboring state. The out-of-network physician's bill is \$4,500. The PPO that takes effect after the deductible has been met is an 80-20 in-network plan and a 60-40 out-of-network plan. How much does the patient owe? How much should the PPO be billed?

#### Case 1.3 Using Insurance Terms

Read the following information from a medical insurance policy.

Policy Number 054351278 Insured Jane Hellman Brandeis Premium Due Quarterly \$1,414.98

#### AMOUNT PAYABLE

Maximum Benefit Limit, per covered person ...... \$2,000,000

Note: After satisfaction of the emergency room deductible, *covered expenses* are subject to any applicable *deductible amounts* and coinsurance provisions.

PREFERRED PROVIDER COINSURANCE PERCENTAGE, per calendar year

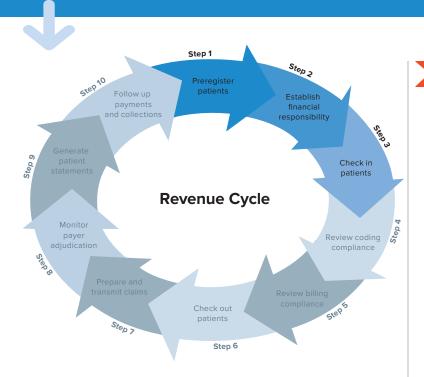
For covered expenses in excess of the applicable stated deductible, payer pays ...... 100%

- A. LO 1.3, 1.4, 1.5 What type of health plan is described: HMO, PPO, or indemnity?
- **B. LO 1.3, 1.4, 1.5** What is the *annual* premium?
- C. LO 1.3, 1.4, 1.5 What is the annual deductible?
- **D. LO 1.3, 1.4, 1.5** What percentage of preferred provider charges does the patient owe after meeting the deductible each year?
- **E. LO 1.3, 1.4, 1.5** If the insured incurs a \$6,000 in-network medical bill after the annual deductible has been paid, how much will the health plan pay?



# ELECTRONIC HEALTH RECORDS, HIPAA, AND HITECH: SHARING AND PROTECTING PATIENTS' HEALTH INFORMATION





# Learning Outcomes

#### After studying this chapter, you should be able to:

- **2.1** Explain the importance of accurate documentation when working with medical records.
- 2.2 Compare the intent of HIPAA, HITECH, and ACA laws.
- 2.3 Describe the relationship between covered entities and business associates.
- 2.4 Explain the purpose of the HIPAA Privacy Rule.
- 2.5 Briefly state the purpose of the HIPAA Security Rule.
- 2.6 Explain the purpose of the HITECH Breach Notification Rule.
- 2.7 Explain how the HIPAA Electronic Health Care Transactions and Code Sets standards influence the electronic exchange of health information.
- 2.8 Describe the four final rules in the Omnibus Rule.
- 2.9 Explain how to guard against potentially fraudulent situations.
- 2.10 Assess the benefits of a compliance plan.

# **KEY TERMS**

abuse

accountable care organization (ACO)

accounting of disclosure

Affordable Care Act (ACA)

audit

authorization

breach

breach notification

business associate (BA)

Centers for Medicare and Medicaid Services (CMS)

clearinghouse

code set

compliance plan

covered entity (CE)

de-identified health information

designated record set (DRS)

documentation

electronic data interchange (EDI)

encounter

encryption

evaluation and management (E/M)

fraud

Health Care Fraud and Abuse Control Program

health information exchange (HIE)

Health Information Technology for Economic and Clinical Health (HITECH) Act

Health Insurance Portability and Accountability Act (HIPAA) of 1996

HIPAA Electronic Health Care Transactions and Code Sets (TCS)

HIPAA National Identifiers

HIPAA Privacy Rule

HIPAA Security Rule

informed consent

malpractice

meaningful use

medical documentation and revenue cycle

medical record

medical standards of care

minimum necessary standard

National Provider Identifier (NPI)

Notice of Privacy Practices (NPP)

Office for Civil Rights (OCR)

Office of E-Health Standards and Services (OESS)

Continued



# KEY TERMS (continued)

Office of the Inspector General (OIG) Omnibus Rule operating rules password protected health information (PHI) relator transaction treatment, payment, and healthcare operations (TPO)

Medical insurance specialists work with important clinical data as well as demographic data. Health plans need patient clinical information to assess the medical necessity of claims sent for payment. To provide the right level of care, other physicians need to know the results of tests and examinations that patients have already had. Keeping all patient data safe and secure is the job of everyone on the healthcare team. But it is no longer a job of managing stacks of paper files. Like shopping, buying tickets, banking, and sharing photos online, healthcare records are moving to a digital platform. Working in this environment requires knowledge of electronic health records and of the federal rules that regulate access to them.

# **2.1** Medical Record Documentation: Electronic Health Records

A patient's **medical record** contains facts, findings, and observations about that patient's health history. The record also contains communications with and about the patient. In a physician practice, the medical record begins with a patient's first contact and continues through all treatments and services. The record provides continuity and communication among physicians and other healthcare professionals who are involved in the patient's care. Patients' medical records are also used in research and for education.

#### **Medical Records**

Medical records, or charts, contain documentation of patients' conditions, treatments, and tests that are created and shared by physicians and other providers to help make accurate diagnoses and to trace the course of care.

#### **COMPLIANCE GUIDELINE**

#### **Medical Standards of Care and Malpractice**

Medical standards of care are state-specified performance measures for the delivery of healthcare by medical professionals. Medical **malpractice** can result when a provider injures or harms a patient because of failure to follow the standards.

A patient's medical record contains the results of all tests a primary care physician (PCP) ordered during a comprehensive physical examination. To follow up on a problem, the PCP could refer the patient to a cardiologist, also sending the pertinent data for that doctor's review. By studying the medical record, the specialist treating a referred patient learns the outcome of previous tests and avoids repeating them unnecessarily.

**Documentation** means organizing a patient's health record in chronological order using a systematic, logical, and consistent method. A patient's health history, examinations, tests, and results of treatments are all documented. Complete and comprehensive documentation is important to show that physicians have followed the **medical standards of care** that apply in their state. Healthcare providers are liable (that is, legally responsible) for providing this level of care to their patients. The term *medical professional liability* describes this responsibility of licensed healthcare professionals.

medical record file containing the documentation of a patient's medical history and related information

malpractice failure to use professional skill when giving medical services that results in injury or harm

**documentation** recording of a patient's health status in a medical record

medical standards of care state-specified performance measures for the delivery of healthcare

Patient medical records are legal documents. Good medical records are a part of the physician's defense against accusations that patients were not treated correctly. They clearly state who performed what service and describe why, where, when, and how it was done. Physicians document the rationale behind their treatment decisions. This rationale is the basis for medical necessity—the clinically logical link between a patient's condition and a treatment or procedure.

#### Advantages of Electronic Health Records

Because of their advantages over traditional paper records, electronic health records are now used by the majority of physician practices. Electronic health records (EHRs) are computerized lifelong healthcare records for an individual that incorporate data from all sources that treat the individual.

EHRs are different from electronic *medical* records (EMRs), which are computerized records of one physician's encounters with a patient over time that are the physician's legal record of patient care. EHRs are also different from a third type of electronic record, personal health records (PHRs), which are private, secure electronic files that are created, maintained, and controlled by patients and contain data such as their current medications, health insurance information, allergies, medical test results, family medical history, and more.

Documents in electronic health records may be created in a variety of ways, but they are ultimately viewed on a computer screen. For example, one general practice uses a number of medical-history-taking templates for gathering and recording "consistent history and physical information from patients." The computer-based templates range in focus from abdominal pain to depression, with from ten to twenty questions each. The on-screen templates are filled out in the exam rooms. Responsible providers then sign the entries, using e-signature technology that verifies the identity of the signer.

EHRs offer both patients and providers significant advantages over paper records:

- ▶ Immediate access to health information: The EHR is simultaneously accessible from computers in the office and in other sites such as hospitals. Compared to sorting through papers in a paper folder, an EHR database can save time when vital patient information is needed. Once information is updated in a patient record, it is available to all who need access, whether across the hall or across town.
- ► Computerized physician order entry management: Physicians can enter orders for prescriptions, tests, and other services at any time. This information is then transmitted to the staff for implementation or directly to pharmacies linked to the practice.
- Clinical decision support: An EHR system can provide access to the latest medical research on approved medical websites to help medical decision making.
- Automated alerts and reminders: The system can provide medical alerts and reminders for office staff to ensure that patients are scheduled for regular screenings and other preventive practices. Alerts can also be created to identify patient safety issues, such as possible drug interactions.
- ▶ Electronic communication and connectivity: An EHR system can provide a means of secure and easily accessible communication between physicians and staff and in some offices between physicians and patients.
- ▶ Patient support: Some EHR programs allow patients to access their medical records and request appointments. These programs also offer patient education on health topics and instructions on preparing for common medical tests, such as an HDL cholesterol test.
- Administration and reporting: The EHR may include administrative tools, including reporting systems that enable medical practices to comply with federal and state reporting requirements.
- ▶ Error reduction: An EHR can decrease medical errors that result from illegible chart notes because notes are entered electronically on a computer or a handheld device.

#### COMPLIANCE **GUIDELINE**

#### Documentation and Billing: **A Vital Connection**

The connection between documentation and billing is essential: If a service is not documented, it cannot be billed.

#### BILLING TIP

#### Medical Necessity

Services are medically necessary when they are reasonable and essential for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Such services must also be consistent with generally accepted standards of care.

#### **BILLING TIP**

#### **Hybrid Record Systems**

Although the majority of physician practices use EHRs, most also still have paper records. The use of electronic along with paper records is called a hybrid record system.

encounter visit between a patient and a medical professional

Nevertheless, the accuracy of the information in the EHR is only as good as the accuracy of the person entering the data; it is still possible to click the wrong button or enter the wrong letter.

#### **Documenting Encounters with Providers**

Every patient encounter—the meeting, face-to-face or via telephone or emessaging, between a patient and a provider in a medical office, clinic, hospital, or other locationshould be documented with the following information:

- Patient's name
- Encounter date and reason
- Appropriate history and physical examination
- Review of all tests that were ordered
- Diagnosis
- ▶ Plan of care, or notes on procedures or treatments that were given
- Instructions or recommendations that were given to the patient
- Signature of the provider who saw the patient

In addition, a patient's medical record must contain:

- ▶ Biographical and personal information, including the patient's full name, date of birth, full address, marital status, home and work telephone numbers, and employer information as applicable
- ▶ Records of all communications with the patient, including letters, telephone calls, faxes, and e-mail messages; the patient's responses; and a note of the time, date, topic, and physician's response to each communication
- ▶ Records of prescriptions and instructions given to the patient, including refills
- Scanned records or original documents that the patient has signed, such as an authorization to release information and an advance directive
- Drug and environmental allergies and reactions, or their absence
- ▶ Up-to-date immunization record and history if appropriate, such as for a child
- Previous and current diagnoses, test results, health risks, and progress
- ▶ Records of referral or consultation letters
- ► Hospital admissions and release documents
- ▶ Records of any missed or canceled appointments
- ▶ Requests for information about the patient (from a health plan or an attorney, for example), and a detailed log of to whom information was released

Medicare's general documentation standards are shown in Table 2.1.

#### **Evaluation and Management Services Reports**

When providers evaluate a patient's condition and decide on a course of treatment to manage it, the service is called evaluation and management (E/M). Evaluation and management services may include a complete interview and physical examination for a new patient or a new problem presented by a person who is already a patient. There are many other types of E/M encounters, such as a visit to decide whether surgery is needed or to follow up on a patient's problem. An E/M service is usually documented with chart notes.

evaluation and management (E/M) provider's evaluation of a patient's condition and decision on a course of treatment to manage it

#### **BILLING TIP**

#### **SOAP Format**

A common documentation structure is the problem-oriented medical record (POMR) that contains *SOAP* notes—Subjective information from the patient, and three elements the provider enters: Objective data such as examination and/or test results, Assessment of the patient's diagnosis, and Plan, the intended course of treatment, such as surgery or medication.