This International Student Edition is for use outside of the U.S.

Medical Insurance

A Revenue Cycle Process Approach

8E

Valerius
Bayes
Newby
Blochowiak

Mc Graw Hill Education

Medical Insurance

A Revenue Cycle Process Approach

Eighth Edition

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

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

Cynthia Newby, CPC, CPC-P

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

Mc Graw Hill Education

MEDICAL INSURANCE

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Brief Contents

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Preface

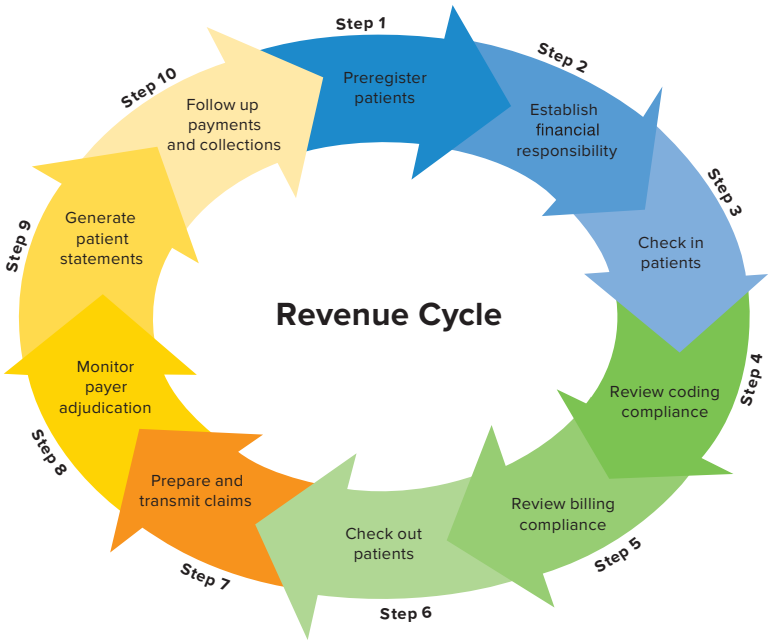
Follow the Money!

Medical insurance plays an important role in the financial well-being of every healthcare business. The regulatory environment of medical insurance is now evolving faster than ever. Changes due to healthcare reform require medical office professionals to acquire and maintain an in-depth understanding of compliance, electronic health records, medical coding, and more.

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

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

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



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

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

Organization of *Medical Insurance, 8e*

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

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

New to the Eighth Edition

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

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

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

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

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

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

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

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

Key content features include the following.

- **Pedagogy**
  - Learning Outcomes reflect the range of difficulty levels to teach and assess critical thinking about medical insurance and coding concepts and continue to reflect the revised version of Bloom's Taxonomy.
  - Objective end-of-chapter questions cover all Learning Outcomes.
- **HIPAA-Related Updates**
  - 2018 ICD-10-CM and CPT/HCPCS codes are included.
  - The new Notice of Privacy Practices (NPP) that addresses disclosures in compliance with HITECH is illustrated.
- **Key Chapter Changes**
  - **Chapter 1:** *New:* Thinking It Through 1.7. *Revised:* Thinking It Through 1.2. *Updated:* statistics and data in Figures 1.1 and 1.4; Compliance Guideline on ICD-10-CM implementation.
  - **Chapter 2:** *New:* two HIPAA/HITECH Tips on Texting and Plans Mandated; PHI on the cloud. *Updated:* four WWW features on HHS, Medical Notice of Privacy Practices, HHS Breach Notifications, and CMS HIPAA Enforcement. *Deleted:* old Figures 2.1, 2.2, and 2.6; information on the National Health Information Network.
  - **Chapter 3:** *Deleted:* old Figure 3.7.
  - **Chapter 4:** *Updated:* all ICD-10-CM codes and conventions for 2018; Figures 4.1 and 4.3; Case 4.1 in Applying Your Knowledge. *Deleted:* key term ICD-9-CM.
  - **Chapter 5:** *New:* Billing Tips on Category III Code Sunsets and Revised Guidelines Coming; symbol for telemedicine. *Updated:* all CPT codes, conventions, and modifiers for 2018; WWW features on CPT Updates, AMA Vaccine Code Updates, and Category II and III Updates; all cases in Applying Your Knowledge; Tables 5.2, 5.3, and 5.6; structure of E/M section. *Deleted:* symbol for moderate sedation.
  - **Chapter 6:** *New:* image for Figure 6.3. *Revised:* Figures 6.1 and 6.2. *Updated:* Case 6.1 in Applying Your Knowledge.
  - **Chapter 7:** *New:* key terms 5010A1 version and Healthcare Provider Taxonomy Code (HPTC); text for 5010A1 Version and the CMS-1500. *Revised:* Figure 7.1; art in Cases 7.2, 7.3, and 7.4. *Updated:* all conventions for completing the CMS-1500 and all Item Numbers; WWW features on POS Codes, Current Taxonomy Code Set, and All Administrative Code Sets for HIPAA Transactions. *Deleted:* old Figures 7.2, 7.3, 7.4, 7.5, 7.6, and 7.8; old Table 7.1; Billing Tip on How Many Pointers?

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

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

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

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

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

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

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

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

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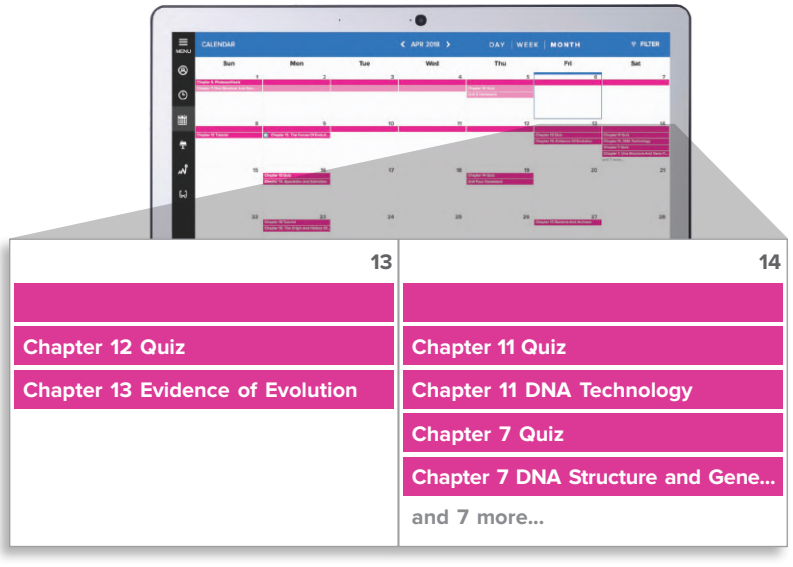

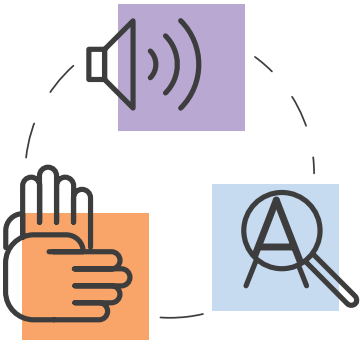

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McGraw-Hill *Connect for Medical Insurance, 8e* will include:

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

INSTRUCTORS' RESOURCES

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

Supplement	Features
Instructor's Manual (organized by Learning Outcomes)	• Lesson Plans • Answer Keys for all exercises
PowerPoint Presentations (organized by Learning Outcomes)	• Key Terms • Key Concepts • Accessible
Electronic Testbank	• Computerized and *Connect* • Word Version • Questions tagged 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, CAAHEP, and CAHIIM • Sample Syllabi • Conversion Guide between seventh and eighth editions • Asset Map—recap of the key instructor resources as well as information on the content available through *Connect*
EHRclinic Simulated Exercises Resources	• Implementation Guide • Technical Support Information • Steps for students completing the simulated exercises in Connect
CMS-1500 and UB-04 Forms	• PDFs of both forms

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Market Surveys

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

Marie A. Auclair, MSW, CCA, CPC
Springfield Technical Community College

Sharon Breeding, MAE
Bluegrass Community and Technical College

Angela M. Chisley, AHI, CMA, RMA
College of Southern Maryland

Regina B. Clawson, MBA
York Technical College

Toni L. Clough, MBA
Umpqua Community College

Denise Cross, BHSA, CMA (AAMA)
Jackson College

Laura A. Diggle, MS, CMA (AAMA)
Ivy Tech Community College

Mary Douglas, CPC
Jackson College

Savanna Garrity, CPC, MPA
Madisonville Community College

Dan Guerra
Community Business College

Sarah Jordan, AAS in Accounting, BSBA, MHA, CEHRS, CBCS, CMAA
South Piedmont Community College

Keita Kornegay, CMAA, CEHRS, CBCS
Wilson Community College

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

Breanne Marshburn, MHA, CPhT
Randolph Community College

Michelle C. McCranie, AAS, CPhT, CMA
Ogeechee Technical College

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

Tracey A. McKethan, MBA, RHIA, CCA
Springfield Technical Community College

Tanya Ocampo, RHIT
Meridian Community College

Paula Phelps, MBA, RMA
Cowley College

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

Vicki L. Schuhmacher, BSM, CMA (AAMA)
Ivy Tech Community College

Janet Seggern, M.Ed., M.S., CCA
Lehigh Carbon Community College

Julia Steff, RHIA, CPHQ, CPHI, CCS, CCS-P
Palm Beach State College

Rebecca L. Stimpson, MS
Carteret Community College

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

Karen Warner, CPC
Carroll Community College

Kari Williams, RMA (AMT), BS, DC
Front Range Community College

Dana Woods, BS, CMA (AAMA)
Southwestern Illinois College

Bettie Wright, MBA, CMA (AAMA)
Umpqua Community College

Cindy Zumbrun, MEd, RHIT, CCS-P
Allegany College of Maryland

Technical Editing/Accuracy Panel

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

Cherelle Aguigui, MS, RHIA
American College for Medical Careers

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

Angela M. Chisley, AHI, CMA, RMA
Gwinnett College

Laura A. Diggle, MS, CMA (AAMA)
Ivy Tech Community College

Savanna Garrity, MPA, CPC
Madisonville Community College

Susan Holler, MSEd, CPC, CCS-P, CMRS
Bryant & Stratton College

Janis A. Klawitter, AS, CPC, CPB, CPC-I, Provider Audits/ Analytics
Bakersfield Family Medical Center

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

Jillian McDonald BS, RMA(AMT), EMT, CPT(NPA)
Goodwin College

Janna Pacey, MSCTE, RHIA
Grand Valley State University

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

Audrey J. Theisen, BS, RHIA, MSCIS, PhD
Front Range Community College

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

Erica Wilson, MS, MHA, RHIA, CPC
Southern Regional Technical College

Digital Products

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

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

Tammy L. Burnette, PhD
Tyler Junior College

Phyllis A. Davis, BS, CCS, CPC, CPCP, CPCO, CPCI
Ultimate Medical Academy, Rasmussen College

Denise DeDeaux, MBA
Fayetteville Technical Community College

Laura A. Diggle, MS, CMA (AAMA)
Ivy Tech Community College

Mary Douglas, CPC
Jackson College

Amy L. Ensign, BHSA, CMA (AAMA), RMA (AMT)
Baker College of Clinton Township

Savanna Garrity, MPA, CPC
Madisonville Community College

Larena Grieshaber, CPC
Northeast State Community College

Judith Hurtt, MEd
East Central Community College

Shalena Jarvis, RHIT, CCS

Janis A. Klawitter, AS, CPC, CPB, CPC-I, Provider Audits/ Analytics
Bakersfield Family Medical Center

Keita Kornegay, CMAA, CEHRS, CBCS
Wilson Community College

Lynnae Lockett, RN, RMA (AMT), CMRS, MSN/Ed
Bryant & Stratton College

Tracey A. McKethan, MBA, RHIA, CCA
Springfield Technical Community College

Janna Pacey, MSCTE, RHIA
Grand Valley State University

Shauna Phillips, RMA, AHI, CCMA, CMAA, CPT
PIMA Medical Institute

Patricia A. Saccone, MA, RHIA, CDIP, CCS-P, CPB
Waubonsee Community College

Audrey J. Theisen, BS, RHIA, MSCIS, PhD
Front Range Community College

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

Erica Wilson, MS, MHA, RHIA, CPC
Southern Regional Technical College

Acknowledgments from the Authors

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Part 1

WORKING WITH MEDICAL INSURANCE AND BILLING

1 INTRODUCTION TO THE REVENUE CYCLE

KEY TERMS

accounts payable (AP)
accounts receivable (AR)
adjudication
benefits
capitation
cash flow
certification
coinsurance
compliance
consumer-driven health plan (CDHP)
copayment
covered services
deductible
diagnosis code
electronic health record (EHR)
ethics
etiquette
excluded services
fee-for-service
healthcare claim
health information technology (HIT)
health maintenance organization (HMO)
health plan
indemnity plan
managed care
managed care organization (MCO)
medical coder
medical insurance
medical insurance specialist
medical necessity
network
noncovered services
out-of-network
out-of-pocket
participation
patient ledger
payer
per member per month (PMPM)
PM/EHR
policyholder
practice management program (PMP)
preauthorization
preferred provider organization (PPO)
premium

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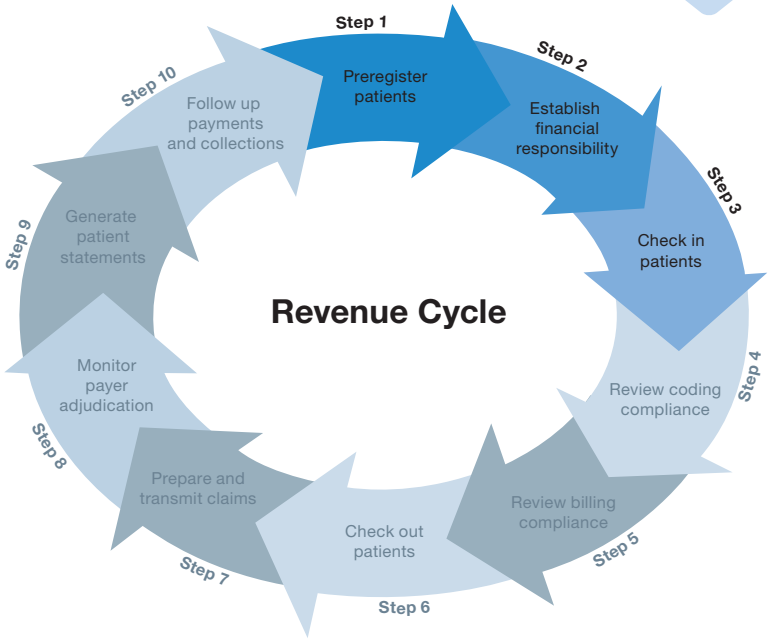

Learning Outcomes

After studying this chapter, you should be able to:

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

KEY TERMS *(continued)*

preventive medical services
primary care physician (PCP)
procedure code
professionalism
provider
referral
revenue cycle
schedule of benefits
self-funded (self-insured) health plan
third-party payer

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

1.1 Working in the Medical Insurance Field

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

Administrative Complexity Increases Career Opportunities

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

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

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

Helping to Ensure Financial Success

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

cash flow movement of monies into or out of a business

accounts receivable (AR) monies owed to a medical practice

accounts payable (AP) a practice's operating expenses

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

U.S. Department of Labor
Bureau of Labor Statistics

Occupational Outlook Handbook

Medical Records and Health Information Technicians

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

Medical Assistants

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

Medical Administrative Support

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

FIGURE 1.1 Employment Opportunities

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

revenue cycle all administrative and clinical functions that help capture and collect patient

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

into the practice from patients and insurance companies paying for medical services to pay the practice's bills.

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

Following Procedures

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

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

Communicating

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

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

Using Health Information Technology

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

health information technology (HIT) computer information systems that record, store, and manage patient information

Practice Management Programs

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

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

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

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

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

Electronic Health Records

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

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

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

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

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

A Note of Caution: What Health Information Technology Cannot Do

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

THINKING IT THROUGH 1.1

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

1.2 Medical Insurance Basics

Understanding how to work with the revenue cycle begins with medical insurance basics. **Medical insurance,** which is also known as *health insurance*, is a written policy that states the terms of an agreement between a **policyholder**—an individual—and a **health plan**—an insurance company. The policyholder (also called the *insured,* the *member,* or

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

policyholder person who buys an insurance plan

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