# *INSTRUCTOR'S MANUAL*

For use with

# MEDICAL INSURANCE
## A Revenue Cycle Process Approach

Eighth Edition
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**INSTRUCTOR'S MANUAL FOR MEDICAL INSURANCE, Eighth Edition**



CPT codes are based on CPT 2018.
ICD-10-CM codes are based on ICD-10-CM 2018.

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# CONTENTS

# INTRODUCTION

Broad pressure to control costs in the healthcare industry creates a complex billing environment. Payment has shifted from straightforward fee-for-service insurance to a complex mixture of contracts with payers. Providers must ensure patient satisfaction and also use health information technology effectively and efficiently to receive maximum appropriate payment for their services. Additional pressure results from federal government prosecution of health care fraud and abuse as a top policy objective. HIPAA and HITECH have also created new privacy, security, transactions, and code sets laws, including the transition to ICD-10-CM/PCS, that must be implemented. Failure to comply with proper billing and coding procedures can have significant financial and legal consequences.

The eighth edition of *Medical Insurance: A Revenue Cycle Process Approach* continues to emphasize the medical revenue cycle—ten steps that clearly identify all the components needed to successfully manage the medical insurance claims process. The cycle shows how medical professionals "follow the money." The program assists instructors in presenting clear, up-to-date instruction to give students the skills and knowledge they will need to perform the current duties of medical insurance specialists and to succeed moving forward in a changing environment. Therefore, the text reflects judgments about what to emphasize, such as the increased use of health information technology, and then necessarily what to exclude, such as detailed histories of insurance programs.

In addition to current duties, the text covers trends, developments, and resources, so that students will be able to understand the inevitable changes as they occur. The text and the supplementary workbook and website reinforce problem analysis, critical thinking, effective use of resources, and communication, the capabilities that will underpin students' future employment success as important members of the health care team.

## *KEY CHANGES FOR THE EIGHTH EDITION*

**Exercises**

Starting in Chapter 8, in-chapter exercises give students the opportunity to get hands-on experience with claim completion through simulations of real software. *Medical Insurance, 8e* offers these options for completing these tasks:

- **Paper Claim Form:** Students gaining experience by completing a paper CMS-1500 claim form use the blank form supplied (from the back of *Medical Insurance, 8e)* 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® or Medisoft simulations as part of the options.

## Changes to Content by Chapter

- **Chapter 1:** Figure 1.1 and 1.4 updated with new information. Thinking It Through features 1.2 and 1.7 updated with new questions. Learning Outcome 1.7 has a new introductory paragraph and current figures. The Compliance Guideline on ICD-9-CM Versus ICD-10-CM has been updated to reflect changes.

- **Chapter 2:** Dated Figures have been deleted with the remaining Figures renumbered. Two new HIPAA/HITECH Tip features were added, titled Texting and Plans Mandated.

- **Chapter 3:** New key terms: insured/subscriber, which combined two previous key terms. Dated Figures have been deleted with the remaining Figures renumbered.

- **Chapter 4:** All ICD-10-CM codes have been checked and updated as needed. Figures 4.1 and 4.3 have been updated with new codes and information. Thinking It Through features 4.5 and 4.7 have been updated with new questions. Applying Your Knowledge: Case 4.1 now has new questions.

- **Chapter 5:** All CPT/HCPCS codes have been checked and updated as needed. WWW Features and Tables 5.2, 5.3, and 5.6 are updated with new information and for new CPT conventions. New Billing Tip titled Revised Guidelines Coming. New subheading Symbol for Telemedicine to cover this new CPT convention. New questions in the Applying Your Knowledge Cases 5.1, 5.2, 5.3, and 5.5.

- **Chapter 6:** All codes have been checked and updated as needed. Dated Figures have been deleted with the remaining Figures renumbered and updated. Thinking It Through feature 6.4 has been updated with new questions. New questions in the Review Questions section and in Applying Your Knowledge Case 6.1.

- **Chapter 7:** New key terms: 5010A1 version; Healthcare Provider Taxonomy Code (HPTC). Multiple Item Number definitions and text descriptions have been extensively revised throughout to reflect the most recent NUCC CMS-1500 instructions, along with new explanations for expanded Item Numbers. Dated Figures and Tables have been deleted with the remaining Figures and Tables renumbered and updated. New Billing Tip titled ICD Indicator. Website addresses for several WWW features have been revised or updated. Updated Applying Your Knowledge Cases 7.2, 7.3, and 7.4.

- **Chapter 8:** New year-specific financial information inserted to match current rates. Figures and WWW features were updated throughout to make current. New questions added to Thinking It Through 8.9. Updated Applying Your Knowledge Cases 8.1 and 8.4.

- **Chapter 9:** New key terms: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); Medicare Beneficiary Identifier (MBI); Quality Payment Program (QPP). All of the Medicare-specific facts, figures, and information were updated throughout to make current. Several Billing Tips updated to reflect new Medicare features and costs. New information added to describe the new Quality Payment Program (QPP). Figures 9.1, 9.7, and 9.9 are new/updated with current data and information. New questions added to Thinking It Through 9.8 and the Review Questions. Updated Applying Your Knowledge Cases 9.1, 9.2, and 9.3.

- **Chapter 10:** The information about the Medicaid program and the options available to states has been updated. Figure 10.5 updated per new claim completion requirements. New questions added to Thinking It Through 10.2 and 10.7. Updated Applying Your Knowledge Cases 10.1 and 10.2.

- **Chapter 11:** New key terms: Prime Service Area; TRICARE Select. The information about TRICARE enrollment and coverage costs has been updated, with descriptions of the new TRICARE programs. New Learning Outcomes 11.3 and 11.4 with new text to describe TRICARE Prime and TRICARE Select. Figures 11.1 and 11.2 contain a new TRICARE map and claim completion form. New questions added to the Review Questions and Applying Your Knowledge Cases 11.1, 11.2, and 11.3 have been updated.

- **Chapter 12:** The information about FECA and eligibility in state workers' compensation plans has been updated. Figure 12.2 and Applying Your Knowledge Cases 12.1 and 12.2 have been updated.

- **Chapter 13:** Thinking It Through 13.1, 13.3, and 13.5, as well as Figures 13.1 and 13.9 have been updated with new information and claims. New Billing Tip added on Annual Appeal Amounts. Applying Your Knowledge Cases 13.1 and 13.2 have been updated.

- **Chapter 14:** Figures 14.2, 14.3, and 14.4, along with Thinking It Through 14.2, 14.4, and 14.8 have all been updated with new information. Applying Your Knowledge Cases 14.1 has been updated.

- **Chapters 15 and 16:** The case studies for ICD-10-CM and for NUCC CMS-1500 guidelines have been updated, along with the dates, policy information, charges, and CPT/HCPCS codes used. Several Figures and Tables have been updated to reflect these changes. The most recent CMS-1500 claim forms have been utilized.

- **Chapter 17:** This chapter has been updated to reflect the most current CPT and ICD-10-CM codes. Figure 17.3 has new art for the form completion and a new WWW feature titled Medicare Secondary Payer Questionnaire has been added to support this update. New questions added to the Review Questions and Applying Your Knowledge Cases 17.1 and 17.2 have been updated.

## *STRUCTURE AND FEATURES OF THE TEXT/WORKBOOK*

The text/workbook is divided into seventeen chapters. All seventeen chapters cover an important topic concerning insurance procedures.

The optimal course of study is to build knowledge and skills by following the order of the text presentation. However, since curriculum requirements vary, each chapter is complete, and includes its own learning objectives, key terms, and end-of-chapter material. Thus, the chapter order can be changed or material can be omitted to fit various instructional requirements. The text is designed for a one-semester medical insurance course, and covers medical insurance, medical coding basics, and a brief introduction to hospital billing. The text may be modified to suit the instructor's curriculum requirements. Following are examples of possible modifications:

- If students complete a HIPAA course in the curriculum, Chapter 2 of *Medical Insurance* may be omitted.
- If students are knowledgeable regarding medical coding, Chapters 4 and 5 may be omitted.
- Instructors who do not wish to present the topic of hospital billing may omit Chapter 17.

When chapters are not presented as class work, it is suggested that they be assigned for independent study. In particular, Chapters 4 and 5 on medical coding provide an excellent review/refresher of basic coding procedures and guidelines.

Note that Chapter 6, *Visit Charges and Compliant Billing*, should **not** be omitted. It presents essential, timely material not covered in most law and ethics courses or in introductory coding classes regarding compliance.

**Chapter Structure**

- *Learning Outcomes* describe the most important information the chapter contains.
- *Key Terms* provide an alphabetic list of the most important vocabulary terms in the chapter. The key terms are printed in bold-faced type and defined when introduced. A complete glossary at the end of the book defines each key term as well as other important terms medical insurance specialists need to know.
- Note that the key terms include healthcare vocabulary but not words that are in common general use, such as mortality and morbidity, which a student can readily research.
- Chapter text provides essential background material and information on the procedures being taught.
- *Chapter Summary* covers key topics in a tabular, step-by-step format with page references to help with review of the material.
- Review questions and *Applying Your Knowledge* provide objective exercises and cases to test the students' understanding of the chapter's concepts and procedures. These exercises are tagged with the chapter's Learning Outcomes.

**Pedagogy Reinforced**

- Learning Outcomes reflect the revised version of Bloom's Taxonomy and the range of difficulty levels to teach and assess critical thinking about medical insurance and coding concepts.
- Major chapter heads reflect the numbered Learning Outcomes.
- In addition to the listing of learning outcomes and the listing of key terms, each chapter opener displays the Revenue Cycle, with the steps relevant to that chapter highlighted.
- Key terms are defined in the margins for easy reference, tested at the end of the chapter, and listed in the Glossary toward the end of the book.
- Billing Tips, Compliance Guidelines, and HIPAA/HITECH tips highlight key concepts or provide additional insights to help students navigate through the material.
- "Thinking It Through" questions at the end of each section help assess each Learning Outcome.

## *STRUCTURE AND FEATURES OF THE INSTRUCTOR'S MATERIALS*

***Instructor Manual***

Following this introduction, the instructor manual contains these sections:

- Syllabi, with more information available at McGraw-Hill Connect
- Lesson plans, provided for each chapter, are intended to assist the instructor in preparing for class, presenting key concepts, and assessing student comprehension.
  Each lesson plan has these parts:
  Class Preparation: *The Teaching Focus and the Learning Outcomes*
  Class Presentation: *The Lecture Outline*
    - PowerPoint Range
    - Key Topics

  Class Assessment: *The Checklist*
    - Thinking It Through
    - Review Questions
    - Applying Your Knowledge
    - Medical Coding Workbook for Text Chapters 4, 5, and 17
    - Testbank
    - Connect

  Answers
    - Thinking It Through
    - Review Questions
    - Applying Your Knowledge

***Instructors' Resources***

| **Supplement** | **Features** |
|---|---|
| Instructor's Manual (organized by Learning Outcomes) | ■ Lesson Plans<br>■ Answer Keys for all exercises |
| PowerPoint Presentations (organized by Learning Outcomes) | ■ Key Terms<br>■ Key Concepts<br>■ Accessible |
| Electronic Testbank | ■ Computerized and Connect<br>■ Word version<br>■ Questions have tagging for Learning Outcomes, Level of Difficulty, Level of Bloom's Taxonomy, Feedback, ABHES, CAAHEP, CAHIIM, and Estimated Time of Completion |
| Tools to Plan Course | ■ Correlations of the Learning Outcomes to Accrediting Bodies such as ABHES, CAHEP, and CAHIIM<br>■ Sample Syllabi<br>■ Conversion Guide Between seventh and eighth editions<br>■ Asset Map—recap of the key instructor resources, as well as information on the content available through Connect |
| EHRclinic Simulated Exercises Resources | ■ Implementation Guide<br>■ Technical Support Information<br>■ Steps for students completing the simulated exercises in Connect |

| | |
|---|---|
| CMS-1500 and UB-04 Forms | ■ PDFs of both forms |

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## *ANCILLARY MATERIAL*

***Workbook for Use with Medical Insurance: A Revenue Cycle Process Approach, Eighth Edition***

***(1-260-48914-0, 978-1-260-48914-9)***
The workbook is intended to strengthen, reinforce and expand student learning of the skills and concepts presented in the text. This workbook complements the text and follows the same learning outcomes.

Included is a brief review of the math skills necessary for processing medical insurance claims. Reinforcement of reading assignments (or note taking) is easy for students following the assisted outlining activity. The key term activities help strengthen students' vocabulary for each chapter and the applying concepts activities provide additional hands-on practice with the concepts and skills presented in each chapter. Instructors can measure students' progress in meeting learning outcomes with the short answer questions, or students can perform quick checks with the self-quiz questions. Instructors can expand on the Internet activities to deepen student understanding or to introduce new topics, for instance, when private and governmental third-party providers' policies change.

For short programs, the workbook materials can be used as homework assignments for reinforcement, follow-up, or extra instruction. For longer programs, the workbook materials can be used in class as well as for homework assignments. Additional class time would also provide the opportunity to have students work in teams/groups on several of the Web exercises.

Instructors may choose to use sections of the workbook in class, for example, using the key terms section as a pretest. Instructors may select individual assignments for each chapter depending on the progress of the class or assign specific activities to students who might be having difficulty grasping certain themes. For example, the instructor might assign all students the assisted outlining activity to reinforce the reading of each chapter or the self quiz questions could be used by students individually or as a class as a pretest prior to chapter or unit tests.

Other students may need critical thinking skills sharpened or wish to focus on one of the Web activities. The additional activities could be used in their entirety or portions selected to highlight individual concepts from the text.

Keys to all workbook material are included in this instructor's manual. Instructors may wish to provide students access to the answers to workbook exercises in order to monitor their progress.

***Medical Coding Workbook for Physician Practices & Facilities, Coding Exercises for ICD, CPT, and HCPCS, 2018-2019 Edition ((1-259-63002-1, 978-1-259-63002-6))***

Since 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 baseline for correct claims. The *Medical Coding Workbook for Physician Practices & Facilities, 2018-2019* provides practice and instruction in coding and compliance skills. 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.

# LESSON PLANS

## HOW TO USE THE LESSON PLANS

Lesson plans, provided for each chapter, are intended to assist the instructor in preparing for class, presenting key concepts, and assessing student comprehension.

Each lesson plan has these parts:

- Class Preparation: *The Teaching Focus and the Learning Outcomes*
- Class Presentation: *The Lecture Outline*
  - PowerPoint Range
  - Key Topics
- Class Assessment: *The Checklist*
  - Thinking It Through
  - Review Questions
  - Applying Your Knowledge
  - Workbook
  - Testbank
  - Connect

  *Optional:*
  - Medical Coding Workbook Exercises Correlated to Text Chapters 4, 5, and 17
- Answers to Thinking It Through Questions, Chapter Review Questions, and Applying Your Knowledge Cases

Chapter content is followed by the answers to the correlated workbook chapter.

# Chapter 1 Introduction to the Revenue Cycle

***TEACHING FOCUS AND LEARNING OUTCOMES***

The current employment environment for administrative staff in physician practices reflects the pressures of decreasing provider compensation, rising costs for medical services and for employer and employee medical insurance, increased governmental regulation, increased public awareness of healthcare issues, and increased reimbursement complexity. These elements underpin the changes that occur almost daily in physician/patient relations and related billing/reimbursement issues, so students need to understand this background. They also need to develop the ability to analyze problems, identify the information that is required, research/abstract that information, determine the best course of action, and work in a team to communicate information and share results.

In Chapter 1, students begin their understanding of the work and the employment environment of medical insurance and billing. The chapter covers medical insurance and plans, reimbursement methods, and payers, concluding with the requirements for success as a medical insurance specialist. It provides the instructional material for accomplishing four goals:

1. Introduce the role, responsibilities, and employment opportunities of the medical insurance specialist.
2. Teach basic insurance terms and concepts.
3. Preview the revenue cycle.
4. Explain that the organization of *Medical Insurance, 8e* follows and reinforces the revenue cycle.

The order of presentation for this chapter is:

- Present basic information on insurance terminology
- Present basic information on healthcare plans and payers
- Describe the duties of the medical insurance specialist in following the revenue cycle, and preview the text's chapter structure in relation to the cycle
- Briefly focus on the interplay among procedures, communication, and information technology in the revenue cycle
- Present information on the medical insurance specialist's skills, attitudes, possible certifications, and office ethics/etiquette that lead to successful employment

The learning outcomes for this chapter are:

LO 1.1 Identify three ways that medical insurance specialists help ensure the financial success of physician practices.

LO 1.2 Differentiate between covered and noncovered services under medical insurance policies.

LO 1.3 Compare indemnity and managed care approaches to health plan organization.

LO 1.4 Discuss three examples of cost containment employed by health maintenance organizations.

LO 1.5 Explain how a preferred provider organization works.

LO 1.6 Describe the two elements that are combined in a consumer-driven health plan.

LO 1.7 Define the three major types of medical insurance payers.

LO 1.8 Explain the ten steps in the revenue cycle.

LO 1.9 Analyze how professionalism, ethics, and etiquette contribute to career success.

LO 1.10 Evaluate the importance of professional certification for career advancement.

***LECTURE OUTLINE***

1.1 WORKING IN THE MEDICAL INSURANCE FIELD Slides Chapter 1: 8 – 10

1. Rising spending in the medical insurance field
2. Growing employment opportunities due to administrative complexity
3. Role of knowledgeable medical office administrative staff in practice profitability and patient satisfaction
4. Importance of following procedures
5. Need to communicate effectively both to patients and other staff members
6. Using health information technology—practice management programs and electronic medical records

1.2 MEDICAL INSURANCE BASICS Slides Chapter 1: 11 – 15

1. Medical insurance contract and benefits terms
2. Group versus individual policies
3. Disability/automotive insurance and workers' compensation

1.3 HEALTHCARE PLANS Slides Chapter 1: 16 – 18

1. Indemnity plans
    a. Conditions for payment
    b. Work through indemnity math example (text page 9)
2. Managed care plans
    a. Health maintenance organizations (HMOs)
    b. Point-of-service (POS) plans

c. Preferred provider organizations (PPOs)

d. Consumer-driven health plans

1.4 HEALTH MAINTENANCE ORGANIZATIONS Slides Chapter 1: 19 – 21

1. Capitation in HMOs
2. Medical management practices
3. Point-of-service plans

1.5 PREFERRED PROVIDER ORGANIZATIONS Slide Chapter 1: 22

1. Explanation of features
2. Example of operation
3. Cost-control

1.6 CONSUMER-DRIVEN HEALTH PLANS Slide Chapter 1: 23

1. Two elements
2. Cost containment

1.7 MEDICAL INSURANCE PAYERS Slide Chapter 1: 24

1. Private payers
2. Self-funded health plans
3. Government-sponsored healthcare programs

1.8 THE REVENUE CYCLE Slides Chapter 1: 25 – 27

1. Review of main job functions
2. Revenue cycle

Step 1 Preregister patients

Step 2 Establish financial responsibility

Step 3 Check in patients

Step 4 Review coding compliance

Step 5 Review billing compliance

Step 6 Check out patients

Step 7 Prepare and transmit claims

Step 8 Monitor payer adjudication

Step 9 Generate patient statements

Step 10 Follow up payments and collections

3. Explain the structure of *Medical Insurance 8e,* showing the relation of the text chapters to the revenue cycle

1.9 ACHIEVING SUCCESS Slides Chapter 1: 28 – 29

1. Work environments
2. Skills and attributes required for success
3. Medical ethics versus etiquette

1.10 MOVING AHEAD Slide Chapter 1: 30

1. Certification options
2. Continuing education

*Option:* Have students explore www.payscale.com (under your guidance, so they do not sign up for anything that has a charge) to look at pay ranges for job titles such as medical office assistant, medical coder, and other job titles.

***CLASS ASSESSMENT CHECKLIST***

| **Assessment Tool** | **Instructor's Notes** |
|---|---|
| **Thinking It Through** | |
| **Review Questions** | |
| **Applying Your Knowledge** | |
| **Workbook** | |
| **Testbank** | |
| **Connect** | |

***ANSWERS***

## ANSWERS TO THINKING IT THROUGH

*Thinking It Through 1.1*
1. Students should expect that employment opportunities for medical insurance specialists in physician practices will continue to grow, primarily due to an aging population and the increases in health care spending.

*Thinking It Through 1.2*
1. Students may describe managed care or indemnity coverage. Ask students to locate the policies' sections on benefits, exclusions, and financial responsibilities. In class, students should share their plan's policy information or recount the coverage offered by Medicare. Use this conversation to introduce the next section, *Health Care Plans,* which will enable them to categorize plans and compare costs versus benefits.

*Thinking It Through 1.3*
1. Indemnity care health plans are more likely to offer a greater choice of physicians, as managed care offers a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and other charges.

*Thinking It Through 1.4*
1. Use this exercise to point out how students need to learn to analyze information presented in chart or table format.
A. The health plan covers diabetic supplies and emergency services, but not dental exams.
B. PCP visits have a lower copayment than specialty visits.

*Thinking It Through 1.5*
1. Students should identify PPOs as the most popular type of insurance plan due to their extensive network of physicians and hospitals, their negotiated discounts from usual fees, and lack of a requirement for referrals.

*Thinking It Through 1.6*
1. Consumer-driven health plans combine a health plan, usually a PPO, 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.

*Thinking It Through 1.7*
1. Student answers may vary greatly, and they should be prepared to explain their position.

*Thinking It Through 1.8*
1. A. Yes—essential
B. Yes—essential
C. No—not essential
D. No—detailed procedure not warranted by simple diagnosis

*Thinking It Through 1.9*
1. Purchasing supplies from a relative could raise the question of a conflict of interest and should be avoided.
2. Reporting overstated codes on insurance claims is not ethical.

*Thinking It Through 1.10*
1. Certification is important for administrative medical office employees as it demonstrates an advanced level of dedication and ambition on their part, and demonstrates that they are proficient in the field that they pursue. As far as personal goals are concerned, students should express some interest in obtaining a certification in a specialty that is relevant to the career they intend to pursue.

**ANSWERS TO REVIEW QUESTIONS**

**Matching**
1. H
2. F
3. A
4. G
5. E
6. I
7. D
8. B
9. C
10. J
11. L
12. M
13. K
14. C
15. A
16. B
17. A
18. B
19. B
20. A
21. D
22. D
23. D

**Short Answer**
24. (Step 1) Preregister patients, (Step 2) establish financial responsibility, (Step 3) check in patients, (Step 4) review coding compliance, (Step 5) review billing compliance, (Step 6) check out patients (Step 7) prepare and transmit claims, (Step 8) monitor payer adjudication (Step 9) generate patient statements, and (Step 10) follow up payments and collections.
25. Four of the following: medical terminology, anatomy and physiology, communication skills, attention to detail, flexibility, computer skills, honesty and integrity, ability to work as team member

**ANSWERS TO APPLYING YOUR KNOWLEDGE**

**Case 1.1**
A. $10
B. The patient is responsible for a deductible of $250. After that deductible is met, the patient is responsible for 20 percent of the fee.
C. The patient must receive approval in advance for hospital admission. This approval must be obtained at least seven days before a scheduled visit to the hospital and within forty-eight hours of an admission based on an emergency (or on the next business day after a weekend or holiday emergency admission).

**Case 1.2**
A. $95
B. $750, $250
C. $336, $84
D. $0
E. $535.50; $229.50
F. $1,055.60
G. The patient owes $1,890; the payer will not pay until the annual deductible has been met.
H. The patient owes $2,100; the payer owes $2,400.

**Case 1.3**
A. PPO
B. $5,659.92
C. $2,500
D. 0
E. $6,000

## ANSWERS TO WORKBOOK

## Chapter 1

ASSISTED OUTLINING
1. handling patients' financial arrangements
2. billing insurance companies
3. processing payments

### 1.1 Working in the Medical Insurance Field
1. A shift of payment responsibility from employers and insurance companies to patients
2. Physicians must manage the business side of their practices in order to remain profitable
3. nearly 20
4. To make sure that sufficient monies flow into the practice from patient and insurance companies paying for medical services, and to pay the practice's operating expenses.

5. office manager, practice manager, or practice administrator
6. There are many possible student answers, including courteousness, empathy, attentiveness, helpfulness, etc.
7. (1) practice management program (PMP)
(2) electronic health record (EHR)
(3) PM/EHR
8. individual

**1.2 Medical Insurance Terms**
1. policyholder and health plan
2. necessary
3. preventive
4. Covered services will be reimbursed by a third party payer; noncovered services will not be reimbursed by a third party payer and are the responsibility of the patient.
5. (1) Most medical policies do not cover dental services, eye examinations or eyeglasses, employment-related injuries, cosmetic procedures, or experimental procedures.
(2) Policies may exclude specific items such as vocational rehabilitation or surgical treatment of obesity.
(3) Many policies do not have a prescription drug benefit.
6. group
7. work
8. job

**1.3 Health Care Plans**
1. indemnity
2. managed care
3. (1) The medical charge must be for medically necessary services and covered by the insured's health plan.
(2) The patient's payment of the policy's premium must be up to date.
(3) If part of the policy, a deductible must have been met (paid).
(4) Any coinsurance must be taken into account.
4. after
5. (1) health maintenance organizations
(2) point-of-service plans
(3) preferred provider organizations
(4) consumer-directed health plans

**1.4 Health Maintenance Organizations**
1. networks
2. before
3. (1) Restricting patients' choice of providers.
(2) Requiring preauthorization for services.

(3) Controlling the use of services.
(4) Controlling drug costs.
(5) Cost-sharing.
(6) Requiring referrals.
4. (1) preventive care and
(2) pay-for-performance
(3) disease/case management
5. open

**1.5 Preferred Provider Organizations**
1. PPOs

**1.6 Consumer-Driven Health Plan**
1. (1) The first element is a health plan, usually a PPO, that has a high deductible (such as $1000) and low premiums.
(2) The second element is a special "savings account" that is used to pay medical bills before the deductible has been met.

**1.7 Medical Insurance Payers**
1. private payers
2. self-funded health plans
3. government-sponsored health care programs
4. insurance
5. itself
6. Medicare is a 100 percent federally funded health plan that covers people who are sixty-five and over and, regardless of age, are disabled or have permanent kidney failure (end-stage renal disease, or ESRD).
7. Medicaid, a federal program that is jointly funded by federal and state governments, covers low-income people who cannot afford medical care. Medicaid is administered by each state, which determines the program's qualifications and benefits under broad federal guidelines.
8. TRICARE, a Department of Defense program, covers medical expenses for active-duty 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.)
9. CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, covers veterans with permanent service-related disabilities and their spouses and dependents. It also covers surviving spouses and dependent children of veterans who died from service-related disabilities.

**1.8 The Revenue Cycle**
1. Verifying patient insurance information, eligibility, and authorization requirements before

medical services are provided
2. Collecting payments up front, such as copayments or balances due
3. Maintaining up-to-date information about patients, private payers' reimbursement guidelines, and government programs' regulations
4. Following federal, state, and local legal guidelines and regulations on the confidentiality of all information about patients
5. Abstracting information from patients' records to provide accurate billing information
6. Calculating provider reimbursement, billing health plans or patients, and maintaining effective communication to avoid problems or delayed payments
7. Assisting patients with insurance information and required documents
8. Processing payments and requests for further information about claims and bills
9. Maintaining financial records
10. Updating the forms the practice uses for patient information and health care claims processing

Revenue Cycle

| | |
|---|---|
| Before the encounter | Step 1: Preregister patients |
| During the encounter | Step 2: Establish financial responsibility |
| | Step 3: Check in patients |
| | Step 4: Review coding compliance |
| | Step 5: Review billing compliance |
| | Step 6: Check out patients |
| After the encounter | Step 7: Prepare and transmit claims |
| | Step 8: Monitor payer adjudication |
| | Step 9: Generate patient statements |
| | Step 10: Follow up payments and collections |

**1.9 Achieving Success**

Answers 1–5 will include physicians' practices, clinics, for hospitals or nursing homes, and in other health care settings such as insurance companies as claims examiners, provider relations representatives, or benefits analysts, in government and public health agencies, companies that offer billing or consulting services to health care providers is an option, as is self-employment as a claims assistance professional.
6. Knowledge of medical terminology, anatomy, physiology, and medical coding
7. Communication skills
8. Attention to detail
9. Flexibility
10. Health information technology (HIT) skills
11. Honesty and integrity
12. Ability to work as a team member
13. Appearance

14. Attendance
15. Initiative
16. Courtesy
17. 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. Professional etiquette is the correct behavior in a medical practice. It is generally covered in the practice's employee policy and procedure manual, and typically includes respectful and courteous treatment of patients and all others who interact with the practice's staff.

**1.10 Moving Ahead**
1–3 At least three of these options:
(1) Completed a medical insurance specialist program, coding specialist program, or medical assisting or health information technology
(2) Earn an associate degree or a certificate of proficiency by completing a program in a curriculum area such as health care business services.
(3) Further baccalaureate and graduate study enable advancement to managerial positions.
(4) Become a member of a medical insurance, medical billing, medical assisting, medical management, etc. organization.
(5) Obtain certification in coding, medical assisting, medical billing, medical office management, etc.
4. Certification by a professional organization provides evidence to prospective employers that the applicant has demonstrated a superior level of skill on a national test, and helps people to move ahead in their careers.

**Chapter 1 Key**

***Key Terms***

**Multiple Choice**
1. B
2. D
3. B
4. A
5. A
6. B
7. C
8. D
9. C
10. C

**Self-Quiz**

1. The patient is the *first party*; the physician is the *second party*; and the health plan is the *third party*, who agrees to carry the risk of paying for those services and is thus called the *third-party payer*.
2. A medically necessary service is reasonable and consistent with generally accepted professional medical standards for the diagnosis or treatment of illness or injury.
3. The payment is retroactive, the fee is paid after the patient receives services from the provider.
4. The payment is prospective, that is paid before the patient visit.
5. A policyholder and a health plan**.**
6. benefits
7. Payment for the cost of medically necessary medical services policyholders and their dependents receive.
8. The schedule of benefits of the insurance policy.
9. to manage care by establishing effective and efficient health care delivery systems that ensure quality and at the same time control health care costs.
10. from capit-, Latin for head
11. A fixed prepayment to a medical provider for all necessary, contracted services provided to each patient who is a plan member for a specific period of time.
12. The capitated rate payment system is a prospective payment—it is paid before the patient visit.
13. to understand patients' responsibilities for paying for medical services, to analyze charges and insurance coverage to prepare accurate, timely claims, and to collect payment for medical services from health plans and from patients
14. scheduling appointments, billing, and financial record keeping
15. physician offices, clearinghouses, insurance companies, billing services, hospitals, outpatient facilities, mental health care facilities, nursing homes, managed care organizations, government and/or public health agencies

**Critical Thinking Questions**

1. Both answers can be supported by arguments for covering excluded services as being the socially responsible thing to do. Upholding some excluded services helps keep costs down for insurance companies and subsequently lowers premiums.
2. This can be answered in many ways, depending upon the student.
3. Although this may be answered in many ways, perhaps the majority of students will choose a managed care plan that offers the most choice. This would mimic the general public's preference.
4. Fee-for-service plans place fewer restrictions on the provider. Capitated plans allow for steady cash-flow each month.
5. Students may wish to create some type of listing of what skills/attributes they currently possess and those that need work. The instructor may also use this as an evaluation of a student's soft skills or have students work together to identify one another's skills/attributes or

lack thereof.

***Web Activities***

**Surfing the Net**

1. Answers will vary according to state and insurer.
For example, in Pennsylvania students might use the URL for Geisinger: www.geisinger.org/health-plan.
2. Answers will vary according to state and insurer.
3. Answers will vary according to state and insurer.

**Using the Web Wisely**

The website of the Medical Billing Advocates of America is: www.billadvocates.com/
4. Authority
Some information can be found by clicking on About - Contact Us. The site does not list any author names at this time; the corporate name (MBAA) is used.
5. Purpose and coverage
It is .com, a business site. By reading the Mission Statement, the student can learn about the purpose of the organization. Coverage of the topic appears to be of only one point-of-view. More than once, a home study course, for a fee, is offered to help persons become Medical Billing Advocates.
6. Accuracy
Whether the page is edited or reviewed by outside specialists is not apparent from viewing the site. Not enough specific are given in the narrative quoting outrageous medical bill charges to verify the facts. No references are used. This is a good critical thinking skills question for students. The author's opinion is that this is simply a sales site targeting persons who wish to hold themselves out as specialists in saving money on medical bills.
7. Timeliness
No dates are given for creation or updating.
8. Integrity of the information
Again, no references sources are used. Pictures are general and probably simple down-loaded files.
9. Objectivity or point of view
The site seems to offer an "us against them" attitude, with us being the consumer and them being the third-payers, providers, hospitals, etc. The site definitely uses provocative language—and in bold for added emphasis. There are no ads on this page, although students may get popups or other ads depending on their computer's settings.

**Web Scavenger Hunt**

This URL is for the American Medical Billing Association's (AMBA) page for certified medical reimbursement specialist—www.ambanet.net/cmrs.htm. The site lists the process for earning the Certified Medical Reimbursement Specialist designation through AMBA.

This URL is for the American Health Information Management Association's (AHIMA) page for coding certification—www.ahima.org/certification/. The site lists the various credentials and their requirements.

This URL is for the American Academy of Professional Coders' page for coding certification—www.aapc.com/certification/index.aspx. The site lists the various credentials and their requirements.

This URL is for the Professional Association of Health Care Office Management's (PAHCOM) page for certification of office mangers specializing in physician practice management—www.pahcom.com/cmm/overview.html. The site lists the requirements for the Certified Medical Manager designation.

**Using Math in the Medical Office**

Exercise 1

| | |
|---|---|
| A. 75% | 0.75 |
| B. 25.3% | 0.253 |
| C. 47% | 0.47 |
| D. 88.5% | 0.885 |
| E. 07% | 0.07 |

Exercise 2

| | |
|---|---|
| A. 36% of 50 | 18 |
| B. 73.5% of 425 | 312.375 |
| C. 25% of 350 | 87.5 |
| D. 10% of 650 | 65 |
| E. 12.5% of 700 | 87.5 |

Exercise 3

| | |
|---|---|
| A. 0.10 | 10% |
| B. 0.875 | 87.5% or 87½ % |
| C. 0.06 | 6% |
| D. 0.80 | 80% |
| E. 0.167 | 16.7% |

Exercise 4

| | |
|---|---|
| A. 32 out of 35 | 91% |
| B. 109 out of 125 | 87% |
| C. 43 out of 60 | 72% |
| D. 19 out of 25 | 76% |
| E. 385 out of 600 | 64% |

Exercise 5
A. The insurance plan will be billed $255. The patient owes $85.
B. The insurance plan will cover $55.25. The patient will be billed $9.75.

Exercise 6
A. The insurance company will owe $620.10. The patient will pay the $1000 deductible as well as the 10 percent coinsurance of $68.90. for a total of $1068.90.
B. The patient owes a $20 copayment.
C. The patient will pay the $100 deductible plus her 45 percent coinsurance of $50.40, for a total of $150.40. The insurance company will reimburse $61.60.

| | | |
|---|---|---|
| Juanita Berrios Pt. | #483680 | Primary ins. – Mgd. Care |
| 721 Tamarack Street | 610-555-3842 | Secondary ins. – none |
| Allentown, PA 18105 | | |

| **Date/Pro** | | **Charge** | **Payment/Adj** | **Balance** |
|---|---|---|---|---|
| 4/11 | OV | 135.00 | Copay 20.00 | 115.00 |
| 4/11 | PMT | | Insurance 115.00 | 0.00 |
| 5/3 | OV | 212.00 | Patient 150.40 | 61.60 |
| 5/3 | PMT | | Insurance 61.60 | 115.00 |

Or, students may also detail each step of the process.

| | | |
|---|---|---|
| Juanita Berrios Pt. | #483680 | Primary ins. – Mgd. Care |
| 721 Tamarack Street | 610-555-3842 | Secondary ins. – none |
| Allentown, PA 18105 | | |

| **Date/Pro** | | **Charge** | **Payment/Adj** | **Balance** |
|---|---|---|---|---|
| 4/11 | OV | 135.00 | | 135.00 |
| 4/11 | PMT | | Copay 20.00 | 115.00 |
| 5/3 | OV | 212.00 | | 327.00 |
| 5/3 | PMT | | Patient 100.00 | 227.00 |
| 5/3 | PMT | | Patient 50.40 | 176.60 |

**Applying Concepts**
1. For the first hospital visit, the patient will be billed/pay $612. The insurance plan will not yet pay as the patient has not yet met the deductible amount of $750.
$750 – $612 = $138 remaining deductible
For the second hospital visit, the patient will be billed/pay $138, the remaining amount of the deductible. The insurance plan will reimburse $220, the charges left after the deductible has been met.

$358 – $138 = $220
2. The patient will owe $45 (of the $100 deductible for office visits) to the office and $1000 (the full amount of the hospital deductible) to the hospital. (This is assuming the provider properly codes for the visit prior to admission.)
3. The patient will pay the $10 copayment and an additional $22.50 (30% of $75) in coinsurance for a total of $32.50.
4. Holly must pay the full amount, $1732, to the hospital in Maine as it is out of network. Holly will be reimbursed $1732 after submitting a claim to her HMO as this episode of care was for an emergency.
5. Insurer A will reimburse $676 which is 80 percent of $845. The amount remaining unpaid is $169. Insurer B will reimburse $135.20 which is 80 percent of $169. The amount remaining unpaid is $33.80. The patient will be billed for $33.80.
6. The patient's insurance plan will cover 80% of the $95 complete eye exam, or $76. The patient must pay the 20% copayment of $19 and $65 for the refraction exam. Neither party will pay for the Glaucoma check as there was no charge.
7. Shane's deductible will be $250. The health plan will reimburse $125; Sheena is responsible for paying the $250 deductible for Shane. Sharon's deductible will be $250. The health plan will reimburse $725; Sheena is responsible for paying the $250 deductible for Sharon. Sheena will pay a total deductible of $500 plus 10% of the charges after the deductible is met, or $85.
8. The insurance plan will pay $255 ($265 minus the $10 co-pay). Mr. Anthony will pay a $10 copay.
9. The insurance plan will pay $12, which is 80 percent of the difference between the charges and the deductible ($15). Mr. Anthony owes $250 deductible plus $3 for coinsurance, for a total of $253.

# *INSTRUCTOR'S MANUAL*

For use with

# MEDICAL INSURANCE
## A Revenue Cycle Process Approach

**Includes 2021 E/M Code Updates**

Eighth Edition
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Cynthia Newby, CPC, CPC-P
Amy L. Blochowiak, MBA, ACS, AIAA, AIRC, ARA, FLHC, FLMI, HCSA, HIA, HIPAA, MHP, PCS, SILAF

CPT codes are based on CPT 2018.
ICD-10-CM codes are based on ICD-10-CM 2018.

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, and McGraw-Hill does not guarantee the accuracy of the information presented at these sites.

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## 2021 E/M Code Updates

2021 Evaluation and Management (E/M) Code Update Resources

For instructors using CPT 2021, note that important changes have been made to the correct assignment of E/M codes for office or other outpatient services visits. An updated version of *Medical Insurance 8e* is available for your use that contains an updated Chapter 5 for students. The encounter form that is presented in Chapter 3 (Figure 3.10) and used for chapter exercises has also been updated to show the new codes and their short forms.

An appendix to this Instructor's Manual presents a revised answer key for the Thinking It Throughs and end-of-chapter questions that are affected. Also provided are edits you may choose to make to Chapter 5 of the PowerPoint presentation and to Chapter 5 of the TestBank.

# CONTENTS

# INTRODUCTION

Broad pressure to control costs in the healthcare industry creates a complex billing environment. Payment has shifted from straightforward fee-for-service insurance to a complex mixture of contracts with payers. Providers must ensure patient satisfaction and also use health information technology effectively and efficiently to receive maximum appropriate payment for their services. Additional pressure results from federal government prosecution of health care fraud and abuse as a top policy objective. HIPAA and HITECH have also created new privacy, security, transactions, and code sets laws, including the transition to ICD-10-CM/PCS, that must be implemented. Failure to comply with proper billing and coding procedures can have significant financial and legal consequences.

The eighth edition of *Medical Insurance: A Revenue Cycle Process Approach* continues to emphasize the medical revenue cycle—ten steps that clearly identify all the components needed to successfully manage the medical insurance claims process. The cycle shows how medical professionals "follow the money." The program assists instructors in presenting clear, up-to-date instruction to give students the skills and knowledge they will need to perform the current duties of medical insurance specialists and to succeed moving forward in a changing environment. Therefore, the text reflects judgments about what to emphasize, such as the increased use of health information technology, and then necessarily what to exclude, such as detailed histories of insurance programs.

In addition to current duties, the text covers trends, developments, and resources, so that students will be able to understand the inevitable changes as they occur. The text and the supplementary workbook and website reinforce problem analysis, critical thinking, effective use of resources, and communication, the capabilities that will underpin students' future employment success as important members of the health care team.

## *KEY CHANGES FOR THE EIGHTH EDITION*

**Exercises**

Starting in Chapter 8, in-chapter exercises give students the opportunity to get hands-on experience with claim completion through simulations of real software. *Medical Insurance, 8e* offers these options for completing these tasks:

- **Paper Claim Form:** Students gaining experience by completing a paper CMS-1500 claim form use the blank form supplied (from the back of *Medical Insurance, 8e)* 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® or Medisoft simulations as part of the options.

## Changes to Content by Chapter

- **Chapter 1:** Figure 1.1 and 1.4 updated with new information. Thinking It Through features 1.2 and 1.7 updated with new questions. Learning Outcome 1.7 has a new introductory paragraph and current figures. The Compliance Guideline on ICD-9-CM Versus ICD-10-CM has been updated to reflect changes.

- **Chapter 2:** Dated Figures have been deleted with the remaining Figures renumbered. Two new HIPAA/HITECH Tip features were added, titled Texting and Plans Mandated.

- **Chapter 3:** New key terms: insured/subscriber, which combined two previous key terms. Dated Figures have been deleted with the remaining Figures renumbered.

- **Chapter 4:** All ICD-10-CM codes have been checked and updated as needed. Figures 4.1 and 4.3 have been updated with new codes and information. Thinking It Through features 4.5 and 4.7 have been updated with new questions. Applying Your Knowledge: Case 4.1 now has new questions.

- **Chapter 5:** All CPT/HCPCS codes have been checked and updated as needed. WWW Features and Tables 5.2, 5.3, and 5.6 are updated with new information and for new CPT conventions. New Billing Tip titled Revised Guidelines Coming. New subheading Symbol for Telemedicine to cover this new CPT convention. New questions in the Applying Your Knowledge Cases 5.1, 5.2, 5.3, and 5.5.

- **Chapter 6:** All codes have been checked and updated as needed. Dated Figures have been deleted with the remaining Figures renumbered and updated. Thinking It Through feature 6.4 has been updated with new questions. New questions in the Review Questions section and in Applying Your Knowledge Case 6.1.

- **Chapter 7:** New key terms: 5010A1 version; Healthcare Provider Taxonomy Code (HPTC). Multiple Item Number definitions and text descriptions have been extensively revised throughout to reflect the most recent NUCC CMS-1500 instructions, along with new explanations for expanded Item Numbers. Dated Figures and Tables have been deleted with the remaining Figures and Tables renumbered and updated. New Billing Tip titled ICD Indicator. Website addresses for several WWW features have been revised or updated. Updated Applying Your Knowledge Cases 7.2, 7.3, and 7.4.

- **Chapter 8:** New year-specific financial information inserted to match current rates. Figures and WWW features were updated throughout to make current. New questions added to Thinking It Through 8.9. Updated Applying Your Knowledge Cases 8.1 and 8.4.

- **Chapter 9:** New key terms: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); Medicare Beneficiary Identifier (MBI); Quality Payment Program (QPP). All of the Medicare-specific facts, figures, and information were updated throughout to make current. Several Billing Tips updated to reflect new Medicare features and costs. New information added to describe the new Quality Payment Program (QPP). Figures 9.1, 9.7, and 9.9 are new/updated with current data and information. New questions added to Thinking It Through 9.8 and the Review Questions. Updated Applying Your Knowledge Cases 9.1, 9.2, and 9.3.

- **Chapter 10:** The information about the Medicaid program and the options available to states has been updated. Figure 10.5 updated per new claim completion requirements. New questions added to Thinking It Through 10.2 and 10.7. Updated Applying Your Knowledge Cases 10.1 and 10.2.

- **Chapter 11:** New key terms: Prime Service Area; TRICARE Select. The information about TRICARE enrollment and coverage costs has been updated, with descriptions of the new TRICARE programs. New Learning Outcomes 11.3 and 11.4 with new text to describe TRICARE Prime and TRICARE Select. Figures 11.1 and 11.2 contain a new TRICARE map and claim completion form. New questions added to the Review Questions and Applying Your Knowledge Cases 11.1, 11.2, and 11.3 have been updated.

- **Chapter 12:** The information about FECA and eligibility in state workers' compensation plans has been updated. Figure 12.2 and Applying Your Knowledge Cases 12.1 and 12.2 have been updated.

- **Chapter 13:** Thinking It Through 13.1, 13.3, and 13.5, as well as Figures 13.1 and 13.9 have been updated with new information and claims. New Billing Tip added on Annual Appeal Amounts. Applying Your Knowledge Cases 13.1 and 13.2 have been updated.

- **Chapter 14:** Figures 14.2, 14.3, and 14.4, along with Thinking It Through 14.2, 14.4, and 14.8 have all been updated with new information. Applying Your Knowledge Cases 14.1 has been updated.

- **Chapters 15 and 16:** The case studies for ICD-10-CM and for NUCC CMS-1500 guidelines have been updated, along with the dates, policy information, charges, and CPT/HCPCS codes used. Several Figures and Tables have been updated to reflect these changes. The most recent CMS-1500 claim forms have been utilized.

- **Chapter 17:** This chapter has been updated to reflect the most current CPT and ICD-10-CM codes. Figure 17.3 has new art for the form completion and a new WWW feature titled Medicare Secondary Payer Questionnaire has been added to support this update. New questions added to the Review Questions and Applying Your Knowledge Cases 17.1 and 17.2 have been updated.

The text/workbook is divided into seventeen chapters. All seventeen chapters cover an important topic concerning insurance procedures.

The optimal course of study is to build knowledge and skills by following the order of the text presentation. However, since curriculum requirements vary, each chapter is complete, and includes its own learning objectives, key terms, and end-of-chapter material. Thus, the chapter order can be changed or material can be omitted to fit various instructional requirements. The text is designed for a one-semester medical insurance course, and covers medical insurance, medical coding basics, and a brief introduction to hospital billing. The text may be modified to suit the instructor's curriculum requirements. Following are examples of possible modifications:

- If students complete a HIPAA course in the curriculum, Chapter 2 of *Medical Insurance* may be omitted.
- If students are knowledgeable regarding medical coding, Chapters 4 and 5 may be omitted.
- Instructors who do not wish to present the topic of hospital billing may omit Chapter 17.

When chapters are not presented as class work, it is suggested that they be assigned for independent study. In particular, Chapters 4 and 5 on medical coding provide an excellent review/refresher of basic coding procedures and guidelines.

Note that Chapter 6, *Visit Charges and Compliant Billing*, should **not** be omitted. It presents essential, timely material not covered in most law and ethics courses or in introductory coding classes regarding compliance.

**Chapter Structure**

- *Learning Outcomes* describe the most important information the chapter contains.
- *Key Terms* provide an alphabetic list of the most important vocabulary terms in the chapter. The key terms are printed in bold-faced type and defined when introduced. A complete glossary at the end of the book defines each key term as well as other important terms medical insurance specialists need to know.
- Note that the key terms include healthcare vocabulary but not words that are in common general use, such as mortality and morbidity, which a student can readily research.
- Chapter text provides essential background material and information on the procedures being taught.
- *Chapter Summary* covers key topics in a tabular, step-by-step format with page references to help with review of the material.
- Review questions and *Applying Your Knowledge* provide objective exercises and cases to test the students' understanding of the chapter's concepts and procedures. These exercises are tagged with the chapter's Learning Outcomes.

**Pedagogy Reinforced**

- Learning Outcomes reflect the revised version of Bloom's Taxonomy and the range of difficulty levels to teach and assess critical thinking about medical insurance and coding concepts.
- Major chapter heads reflect the numbered Learning Outcomes.
- In addition to the listing of learning outcomes and the listing of key terms, each chapter opener displays the Revenue Cycle, with the steps relevant to that chapter highlighted.
- Key terms are defined in the margins for easy reference, tested at the end of the chapter, and listed in the Glossary toward the end of the book.
- Billing Tips, Compliance Guidelines, and HIPAA/HITECH tips highlight key concepts or provide additional insights to help students navigate through the material.
- "Thinking It Through" questions at the end of each section help assess each Learning Outcome.

## *STRUCTURE AND FEATURES OF THE INSTRUCTOR'S MATERIALS*

### *Instructor Manual*

Following this introduction, the instructor manual contains these sections:

- Syllabi, with more information available at McGraw-Hill Connect
- Lesson plans, provided for each chapter, are intended to assist the instructor in preparing for class, presenting key concepts, and assessing student comprehension. Each lesson plan has these parts:
  Class Preparation: *The Teaching Focus and the Learning Outcomes*
  Class Presentation: *The Lecture Outline*
    - PowerPoint Range
    - Key Topics

  Class Assessment: *The Checklist*
    - Thinking It Through
    - Review Questions
    - Applying Your Knowledge
    - Medical Coding Workbook for Text Chapters 4, 5, and 17
    - Testbank
    - Connect

  Answers
    - Thinking It Through
    - Review Questions
    - Applying Your Knowledge

### *Instructors' Resources*

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

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## *ANCILLARY MATERIAL*

***Workbook for Use with Medical Insurance: A Revenue Cycle Process Approach, Eighth Edition***

***(1-260-48914-0, 978-1-260-48914-9)***
The workbook is intended to strengthen, reinforce and expand student learning of the skills and concepts presented in the text. This workbook complements the text and follows the same learning outcomes.

Included is a brief review of the math skills necessary for processing medical insurance claims. Reinforcement of reading assignments (or note taking) is easy for students following the assisted outlining activity. The key term activities help strengthen students' vocabulary for each chapter and the applying concepts activities provide additional hands-on practice with the concepts and skills presented in each chapter. Instructors can measure students' progress in meeting learning outcomes with the short answer questions, or students can perform quick checks with the self-quiz questions. Instructors can expand on the Internet activities to deepen student understanding or to introduce new topics, for instance, when private and governmental third-party providers' policies change.

For short programs, the workbook materials can be used as homework assignments for reinforcement, follow-up, or extra instruction. For longer programs, the workbook materials can be used in class as well as for homework assignments. Additional class time would also provide the opportunity to have students work in teams/groups on several of the Web exercises.

Instructors may choose to use sections of the workbook in class, for example, using the key terms section as a pretest. Instructors may select individual assignments for each chapter depending on the progress of the class or assign specific activities to students who might be having difficulty grasping certain themes. For example, the instructor might assign all students the assisted outlining activity to reinforce the reading of each chapter or the self quiz questions could be used by students individually or as a class as a pretest prior to chapter or unit tests.

Other students may need critical thinking skills sharpened or wish to focus on one of the Web

activities. The additional activities could be used in their entirety or portions selected to highlight individual concepts from the text.

Keys to all workbook material are included in this instructor's manual. Instructors may wish to provide students access to the answers to workbook exercises in order to monitor their progress.

***Medical Coding Workbook for Physician Practices & Facilities, Coding Exercises for ICD, CPT, and HCPCS, 2018-2019 Edition ((1-259-63002-1, 978-1-259-63002-6))***

Since 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 baseline for correct claims. The *Medical Coding Workbook for Physician Practices & Facilities, 2018-2019* provides practice and instruction in coding and compliance skills. 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.

# LESSON PLANS

## HOW TO USE THE LESSON PLANS

Lesson plans, provided for each chapter, are intended to assist the instructor in preparing for class, presenting key concepts, and assessing student comprehension.

Each lesson plan has these parts:

- Class Preparation: *The Teaching Focus and the Learning Outcomes*
- Class Presentation: *The Lecture Outline*
  - PowerPoint Range
  - Key Topics
- Class Assessment: *The Checklist*
  - Thinking It Through
  - Review Questions
  - Applying Your Knowledge
  - Workbook
  - Testbank
  - Connect

  *Optional:*
  - Medical Coding Workbook Exercises Correlated to Text Chapters 4, 5, and 17
- Answers to Thinking It Through Questions, Chapter Review Questions, and Applying Your Knowledge Cases

Chapter content is followed by the answers to the correlated workbook chapter.

# Chapter 1 Introduction to the Revenue Cycle

***TEACHING FOCUS AND LEARNING OUTCOMES***

The current employment environment for administrative staff in physician practices reflects the pressures of decreasing provider compensation, rising costs for medical services and for employer and employee medical insurance, increased governmental regulation, increased public awareness of healthcare issues, and increased reimbursement complexity. These elements underpin the changes that occur almost daily in physician/patient relations and related billing/reimbursement issues, so students need to understand this background. They also need to develop the ability to analyze problems, identify the information that is required, research/abstract that information, determine the best course of action, and work in a team to communicate information and share results.

In Chapter 1, students begin their understanding of the work and the employment environment of medical insurance and billing. The chapter covers medical insurance and plans, reimbursement methods, and payers, concluding with the requirements for success as a medical insurance specialist. It provides the instructional material for accomplishing four goals:

1. Introduce the role, responsibilities, and employment opportunities of the medical insurance specialist.
2. Teach basic insurance terms and concepts.
3. Preview the revenue cycle.
4. Explain that the organization of *Medical Insurance, 8e* follows and reinforces the revenue cycle.

The order of presentation for this chapter is:

- Present basic information on insurance terminology
- Present basic information on healthcare plans and payers
- Describe the duties of the medical insurance specialist in following the revenue cycle, and preview the text's chapter structure in relation to the cycle
- Briefly focus on the interplay among procedures, communication, and information technology in the revenue cycle
- Present information on the medical insurance specialist's skills, attitudes, possible certifications, and office ethics/etiquette that lead to successful employment

The learning outcomes for this chapter are:

LO 1.1 Identify three ways that medical insurance specialists help ensure the financial success of physician practices.

LO 1.2 Differentiate between covered and noncovered services under medical insurance policies.

LO 1.3 Compare indemnity and managed care approaches to health plan organization.

LO 1.4 Discuss three examples of cost containment employed by health maintenance organizations.

LO 1.5 Explain how a preferred provider organization works.

LO 1.6 Describe the two elements that are combined in a consumer-driven health plan.

LO 1.7 Define the three major types of medical insurance payers.

LO 1.8 Explain the ten steps in the revenue cycle.

LO 1.9 Analyze how professionalism, ethics, and etiquette contribute to career success.

LO 1.10 Evaluate the importance of professional certification for career advancement.

***LECTURE OUTLINE***

1.1 WORKING IN THE MEDICAL INSURANCE FIELD Slides Chapter 1: 8 – 10

1. Rising spending in the medical insurance field
2. Growing employment opportunities due to administrative complexity
3. Role of knowledgeable medical office administrative staff in practice profitability and patient satisfaction
4. Importance of following procedures
5. Need to communicate effectively both to patients and other staff members
6. Using health information technology—practice management programs and electronic medical records

1.2 MEDICAL INSURANCE BASICS Slides Chapter 1: 11 – 15

1. Medical insurance contract and benefits terms
2. Group versus individual policies
3. Disability/automotive insurance and workers' compensation

1.3 HEALTHCARE PLANS Slides Chapter 1: 16 – 18

1. Indemnity plans
    a. Conditions for payment
    b. Work through indemnity math example (text page 9)
2. Managed care plans
    a. Health maintenance organizations (HMOs)
    b. Point-of-service (POS) plans
    c. Preferred provider organizations (PPOs)

d. Consumer-driven health plans

1.4 HEALTH MAINTENANCE ORGANIZATIONS Slides Chapter 1: 19 – 21

1. Capitation in HMOs
2. Medical management practices
3. Point-of-service plans

1.5 PREFERRED PROVIDER ORGANIZATIONS Slide Chapter 1: 22

1. Explanation of features
2. Example of operation
3. Cost-control

1.6 CONSUMER-DRIVEN HEALTH PLANS Slide Chapter 1: 23

1. Two elements
2. Cost containment

1.7 MEDICAL INSURANCE PAYERS Slide Chapter 1: 24

1. Private payers
2. Self-funded health plans
3. Government-sponsored healthcare programs

1.8 THE REVENUE CYCLE Slides Chapter 1: 25 – 27

1. Review of main job functions
2. Revenue cycle

Step 1 Preregister patients

Step 2 Establish financial responsibility

Step 3 Check in patients

Step 4 Review coding compliance

Step 5 Review billing compliance

Step 6 Check out patients

Step 7 Prepare and transmit claims

Step 8 Monitor payer adjudication

Step 9 Generate patient statements

Step 10 Follow up payments and collections

3. Explain the structure of *Medical Insurance 8e,* showing the relation of the text chapters to the revenue cycle

1.9 ACHIEVING SUCCESS Slides Chapter 1: 28 – 29

1. Work environments
2. Skills and attributes required for success
3. Medical ethics versus etiquette

1.10 MOVING AHEAD Slide Chapter 1: 30

1. Certification options
2. Continuing education

*Option:* Have students explore www.payscale.com (under your guidance, so they do not sign up for anything that has a charge) to look at pay ranges for job titles such as medical office assistant, medical coder, and other job titles.

***CLASS ASSESSMENT CHECKLIST***

| **Assessment Tool** | **Instructor's Notes** |
|---|---|
| **Thinking It Through** | |
| **Review Questions** | |
| **Applying Your Knowledge** | |
| **Workbook** | |
| **Testbank** | |
| **Connect** | |

***ANSWERS***

## ANSWERS TO THINKING IT THROUGH

*Thinking It Through 1.1*
1. Students should expect that employment opportunities for medical insurance specialists in physician practices will continue to grow, primarily due to an aging population and the increases in health care spending.

*Thinking It Through 1.2*
1. Students may describe managed care or indemnity coverage. Ask students to locate the policies' sections on benefits, exclusions, and financial responsibilities. In class, students should share their plan's policy information or recount the coverage offered by Medicare. Use this conversation to introduce the next section, *Health Care Plans,* which will enable them to categorize plans and compare costs versus benefits.

*Thinking It Through 1.3*
1. Indemnity care health plans are more likely to offer a greater choice of physicians, as managed care offers a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and other charges.

*Thinking It Through 1.4*
1. Use this exercise to point out how students need to learn to analyze information presented in chart or table format.
A. The health plan covers diabetic supplies and emergency services, but not dental exams.
B. PCP visits have a lower copayment than specialty visits.

*Thinking It Through 1.5*
1. Students should identify PPOs as the most popular type of insurance plan due to their extensive network of physicians and hospitals, their negotiated discounts from usual fees, and lack of a requirement for referrals.

*Thinking It Through 1.6*
1. Consumer-driven health plans combine a health plan, usually a PPO, 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.

*Thinking It Through 1.7*
1. Student answers may vary greatly, and they should be prepared to explain their position.

*Thinking It Through 1.8*
1. A. Yes—essential
B. Yes—essential
C. No—not essential
D. No—detailed procedure not warranted by simple diagnosis

*Thinking It Through 1.9*

1. Purchasing supplies from a relative could raise the question of a conflict of interest and should be avoided.
2. Reporting overstated codes on insurance claims is not ethical.

*Thinking It Through 1.10*
1. Certification is important for administrative medical office employees as it demonstrates an advanced level of dedication and ambition on their part, and demonstrates that they are proficient in the field that they pursue. As far as personal goals are concerned, students should express some interest in obtaining a certification in a specialty that is relevant to the career they intend to pursue.

**ANSWERS TO REVIEW QUESTIONS**

**Matching**
1. H
2. F
3. A
4. G
5. E
6. I
7. D
8. B
9. C
10. J
11. L
12. M
13. K
14. C
15. A
16. B
17. A
18. B
19. B
20. A
21. D
22. D
23. D

**Short Answer**
24. (Step 1) Preregister patients, (Step 2) establish financial responsibility, (Step 3) check in patients, (Step 4) review coding compliance, (Step 5) review billing compliance, (Step 6) check out patients (Step 7) prepare and transmit claims, (Step 8) monitor payer adjudication (Step 9) generate patient statements, and (Step 10) follow up payments and collections.
25. Four of the following: medical terminology, anatomy and physiology, communication skills, attention to detail, flexibility, computer skills, honesty and integrity, ability to work as team member

**ANSWERS TO APPLYING YOUR KNOWLEDGE**

**Case 1.1**
A. $10
B. The patient is responsible for a deductible of $250. After that deductible is met, the patient is responsible for 20 percent of the fee.
C. The patient must receive approval in advance for hospital admission. This approval must be obtained at least seven days before a scheduled visit to the hospital and within forty-eight hours of an admission based on an emergency (or on the next business day after a weekend or holiday emergency admission).

**Case 1.2**
A. $95
B. $750, $250
C. $336, $84
D. $0
E. $535.50; $229.50
F. $1,055.60
G. The patient owes $1,890; the payer will not pay until the annual deductible has been met.
H. The patient owes $2,100; the payer owes $2,400.

**Case 1.3**
A. PPO
B. $5,659.92
C. $2,500
D. 0
E. $6,000

## ANSWERS TO WORKBOOK

## Chapter 1

ASSISTED OUTLINING
1. handling patients' financial arrangements
2. billing insurance companies
3. processing payments

### 1.1 Working in the Medical Insurance Field
1. A shift of payment responsibility from employers and insurance companies to patients
2. Physicians must manage the business side of their practices in order to remain profitable
3. nearly 20
4. To make sure that sufficient monies flow into the practice from patient and insurance companies paying for medical services, and to pay the practice's operating expenses.
5. office manager, practice manager, or practice administrator

6. There are many possible student answers, including courteousness, empathy, attentiveness, helpfulness, etc.
7. (1) practice management program (PMP)
(2) electronic health record (EHR)
(3) PM/EHR
8. individual

**1.2 Medical Insurance Terms**
1. policyholder and health plan
2. necessary
3. preventive
4. Covered services will be reimbursed by a third party payer; noncovered services will not be reimbursed by a third party payer and are the responsibility of the patient.
5. (1) Most medical policies do not cover dental services, eye examinations or eyeglasses, employment-related injuries, cosmetic procedures, or experimental procedures.
(2) Policies may exclude specific items such as vocational rehabilitation or surgical treatment of obesity.
(3) Many policies do not have a prescription drug benefit.
6. group
7. work
8. job

**1.3 Health Care Plans**
1. indemnity
2. managed care
3. (1) The medical charge must be for medically necessary services and covered by the insured's health plan.
(2) The patient's payment of the policy's premium must be up to date.
(3) If part of the policy, a deductible must have been met (paid).
(4) Any coinsurance must be taken into account.
4. after
5. (1) health maintenance organizations
(2) point-of-service plans
(3) preferred provider organizations
(4) consumer-directed health plans

**1.4 Health Maintenance Organizations**
1. networks
2. before
3. (1) Restricting patients' choice of providers.
(2) Requiring preauthorization for services.
(3) Controlling the use of services.
(4) Controlling drug costs.

(5) Cost-sharing.
(6) Requiring referrals.
4. (1) preventive care and
(2) pay-for-performance
(3) disease/case management
5. open

**1.5 Preferred Provider Organizations**
1. PPOs

**1.6 Consumer-Driven Health Plan**
1. (1) The first element is a health plan, usually a PPO, that has a high deductible (such as $1000) and low premiums.
(2) The second element is a special "savings account" that is used to pay medical bills before the deductible has been met.

**1.7 Medical Insurance Payers**
1. private payers
2. self-funded health plans
3. government-sponsored health care programs
4. insurance
5. itself
6. Medicare is a 100 percent federally funded health plan that covers people who are sixty-five and over and, regardless of age, are disabled or have permanent kidney failure (end-stage renal disease, or ESRD).
7. Medicaid, a federal program that is jointly funded by federal and state governments, covers low-income people who cannot afford medical care. Medicaid is administered by each state, which determines the program's qualifications and benefits under broad federal guidelines.
8. TRICARE, a Department of Defense program, covers medical expenses for active-duty 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.)
9. CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, covers veterans with permanent service-related disabilities and their spouses and dependents. It also covers surviving spouses and dependent children of veterans who died from service-related disabilities.

**1.8 The Revenue Cycle**
1. Verifying patient insurance information, eligibility, and authorization requirements before medical services are provided
2. Collecting payments up front, such as copayments or balances due
3. Maintaining up-to-date information about patients, private payers' reimbursement

guidelines, and government programs' regulations
4. Following federal, state, and local legal guidelines and regulations on the confidentiality of all information about patients
5. Abstracting information from patients' records to provide accurate billing information
6. Calculating provider reimbursement, billing health plans or patients, and maintaining effective communication to avoid problems or delayed payments
7. Assisting patients with insurance information and required documents
8. Processing payments and requests for further information about claims and bills
9. Maintaining financial records
10. Updating the forms the practice uses for patient information and health care claims processing

Revenue Cycle

| | |
|---|---|
| Before the encounter | Step 1: Preregister patients |
| During the encounter | Step 2: Establish financial responsibility |
| | Step 3: Check in patients |
| | Step 4: Review coding compliance |
| | Step 5: Review billing compliance |
| | Step 6: Check out patients |
| After the encounter | Step 7: Prepare and transmit claims |
| | Step 8: Monitor payer adjudication |
| | Step 9: Generate patient statements |
| | Step 10: Follow up payments and collections |

**1.9 Achieving Success**

Answers 1–5 will include physicians' practices, clinics, for hospitals or nursing homes, and in other health care settings such as insurance companies as claims examiners, provider relations representatives, or benefits analysts, in government and public health agencies, companies that offer billing or consulting services to health care providers is an option, as is self-employment as a claims assistance professional.
6. Knowledge of medical terminology, anatomy, physiology, and medical coding
7. Communication skills
8. Attention to detail
9. Flexibility
10. Health information technology (HIT) skills
11. Honesty and integrity
12. Ability to work as a team member
13. Appearance
14. Attendance
15. Initiative
16. Courtesy
17. 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. Professional etiquette is the correct behavior in a medical practice. It is generally covered in the practice's employee policy and procedure manual, and typically includes respectful and courteous treatment of patients and all others who interact with the practice's staff.

**1.10 Moving Ahead**

1–3 At least three of these options:
(1) Completed a medical insurance specialist program, coding specialist program, or medical assisting or health information technology
(2) Earn an associate degree or a certificate of proficiency by completing a program in a curriculum area such as health care business services.
(3) Further baccalaureate and graduate study enable advancement to managerial positions.
(4) Become a member of a medical insurance, medical billing, medical assisting, medical management, etc. organization.
(5) Obtain certification in coding, medical assisting, medical billing, medical office management, etc.
4. Certification by a professional organization provides evidence to prospective employers that the applicant has demonstrated a superior level of skill on a national test, and helps people to move ahead in their careers.

**Chapter 1 Key**

***Key Terms***

**Multiple Choice**

1. B
2. D
3. B
4. A
5. A
6. B
7. C
8. D
9. C
10. C

**Self-Quiz**

1. The patient is the *first party*; the physician is the *second party*; and the health plan is the *third party*, who agrees to carry the risk of paying for those services and is thus called the *third-party payer*.

2. A medically necessary service is reasonable and consistent with generally accepted professional medical standards for the diagnosis or treatment of illness or injury.
3. The payment is retroactive, the fee is paid after the patient receives services from the provider.
4. The payment is prospective, that is paid before the patient visit.
5. A policyholder and a health plan**.**
6. benefits
7. Payment for the cost of medically necessary medical services policyholders and their dependents receive.
8. The schedule of benefits of the insurance policy.
9. to manage care by establishing effective and efficient health care delivery systems that ensure quality and at the same time control health care costs.
10. from capit-, Latin for head
11. A fixed prepayment to a medical provider for all necessary, contracted services provided to each patient who is a plan member for a specific period of time.
12. The capitated rate payment system is a prospective payment—it is paid before the patient visit.
13. to understand patients' responsibilities for paying for medical services, to analyze charges and insurance coverage to prepare accurate, timely claims, and to collect payment for medical services from health plans and from patients
14. scheduling appointments, billing, and financial record keeping
15. physician offices, clearinghouses, insurance companies, billing services, hospitals, outpatient facilities, mental health care facilities, nursing homes, managed care organizations, government and/or public health agencies

**Critical Thinking Questions**
1. Both answers can be supported by arguments for covering excluded services as being the socially responsible thing to do. Upholding some excluded services helps keep costs down for insurance companies and subsequently lowers premiums.
2. This can be answered in many ways, depending upon the student.
3. Although this may be answered in many ways, perhaps the majority of students will choose a managed care plan that offers the most choice. This would mimic the general public's preference.
4. Fee-for-service plans place fewer restrictions on the provider. Capitated plans allow for steady cash-flow each month.
5. Students may wish to create some type of listing of what skills/attributes they currently possess and those that need work. The instructor may also use this as an evaluation of a student's soft skills or have students work together to identify one another's skills/attributes or lack thereof.

***Web Activities***

**Surfing the Net**

1. Answers will vary according to state and insurer.
For example, in Pennsylvania students might use the URL for Geisinger: www.geisinger.org/health-plan.
2. Answers will vary according to state and insurer.
3. Answers will vary according to state and insurer.

**Using the Web Wisely**
The website of the Medical Billing Advocates of America is: www.billadvocates.com/
4. Authority
Some information can be found by clicking on About - Contact Us. The site does not list any author names at this time; the corporate name (MBAA) is used.
5. Purpose and coverage
It is .com, a business site. By reading the Mission Statement, the student can learn about the purpose of the organization. Coverage of the topic appears to be of only one point-of-view. More than once, a home study course, for a fee, is offered to help persons become Medical Billing Advocates.
6. Accuracy
Whether the page is edited or reviewed by outside specialists is not apparent from viewing the site. Not enough specific are given in the narrative quoting outrageous medical bill charges to verify the facts. No references are used. This is a good critical thinking skills question for students. The author's opinion is that this is simply a sales site targeting persons who wish to hold themselves out as specialists in saving money on medical bills.
7. Timeliness
No dates are given for creation or updating.
8. Integrity of the information
Again, no references sources are used. Pictures are general and probably simple down-loaded files.
9. Objectivity or point of view
The site seems to offer an "us against them" attitude, with us being the consumer and them being the third-payers, providers, hospitals, etc. The site definitely uses provocative language—and in bold for added emphasis. There are no ads on this page, although students may get popups or other ads depending on their computer's settings.

**Web Scavenger Hunt**
This URL is for the American Medical Billing Association's (AMBA) page for certified medical reimbursement specialist—www.ambanet.net/cmrs.htm. The site lists the process for earning the Certified Medical Reimbursement Specialist designation through AMBA.

This URL is for the American Health Information Management Association's (AHIMA) page for coding certification—www.ahima.org/certification/. The site lists the various credentials and their requirements.

This URL is for the American Academy of Professional Coders' page for coding certification—

www.aapc.com/certification/index.aspx. The site lists the various credentials and their requirements.

This URL is for the Professional Association of Health Care Office Management's (PAHCOM) page for certification of office mangers specializing in physician practice management—www.pahcom.com/cmm/overview.html. The site lists the requirements for the Certified Medical Manager designation.

**Using Math in the Medical Office**

Exercise 1

| | |
|---|---|
| A. 75% | 0.75 |
| B. 25.3% | 0.253 |
| C. 47% | 0.47 |
| D. 88.5% | 0.885 |
| E. 07% | 0.07 |

Exercise 2

| | |
|---|---|
| A. 36% of 50 | 18 |
| B. 73.5% of 425 | 312.375 |
| C. 25% of 350 | 87.5 |
| D. 10% of 650 | 65 |
| E. 12.5% of 700 | 87.5 |

Exercise 3

| | |
|---|---|
| A. 0.10 | 10% |
| B. 0.875 | 87.5% or 87½ % |
| C. 0.06 | 6% |
| D. 0.80 | 80% |
| E. 0.167 | 16.7% |

Exercise 4

| | |
|---|---|
| A. 32 out of 35 | 91% |
| B. 109 out of 125 | 87% |
| C. 43 out of 60 | 72% |
| D. 19 out of 25 | 76% |
| E. 385 out of 600 | 64% |

Exercise 5

A. The insurance plan will be billed $255. The patient owes $85.
B. The insurance plan will cover $55.25. The patient will be billed $9.75.

Exercise 6

A. The insurance company will owe $620.10. The patient will pay the $1000 deductible as well as the 10 percent coinsurance of $68.90. for a total of $1068.90.
B. The patient owes a $20 copayment.
C. The patient will pay the $100 deductible plus her 45 percent coinsurance of $50.40, for a total of $150.40. The insurance company will reimburse $61.60.

| | | |
|---|---|---|
| Juanita Berrios Pt. | #483680 | Primary ins. – Mgd. Care |
| 721 Tamarack Street | 610-555-3842 | Secondary ins. – none |
| Allentown, PA 18105 | | |

| **Date/Pro** | | **Charge** | **Payment/Adj** | **Balance** |
|---|---|---|---|---|
| 4/11 | OV | 135.00 | Copay 20.00 | 115.00 |
| 4/11 | PMT | | Insurance 115.00 | 0.00 |
| 5/3 | OV | 212.00 | Patient 150.40 | 61.60 |
| 5/3 | PMT | | Insurance 61.60 | 115.00 |

Or, students may also detail each step of the process.

| | | |
|---|---|---|
| Juanita Berrios Pt. | #483680 | Primary ins. – Mgd. Care |
| 721 Tamarack Street | 610-555-3842 | Secondary ins. – none |
| Allentown, PA 18105 | | |

| **Date/Pro** | | **Charge** | **Payment/Adj** | **Balance** |
|---|---|---|---|---|
| 4/11 | OV | 135.00 | | 135.00 |
| 4/11 | PMT | | Copay 20.00 | 115.00 |
| 5/3 | OV | 212.00 | | 327.00 |
| 5/3 | PMT | | Patient 100.00 | 227.00 |
| 5/3 | PMT | | Patient 50.40 | 176.60 |

**Applying Concepts**
1. For the first hospital visit, the patient will be billed/pay $612. The insurance plan will not yet pay as the patient has not yet met the deductible amount of $750.
$750 – $612 = $138 remaining deductible
For the second hospital visit, the patient will be billed/pay $138, the remaining amount of the deductible. The insurance plan will reimburse $220, the charges left after the deductible has been met.
$358 **–** $138 = $220
2. The patient will owe $45 (of the $100 deductible for office visits) to the office and $1000 (the full amount of the hospital deductible) to the hospital. (This is assuming the provider properly codes for the visit prior to admission.)
3. The patient will pay the $10 copayment and an additional $22.50 (30% of $75) in coinsurance for a total of $32.50.
4. Holly must pay the full amount, $1732, to the hospital in Maine as it is out of network. Holly

will be reimbursed $1732 after submitting a claim to her HMO as this episode of care was for an emergency.
5. Insurer A will reimburse $676 which is 80 percent of $845. The amount remaining unpaid is $169. Insurer B will reimburse $135.20 which is 80 percent of $169. The amount remaining unpaid is $33.80. The patient will be billed for $33.80.
6. The patient's insurance plan will cover 80% of the $95 complete eye exam, or $76. The patient must pay the 20% copayment of $19 and $65 for the refraction exam. Neither party will pay for the Glaucoma check as there was no charge.
7. Shane's deductible will be $250. The health plan will reimburse $125; Sheena is responsible for paying the $250 deductible for Shane. Sharon's deductible will be $250. The health plan will reimburse $725; Sheena is responsible for paying the $250 deductible for Sharon. Sheena will pay a total deductible of $500 plus 10% of the charges after the deductible is met, or $85.
8. The insurance plan will pay $255 ($265 minus the $10 co-pay). Mr. Anthony will pay a $10 copay.
9. The insurance plan will pay $12, which is 80 percent of the difference between the charges and the deductible ($15). Mr. Anthony owes $250 deductible plus $3 for coinsurance, for a total of $253.