

14TH
EDITION

UNDERSTANDING HEALTH INSURANCE

A GUIDE TO BILLING AND REIMBURSEMENT

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***Understanding Health Insurance: A Guide to
Billing and Reimbursement, 14th edition***
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Library of Congress Control Number: 2017957882

ISBN: 978-1-337-55422-0

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Printed in the United States of America
Print Number: 01 Print Year: 2018

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Preface

Introduction

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

Objectives

The objectives of this text are to:

1. Introduce information about major insurance programs and federal health care legislation.
2. Provide a basic knowledge of national diagnosis and procedure coding systems.
3. Explain the impact of coding compliance and clinical documentation improvement (CDI) on health care settings.
4. Simplify the process of completing claims.

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

Features of the Text

Major features of this text include:

- Key terms, section headings, and learning objectives at the beginning of each chapter help organize the material. They can be used as a self-test for checking comprehension and mastery of chapter content. Boldfaced key terms appear throughout each chapter to help learners master the technical vocabulary associated with claims processing.
- CPT, HCPCS level II, and ICD-10-CM coverage presents the latest coding information, numerous examples, and skill-building exercises. Detailed content prepares students for changes they will encounter on the job.
- CMS-1500 claims appear throughout the text to provide valuable practice with manual claims completion, and SimClaim™ practice software, available online within MindTap, presents the electronic version. The UB-04 claim appears in chapter 11 with its claims completion instructions.
- Coding exercises are located throughout textbook Chapters 6 through 8 and 10, and claims completion exercises are located throughout Chapters 11 through 17. Answers to exercises are available from your instructor.
- Numerous examples are provided in each chapter to illustrate the correct application of rules and guidelines.

- Notes clarify chapter content, focusing the student's attention on important concepts. Coding Tips provide practical suggestions for mastering the use of the CPT, HCPCS level II, and ICD-10-CM coding manuals. HIPAA Alerts draw attention to the impact of this legislation on privacy and security requirements for patient health information.
- The Study Checklist at the end of each chapter directs students to other learning aids that enhance understanding of the chapter's concepts while building confidence.
- End-of-chapter reviews reinforce learning and are in multiple-choice format with a coding completion fill-in-the-blank format available for coding chapters. Answers to chapter reviews are available from your instructor.
- SimClaim™, the practice software available online within MindTap, contains case studies that include billing data and patient histories, and allow for data entry on CMS-1500 claims, with immediate feedback. The complete SimClaim™ *Procedure Manual* is easily accessed online and provides complete instructions for working with the software. (Instructions for using SimClaim™ are located at the end of this Preface.)
- **MindTap** is a fully online, interactive learning platform that combines readings, multimedia activities, and assessments into a singular learning path, elevating learning by providing real-world application to better engage students. MindTap can be accessed at www.cengagebrain.com.

New to this Edition

- Chapter 1: Content about the AAPC, its use of only the abbreviation, the name of its monthly publication, and its new credentials was updated; the MAB's new CMRT credential was added to the content.
- Chapter 2: Content about health insurance coverage statistics was updated and new legislation was added (e.g., eHealth Exchange, MACRA IMPACT Act, NOTICE Act, CURES Acts, Veterans' Choice). Content about *rural health information organizations (RHIOs)*, *esMD*, and the new quality payment program, which includes *eCQMs*, *Advanced APMs*, and *MIPS*, was also added.
- Chapter 3: Content about *HEDIS®* and *Quality Compass®* was added.
- Chapter 4: The chapter was renamed Revenue Cycle Management to better reflect its content. *Revenue cycle management* and *chargemaster* content from Chapter 9 was relocated to this chapter, *encounter form* content was added, and content about *utilization management (utilization review)*, *case management*, *claims denial*, *claims rejection*, and *data management* was added. *Preauthorization* content was expanded, and examples were added. The *ledger card* and *day sheet* images were updated, and content about CMS's *quarterly provider update (QPU)* was added.
- Chapter 5: Content about *utilization management*, *Conditions of Participation (CoPs)*, *Conditions for Coverage (CfCs)*, *deeming authority*, *merit-based incentive payment system (MIPS)*, *Health Care Fraud Prevention and Enforcement Action Team (HEAT)*, *Hospital Outpatient Quality Reporting Program (Hospital OQR)*, and *UB-04 flat file* were added. The *recovery audit contractor (RAC) program map* was updated, and a table about *provider options for RAC Program overpayment determination* was added. Examples of fraud and abuse were updated.
- Chapter 6: ICD-10-CM and ICD-10-PCS guidelines and codes were updated. Specifically, the official coding guidelines about *Excludes1* and *With* were updated.
- Chapter 7: CPT coding guidelines and codes were updated. Content about *telemedicine* and the *Medicare Outpatient Observation Notice (MOON)* was added.
- Chapter 8: HCPCS level II guidelines and codes were updated.
- Chapter 9: Content about the new *Federally Qualified Health Centers Prospective Payment System (FQHC PPS)* was added along with content about *intensity of services (IS)* and *pay for performance (P4P)*. Examples for *Changes to CMS Payment Systems* were added. Content about revenue cycle management

and chargemasters was relocated to Chapter 4; content about the UB-04 claim was relocated to Chapter 11.

- Chapter 10: The chapter title was changed to *Coding Compliance, Clinical Documentation Improvement, and Coding for Medical Necessity*, and related content was added. Coding exercises continue to be included in the chapter.
- Chapters 11 to 17: ICD-10-CM, HCPCS level II, and CPT codes were updated. Insurance claims completion instructions and the CMS-1500 claim were revised according to the latest industry guidelines and standards. *UB-04* content from Chapter 9 was relocated to the end of Chapter 11. Chapter 13 contains edits to the BCBS Health Care Anywhere plans. Chapter 14 contains new content about *ambulance services* and the *billing of telehealth services*. Chapter 15 contains new content about the impact of the Affordable Care Act (Obamacare) on Medicaid eligibility. Chapter 16 contains revised content about the reduction in the number of TRICARE regions, including a new map, and new content about TRICARE eligibility programs. Chapter 17 revised the name of the Federal Black Lung Program to include its new name, the Coal Mine Workers' Compensation Program, and new content about the Employees' Compensation Appeals Board (ECAB) was added.
- SimClaim™ practice software available within MindTap, includes updated ICD-10-CM, HCPCS level II, and CPT Codes. SimClaim™ Case Studies: Set One and SimClaim™ Case Studies: Set Two have been relocated from the textbook to the Student Companion site at www.cengagebrain.com.

Organization of This Textbook

- Chapter outlines, key terms, objectives, chapter exercises, end-of-chapter summaries, and reviews facilitate student learning.
- A Study Checklist at the end of each chapter directs learners to various methods of review, reinforcement, and testing.
- Chapter 1, Health Insurance Specialist Career, contains an easy-to-read table that delineates training requirements for health insurance specialists.
- Chapter 2, Introduction to Health Insurance, contains content about health care insurance developments. A table containing the history of significant health insurance legislation in date order simplifies laws and regulations implemented. Meaningful use content remains in the chapter to serve as background for content about the new quality payment program (e.g., Advanced APMs, eQMs, MIPS).
- Chapter 3, Managed Health Care, contains content about managed care plans, consumer-directed health plans, health savings accounts, and flexible spending accounts. A table contains the history of significant managed health care legislation in date order to organize the progression of laws and regulations.
- Chapter 4, Revenue Cycle Management, contains content about managing the revenue cycle claims processing steps, and the denials/appeals process.
- Chapter 5, Legal and Regulatory Issues, emphasizes confidentiality of patient information, retention of patient information and health insurance records, the Federal False Claims Act, the Health Insurance Portability and Accountability Act of 1996, and federal laws and events that affect health care.
- Chapter 6, ICD-10-CM Coding, contains coding conventions and coding guidelines with examples. An overview about ICD-10-PCS is also provided, and additional content can be found at the www.cengagebrain.com Student Resources online companion. The coding conventions for the ICD-10-CM Index to Disease and Injuries and ICD-10-CM Tabular List of Diseases and Injuries are clearly explained and include examples. In addition, examples of coding manual entries are included.



Note:

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

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

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



Note:

CPT codes were updated using the AMA's downloadable CPT data files.

Resources for the Instructor

Spend less time planning and more time teaching with Cengage Learning's Instructor Resources to Accompany the Fourteenth Edition of *Understanding Health Insurance*. As an instructor, you will find these resources offer invaluable assistance anywhere, at any time.

All instructor resources can be accessed by going to www.cengagebrain.com to create a unique user login. Contact your sales representative for more information. Online instructor resources at the Instructor Companion Website are password-protected and include the following:

Instructor's Manual

In Adobe's PDF format, the Instructor's Manual contains the following sections:

- Section I – Preparing Your Course
- Section II – Answer Keys to Textbook Chapter Exercises and Reviews
- Section III – Answer Keys to SimClaim™ Case Studies: Set One, and SimClaim™ Case Studies: Set Two
- Section IV – Instructor's Materials
- Section V – Answer Keys to Workbook Chapter Assignments
- Section VI – Answer Key to Mock CMRS Exam
- Section VII – Answer Key to Mock CPC-P Exam
- Section VIII – Answer Key to Mock CPB Exam

Test Bank

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

Slide Presentations

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

Curriculum and Conversion Guides

Insurance Billing & Coding Curriculum Guide helps you plan your course using *Understanding Health Insurance* and other Cengage resources. Conversion grids map the Thirteenth Edition to the Fourteenth Edition, and to competitive titles.

SimClaim™ Software

SimClaim™, interactive CMS-1500 claims completion software, includes 40 fully revised coding case studies.

Updates and Resources

Revisions to the text, Instructor's Manual, SimClaim™, and test bank due to coding updates are posted. The Instructor Site also includes access to all student supplements, as well as additional textbook content.

Resources for the Student

Student Workbook (ISBN 978-1-337-55423-7)

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

Each chapter contains review questions, in multiple-choice format, to emulate credentialing exam questions. In Chapters 11 through 17, additional case studies allow more practice in completing the CMS-1500 claim. Appendix A contains a mock CMRS exam; Appendix B contains a mock CPC-P exam; and Appendix C contains a mock CPB exam.

Student Companion Site

Additional student resources can be found online at www.cengagebrain.com. Student resources include:

- CMS-1500 and UB-04 claims (blank fill-in forms)
- 1995 and 1997 documentation guidelines for evaluation and management services
- Revisions to the textbook and workbook due to coding updates
- E/M CodeBuilder (that can be printed to use as a worksheet)
- Final test for AAPC CEU approval

MindTap

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

MindTap includes:

- An interactive eBook with highlighting and note-taking capability
- Flashcards for practicing chapter terms
- Computer-graded activities and exercises
 - Self-check and application activities, integrated with the eBook
 - Case studies with videos
- Easy submission tools for instructor-graded exercises

ISBNs: 978-1-337-55428-2 (electronic access code); 978-1-337-55429-9 (printed access card)

About the Author

Michelle A. Green, MPS, RHIA, FAHIMA, CPC, has been a college professor since 1984. She taught traditional classroom-based courses until 2000 at Alfred State College, when she transitioned all of the health information technology and coding/reimbursement specialist courses to an Internet-based format and continued teaching full-time online until 2016. Upon relocating to Syracuse, New York, she began teaching as an adjunct professor for the health information technology program for Mount Wachusett Community College, Gardner, Massachusetts. In 2017, she also started teaching for the health information technology program at Mohawk Valley Community College, Utica, New York. Michelle A. Green's teaching responsibilities include health information management, insurance and reimbursement, revenue cycle management, and ICD-10-CM, ICD-10-PCS, CPT, and HCPCS level II coding courses. Prior to 1984, she worked as a director of health information management at two acute care hospitals in the Tampa Bay, Florida, area. Both positions required her to assign codes to inpatient cases. Upon becoming employed as a college professor, she routinely spent semester breaks coding for a number of health care facilities so that she could further develop her inpatient and outpatient coding skills.



Reviewers

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

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Acknowledgments

In memory of my son, Eric, who always kept me “on task” by asking, “How much did you get finished in the chapter today, Mom?” Thank you for truly understanding my need to pursue my passion for teaching and writing. You always proudly introduced me as your mom, the teacher and writer. You remain forever in my heart, Eric.

A special thank you to my brother, Dave Bartholomew, for his encouragement and support. You are my rock!

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

To my technical reviewer, Marsha Diamond, thank you for your incredible attention to detail and wonderful knowledge about all things coding and reimbursement!

To my senior content developer, Beth Williams, thank you for your invaluable support, patience, and guidance.

To my senior content project manager, Kara DiCaterino, I truly appreciate every single thing you do!

To my mom, Alice B. Bartholomew, for writing real-life case studies for my textbooks and having originally helped me select a health care career. Your guidance is so appreciated.

Special appreciation is expressed to Optum Publishing Group for granting permission to reprint selected tables and pages from:

- *HCPCS Level II Professional*
- *ICD-10-CM Professional*
- *ICD-10-PCS Professional*

Feedback

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

How to Use This Text

Chapter Outline

Health Insurance Overview
Health Insurance Career Opportunities
Education and Training

Job Responsibilities
Professionalism

Objectives

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

1. Define key terms.
2. Discuss introductory health insurance concepts.
3. Identify career opportunities available in health insurance.
4. List the education and training requirements of a health insurance specialist.
5. Describe the job responsibilities of a health insurance specialist.
6. Explain the role of workplace professionalism in career success.

Key Terms

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

Objectives and Key Terms

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

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

Introduction

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

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

Introduction

Managed health care (managed care) combines health care delivery with the financing of services provided. The intent was to replace conventional fee-for-service plans with more affordable quality care to health care consumers and providers who agreed to certain restrictions (e.g., patients would receive care only from providers who are members of a managed care organization). Managed care is currently being challenged by the growth of **consumer-directed health plans (CDHPs)**, which define employer contributions and ask employees to be more responsible for health care decisions and cost-sharing. You might think of a CDHP as a sort of “401(k) plan for health care” (recalling the shift from employer defined-benefit pension plans to employer defined-contribution 401(k) plans).

Notes

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

Note:

Health insurance specialists and medical assistants obtain employment in clinics, health care clearinghouses, health care facility billing departments, insurance companies, and physicians' offices, as well as with third-party administrators (TPAs). When employed by clearinghouses, insurance companies, or TPAs, they often have the opportunity to work at home, where they process and verify health care claims using an Internet-based application server provider (ASP).

HIPAA Alert!

With the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Congress increased the potential fine from \$2,000 to \$10,000 if a nonPAR does not heed Medicare administrative contractor (MAC) warnings to desist from flagrant abuse of the limiting charge rules.

Coding Tip:

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

Icons

Icons draw attention to critical areas of content or provide experience-based recommendations. For example, the **HIPAA ALERT!** identifies issues related to the security of personal health information in the medical office. The **Coding Tip** provides recommendations and hints for selecting codes and for the correct use of the coding manuals. Other icons include **Managed Care Alert**, **Hint**, **Remember!**, and **Caution**.

Table 13-1 CMS-1500 claims completion instructions for BCBS fee-for-service plans

**Note:**

Refer to Chapter 11 for clarification of claims completion (e.g., entering names, mailing addresses, ICD-10-CM codes, diagnosis pointer letters, NPI, and so on).

Block	Instructions
1	Enter an X in the <i>Other</i> box if the patient is covered by an individual or family health plan. Or, enter an X in the <i>Group Health Plan</i> box if the patient is covered by a group health plan. Note: The patient is covered by a group health plan if a group number is printed on the patient's insurance identification card (or a group number is included on case studies located in this textbook, workbook, and SimClaim™ software).
1a	Enter the BCBS plan identification number as it appears on the patient's insurance card. <i>Do not enter hyphens or spaces in the number.</i>
2	Enter the patient's last name, first name, and middle initial (separated by commas) (e.g., DOE, JANE, M).
3	Enter the patient's birth date as MM DD YYYY (with spaces). Enter an X in the appropriate box to indicate the patient's gender. If the patient's gender is unknown, leave blank.
4	Enter the policyholder's last name, first name, and middle initial (separated by commas).

Claims Instructions

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

Internet Links

AAPC: www.aapc.com
 American Association of Medical Assistants (AAMA): www.aama-ntl.org
 American Health Information Management Association (AHIMA): www.ahima.org
 American Medical Billing Association (AMBA): www.ambanet.net
 Centers for Medicare and Medicaid Services (CMS): www.cms.gov
 Medical Association of Billers (MAB): www.physicianswebsites.com
 U.S. Department of Labor, Bureau of Labor Statistics (BLS): www.bls.gov

Study Checklist

- ☐ Read this textbook chapter and highlight key concepts. (Use colored highlighter sparingly throughout the chapter.)
- ☐ Create an index card for each key term. (Write the key term on one side of the index card and the concept on the other. Learn the definition of each key term, and match the term to the concept.)
- ☐ Access chapter Internet links to learn more about concepts.
- ☐ Answer the chapter review questions, verifying answers with your instructor.
- ☐ Complete the Workbook chapter, verifying answers with your instructor.
- ☐ Form a study group with classmates to discuss chapter concepts in preparation for an exam.

Review

Multiple Choice

- Select the most appropriate response.
- The document submitted to the payer requesting reimbursement is called a(n)
 - explanation of benefits.
 - health insurance claim.
 - remittance advice.

Study Checklist

The **Study Checklist** appears at the end of each chapter. This list directs you to other learning and application aids. Completing each of the items in the checklist helps you gain confidence in your understanding of the key concepts and in your ability to apply them correctly.

Internet Links

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

Reviews and Exercises

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

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

Exercise 10.1 – Choosing the First-Listed Diagnosis

Review the list of symptoms, complaints, and disorders in each case. Then, underline the first-listed diagnosis.

- Occasional bouts of urinary frequency, but symptom-free today
Sore throat with swollen glands and enlarged tonsils
Acute pharyngitis with negative rapid strep test
Urinalysis test negative
- Edema, left lateral malleolus
Limited range of motion due to pain
Musculoligamentous sprain, left ankle
X-ray negative for fracture
- Distended urinary bladder
Benign prostatic hypertrophy (BPH) with urinary retention
Enlarged prostate
Pale, diaphoretic, and in acute distress
- Pale, diaphoretic, and in acute distress
Bacterial endocarditis
Limited chest expansion, scattered bilateral wheezes
Pulse 112 and regular, respirations 22 with some shortness of breath
- Right leg still weak
Partial drop foot gait, right
Tightness in lower back

Summary

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

Summary

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

How to Use SimClaim™ CMS-1500 Software

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

How to Access

Student practice software is available through the online MindTap program, accessed at www.cengagebrain.com

General Instructions and Hints for Completing CMS-1500 Claims in SimClaim™

Please read through the following general instructions before beginning work in the SimClaim™ program:

- **Certain abbreviations are allowed in the program**—for example, ‘St’ for Street, ‘Dr’ for Drive, ‘Rd’ for Road, ‘Ct’ for Court. No other abbreviations will be accepted as correct by the program.
- **Only one Diagnosis Pointer in Block 24E per line**—though SimClaim™ allows for more than one Diagnosis Pointer to be entered, only one diagnosis pointer is allowed in Block 24E for each line item as per textbook instructions.
- **No Amount Paid Indicated**—If there is no amount paid indicated on the case study, *leave the field blank*.
- **Secondary Insurance Claims**—If a Case Study indicates that a patient’s Primary Insurance payer has paid an amount, fill out a second claim for the Secondary Insurance that reflects the amount reimbursed by primary insurance when indicated.
- **Fill out Block 32** only when the facility is other than the office setting, as indicated on the Case Study.
- **Enter all dates** as listed on the Case Study.
- For additional help using SimClaim™, refer to the specific payer guidelines found in your textbook.

Health Insurance Specialist Career

CHAPTER

1

Chapter Outline

Health Insurance Overview

Health Insurance Career Opportunities

Education and Training

Job Responsibilities

Professionalism

Objectives

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

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bonding insurance	<i>Current Procedural Terminology (CPT)</i>	health insurance claim	
	embezzle	health insurance specialist	
	errors and omissions insurance	Healthcare Common Procedure Coding System (HCPCS)	
	ethics	hold harmless clause	

medical assistant	medical necessity	professionalism	<i>respondeat superior</i>
Medical Association of Billers (MAB)	national codes	property insurance	scope of practice
medical malpractice insurance	professional liability insurance	reimbursement specialist	workers' compensation insurance
		remittance advice (remit)	

Introduction

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



Note:

Reimbursement specialist is another title for health insurance specialist.

Health Insurance Overview

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

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

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

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

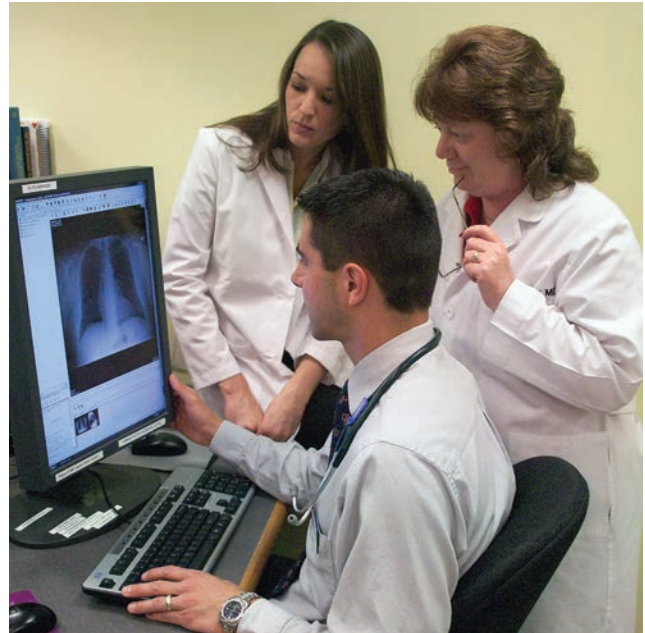


Figure 1-1 Health care providers viewing an electronic image of a patient's chest x-ray.

Health Insurance Career Opportunities

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

Health insurance specialists (or **reimbursement specialists**) review health-related claims to match medical necessity to procedures or services performed before payment (reimbursement) is made to the provider. A **claims examiner** employed by a third-party payer reviews health-related claims to determine whether the charges are reasonable and for medical necessity. **Medical necessity** involves *linking every procedure or service code reported on the claim to a condition code (e.g., disease, injury, sign, symptom, other reason for encounter) that justifies the need to perform that procedure or service* (Figure 1-2).

The claims review process requires verification of the claim for completeness and accuracy, as well as comparison with third-party payer guidelines (e.g., expected treatment practices) to (1) authorize appropriate payment or (2) refer the claim to an investigator for a more thorough review. A **medical assistant** (Figure 1-3) is employed by a provider to perform administrative and clinical tasks that keep the office or



Note:

Information about salaries can be located at the www.bls.gov, www.aapc.com, and www.ahima.org websites.



Figure 1-2 Health insurance specialist locating code number for entry in CMS-1500 claims software.



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

clinic running smoothly. Medical assistants who specialize in administrative aspects of the profession answer telephones, greet patients, update and file patient medical records, complete insurance claims, process correspondence, schedule appointments, arrange for hospital admission and laboratory services, and manage billing and bookkeeping.



Note:

Health insurance specialists and medical assistants obtain employment in clinics, health care clearinghouses, health care facility billing departments, insurance companies, and physicians' offices, as well as with third-party administrators (TPAs). When employed by clearinghouses, insurance companies, or TPAs, they often have the opportunity to work at home, where they process and verify health care claims using an Internet-based application server provider (ASP).

EXAMPLE 1: PROCEDURE: KNEE X-RAY

DIAGNOSIS: Shoulder pain

In this example, the provider is not reimbursed because the reason for the x-ray (shoulder pain) does not match the type of x-ray performed (knee). For medical necessity, the provider would need to document a diagnosis such as "fractured patella (knee bone)."

EXAMPLE 2: PROCEDURE: CHEST X-RAY

DIAGNOSIS: Severe shortness of breath

In this example, the provider is reimbursed because medical necessity for performing the procedure is demonstrated.

Coding is the process of assigning ICD-10-CM, ICD-10-PCS, CPT, and HCPCS level II codes, which contain alphanumeric and numeric characters (e.g., A01.1, 0DTJ0ZZ, 99201, K0003), to diagnoses, procedures, and services. Coding systems include:



Note:

ICD-10-PCS codes are assigned to inpatient hospital procedures only.

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



Note:

On December 31, 2003, CMS phased out the use of local codes, previously known as HCPCS level III codes. However, some third-party payers continue to use HPCS level III codes.

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

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



Note:

In addition to many other functions, health information technicians perform insurance specialist functions by assigning codes to diagnoses and procedures and, when employed in a provider's office, by processing claims for reimbursement. (**Health information technicians** manage patient health information and medical records, administer computer information systems, and code diagnoses and procedures for health care services provided to patients.) The *Occupational Outlook Handbook* states that employment is projected to grow much faster than the average for all occupations because the demand for health services is expected to increase as the population ages.

Education and Training

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

Table 1-1 Training requirements for health insurance specialists

Coursework	Description
Anatomy and Physiology, Medical Terminology, Pharmacology, and Pathophysiology	Knowledge of anatomic structures and physiological functioning of the body, medical terminology, and essentials of pharmacology are necessary to recognize abnormal conditions (pathophysiology). Fluency in the language of medicine and the ability to use a medical dictionary as a reference are crucial skills.
Diagnosis and Procedure/Service Coding	<p>Understanding the rules, conventions, and applications of coding systems ensures proper selection of diagnosis and procedure/service codes, which are reported on insurance claims for reimbursement purposes.</p> <p>EXAMPLE: Patient undergoes a simple suture treatment of a 3-cm facial laceration. When referring to the CPT index, there is no listing for "Suture, facial laceration." There is, however, an instructional notation below the entry for "Suture" that refers the coder to "Repair." When "Repair" is referenced in the index, the coder must then locate the subterms "Skin," "Wound," and "Simple." The code range in the index is reviewed, and the coder must refer to the tabular section of the coding manual to select the correct code.</p>
Verbal and Written Communication	Health insurance specialists explain complex insurance concepts and regulations to patients and must effectively communicate with providers regarding documentation of procedures and services (to reduce coding and billing errors). Written communication skills are necessary when preparing effective appeals for unpaid claims.
Critical Thinking	<p>Differentiating among technical descriptions of similar procedures requires critical thinking skills.</p> <p>EXAMPLE: Patient is diagnosed with spondy/osis, which is defined as any condition of the spine. A code from category M47 of ICD-10-CM would be assigned. If the diagnosis was mistakenly coded as spondy/olysis, which is a defect of the articulating portion of the vertebra, ICD-10-CM category Q76 (if congenital) or M43 (if acquired) codes would be reported in error.</p>
Data Entry	<p>Federal regulations require electronic submission of most government claims, which means that health insurance specialists need excellent keyboarding skills and basic finance and math skills. Because insurance information screens with different titles often contain identical information, the health insurance specialist must carefully and accurately enter data about patient care.</p> <p>EXAMPLE: Primary and secondary insurance computer screens require entry of similar information. Claims are rejected by insurance companies if data are missing or erroneous.</p>
Internet Access	Online information sources provide access to medical references, insurance company manuals, and procedure guidelines. The federal government posts changes to reimbursement methodologies and other policies on websites. Internet forums allow health insurance specialists to network with other professionals.