At-Home Professions®

Healthcare Documentation Program

Introduction to the Healthcare Industry & Medical Terminology

Course 1

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Healthcare Documentation Program

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Lesson 1
The World of Health Care

Step 1: Learning Objectives for Lesson 1

When you have completed the instruction in this lesson, you will be trained to:

- Describe medical personnel and their role in quality health care.
- Describe the average day of various healthcare professionals.
- Describe the personal qualities of a healthcare professional.
- Describe the desirable character traits of a healthcare document specialist.

Step 2: Lesson Preview

Welcome to the exciting world of the healthcare document specialist.

You have also chosen a terrific time to enter the healthcare industry. Healthcare, in general, has been—and continues to be—one of the fastest-growing employment industries in the United States. Economists and staffing experts claim that while other industries are cutting back and laying off employees, the healthcare industry is in dire need of workers. In fact, the healthcare industry will add *20.5 million* new jobs between 2010 and 2020—more than any other industry, according to the U.S. Bureau of Labor Statistics.[1] Not only will the demand for healthcare professionals increase but the earnings potential is excellent.

The healthcare document specialist plays a vital role in the medical profession, and we have written this program to help you be successful. The program will show you how to manage patient records through transcribing and editing medical reports, coding insurance bills and billing medical insurance companies. You will also learn medical terminology, how to work with electronic healthcare (or medical) records and anatomy and physiology. You will learn how to work with today's technology—using software programs for billing, coding, transcription and editing and electronic health reports. You will have the knowledge you need to find the job you want. And when you are ready to find that job, we are here to help. We offer graduate assistance to every student who completes our programs. We teach you how to market yourself and how to prepare for your new career. We know you are ready to learn, and be assured that we are ready to teach you—from the very first page until you graduate and are working in the field, we are dedicated to your success.

Now let's talk a little bit about how your program is organized. Your program is divided into courses, which are then divided into lessons. Each lesson contains skills that you will master on your way to graduation. The lessons are easy to follow and offer step-by-step instruction to make learning simple—even fun!

Each new lesson will begin with Learning Objectives and a Lesson Preview. The Learning Objectives tell you what you should learn by the end of the lesson, and the Lesson Preview provides a brief description of the lesson. From there, you will read new material and complete Practice Exercises. This combination of new material followed by a review may repeat two or more times per lesson. This format helps you apply what you learn and retain the information.

Finally, you will take a graded Quiz periodically in the program. Quizzes highlight what's important in the program. You will know many of the items on the Quiz without looking back at the lesson. However, if you don't remember or aren't sure of an answer, you can find the information in your lesson. All of your Quizzes are open book! We want you to learn how to use your resources to find the right answer rather than memorize the material.

If you have questions about any part of the program, feel free to contact an instructor. The instructional faculty is available to make your trip through this material enjoyable and rewarding.

In this first lesson, you'll study the key players in the healthcare field. You'll look at a typical day in the life of several healthcare professionals. Finally, we will look at the personal qualities, teamwork and character traits of a successful healthcare professional. Before we do, let's review how to set goals and manage your time during your studies and in your new career.

Step 3: Set Goals

Studies prove that people who set a series of smaller, short-term goals achieve their dreams more often than those who only set long-term goals. Let's take a few moments to consider a few, shorter-term goals—in addition to the date you have in mind to begin your new career as a healthcare document specialist!

Take a few moments to set some short-term goals. For instance, consider submitting your first Quiz today…you can even get instant results on your first Quiz by submitting your Quiz online—or call the school and submit your answers over the phone! Set a goal to complete the first three Quizzes by a certain date. Or commit to a specific date to complete Course One, for example. Whatever goals you decide on, do what works for you—make your goals realistic yet challenging.

Just think…in a matter of only a few weeks, you could be working on Course Two! The timeline and choice are yours; only you know what will work best for you.

Yes, you can study at your own pace. It's not necessary to blaze through a course on your way to earning your Healthcare Document Specialist certificate. In fact, you could read only one lesson a month if you really wanted to. But is that a good idea? Do you think that you would remember what you learned each month and be able to build upon it? When it's time for a Quiz, you'd probably have to put in a lot more study time if you used that approach!

Step 4: Time Management

Now, what about time management to help you meet your goals? Well, there's no denying that time is a valuable resource. We all share the same amount of minutes and hours available each day. Since you cannot change this fact or borrow time from previous days, all that you can do is use the time wisely. Time management consists of effectively and efficiently organizing yourself to make the best use of the time available and making the choices most appropriate for you. Let's clarify the difference between effectiveness and efficiency. Selecting the right task demonstrates effectiveness, allowing you to work smarter by working on what is important, and efficiency describes finding the best methods to complete that task.

To better learn to manage your time effectively, identify and set daily goals. Write down your daily goals to make them more visible to you and increase your commitment to them. Time management consultants agree that a daily to-do list is invaluable. Make your list a regular part of your routine. List all of the activities that you want to accomplish that day and rank them by level of importance. The ranking order works well because you rank the activities that allow you to achieve the most important goals first.

One of the most essential tools for effective use of time is a schedule. To begin working on a schedule, set aside a period of time each day to reflect and plan. This brief time spent each day will save you hours in the long run. Also, estimate in advance how much time a particular task will take. For example, pretend you set a goal to successfully finish a particular Quiz by the end of the week. You estimate it will take you six hours to prepare for and complete the Quiz, and you estimate you have two hours available for schoolwork each day. You don't want to wait until your goal completion date to begin the Quiz because somehow you will be trying to pack six hours of work into two hours. If you do this, you will not meet your goal—either you will not complete the Quiz or you will rush through the assignment and not perform as well as you originally hoped. And don't forget to schedule time for breaks and relaxation!

The final step in planning your work is to work your plan. Keep your schedule visible as a reminder of your goals. To finalize your scheduling, keep track of your progress toward a particular goal, and record your accomplishments.

Regardless of how well you plan your goals and schedule your time, you will inevitably run into obstacles. That's OK—you can conquer these obstacles.

One such obstacle stems from overcommitment. By spending time on what others want, you become unable to concentrate on your own goals. Many individuals do not know how or are afraid to refuse a request. Remember, your goals are important, and it's okay to politely refuse requests that are not in your best interest!

Another obstacle you may encounter is an inability to delegate, or entrust tasks to others. However, delegating is a key concept in successful time management. If you don't delegate, the result is less time spent on the critical tasks that need your attention. You often perform activities at work and home out of habit. Try this technique: Whenever you face a task, ask yourself if someone else can handle it. Think about it. Can your daughter throw in a load of laundry while you study? Can your husband drive your son to basketball practice while you work on a Quiz? Probably. So ask them to do so!

Keeping an orderly desk can also help you manage time. Your desk can and should be a tool to make you more effective. Michael LeBoeuf, author of *Working Smart*, offers some guidelines for this topic. For example, keep only one project at a time on top of your desk, making that project your top priority. If you have a school Quiz to finish, that should be the only item on your desk. Also, keep items off your desk until you are ready for them. And don't be sidetracked by other tasks because they are easier or more appealing. Sure, maybe Lesson 8 of your course material seems more interesting than Lesson 5, but you should work on the top priority item—Lesson 5—and continue working on it until completion. When you complete a task, send it on its way. Then check your priorities, and move to the next item. Time management consists of simply organizing yourself to make the best use of the time available.

Everyone has the same amount of time available. What you do with that time is up to you to decide. Some people, through successful time management principles, make the most of their lives and create greater personal satisfaction for themselves and those around them. So, give a few of these time management ideas a try!

Set a Schedule and Stick to It

When we talked about time management, we talked about the importance of scheduling. Well, creating a schedule for your studies is an important success strategy. You can create a weekly organizer, and fill in the days and dates.

Each week, write in all of your nonnegotiable commitments for the week, such as when you're at your job or busy with your family. Then, find time slots that won't be interrupted. Write **STUDY TIME** in big red letters across these times. Highlight them. Put stars by them. Do whatever it takes to keep these appointments. And remember to check your calendar often. Here's a sample weekly organizer that you can use as a guide.

Weekly Organizer							
day/ date							
am 5							
6							
7							
8							
9							
10							
11							
noon							
pm 1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							

In addition, you should study somewhere that is quiet, comfortable and well-lit. Do not allow yourself to be distracted, and schedule study times when you are alert and likely to be at your best. Lastly, your study sessions don't have to be marathons, but you should make studying a part of your daily routine.

So there you have it. You know all about success strategies and how these strategies can help you reach your goals. Remember to put what you've learned here to use. These success strategies have proven to be a great help to students—that's why they're called success strategies! So take advantage of them. Use them to help you succeed at being a good student, earning your certificate, starting a new job and doing well in your career!

Now that you can manage time, let's look at motivation.

Step 5: Stay Motivated

As you learned earlier, you can set goals and establish a study schedule to aid in your success. It also helps to stay motivated. To keep your motivation up, study a little bit every day so that your momentum moves forward. In addition, completing the Practice Exercises will help you complete upcoming Quizzes. We want to help you succeed, and want to see you finish your program.

The most important factor in motivation is you! *You* are your own best motivator, so realize what motivates *you* to study. Perhaps your goal is to start a new, successful career, or start your own work-at-home business. It's helpful to know what drives you, so you can determine how to get there.

Set smaller goals (daily, weekly and/or monthly) that can help you reach your larger goals. If you want to run a marathon, you don't decide one day to run 26 miles. Instead, you set smaller, short-term goals that will help you run a marathon. You run a few miles each week and continue to add miles as you train. The same applies to your life—set smaller, short-term goals that will lead to your overall goal.

Another factor in motivation is procrastinating. Avoid procrastination! Keep going forward and completing each lesson, Practice Exercise and Quiz as you reach it. Each small goal will help you complete your larger goal—starting your new career. When you finish one lesson, preview the lesson objectives for the next lesson or begin reading your next lesson to keep up your momentum.

Sometimes it helps to talk with a mentor or a friend. A third person can support your goals, cheer for your progress and encourage you to do more. And remember, our instructors are only a phone call or e-mail away and are always happy to help!

Step 6: Teamwork in the Healthcare Profession

Now that you have some tips for staying motivated under your belt, let's identify some of the key players in the healthcare profession and elaborate on what they do. In most professions, success comes from a team of people working together to accomplish goals. In medicine, *physicians* certainly cannot perform their jobs alone. Many people work hard, some behind the scenes, others more visibly, to ensure that our healthcare system runs properly. When you go to see the doctor, you don't just see the doctor. You might see a number of professionals, including a receptionist or an office manager. Throughout a visit, a doctor may talk to several staff people; all of these people are essential members of the medical care team.

Before moving on, it's important that you understand the difference between inpatient and outpatient coding. An **inpatient setting** is a facility, other than psychiatric, that providers diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions. Meanwhile, an **outpatient setting** may be a provider's office, urgent care center, emergency department or an outpatient surgical facility. While inpatient settings may be mentioned, this course focuses on the outpatient setting.

Physicians

Physicians or doctors are the most prominent members of the medical care team. They perform life-saving procedures. They cure the sick and help heal wounds. Becoming a doctor of medicine is one of the most challenging career paths a person can choose. Not only do physicians earn four-year college degrees, but they also must complete medical school and one or more residency assignments. During residency, 85- to 100-hour work weeks are common. Because of this huge commitment, doctors deservedly receive much of the attention in the medical field.

Let's look at a medical service from the physician's point of view.

Dr. Green is a physician who works at Weston Medical Clinic. He sees his first patient, Hannah, at 8 a.m. He examines Hannah, a woman in her mid-30s, complaining of pain to her right arm. A concise statement that describes why a patient is seeking treatment is called the **chief complaint**. Dr. Green documents the patient's description of the development of the condition. Then, Dr. Green asks a series of questions to identify signs and symptoms that Hannah may be experiencing.

Next, Dr. Green does an examination and documents the objective findings. After the exam, Dr. Green recommends that x-rays be taken. The x-rays indicate a fracture. The physician's opinion about what is wrong with the patient or what is causing the patient's complaint is the **diagnosis**.

Finally, Dr. Green puts her arm in a cast, which is a *procedure*. A **procedure** is anything the physician does to determine a diagnosis and help the patient heal.

This sequence began with a *complaint*—"my arm hurts"— and was followed by a history and exam to determine the *diagnosis* aided by tests—a broken arm as seen on the x-ray. The sequence is completed with a *service* or *procedure*—the fracture care. Doctors perform one or more of these steps with every patient they see. And every time a doctor performs these duties, the steps must be recorded into the patient's medical record. The diagnosis and procedure, along with any tests done, eventually are transcribed, coded and billed by you, the healthcare document specialist! You will learn all about coding, billing and transcribing the diagnoses, procedures and services as you move through this program.

After Dr. Green dismisses the patient, he records some notes about the encounter. Dr. Green also makes some notes on the patient's history or chart. Now he is ready to see his second patient.

In summary, physicians diagnose illnesses and injuries. They prescribe drugs to alleviate symptoms, treat conditions and ease pain. They rely on their training to make quality, accurate decisions. However, as good as physicians are, their staff ultimately supports them as they provide quality treatment. *Nurses* are one essential part of the medical staff.

Nurses

As professionals who perform a variety of tasks in the medical world, **nurses** often must follow through with treatments physicians prescribe. Nurses can give injections and check a patient's vital signs, as well as assist in surgery. It's also true that nurses must often do the thankless jobs—cleaning up exam rooms and organizing supplies.

Without nurses, the number of patients a doctor sees in a day would drop dramatically. Nurses allow doctors to see more patients and are able to focus on those patients who require the most care.

Nurse's and Physician Assistants

Two other categories of personnel in the medical field are *nurse's* and *physician assistants*. **Nurse's assistants**, or nursing aides, help nurses with daily duties, such as paperwork, general organization and taking a patient's temperature, weight and blood pressure. Some nurse's assistants also talk to patients and make sure they're comfortable.

Physician assistants or **PAs** are normally under the supervision of a doctor and can perform some of the same functions as a doctor. PA duties might include stitching up a cut, taking a patient history and even performing lab work.

Emergency Personnel

Emergency personnel are a group of professionals with the sole responsibility of providing immediate medical assistance and transporting the patient to the hospital for treatment. When someone is hurt and needs an ambulance, these people respond. Police officers, firefighters and other rescue professionals all have some level of medical training.

You have probably heard of *emergency medical technicians (EMTs)* and *paramedics*. **EMTs** take classes that enable them to stabilize patients who have a wide variety of emergency medical conditions. They are often members of ambulance crews and volunteer fire-fighting organizations. Paramedics have more training than EMTs. **Paramedics** are not only able to stabilize patients, but they can also begin treatments to cure patients, such as administering medication.

Support Staff

Physicians and nurses rely heavily on support staff to keep a medical office or clinic running smoothly. As you might guess, each of these positions plays an important role in the medical world.

Office Professionals

Office professionals include office managers and receptionists. Without this staff, many medical offices would grind to a halt! These people organize schedules, record appointments and answer patient questions. Office staff members have terrific communication and organization skills. They also must make a good first impression. The office manager may be the first person a patient sees upon entering a medical office, and the manager's attitude can mean the difference between a pleasant visit and a nightmare for the patient.

Medical Transcriptionists and Editors

Do you remember when the doctor in our previous example recorded some notes about a patient encounter? Well, that dictation went to a **medical transcriptionist** who listened to the doctor's dictation and typed what she heard. This then was added to the patient's medical record. By using transcriptionists, doctors save time by speaking their notes. Some medical transcriptionists also serve as *medical editors*. **Medical editors** listen to the doctors' spoken notes while editing rough reports that a speech recognition program produced based on the doctors' dictation.

You'll explore medical records in more detail later in this course.

Medical Coding Specialists

Medical coding specialists assign medical codes to the information obtained from a patient's visit to a medical facility. Each patient's diagnosis, treatment and tests must be coded. The medical coding specialist gets the medical report that the physician dictated and that the transcriptionist created. This employee examines the diagnosis and the treatment performed and assigns codes to each one. To code, the medical coding specialist looks up the information in a reference book and finds the right set of numeric or alphanumeric codes that describes exactly what occurred during the patient's visit.

Medical Billing Specialists

Medical billing specialists are a perfect example of how interrelated one job is to the next in a medical office. Remember, medical coding specialists assign appropriate codes describing what occurs during a patient's medical visit, while **medical billing specialists** use the codes that a medical coder assigns to complete the insurance forms. These forms are necessary to collect payment from the insurance companies. Billing specialists know that the provider doesn't get paid unless the form is completed and filed correctly.

Now that you know the job duties of many of those in the healthcare world, let's look at the day in the life of several healthcare professionals.

Step 7: Healthcare Professionals

Now that you know a bit about team players involved in healthcare, let's build on that knowledge. We'll take a look at three different healthcare professionals, following them through a portion of a day so that you can get an idea as to the environments they work in and the tasks they must complete. Keep in mind that these are very general examples. However, as a healthcare document specialist, you will be able to perform the work of these professionals!

Medical Transcriptionist/Editor

Taylor is the medical transcriptionist and editor for Weston Medical Clinic and has worked as a medical transcriptionist for about 10 years. Before Weston, she worked with a transcription company that had several doctor's offices and medical facilities in different parts of the country. Taylor has seen the change in the medical transcription field and has moved from transcribing audio tapes from offices in her area to transcribing digital sound files for facilities in other states. Now she works from home as a medical transcriptionist and editor for Weston Medical Clinic. Let's take a look at a typical day for Taylor.

Taylor wakes up and heads downstairs to her home office by 8 a.m. Taylor logs onto the shared drive to which all the transcriptionists have access. Every doctor at the clinic has a folder on the shared drive. Each physician carries around digital hand-held devices and dictates information directly into it. These sound files are then loaded onto the shared drive and saved into the corresponding doctor's folders. Taylor opens up one of the sound files that she needs to transcribe. She uses a special program that is connected to the patients' **electronic health records** (**EHRs**), which are computerized medical records. After Taylor is finished typing it, she saves it to the patient's chart on the computer and moves the sound file into a folder for the finished reports. Once the transcribed report is saved in the patient's chart, it goes back to the physician for a signature. The physician opens up the report and signs it electronically. Then Taylor is ready to start another report!

Some of Taylor's doctors use *speech recognition technology* (*SRT*)—which we'll discuss later in your program—to transcribe reports. The SRT program takes the physician's dictation and creates a rough report. Taylor listens to the dictation and follows along with the report to make sure it's accurate. Additionally, Taylor edits as necessary and puts the report in the correct format.

Taylor appreciates this technology because she doesn't have to type all of the physician's notes, and it has created a new role for transcriptionists. Most of the time, Taylor only has to alter portions of the report as she carefully edits it. Taylor also appreciates the time the technology saves; she can work from home because she can access the files and programs she needs electronically!

Medical Coding Specialist

Marge is the medical coding specialist for Weston Medical Clinic. Like Taylor, she works at home. After getting her children off to school and refreshing her cup of coffee, Marge heads to her home office, ready to start her day! At Weston Medical Clinic, the coding specialist is one day behind the reception area. For instance, the medical coding specialist works on Tuesday's dictations on Wednesday, Wednesday's dictation on Thursday and so on.

Marge logs onto her computer with her password and downloads the dictation that Taylor created and saved to the EHR. Marge spends most of the remainder of the day reading the dictation to assign the correct diagnoses and treatments. You will learn how to determine the correct diagnosis and procedure codes later in this program. After assigning the codes to a record, Marge saves the EHR and moves to the next record.

Just before her children arrive home from school, Marge receives a phone call from Joann, Weston Medical Clinic's billing specialist. Joann has received denial for a claim and asks Marge to pull up the dictation to check for accurate coding. Marge reviews the record and notes the numbers for the code were transposed. She provides the correct code for Joann to resubmit the claim.

By the end of the day, Marge has completed the coding for all of the services performed at Weston Medical Clinic the previous day.

Medical Billing Specialist

Joann is the billing specialist for Weston Medical Clinic. She usually starts the day by going through the claims that are still **outstanding**, which are bills that haven't been paid yet. For this clinic, most of these outstanding claims are waiting for insurance payments. The others are due either from patients who don't have insurance or from patients who need to pay the remaining portions of the bills that their insurance policies did not cover.

A few of the insurance claims are late in being paid, so Joann starts calling the individual insurance companies, trying to track down each claim. It takes two hours for her to work through 10 claims. This type of follow-up is very important for the clinic. It prevents any claim from "slipping through the cracks" of the insurance world. After getting a better idea of when to expect payment for the 10 claims, Joann works on the individual claims or those that have a balance due from the patient.

Joann checks the individual claims for the time of notification to determine how long it has been since each person received the bill. She marks those that are 60 or more days past due. These people will soon receive another reminder requesting payment.

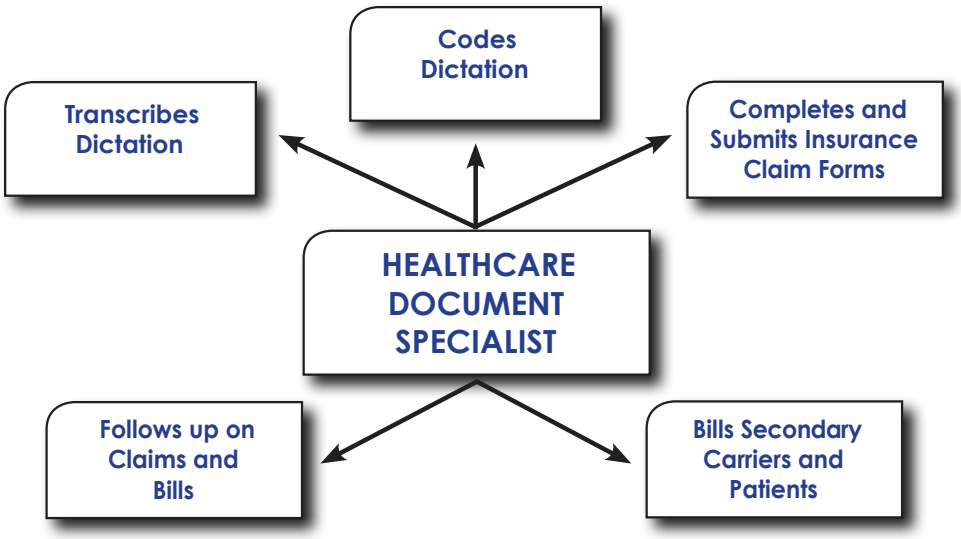
Finally, Joann is ready to work on creating claims for the services that have been coded by Marge. Joann checks the patient information to make sure that the patient included all necessary information, including the name, address, insurance company and policy number. After making sure all the information is correct, she transfers the codes to an insurance claim form, most commonly a CMS-1500. You will learn how to fill out this form later in the program. By 4:30 p.m., Joann has processed the claims. They will be submitted to their respective insurance companies, and the clinic waits for payment.

By reading about the work of medical transcriptionists and editors, coders and billers, you now have an idea of what a healthcare document specialist does every day. Let's continue by studying some general responsibilities of the healthcare document specialist.

Step 8: Responsibilities

You just read about the work of medical coders, billers and transcriptionists and editors. Keep in mind that as a healthcare document specialist, you may perform any or all of the same tasks as these professionals, making you a triple-threat when it comes to finding employment! So, as healthcare document specialist, you have five basic responsibilities:

1. **Transcribe/Edit Dictation.**
   As a healthcare document specialist, you will create dictation by transcribing digital voice files into dictation, or by editing text that has been created by computer software systems.
2. **Code Dictation.**
   Once the dictation is complete, the healthcare document specialist will read the dictation to determine the diagnoses and procedures that apply. Reference manuals are used to assign codes to represent the diagnoses and procedures.
3. **Complete and Submit Insurance Claim Forms.**
   Using the codes obtained from the reference manuals, as well as patient and physician information, you will complete and submit the appropriate insurance claim form.
4. **Follow Up on Claims and Bills.**
   After you submit the insurance claim form, you might need to contact the insurance company regarding the claim. You might also need to follow up with patients to secure payment.
5. **Secondary Insurance Claims and Patient Billing.**
   After the primary insurance carrier has paid its share of the bill, if the patient has secondary insurance, you will submit a bill to the secondary carrier. If the patient does not have secondary insurance, then the patient may be responsible for paying whatever remains after the primary carrier has paid.



Let's pause and complete a quick Practice Exercise.

Step 9: Practice Exercise 1-1

Select the best answer from the choices provided, and write your answers on scratch paper.

1. **The _____ is usually the first person in the doctor's office to see a patient.**
   a. office manager
   b. doctor
   c. EMT
   d. healthcare document specialist

2. **When the patient tells the doctor what's wrong, the information is called the _____.**
   a. diagnosis
   b. problem
   c. chief complaint
   d. procedure

3. **An outstanding claim is one that _____.**
   a. the insurance company has paid
   b. has multiple charges
   c. is filled out correctly
   d. hasn't been paid yet

Answer the following as directed.

4. **Describe the five basic responsibilities of a healthcare document specialist.**

Step 10: Review Practice Exercise 1-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 11: Personal Qualities

If you think about it, there are a large number of potential clients available in most towns. Even small towns usually have one or two practices and a hospital. Many times qualified help is hard to find, and because you have a skill that is in great demand, you have the opportunity to make good money. Though salaries vary depending on experience, the number of hours worked and location, you'll be pleased to discover the amount of money you can earn as a healthcare document specialist. And remember that as your experience builds, you can add to your earnings while being a vital part of a medical team and doing work that helps people.

The main thing to remember when you approach a potential client or employer is that you are the best healthcare document specialist for the job. Your competence means money to your employers! You should remember and practice three qualities: *professionalism*, *presentation* and *adaptability*.

Professionalism

Professionalism is the conduct, aim or qualities that characterize a profession or professional person. As with any business, the image you project is important. You must be professional. Professionalism includes how you dress, talk and interact with your clients. When you have an initial meeting with potential clients, your level of professionalism will affect their impression of you.

When you select what to wear, be conservative but not bland. Your attire should be clean, wrinkle-free and professional. Try to choose something you feel comfortable wearing. If you are comfortable, you will be able to concentrate on other important things, such as your presentation and answering any questions your potential client may have. An uncomfortable outfit, whether in style, color or both, will distract you.

Let's look at the following example to see how professionalism affects our choices.

Jane entered the Haber Dash Men's Store to exchange a tie for her husband. As she approached the counter, she saw that two clerks were at either end. She noticed that one clerk wore a t-shirt and torn jeans and had a few visible piercings. The other clerk was dressed conservatively in black pants, a starched white shirt and a snazzy bow tie. In a split second, she decided who looked the most helpful. She thought the conservatively dressed clerk would be more sympathetic to her tie dilemma, so she approached him for assistance.

Has this ever happened to you? Perhaps if Jane wanted advice on which CD to buy for her son, the other clerk would have appeared more competent. While it may not be fair, Jane made a judgment based on how each employee looked. Of course, no two people look alike, but there are certain factors of appearance that are important in the work setting. This is especially true for a professional healthcare worker.

Another facet of professionalism is delivering what you promise. You've probably heard the saying, "Five minutes early is 10 minutes late." Basically, this means if you have a meeting at 10 a.m., be 15 minutes early. Never be late, especially for a first-time interview. Such promptness shows you are responsible and considerate. If your client is a little late, be understanding. Just make sure you aren't the tardy one. When you are asked for work samples, be prepared. Explain what you know and how you gained your knowledge. If you ever are asked to complete a test task, do so promptly.

Presentation

Presentation is the act of bringing or introducing something into the presence of someone else. Often your initial presentation will decide whether you gain a client or employer. In addition to being on time and dressed properly for the meeting, your presentation can go a long way in influencing your client-to-be—both positively and negatively.

Be sure to present a confident image. Your attitude should say, "I know what I'm doing" without being arrogant or condescending. Remember, this is the client's money you're talking about. Confidence is a must!

Adaptability

Adaptability is the ability to be modified, or changed. To be successful, you must be able to adapt for each client. Some people want tasks done a certain way. Others may have exactly the opposite requirements. Codes are updated annually. Insurance regulations change. Forms are altered. If you get too set in your ways, you might lose clients who require slightly different approaches.

Step 12: Character Traits

What makes a top-notch healthcare document specialist? Let's examine some of the most important character traits of a healthcare professional. You'll be able to boast about these traits by the end of your program!

Curiosity and Drive

A healthcare document specialist needs to have a true interest in the healthcare field. You demonstrated an interest by enrolling in this program! This includes the constant desire to follow the ever-changing face of medicine. As you progress in your field, be willing to open your mind to new information to learn new skills and change your life.

Warmth and Confidence

A healthcare document specialist appreciates the satisfaction of caring for others. You may interact with other people, such as coworkers, doctors and patients, and you can do so in a courteous, pleasant manner. Showing warmth and compassion will put patients at ease. You may be the one assigned to explain the coding and billing process, as well as insurance denials. As you begin your career, be confident in your abilities and understanding of the information you're explaining.

Organizational and Professional Skills

A successful healthcare professional is a multi-tasker because she handles several responsibilities at once. Remember to make lists of things to do so you don't forget any of your tasks for the day. As you start working, you'll learn to keep charts and other paperwork organized so that you can find what you need at a moment's notice. You'll also realize that it's important to keep your work area clean and tidy so there's room to work and you don't lose things. It's also important to be able to **prioritize**, or decide which duties are most urgent. "Should I code Mrs. Smith's record first, or should I follow up on insurance payments?"

As a healthcare document specialist, it's important to keep organized and to prioritize. Let's keep moving!

Step 13: Practice Exercise 1-2

Determine the term(s) to complete each sentence, and write your answers on scratch paper.

1. **A healthcare document specialist should exhibit three personal qualities: _____, _____ and _____.**
2. **The _____ you project is important.**
3. **Handling several responsibilities at once is termed _____.**
4. **_____ is the ability to be modified or changed.**

Answer the following as directed.

5. **Explain the most important character traits of a successful healthcare professional.**

Step 14: Review Practice Exercise 1-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 15: Lesson Summary

Healthcare document specialists are an important part of any medical setting because they are able to perform everything from coding and billing to transcription and editing. This lesson gave you a firm understanding as to what healthcare document specialists and other members of the healthcare team do. You'll work with physicians, nurses, office managers and others to contribute to the best possible patient care.

We also discussed a few important points for you to remember as you move toward your new career. You learned the importance of professionalism, presentation and adaptability. Lastly, this lesson discussed the character traits of a successful healthcare document specialist.

As you continue with this program, you'll see in greater detail just how important healthcare document specialists are to those who work in and rely on medical facilities. This career is in demand! By choosing this program, you have started on an exciting path toward success.

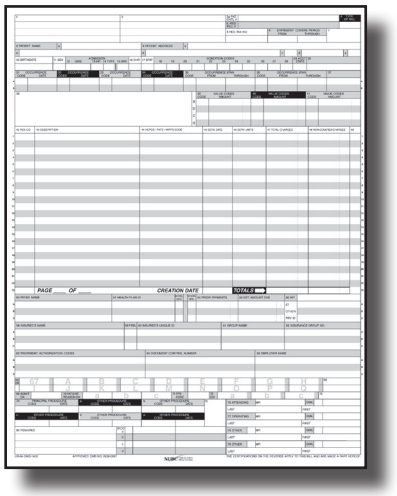
Congratulations—you are now ready for the next lesson in this course!

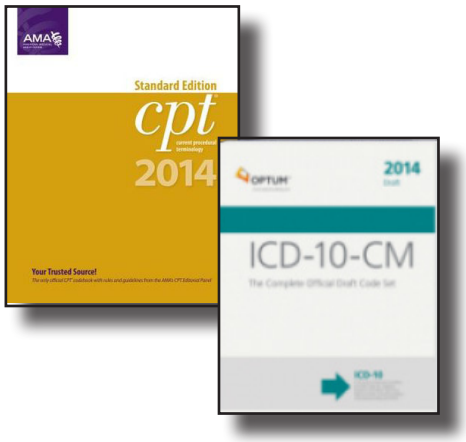
Endnotes

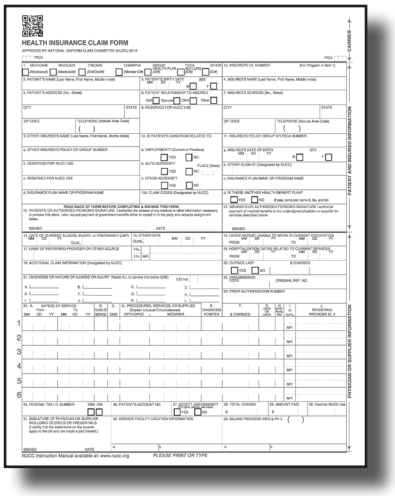
[1] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook. Web. 15 October 2013.

Great Start to the Course!

Each lesson you complete is one step closer to your new career.







Time for the next step!

You'll soon develop a better understanding of insurance terminology, and learn about the tools of the trade.

Continue to Lesson 2.

Lesson 2
Medical Insurance 101

Step 1: Learning Objectives for Lesson 2

When you have completed the instruction in this lesson, you will be trained to:

- Define medical billing terms common to the healthcare profession.
- Discuss the importance of preauthorization.
- Describe the resources used by a healthcare document specialist.
- Explain what a medical bill is and how it is used for reimbursement.
- Discuss the importance of being accurate and thorough.
- Describe the various types of insurance programs available today.

Step 2: Lesson Preview

Liz is a receptionist for Dr. Grant. She is great at making appointments and keeping track of patients. Yesterday, Dr. Grant's healthcare document specialist was out sick, and the doctor asked Liz to check on some information for him. He asked her to verify the diagnosis and procedure codes in a patient's medical record. Then he asked if any of the patients had paid their copayments and if their deductibles had been met yet.

While the doctor was speaking English, this all sounded like another language. Liz didn't have a clue about any of the items Dr. Grant had asked about. Finally, she gave up and asked Dr. Grant to wait until the next day when the healthcare document specialist returned.

In this lesson, you'll study the language of the insurance world. You will find out about the reimbursement process and different types of reimbursement methods. Then we'll briefly discuss preauthorization. Next, we'll examine some of the resources used by the healthcare document specialist. After explaining the basics of diagnostic and procedural coding, we'll discuss the life cycle of a medical bill and the importance of accuracy. Finally, we'll discuss the basics of some of the insurance programs available today. So let's get started!

Step 3: Insurance Terminology

Insurance refers to a contract between an insurance company, also called the **carrier** or **insurer**, and an individual or a group, which is also called the **insured**. Meanwhile, **medical insurance**, also called **health insurance** or **healthcare coverage**, is a contract between an insurance company and the insured for medical benefits. This contract, or **policy**, states that in the case of certain injuries or illnesses, the insurance carrier will pay some or all of the medical bills of the insured. In exchange for this coverage, the insurance carrier collects payments from the insured. These payments are called **premiums**. Premiums are paid in advance, either monthly, quarterly, semi-annually or annually, depending on the contract between the carrier and the insured. When an insurance carrier pays for medical treatment based on a policy, it is paying **benefits**.

The insurance carrier collects premiums from many people and only has to pay benefits to relatively few. That is how insurance companies make money and are able to provide services. Every insurance company requires an itemized list of diagnoses, procedures, pharmaceuticals and other materials before it pays benefits. Every procedure has its own code, and insurance companies use these codes to help determine benefits. Different insurance companies and plans all have their own forms and specific requirements. This is where you, as a healthcare document specialist, enter the picture. When you've completed this program, you can code and prepare claims for providers in the form necessary to meet the standards of insurance companies and government agencies.

Medical providers offer their services in return for payment. **Reimbursement** is a healthcare term that refers to the compensation or repayment for healthcare services. Reimbursement is the process of paying a provider back for services he already performed or provided. In health care, patients may walk out of a clinic without paying a large portion of the medical bill. Providers must seek to be paid back for the services that they have already provided, which is the reimbursement process. There is a hierarchy to this process.

The **first-party payer** is the patient, or the person responsible for the patient's health bill. In some cases, this may be a *guarantor*. A **guarantor** is someone who is responsible for an account because the patient is, for example, a minor. The guarantor is liable for any amounts that have not been paid to the provider, whether the insurance company makes partial payment or declines to pay.

The **second-party** is the physician, clinic or hospital. This group is often known as the **providers** because it provides the health care. An organization other than the patient (first-party) or healthcare provider (second-party) involved in the financing of personal health services is known as the **third-party payer**. Therefore, when you submit a claim to an insurance company for payment on a service, you are billing a third-party payer.

Before moving on, let's review some common, related terms used in medical insurance. Please note that, as with all terminology in this course, you are not expected to memorize the terms. Use your course materials as a reference and refer back to the term when needed. You will find that the more you use the terms, the less you'll need to use your materials as a reference. Soon, you will know and understand the terms from memory.

Allowable Charge

Physicians often sign contracts with certain insurance companies. When physicians enter into contracts with specific companies, they are called **participating providers**.

Participating providers agree to accept a level of payment determined by the insurance company. The **allowable charge** is the maximum amount an insurance carrier will pay for a specific service. When a subscriber sees a nonparticipating provider, sometimes insurance companies will pay minimal benefits. Review the following three levels of payment.

The following three categories classify payments to participating physicians:

1. **Usual, customary and reasonable** is the maximum amount the insurer will consider eligible for reimbursement under a health insurance plan.
2. **Customary maximum** is the fee charged by most providers in the community.
3. **Fixed fee schedule** is the maximum fee allowed by the insurance company for a specific medical service or procedure.

You'll explore each level of payment in greater detail later in the program.

Deductible

The amount of money an individual must pay before insurance benefits begin is called the **deductible**. Usually a policy will not pay the first $250, $500 or $1,000 of medical charges and then will pay a percentage of everything above that amount every year.

Any amount that is "applied to deductible" is an allowable charge that is subtracted from the total deductible amount. The insurance carrier does not pay any money on "applied to deductible" charges.

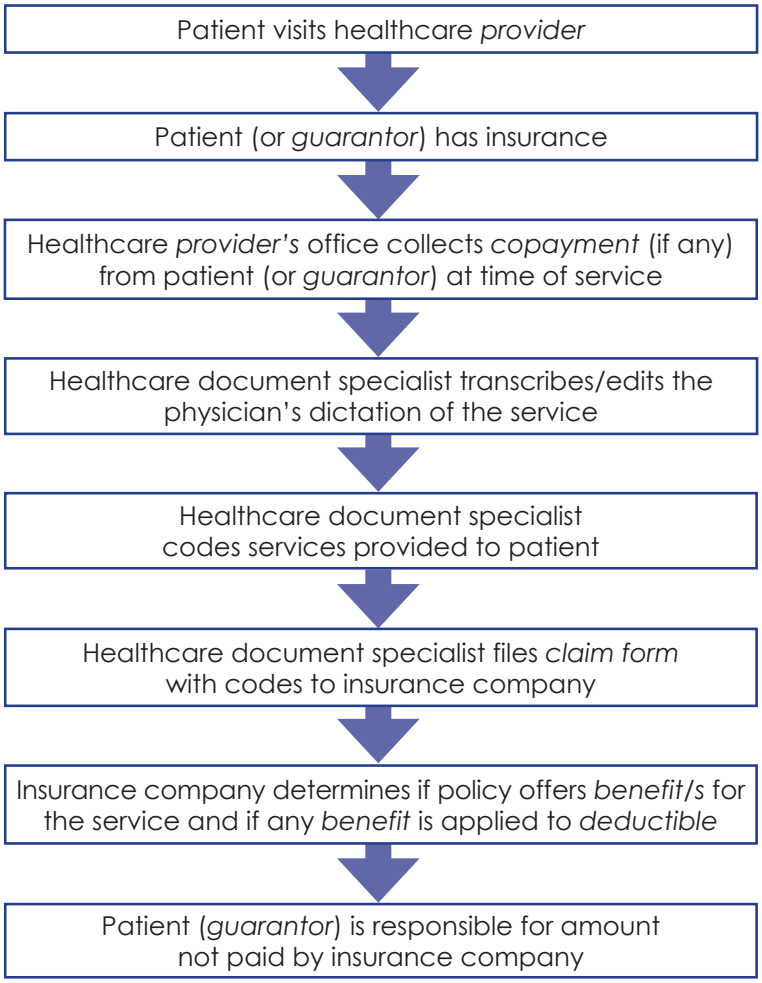
For example, imagine that Toby has a medical policy that has a $250 deductible and, after the deductible is paid, 80 percent coverage. So far this year, Toby has spent $200 of his own money on medical care, and that medical care has been defined as covered under his insurance policy. For the insurance company to begin to pay 80 percent of Toby's covered medical care costs, he must still pay out $50 more for covered charges. After he has met the $250 deductible, Toby's medical insurance benefits will begin, and the carrier will pay 80 percent of each claim submitted for covered charges for the rest of the year.

Copayment

A **copayment** is a flat amount of money paid by the patient. Many policies have a copayment for prescription drugs or office visits to a doctor. That means every time a person has a prescription filled or visits the doctor, it costs her no more than her copayment; however, she must pay that copayment every time she has a prescription filled or goes to the doctor. Some policies require copayments even after the deductible has been met. Other policies have no deductible, but a copayment is required every time any type of medical care is received. Copayments are usually paid immediately at the time of service.

Let's review a *reimbursement* scenario so you can see how your new vocabulary words are used in the billing process (note this is just one of several types of *reimbursement* scenarios).

Reimbursement Scenario



Now that you have a better understanding of these insurance terms, let's turn our attention to explanation of benefits.

Explanation of Benefits

After you have submitted a claim to an insurance carrier and it is processed, the physician will receive an explanation of benefits. The **explanation of benefits (EOB)** is a document that explains how much the insurance company paid and how much is disallowed. The EOB may include payment for one patient or several patients. Always check each patient's name, dates of service, procedures billed for and the amounts billed, the amount allowed, deductibles, copayment amounts and the amount paid on each individual claim.

The physician bills the patient for amounts applied to the patient's deductible, any copayment amounts and noncovered procedures, depending on the contract. Often, a service benefit contract stipulates a maximum charge per service. The insurance company will disallow the difference if a doctor submits a claim for an amount that exceeds that maximum charge. Depending on the insurance coverage, either the patient is responsible for the disallowed amount, or the provider will write-off the amount. You will explore this in more detail later in the program.

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

BLUE CROSS OF COLORADO

Date: 04/10/XX

Policy: STEEL RECYCLING

If you have any questions regarding this notice, please write or call our Customer Service Department at:

MEMBER SERVICE
P.O. BOX 8000
AVON, CO 80000
(612) 936-1234 OR 1-800-936-1234
TDD (612) 936-1234 OR 1-800-936-1234

STEVEN H. MAC
1823 KERRY COURT
BROWN, CO 80001

Patient: FRANCES M MAC
Number: 60508

Explanation of Payments:

Claim Number		Provider/Type of Service	Date of Service From – Through	Billed Charges	Disallowed Amount	*	Deductible	Copay/ Colns	Total Reimbursement Amount
		Roger Small MD*							
66355912		99212	0317XX-0317XX	50.00	6.48	9		20.00	23.52
66355912		84550	0317XX-0317XX	33.00	9.00	9			24.00
Totals				83.00	15.48			20.00	47.52

Payment has been made to: Amount

Family Care **47.52**

Deductible and out of pocket expenses for 03/17/XX-03/17/XX
Copayment $20.00
Non-covered amount **$15.48**
Total Patient Responsibility **$20.00**

* Message 9: This amount is above the maximum allowable reimbursement for this procedure.

Sample EOB for Frances Mac. Notice that the insurance company disallowed $15.48.

Step 4: Preauthorization

John has to go into the hospital. He knows it. His doctor knows it. According to his insurance policy, John must make sure his insurance company knows it as well. If he doesn't notify his insurance company *before* he enters the hospital, the company will reduce or deny his benefits. In addition to hospitalization, many insurance companies require notification before surgery or certain tests are performed. This process of notifying an insurance company before hospitalization, surgery or tests is called **preauthorization**. The insured must call the insurance company (or the company's designated agent, which is sometimes a third-party oversight company) and explain what is planned and why. A third-party oversight company might be contracted with the insurance company to review all hospitalizations and surgeries and certain other tests and procedures to make sure these procedures are medically necessary.

The preauthorization requirement helps reduce fraud by enabling the insurance company to review a patient's case history before major costs occur. Usually the insurance company approves the procedures, but the company might call the doctor handling the case to discuss the procedures.

The insurance company might extend or reduce the proposed hospital stay. For example, if John's doctor wanted him to stay in the hospital for four days after knee surgery, the insurance company might only authorize three days. This authorization is based on an average stay for that particular procedure. If no complications from the surgery arise and John stays four days, the insurance company would pay for only three days. John becomes responsible for the fourth.

In many cases, preauthorization is required even in the event of an emergency. When a patient is admitted to a hospital because of an accident or other emergency, the insurance company requires someone to notify the insurance company within 24 hours of hospitalization. Although the insurance company may deny a claim because preauthorization was not received, usually the company simply reduces the amount it will pay for that claim.

Visitation Limits

In this case, *visitation limits* doesn't refer to how many visitors a patient can have. It refers to the visits to a specialist. **Visitation limits** set the number of visits to specialists that a patient may make, or the number of special treatments a patient may have, such as five physical therapy sessions. Insurance companies set visitation limits.

Now that you're aware of the lingo of the healthcare profession, let's apply what you've learned in the following Practice Exercise.

Step 5: Practice Exercise 2-1

Select the best answer from the choices provided, and write your answers on scratch paper.

1. **_____ is a contract between an individual or group and an insurance company.**
   a. Insurance
   b. Coverage
   c. Deductible
   d. A premium

2. **The payments from the insured person or group that are collected by the carrier are known as _____.**
   a. deductibles
   b. schedules of benefits
   c. premiums
   d. benefits

3. **The second-party payer is the _____.**
   a. patient
   b. guarantor
   c. physician
   d. insurance

4. **The amount of money an individual must pay before insurance benefits begin is called the _____.**
   a. deductible
   b. copayment
   c. premium
   d. benefits

5. **The process of notifying an insurance company before hospitalization, surgery or tests is called _____.**
   a. preadmission screening
   b. preauthorization
   c. postoperative notification
   d. preoperative testing notice

Step 6: Review Practice Exercise 2-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

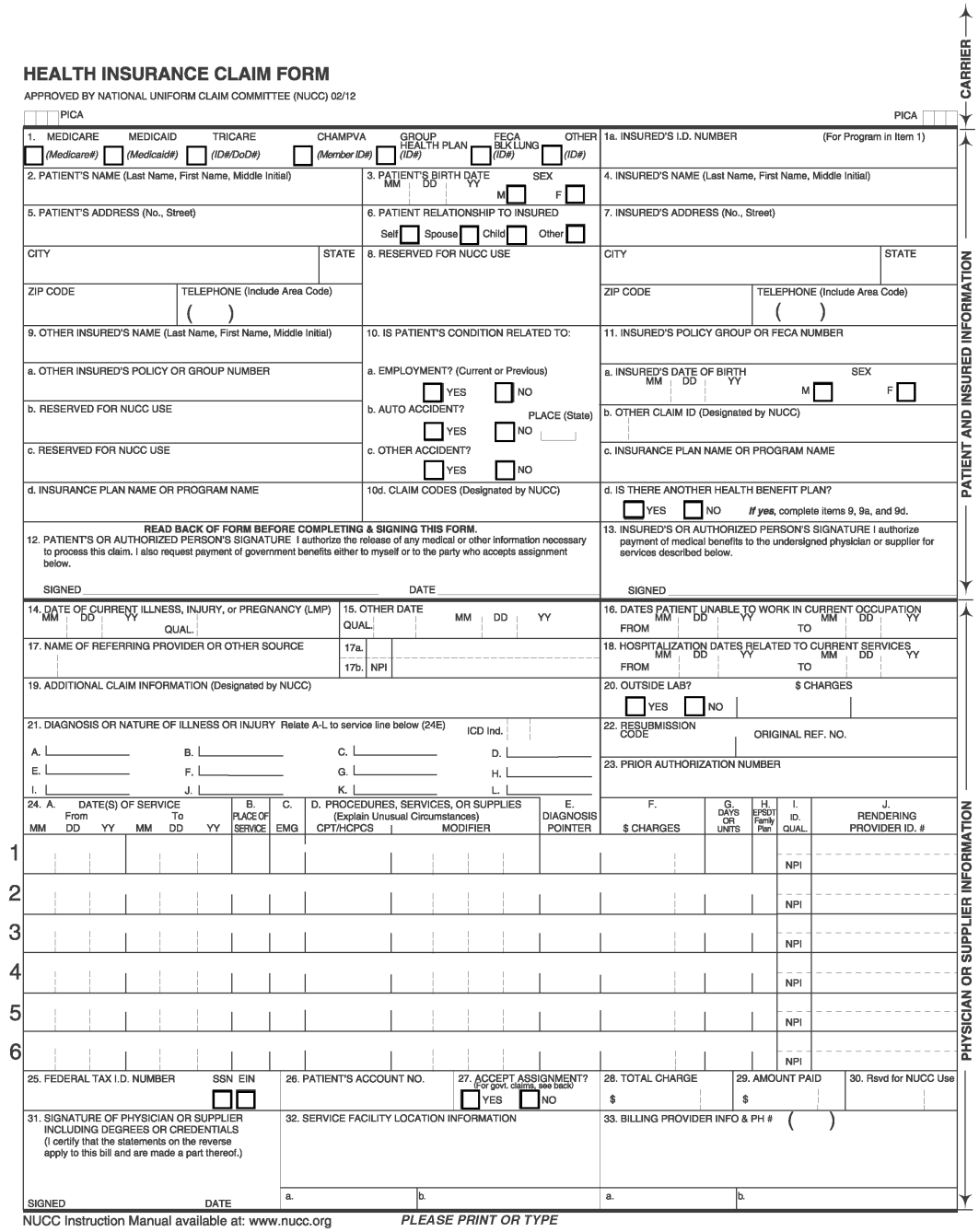
Step 7: Tools of the Trade

There are many resources available to help you succeed as a healthcare document specialist. Now, we will discuss the forms you'll use in billing, and the manuals you'll use to obtain the accurate codes.

CMS-1500

The **claim form** is the document that is completed and submitted to an insurance carrier to request reimbursement for services rendered. The most common insurance forms are the *CMS-1500* and the *UB-04*.

The **CMS-1500** is the standard claim form used to request payment for services rendered by the healthcare provider. Usually, physician's offices and government programs use this form. The National Uniform Claim Committee (NUCC) is responsible for the design and maintenance of the CMS-1500 form. First, providers used the HCFA-1500 (hick-fah) to process their claims. Then, the CMS-1500 became standard. With implementation of the ICD-10 system, version 08/05 was updated to 02/12. You may see this form referenced as CMS-1500 (02/12).



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

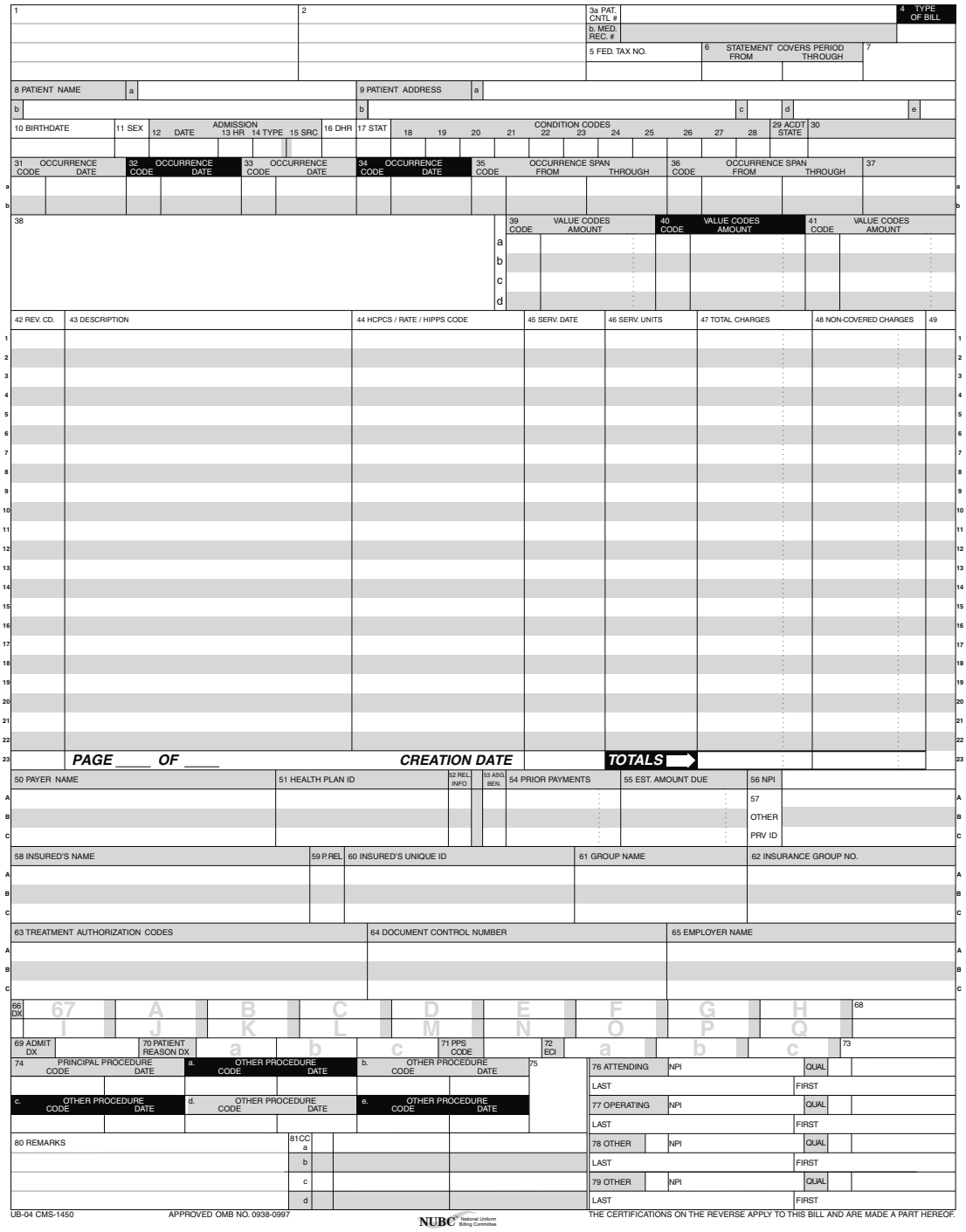
a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

UB-04

The **UB-04**, also known as the CMS-1450, is the uniform claim form used in hospitals and other inpatient settings. The National Uniform Billing Committee (NUBC) is responsible for the design and printing of the UB-04 form. In 1982, the NUBC accepted the UB-82 as a national uniform bill for hospitals. After eight years of collecting information, the NUBC improved on the claim form, resulting in the UB-92. However, more changes were still needed. In 2007, the UB-04 was approved as the mandated claim for inpatient services.



UB-04 Form

As a healthcare document specialist, you'll complete CMS-1500 and UB-04 forms and submit them to insurance companies for payment. You'll learn more about these forms soon.

Coding Resources

Now, let's take a moment to discuss medical codes and how they apply to insurance. After a patient's office visit, tests and other procedures, a claim form is completed. Claim forms require special codes—to identify the *diagnosis* and *procedure*. The **diagnosis** is the physician's opinion about what's wrong with the patient, while a **procedure** is anything the physician does to determine a diagnosis and treat a patient.

Medical coding is the translation of medical record documentation of illnesses, diseases, injuries, treatments and procedures into numeric and alphanumeric characters. These characters are then submitted for reimbursement purposes and statistical analysis. The tools the medical coding specialist utilizes to translate documentation include the *ICD-10-CM*, *CPT*, *HCPCS* and *ICD-10-PCS* manuals.

Accurate and complete coding ensures maximum reimbursement, and provides meaningful statistics to assist the nation with its healthcare needs. Let's look at the basics of each manual now.

ICD-10-CM

The *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*) manual is used to determine diagnostic codes for both inpatient and outpatient services. The *ICD-10-CM* is an alphanumeric classification system. A valid code may be between three and seven characters, with a decimal after the third character.

CPT

The *Current Procedural Terminology* (*CPT*) manual, developed and maintained by the American Medical Association (AMA), contains codes that describe the procedures and services performed by the provider for outpatient services. CPT codes are then used by insurers to determine the amount of reimbursement for the provider. Within the *CPT* manual, there are *Category I, II* and *III* codes.

Category I codes include all of the "regular" CPT codes in the six main sections of the manual. These are all five-digit codes.

Category II codes are a special collection of CPT codes that providers use to track and measure performance internally. Insurance companies do not use these codes to determine reimbursement. Instead, physicians use them to see just how much work they do in certain situations. Category II codes are optional.

Category III codes are temporary codes. These codes, unlike Category I codes, are listed in numeric order, not by anatomic location. After five years, if an emerging technology code is not accepted for placement in the Category I section of the *CPT* manual, it may be renewed for another five years by the actions of the CPT Editorial Panel. Otherwise, it will automatically be removed from the *CPT* manual.

HCPCS Level II

The Centers for Medicare and Medicaid Services (CMS) developed the *Healthcare Common Procedure Coding System, Level II* (*HCPCS*) to carry out the operational needs of the Medicare reimbursement system. **HCPCS Level II codes** consist of five-digit, alphanumeric codes. The CMS developed these codes (and releases updates on January 1st of each year) for physician and nonphysician services that the *CPT* manual does not cover. These codes include drugs, durable medical equipment, ambulance services and prosthetic procedures.

ICD-10-PCS

The *International Classification of Diseases, 10th Revision, Procedural Coding System* (*ICD-10-PCS*) manual is used for inpatient procedures. It is a seven-character, alphanumeric code system using digits 0 through 9 and letters A through H, J through N and P through Z, with no decimal.

Using Medical Codes

Once the medical documentation has been translated into codes, the codes and patient data are then transferred to a claim form and sent to the insurance carrier for reimbursement. The types and frequency of treatments and the diagnoses gathered from the patient information provide the statistics necessary to depict health care in this country overall. The government and insurance companies use these statistics to establish guidelines to develop rates of reimbursement to be paid to medical practices in the future.

As a healthcare document specialist, you might be called upon to double-check records as they come through your service. Usually, double-checking means confirming to be sure the diagnosis matches the procedures. Insurance companies check the procedures to make sure they are consistent with the diagnosis. If they aren't consistent, reimbursement from the insurance company may be delayed, denied or reduced.

Most procedures the doctor performs will have a code. You will enter the correct code in the correct area of the claim form. You'll learn this process later in the course. For now, all you need to know is that the codes are placed on the claim form for reimbursement purposes. Now, let's look at how you'll use these tools to create a medical bill.

Step 8: Life Cycle of a Medical Bill

Imagine you are a patient at a doctor's office. This is the first time you've been to this particular doctor. When you check in with the front desk, the office manager hands you a questionnaire to complete. This form asks for your name, address, telephone number, medical history and insurance information. After you complete the form, you give it back to the receptionist. With this process, you've just started the medical bill's life cycle.

When your examination is complete, the doctor may use an *encounter form* to document your visit. An **encounter form**, also known as a **superbill**, is a template of commonly used codes in the specific practice that serves as a communication device between the physician and the healthcare document specialist. In addition, the physician dictates the details of each visit to substantiate the charges. A medical bill gets created once the diagnosis and procedure codes have been applied to the service. Let's look at the details involved in the billing process.

Processing the Bill

Once the medical bill exists, it goes through several steps on its way to being paid. A patient and provider handle bills for medical care in one of three common ways:

1. The insurance company might require the patient to pay the entire bill at the time of service, before the patient leaves the provider's facility. Then the patient submits a claim to the insurance company for reimbursement.

OR

2. The patient might pay a copayment before leaving. Then the provider submits a claim to the patient's insurance company for the remainder of the bill.

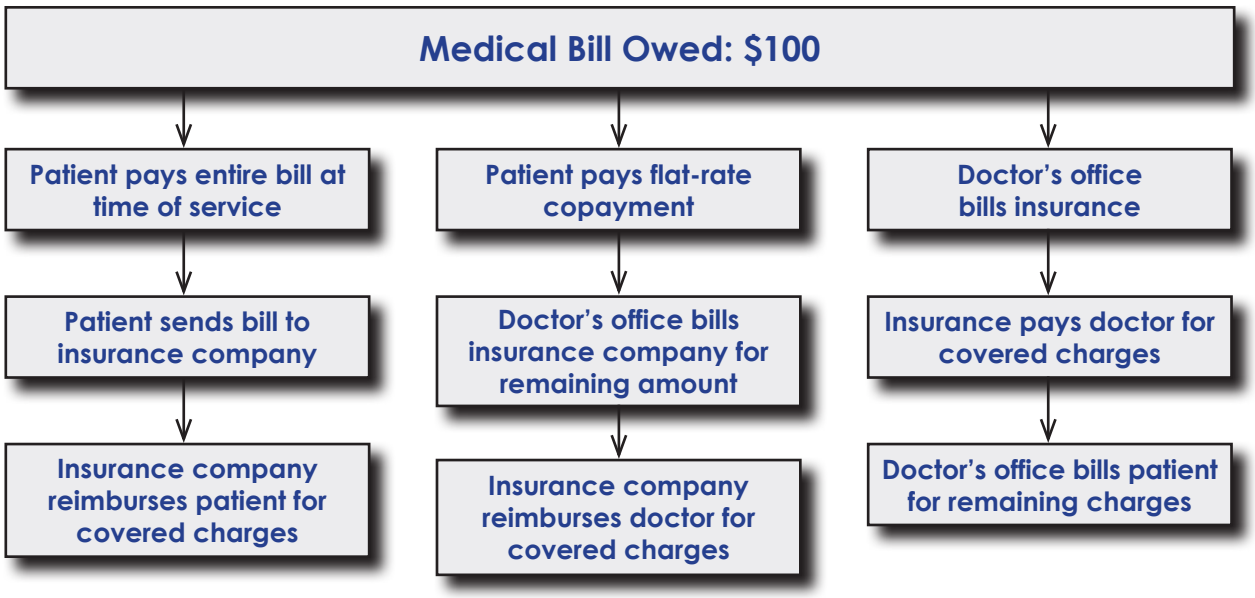
OR

3. The patient might pay nothing at the time of the visit to the provider. Following the patient's visit, the provider submits a claim to the patient's insurance company for the bill. The provider is reimbursed by the insurance company for the charges the patient's insurance policy covers. The doctor's office then sends a bill to the patient for the remaining costs that the insurance doesn't cover.

Processing the bill is slightly different depending on the manner in which the patient pays—either before or after the insurance company pays.

If, as the patient, you have to pay the entire bill on the day of your treatment, then, generally, it is up to you to send the bill to your insurance company. The provider is not obligated to submit claims to an insurance company unless it has a contract with that company or the federal government requires it. However, the provider often submits claims as a courtesy to the patient. The insurance company then reimburses you, the patient, for any covered charges. For example, if your bill is $100 and the insurance pays 80 percent, you receive an $80 reimbursement. The difference between paying at the time of service and the provider billing your insurance company is that when you pay at the time of service, the insurance company pays you directly.

If the provider bills your insurance company first, then usually you leave the office without paying any of the bill or only a copayment. The insurance company receives the doctor's request for payment and pays the covered amount, which varies according to your policy. Then, after the provider receives the insurance payment, her office bills you, the patient, for any balance due. For example, if your bill was $100 and your insurance policy covered 80 percent of the bill, the provider would receive $80 from the insurance company and bill you the remaining $20.



A big part of the healthcare document specialist's role is to submit insurance claims—the bills to insurance companies that request payment in accordance with the appropriate insurance policies. This program will give you the knowledge to be accurate and thorough—two essential qualities of a good healthcare document specialist.

Step 9: Accurate and Thorough

When the correct codes are applied and the claims are accurately completed, payments come quickly, and the providers are happy.

As a healthcare document specialist, you might double-check bills as they come through your office or service. Usually, this means checking to be sure that the diagnosis matches the procedure and that all the patient's information (such as name, address and identification number) is correct. When you check this information, you help to ensure timely payments and, most importantly, appropriate payment amounts. Healthcare document specialists can increase doctors' collections by as much as 10 to 15 percent! That's why healthcare document specialists play such an important role in the healthcare industry.

When bills include mistakes, they may delay payments a month or more, delay processing and cost the provider in denied claims, resubmission costs and reduced payments. Providers need accurate healthcare document specialists—like you—which is one of the great aspects of this career. Healthcare document specialists enjoy job security because people will *always* need doctors, and doctors will *always* need to transcribe or edit, code and file claims for their services. The demand for healthcare services is greater every year, and the ever-increasing number of patients, insurance claims and hospital admissions means more work for you!

Step 10: Practice Exercise 2-2

Select the best answer from the choices provided, and write your answers on scratch paper.

1. **When an insurance company pays for medical services, it _____ either the insured or the provider.**
   a. gerrymanders
   b. processes
   c. collects from
   d. reimburses

2. **A form used by some doctors that contains the most common procedures performed by that doctor is called a(n) _____.**
   a. account-easing document
   b. easy-accounting bill
   c. encounter form
   d. claim form

3. **A patient may simply make a copayment for a visit and then the _____.**
   a. provider bills the insurance company for the remainder of the bill
   b. provider considers the remainder of the bill uncollectible
   c. patient sends a bill to the insurance company
   d. provider sends out a full bill to the patient in 10 days' time

4. **An error on the claim form may _____ reimbursement.**
   a. delay
   b. not impact
   c. speed up
   d. improve

5. **When you write a code on an insurance form, you are _____ that entry.**
   a. deleting
   b. coding
   c. highlighting
   d. eliminating

6. **Diagnosis codes are contained in the _____ manual.**
   a. *CPT*
   b. *ICD-10-PCS*
   c. *ICD-10-CM*
   d. *HCPCS*

Step 11: Review Practice Exercise 2-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 12: Types of Health Insurance

Hundreds of private insurance companies provide medical coverage for individuals and groups. These private insurance companies generally follow standards similar to the government programs we will cover here. This next part of the lesson is designed to introduce you to the many types of government-sponsored insurance programs and each program's requirements for coverage, along with the basic types of private insurance.

Centers for Medicare & Medicaid Services

The **Centers for Medicare & Medicaid Services** (**CMS**) is a branch of the U.S. Department of Health and Human Services and is the administrator for *Medicaid* and *Medicare.* CMS mainly acts as a purchaser of healthcare services for the Medicaid and Medicare programs. The agency also assures that contractors and state agencies properly administer Medicaid and Medicare, assesses the quality of healthcare services and establishes policies for reimbursement to healthcare providers.

Medicare

Medicare is a federally administered, federally funded health insurance program for people age 65 or older, people under age 65 with certain disabilities and people of all ages with End-Stage Renal Disease.[1]

Medicare Part A helps pay for medically necessary inpatient care in a general hospital, skilled nursing facility care, home health care, hospice care and blood (during a covered stay). Medicare Part A is financed by the Social Security payroll withholding tax paid by workers and their employers. Those with Medicare Part A coverage don't have to pay a premium.

Medicare Part B helps pay for a wide range of medical services and supplies not covered by Medicare Part A. **Medicare Part B** helps pay for medical expenses, clinical laboratory services, home health care, outpatient hospital treatment and blood, if medically necessary. Medicare Part B is financed by monthly premiums paid by people who choose to enroll in the program.

Medicare Advantage Plan, or **Medicare Part C**, is a plan that Medicare-approved private companies offer. Medicare pays a fixed amount for care every month to the companies offering Medicare Advantage Plans. These companies must follow the rules Medicare sets, although the out-of-pocket costs and referral rules may vary depending on each private company.

In 2006, Medicare implemented a program that includes prescription drug coverage, called **Medicare Part D**. The program won't cover all of the costs associated with prescription drugs but assists in the yearly out-of-pocket expenses. Coverage for Medicare Part D may include a monthly premium, yearly deductible and copayments

Medicaid

Medicaid is a federally mandated program that provides medical and health related services to those who cannot afford them. In 1965, Title XIX of the Social Security Act became federal law to establish Medicaid officially. Although Medicaid is federally mandated, each state runs its own Medicaid program. Within the federal government guidelines, each state establishes its own eligibility standards; determines the type, amount, duration and scope of services; sets the rate of payment for services; and administers its own program.

Military Insurance

The **Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)** was established in 1966 to provide healthcare coverage for the families of members of the uniformed services. CHAMPUS was developed to control the rising costs of healthcare coverage and to standardize healthcare benefits. Many changes have taken place in the military healthcare system in the past several years. The most important of these changes is the transition from CHAMPUS to the *TRICARE* healthcare system. Although this transition has officially taken place, you may still see references to CHAMPUS in your work as a healthcare professional.

The Department of Defense healthcare program, known as **TRICARE**, provides healthcare coverage for medical services, medications and dental care for military families, retirees and their families and survivors.[2] As its name suggests, TRICARE has three options: *TRICARE Standard*, *TRICARE Extra* and *TRICARE Prime*. In addition, TRICARE has a program for Medicare eligible military retirees known as *TRICARE for Life*. Finally, *CHAMPVA* is healthcare for families of veterans with permanent, service-connected disabilities.

Workers' Compensation

Workers' compensation, also known as work comp, provides coverage to employees and their dependents if the employees suffer a work-related *accident* causing injury, illness or death. An **accident** is described as an unplanned or unexpected happening causing injury or death not due to any fault of the employee.

Two sets of laws govern workers' compensation: *federal compensation laws* and *state compensation laws*. **Federal compensation laws** cover miners, maritime workers and civilian employees of the federal government. **State compensation laws** cover employers and employees within each state. State compensation laws vary from state to state.

Private and Group Health Insurance

Private health insurance spending was reported at $801.2 billion in 2009.[3] That's quite a sum! People are living longer, and the population continues to grow. As a result, more people need health care, whether it's preventive care, such as annual physical exams, or intervention care, such as cancer or illness treatments.

These days, consumers have many options for healthcare insurance. One of those choices is to purchase a *private health insurance* policy. **Private health insurance** offers a variety of healthcare plans that require the *subscriber* to pay premiums. These companies operate for profit, meaning they have stockholders that benefit from the profits. Private insurance companies can raise rates when they need or want to, and they can more easily deny coverage at will.

- Private health insurance operates for profit, and it has stockholders that benefit from those profits.
- Private health insurance can deny coverage at will. This means that it can determine whether to accept a potential subscriber as a customer.
- Private health insurance can raise rates almost at will. States do have some regulations that private carriers must adhere to regarding raising rates.

The concept of prepayment is the basis of many private insurance carriers. When you **prepay** premiums, you pay in advance for coverage of specified services should the need for those services arise. You are paying a small fee *in case* the need for health care arises. The **subscriber**, also called the **insured**, is the person who prepays the fee for insurance coverage. When a subscriber purchases insurance coverage, he purchases a policy. The insurance policy describes the subscriber's benefits and details of coverage.

Many larger employers offer **group health insurance**, which works similarly to private healthcare insurance except that the insurance carrier cannot deny coverage to any of the company's employees, regardless of any pre-existing conditions. Companies purchase a group health plan that they offer as a benefit to their employees. Sometimes the employer pays the entire monthly premium for each employee, but most employers pay a percentage of each employee's premium, leaving the employee to pay the remaining percentage of the insurance premium.

Managed Care

Managed care has boomed because of skyrocketing healthcare costs. Health insurance providers constantly seek ways to hold down costs, but also to predict them. Managed care gives insurance companies a basis for predicting these costs by establishing set fees and costs for healthcare services.

The managed care philosophy has grown at the expense of the traditional *fee-for-service* philosophy that insurance carriers typically held. **Fee-for-service** coverage allows people the most freedom in choosing services and doctors. However, it also creates the largest amount of uncertainty for insurance companies. Companies find it much more difficult to accurately budget for costs when they offer fee-for-service insurance plans.

As insurance companies and employers searched for ways to budget for healthcare costs, several managed care programs evolved, including *HMOs* and *PPOs*.

Health Maintenance Organizations

HMOs represent the most popular choice in managed care. The **health maintenance organization** or **HMO** is a prepaid health plan in which individuals receive medical services from participating providers. Patients cannot see just any physician. Instead, they must see a physician within the HMO. HMOs have their own specialists and general practitioners. Generally, a general practitioner refers a patient to a specialist. A **referral** is an authorization by one physician for a patient to see another physician for a specific health problem.

Preferred Provider Organization

PPOs are similar to HMOs, but there are some key differences. Members of **preferred provider organizations** or **PPOs** can choose their own doctors and treatment facilities. However, there is some motivation for members to choose PPO participating medical care providers. When a member seeks care from a PPO participant, the member's benefits increase. Likewise, when a nonparticipating provider or a nonparticipating facility treats that same member, the benefits are less than they would be through a participating provider.

PPOs operate much like fee-for-service plans when it comes to copayments. Usually, the member must pay between 15 and 25 percent of each bill until the member reaches a *threshold limit*. The **threshold limit** is the amount at which the copayment drops.

Look at the following example for a better understanding of this concept: Bill belongs to a PPO with a 20 percent coinsurance up to a $5,000 threshold limit. Bill must pay the first 20 percent of every bill in a year until his total of bills is $5,000. After that, the PPO pays 100 percent of covered charges.

It's time to review what you've learned about medical insurance. Remember, this is just the basics to give you a better idea of the type of programs available.

Step 13: Practice Exercise 2-3

Select the best answer from the choices provided, and write your answers on scratch paper.

1. **Managed care gives insurance providers a basis for _____ healthcare costs.**
   a. increasing
   b. predicting
   c. eliminating
   d. superseding

2. **_____ limits the patient's freedom to choose doctors.**
   a. Fee-for-service coverage
   b. Managed care coverage
   c. No healthcare plan
   d. All of the above

3. **HMO stands for _____.**
   a. healthcare management organization
   b. home medical option
   c. health maintenance organization
   d. health management organization

4. **The program that provides managed healthcare coverage for military service families is called _____.**
   a. DEERS
   b. HCFA
   c. TRICARE
   d. CHAMPVA

5. **The program that provides health care for the families of veterans with permanent, service-related disabilities is called _____.**
   a. CHAMPVA
   b. TRICARE
   c. DEERS
   d. HCPCS

Determine the term(s) to complete each sentence, and write your answers on scratch paper.

6. **A(n) _____is described as an unplanned or unexpected happening causing injury or death not due to any fault of the employee.**

7. **Medicare is a(n) _____funded health insurance program.**

8. **Medicare Part A covers _____hospital care and services.**

9. **Medicare Part B covers medical _____.**

10. **An advance payment for coverage of potential services is termed _____.**

11. **Private insurance carriers operate _____and can raise rates at will.**

12. **The insured is also known as the _____.**

Step 14: Review Practice Exercise 2-3

Check your answers with the Answer Key at at he back of this book. Correct any mistakes you may have made.

Step 15: Lesson Summary

You now have a foundation to stand on in the world of insurance. Insurance is very important in the medical field. Insurance companies have many regulations, including preauthorization requirements. It's essential that you keep up to date with these procedures and requirements. This lesson introduced you to some insurance terminology, such as copayment and deductibles. You also got an overview of the billing process, and caught a glimpse of two common claim forms, the CMS-1500 and UB-04. You learned about diagnostic and procedure codes, which you will study further in later lessons. Keep in mind that this lesson was a brief overview of how insurance and the coding and billing process work. As we move through this program, you will see the important role you'll play as the healthcare document specialist.

In the next lesson, you'll get a taste of private and group healthcare programs. But first, complete the following Quiz.

Step 16: Quiz 1

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Endnotes

[1] *Overview*. Centers for Medicare & Medicaid Services, 14 Dec. 2012. Web. 13 March 2012.

[2] *Benefits—TRICARE*. Military Advantage. Web. 13 March 2012.

[3] "NHE Fact Sheet." Centers for Medicare & Medicaid Services, Feb. 23, 2012. Web. 12 March 2012.

Lesson 3
Private Insurance and Managed Care

Step 1: Learning Objectives for Lesson 3

When you have completed the instruction in this lesson, you will be trained to:

- Explain the characteristics of private and group healthcare insurance programs.
- Identify the elements found on an insurance identification card.
- Describe the different managed care programs.
- Explain the benefits of a health savings plan.

Step 2: Lesson Preview

Americans have many health insurance options. Some people purchase health insurance individually, while many employers offer health care as a benefit. Managed care programs are becoming a very popular alternative to the once-traditional fee-for-service approach to health care. This lesson will discuss private insurance concepts, including the development of group health insurance. Then, we'll explain the basics of managed care programs. We'll wrap up the lesson by discussing the concept and benefits of a health savings plan.

Step 3: Private and Group Health Insurance

U.S. healthcare spending was reported at $2.6 trillion in 2010.[1] That's quite a sum! People are living longer, and the population continues to grow. As a result, more people need health care, whether it's preventive care, such as annual physical exams, or intervention care, such as cancer or illness treatments.

These days, consumers have many options for healthcare insurance, as you'll learn in this lesson. One of those choices is to purchase a *private health insurance* policy. **Private health insurance** offers a variety of healthcare plans that require the *subscriber* to pay premiums. These companies operate for profit, meaning they have stockholders that benefit from the profits. Private insurance companies can raise rates when they need or want to, and they can more easily deny coverage at will.

Private Health Insurance

Private health insurance operates for profit, and it has stockholders that benefit from those profits.

Private health insurance can deny coverage at will. This means that it can determine whether to accept a potential subscriber as a customer.

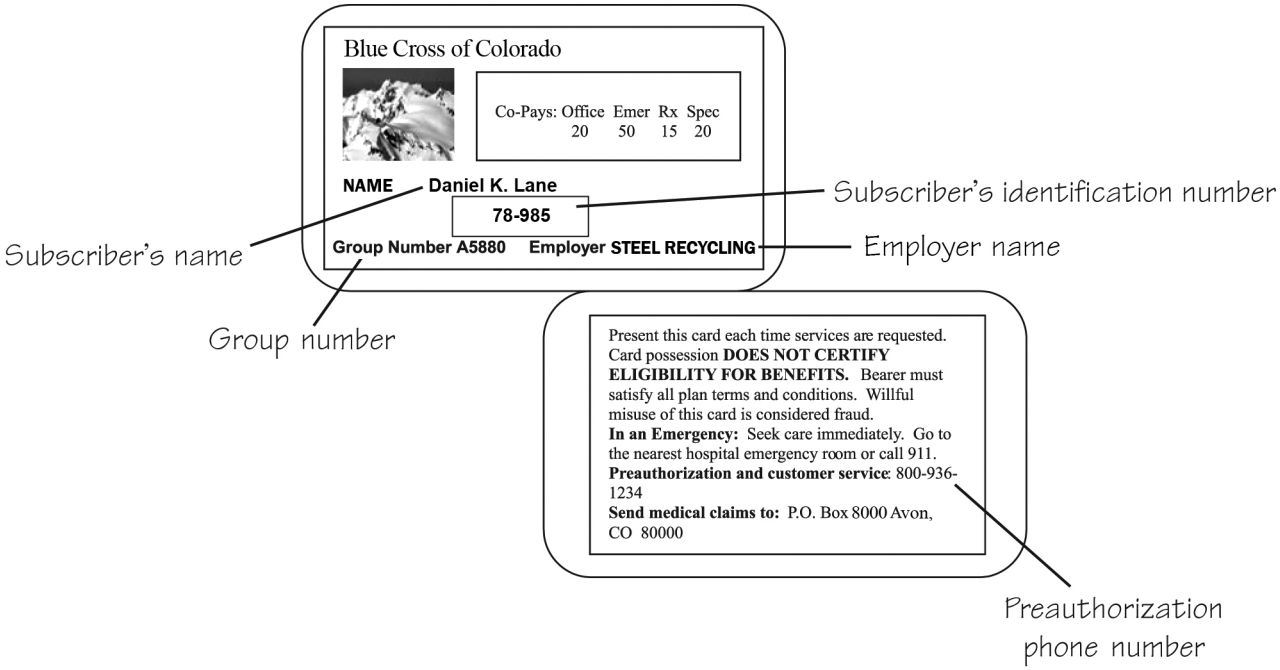
Private health insurance can raise rates almost at will. States do have some regulations that private carriers must adhere to regarding raising rates.

The concept of prepayment is the basis of many private insurance carriers. When you **prepay** premiums, you pay in advance for coverage of specified services should the need for those services arise. You are paying a small fee *in case* the need for health care arises. The **subscriber**, also called the **insured**, is the person who prepays the fee for insurance coverage. When a subscriber purchases insurance coverage, he purchases a policy. The insurance policy describes the subscriber's benefits and details of coverage.

Many larger employers offer **group health insurance**, which works similarly to private healthcare insurance except that the insurance carrier cannot deny coverage to any of the company's employees, regardless of any pre-existing conditions. Companies purchase a group health plan that they offer as a benefit to their employees. Sometimes the employer pays the entire monthly premium for each employee, but most employers pay a percentage of each employee's premium, leaving the employee to pay the remaining percentage of the insurance premium.

Identification Card

Subscribers to a private insurance or group carrier have an insurance identification card. Cards vary in appearance depending on the carrier, but all cards list vital information that allow you to complete the claim form correctly. Offices may make a copy of the front and back of each subscriber's ID card to keep on file.



As you can see from the sample card, the identification card includes the following information:

Subscriber's name
Subscriber's identification number
Group name or employer
Group number
Preauthorization phone number

The back of the card lists the address where you'll send all claims, inquiries and hospital admission information. Also, the back of the card lists important phone numbers that the subscriber and the medical staff may need.

Now that you're familiar with private insurance programs, it's time for a Practice Exercise. In the next section, you'll examine managed care.

Step 4: Practice Exercise 3-1

Determine the term(s) to complete each sentence and write your answers on scratch paper.

1. **The insured is often called the _____.**
2. **A(n) _____ carrier operates for profit and can raise rates at will.**
3. **A(n) _____ describes the subscriber's benefits and coverage.**
4. **Advance payment for coverage of potential services is known as _____.**
5. **A(n) _____ lists vital information that allows completion of claim forms.**

Step 5: Review Practice Exercise 3-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6: Managed Care

The early managed care systems covered a few people at specific work sites or factories. In fact, one of the first managed care systems covered construction workers building the Grand Coulee Dam in Washington in 1938. Since that time, managed care has evolved into a huge insurance industry that boasts coverage for millions of people. How did this all come about? Basically, managed care has boomed because of skyrocketing healthcare costs. Health insurance providers constantly seek ways to hold down costs, but also to predict them. Managed care gives insurance companies a basis for predicting these costs by establishing set fees and costs for healthcare services.

The managed care philosophy has grown at the expense of the *fee-for-service* philosophy that insurance carriers typically held. **Fee-for-service** coverage allows people the most freedom in choosing services and doctors. However, it also creates the largest amount of uncertainty for insurance companies. Companies find it much more difficult to accurately budget for costs when they offer fee-for-service insurance plans.

As insurance companies and employers searched for ways to budget for healthcare costs, several managed care programs evolved, including *HMOs* and *PPOs*, as well as *point of service plans* and *physician provider groups*.

Health Maintenance Organizations

HMOs represent the most popular choice in managed care. The **health maintenance organization** or **HMO** is a prepaid health plan in which individuals receive medical services from participating providers. Patients cannot see just any physician. Instead, they must see a physician within the HMO. HMOs have their own specialists and general practitioners. Generally, a general practitioner refers a patient to a specialist. A **referral** is an authorization by one physician for a patient to see another physician for a specific health problem.

A patient's insurance benefits diminish or may be denied if a nonparticipating provider treats an HMO participant. There are HMO networks, which encompass many organizations. Each network has a company sponsor. Regardless of the company that sponsors the HMO, the HMO's basic operating principles are not affected. HMO participants pay a set fee (usually monthly or annually) and then receive the medical services they need. However, all HMO participants are restricted in their choice of doctors.

In order to facilitate treatment, each HMO participant must work through the participant's *primary physician*. The **primary physician** is a provider who is in charge of a particular patient. This physician oversees all facets of the patient's care. This includes routine treatment and referrals to specialists within the HMO, as well as hospitalization. If the primary physician doesn't authorize a procedure or a specialist, the HMO patient may not receive that procedure or see that specialist.

Preferred Provider Organization

PPOs are similar to HMOs, but there are some key differences. Members of **preferred provider organizations** or **PPOs** can choose their own doctors and treatment facilities. However, there is some motivation for members to choose PPO participating medical care providers. When a member seeks care from a PPO participant, the member's benefits increase. Likewise, when a nonparticipating provider or a nonparticipating facility treats that same member, the benefits are less than they would be through a participating provider.

PPOs operate much like fee-for-service plans when it comes to copayments. Usually, the member must pay between 15 and 25 percent of each bill until the member reaches a *threshold limit*. The **threshold limit** is the amount at which the copayment drops. Look at the following example for a better understanding of this concept.

> Bill belongs to a PPO with a 20 percent coinsurance up to a $5,000 threshold limit. Bill must pay the first 20 percent of every bill in a year until his total of payment is $5,000. After that, the PPO pays 100 percent of covered charges.

Now, how will this apply to you? As an example, Rhonda has had PPO coverage for the last five years. Recently, her employer switched to an HMO option. Rhonda's physician is not in the HMO network, but she decides to make an appointment with him anyway. You know that Rhonda's insurance benefits will diminish or may be denied if a nonparticipating provider treats her, as she is an HMO participant. When the insurance company pays a lower rate, you'll be able to explain the situation to Rhonda because you have a basic knowledge of the difference between HMO and PPO options.

Although HMOs and PPOs are the most common types of managed care plans, there are others, including point of service plans and physician provider groups.

Point of Service Plan

Point of service (**POS**) plans strive to combine the best elements of both HMOs and PPOs. POS plans consist of participating physicians and hospitals. These participating healthcare providers give POS plan members (who are employers or insurance companies) discounted health care for plan participants. This makes POS plans similar to HMOs. However, POS plans also allow covered persons to receive health care from nonparticipating hospitals and providers. As is the case with PPOs, when a nonparticipating provider or facility treats a patient in a POS plan, the patient's benefits are decreased.

The cost management of the HMO combined with the freedom of choice afforded by PPOs makes POS plans a nice compromise in managed care.

Physician Provider Groups

The final type of managed care we will discuss in this lesson is the physician provider group. The physicians in the group own **PPGs**, or **physician provider groups**. These groups negotiate individual contracts with employers, insurance companies and other entities in order to provide healthcare coverage. Because its member physicians own and operate the PPG, a PPG is able to imitate, or act like, HMOs, PPOs, POS plans and other managed care groups. PPGs are more flexible than the other managed care systems.

The PPG does all the billing and collection for the member doctors. This enables the physicians to cut costs while still providing a high level of health care. Specialists are attracted to PPGs because they are cost effective, which enables them to compete with other physicians.

Peer Review Organizations

Peer review organizations examine and ensure quality health care in managed care situations. **Peer review organizations**, also called professional review organizations, consist of physicians who evaluate the physicians in managed care situations to make sure their patients are receiving proper care. Hospitals, insurance companies and even the government health insurance programs use peer review organizations.

Peer review organizations are necessary to oversee physicians in managed care situations. If you think about how managed care is structured, you see that the managed care provider pays the physicians. And, as we learned earlier, the managed care provider is very concerned with healthcare costs. The peer review organizations intend to eliminate any questions of impropriety in managed care.

Step 7: Health Savings Account

The Medicare bill of 2003 put *Health Savings Accounts* into effect. The **Health Savings Account** (**HSA**) was established so that individuals covered by high-deductible health plans could receive tax-preferred treatment of money saved for medical expenses.[2] HSAs are like personal savings accounts that the participant—not the employer or an insurance company—owns, and controls the money. The money deposited into the account is not taxed; however, the money can only be used to pay for healthcare expenses. Now, HSAs aren't for those without insurance. To be eligible to open an HSA, the participant must be under the age of 65 and have insurance with a *high-deductible health plan*. The participant cannot enroll in any other primary health insurance program, including Medicare. However, enrollment in dental, optical, disability and long-term healthcare plans is acceptable. In addition, the participant cannot be a dependent on someone else's tax return.

HSA contributions are made on a yearly basis. As of 2013, individuals could contribute a maximum of $3,250 for the year, and family contributions had a $6,450 maximum.[3] The HSA gives the insured the ability to save for his medical expenses on a tax-free basis. Remember that these contributions are tax free. The earnings on the savings are also tax free, as are the withdrawals used to pay medical expenses.

The HSA can pay "qualified medical expenses," which include most medical care and services, including optical and dental. HSA funds also cover copayments, coinsurance and deductibles.

As noted previously, to set up an HSA, enrollment in a high-deductible health plan is required. An **HDHP** (**high-deductible health plan**) is a health insurance plan in which the insured anticipates paying the first dollar medical expenses—or in other words, the plan includes a very high deductible. In 2013, high-deductible plans started paying after the participant spent at least $1,250 (for an individual) or $2,500 (for a family) of his own money on healthcare expenses.[4]

Billing for an HSA

Health savings accounts are becoming more popular because high-deductible health plans can decrease the costs associated with health insurance. These plans are also popular with individuals because of the tax savings involved. As a healthcare professional, it will be important for you to know how to bill for these situations.

A participant in an HSA receives a debit card. The participant uses the debit card to pay for medical services. Then, the HSA withdraws the expenses.

As a healthcare document specialist, it's not up to you to track or bill the HSA. The participant has insurance and you will submit the claim to the insurance company. After receiving notice from the insurance company, you'll bill the participant the balance. Then, the participant can pay using the HSA debit card if he chooses.

Are you ready to apply what you've learned so far? It's time for another Practice Exercise!

Step 8: Practice Exercise 3-2

Select the best answer from the choices provided, and write your answers on scratch paper.

1. **One of the first managed care systems covered workers building the Grand Coulee Dam in _____.**
   a. 1908
   b. 1928
   c. 1948
   d. 1938

2. **Managed care gives insurance providers a basis for _____ healthcare costs.**
   a. increasing
   b. predicting
   c. eliminating
   d. superseding

3. **HMO stands for _____.**
   a. healthcare management organization
   b. home medical option
   c. health maintenance organization
   d. health management organization

4. **PPGs are _____ groups.**
   a. physician provider
   b. patient provider
   c. preferred physician
   d. preferred provider

5. **HSA stands for _____.**
   a. health service administrator
   b. health savings account
   c. home savings account
   d. health service account

Step 9: Review Practice Exercise 3-2

Check your answers with the answers at the back of this book. Correct any mistakes you may have made.

Step 10: Lesson Summary

Many Americans purchase private health insurance policies from private insurance carriers who operate for profit and can be selective as to who they choose to have as subscribers.

As healthcare costs increased, insurance companies looked for ways to predict and control costs. One answer companies came up with is managed care. Managed care can take many different forms—HMOs, PPOs, POS plans and PPGs are all examples of managed care programs. As a healthcare document specialist, you will become familiar with the requirements of the managed care programs you deal with.

Congratulations! You're making great progress in this course. In the next lesson, you'll continue to build your foundation of knowledge by exploring Medicaid and Medicare.

Endnotes

1 "NHE Fact Sheet." Centers for Medicare & Medicaid Services, 23 Feb. 2012. Web. 15 October 2013.

2 *Health Savings Accounts (HSAs)*. U.S. Department of the Treasury. 4 March 2013. Web. 15 October 2013.

3 *Health Savings Accounts (HSAs)*. U.S. Department of the Treasury. 4 March 2013. Web. 15 October 2013.

4 *Is an HSA right for you?* Mayo Clinic. 13 April 2013. Web. 15 October 2013.

Lesson 4
Medicaid, CHIP and Medicare

Step 1: Learning Objectives for Lesson 4

When you have completed the instruction in this lesson, you will be trained to:

- Describe the Centers for Medicare & Medicaid Services.
- Explain eligibility requirements and services Medicaid provides.
- Discuss the Children's Health Insurance Program.
- Explain eligibility requirements and guidelines Medicare provides.
- Describe the benefits Medicare covers.
- Describe the different supplemental insurances available.

Step 2: Lesson Preview

Although many people have private insurance, a large group of Americans receive some of their healthcare benefits through government programs. The Centers for Medicare & Medicaid Services provides health coverage for 100 million people through Medicaid, the Children's Health Insurance Program and Medicare.[1] In this lesson, we'll explain the history and function of the Centers for Medicare & Medicaid Services. We'll discuss the eligibility requirements and coverage of Medicaid, the Children's Health Insurance Program and Medicare. Finally, we'll talk about supplemental insurance. Are you ready to get started? Let's go!

Step 3: Centers for Medicare & Medicaid Services

The **Centers for Medicare & Medicaid Services** (**CMS**) is a branch of the U.S. Department of Health and Human Services and is the administrator for *Medicaid*, the *Children's Health Insurance Program* and *Medicare*. Let's look at the development of the CMS.

- 1965—Medicare and Medicaid programs were signed into law
- 1977—Health Care Financing Administration (HCFA) was established to administer the Medicare and Medicaid programs
- 1980—Medicare supplemental insurance was brought under Federal oversight

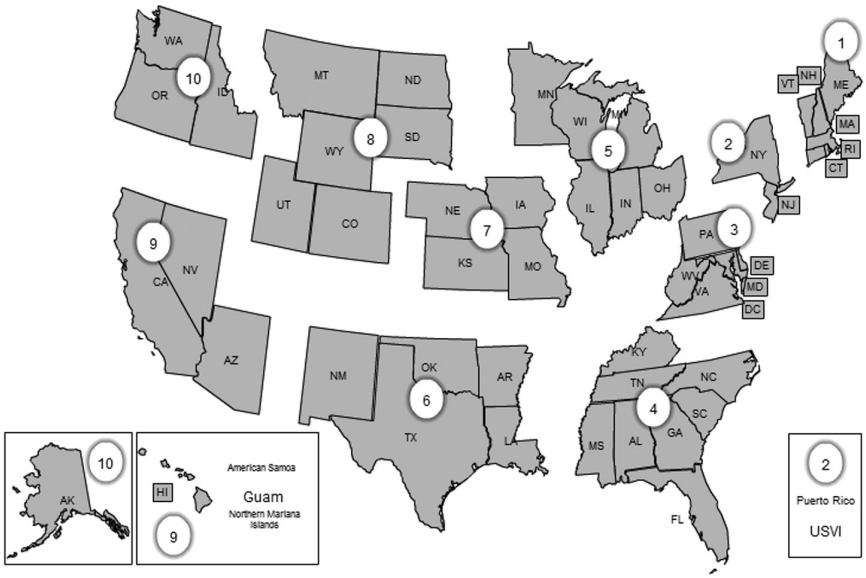
- 1997—State Children's Health Insurance Program (SCHIP) was created, later to be called Children's Health Insurance Program (CHIP)
- 2001—HCFA renamed the Centers for Medicare & Medicaid Services (CMS)

The headquarters for CMS is in Baltimore, Maryland, with 10 regional offices nationwide.

When Medicare and Medicaid were created under the Social Security Act in 1965, Medicare was the responsibility of the Social Security Administration (SSA), and Medicaid was the responsibility of the Social and Rehabilitative Service Administration (SRS). In 1977, when HCFA was created to administer both the Medicare and Medicaid programs, the Medicaid staff was transferred from Washington to Baltimore to join the Medicare staff.

CMS mainly acts as a purchaser of healthcare services for the Medicaid, CHIP and Medicare programs. The agency also assures that contractors and state agencies properly administer Medicaid, CHIP and Medicare, assesses the quality of healthcare services and establishes policies for reimbursement to healthcare providers.

The 10 regional offices (ROs) of CMS provide quality customer service and rights to affordable healthcare services.



Reference: https://www.cms.gov/Consortia/99_RegionalMap.asp

Region 1—Boston
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont
JFK Federal Building, Suite 2325
Boston, MA 02203-0333

Region 2—New York
New Jersey, New York, Puerto Rico and Virgin Islands
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3811
New York, NY 10278-0063

Region 3—Philadelphia
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia
Suite 216, The Public Lender Building
150 S. Independence Mall West
Philadelphia, PA 19106

Region 4—Atlanta
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee
Atlanta Federal Center
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303-8909

Region 5—Chicago
Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Region 6—Dallas
Arkansas, Louisiana, New Mexico, Oklahoma and Texas
1301 Young Street, Suite 714
Dallas, TX 75020

Region 7—Kansas City
Iowa, Kansas, Missouri and Nebraska
601 E. 12th Street, Suite 235
Kansas City, MO 64106

Region 8—Denver
Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming
1600 Broadway, Suite 700
Denver, CO 80202-4367

Region 9—San Francisco
Arizona, California, Hawaii, Nevada and Pacific Territories
90 – 7th Street, Suite 5-300
San Francisco, CA 94103-6706

Region 10—Seattle
Alaska, Idaho, Oregon and Washington
2201 6th Avenue, Suite 801
Seattle, WA 98121

The ROs strive to meet the constant challenges of serving approximately 90 million beneficiaries.[2] The key components of the ROs include representation, protection and monitoring. The ROs represent CMS, and their goal is to develop and maintain partnerships. The ROs protect the regulations, policy and programs developed by CMS to assist in delivering quality healthcare safely and quickly. Finally, the ROs monitor contractors to ensure the implementation of CMS policies and regulations.

Now that you have a background in the CMS organization, let's look at Medicaid in more detail.

Step 4: Medicaid

Medicaid is a federally mandated program that provides medical and health-related services to those who cannot afford them. In 1965, Title XIX of the Social Security Act became federal law to establish Medicaid officially. Although Medicaid is federally mandated, each state runs its own Medicaid program. Within the federal government guidelines, each state establishes its own eligibility standards; determines the type, amount, duration and scope of services; sets the rate of payment for services; and administers its own program.

The requirements for billing vary from state to state. As a healthcare document specialist, you will need to contact your state Medicaid administration to get your state's requirements. Although states administer Medicaid, the states don't financially support it entirely. Each state must provide a certain level of care for eligible participants in the Medicaid program due to the federal government's funding contribution to Medicaid and because Medicaid was established by the federal government. These levels are **minimum standards**, which mean that each participant in Medicaid must receive certain aspects of care. The federal government mandates the minimum standards, but states are free to exceed those standards and provide more care. This is the main reason Medicaid programs vary widely from state to state.

Go to www.cms.gov for more information on your state's program.

Those eligible for Medicaid receive free or low-cost medical care; qualification is based on income and family size. Medicaid provides health coverage for certain low-income people, families and children, pregnant women, the elderly and people with disabilities.[3] It's important to note that Medicaid eligibility requirements are expanding, but only the Medicaid office can determine if one qualifies for coverage or not.

Some Medicaid recipients are required to pay a copayment and/or coinsurance before they can receive state benefits. Remember that a copayment is a flat amount, such as $10, that the insurance policy designates a patient must pay before leaving the doctor's office. Coinsurance is a condition under some health insurance programs that requires the insured to assume a percentage of cost for covered charges. It is important to obtain this copayment when the patient comes in for medical care.

Once Medicaid eligibility is determined, the state authorizes coverage for one month at a time, or up to six months. Eligibility may vary month to month, depending on the amount the recipient receives for income.

Covered Services

States provide various additional services through Medicaid programs; however, basic benefits include:[4]

- Doctor visits
- Emergency care
- Hospital care
- Vaccinations
- Prescription drugs
- Vision
- Hearing
- Long-term care
- Preventative care for children

Preauthorization

Some states require preauthorization for specific services. In this case, preauthorization is the review of proposed treatment by Medicaid to determine whether the treatment is appropriate. The process varies from state to state. Some states require telephone preauthorization while others require a written preauthorization form. Some benefits are denied or reduced if you don't obtain preauthorization for a procedure that requires it.

When it is not possible to obtain prior authorization for the medical care and services needed, obtain immediate approval through a telephone call to your regional office. Be sure to make a note of the date the authorization was given, the name of the person with whom you spoke and any verbal authorization number given to you by the regional office.

Your state regional office can give you a complete list of services and procedures that require preauthorization, but here are a few of the procedures and services commonly requiring preauthorization.

Some of the services and procedures that require preauthorization are:

- Medications
- Medical supplies
- Home health care
- Hemodialysis
- Hearing aids
- Some vision care
- Surgical procedures
- Inpatient hospital care
- Durable medical equipment
- Long-term care facility services
- Prosthetic appliances
- Transportation

Identification Card

For everyone eligible for Medicaid, the state issues either an identification card or coupon, which notes the person's classification of eligibility. States issue cards on the first and 15th of each month, every two months, every three months or every six months.

If you are working directly with patients, be sure to check the expiration dates on these cards before the patients receive any medical services. Cards or coupons should indicate whether patients have any other insurance, copayment requirements or restrictions on the types of services they are eligible to receive. In addition, you should make a copy of the front and the back of each card or coupon at each visit.

Reciprocity

You know Medicaid is a state-administered program. So what happens if a Medicaid recipient requires medical attention in another state? Let's say George Mason, who is a Medicaid recipient, travels outside his home state to look for a job. While he is in the other state, he gets ill. Who pays? The answer is that his home state Medicaid program pays. It is up to the healthcare document specialist to request the proper forms from George's home state. In these circumstances, you would contact the Medicaid regional office for the patient's home state. **Reciprocity** is the process of a home state paying a claim for a medical situation that occurred in another state. Most Medicaid programs have reciprocity provisions.

Now that we've covered Medicaid, let's move on to the Children's Health Insurance Program.

Step 5: Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) was created in 1997, originally known as the State Children's Health Insurance Program (SCHIP). **CHIP** provides free or low-cost health insurance coverage to children up to age 19 who are ineligible for Medicaid but can't afford private insurance. Like Medicaid, CHIP is funded by the federal government in conjunction with every state. Each state administers its own CHIP program with CMS guidance.

With CHIP, all states cover routine check-ups, immunizations, hospital care, dental care and lab and x-ray services. Children get free preventive care, but low premiums and other cost sharing may be required for other services.[5]

Let's pause for a quick review with the following Practice Exercise.

Step 6: Practice Exercise 4-1

Select the best answer from the choices provided, and write your answers on scratch paper.

1. **There are _____ CMS regional offices.**
   a. 10
   b. 12
   c. five
   d. four

2. **Medicaid was officially established in _____.**
   a. 1977
   b. 1975
   c. 1968
   d. 1965

3. **Although _____ is/are financed by state and federal governments, it is/they are run by each state.**
   a. CMS
   b. Medicare and Medicaid
   c. Medicare and CHIP
   d. Medicaid and CHIP

4. **Medicaid recipients each receive ID cards or coupons that note _____.**
   a. his/her income
   b. his/her classification of eligibility
   c. federal claim guidelines
   d. minimum standards

5. **_____ for specific services, or the review of proposed treatment for appropriateness by Medicaid, is required by some states.**
   a. Peer utilization review
   b. Prepayment review
   c. Preauthorization
   d. Postauthorization

6. **Which statement is NOT true of the Children's Health Insurance Program?**
   a. CHIP was created in 1965.
   b. The program was originally known as the State Children's Health Insurance Program (SCHIP).
   c. CHIP provides insurance coverage to children who are ineligible for Medicaid but can't afford private insurance.
   d. CHIP is funded by the federal and state governments.

Step 7: Review Practice Exercise 4-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 8: Medicare

Medicare is a federally administered health insurance program for people age 65 or older, people under age 65 with certain disabilities and people of all ages with end-stage renal disease.[6]

A physician who agrees to accept payment from Medicare signs an agreement to accept assignment on all Medicare claims. A **PAR** provider is a physician who participates with Medicare, while a physician who does not participate is called a **non-PAR** provider.

Medicare payments are based on specific criteria, including approved charges. An **approved charge** is whichever charge is the lowest of the following three:

- **Customary charge**—The amount a physician would normally charge for a specific service.
- **Prevailing charge**—An amount based on customary charges of physicians in the same geographical area.
- **Actual charge**—The amount the physician actually charges on the Medicare claim.

Physicians who accept assignments agree to the approved charges as payment in full for the procedure or service. The physician may bill for coinsurance and deductibles, as well as for services not covered by Medicare. However, the physician may not collect **excess charges**, defined as any charges higher than the amount allowed by Medicare for a specific covered service.

Non-PAR providers may choose to accept assignment on a case-by-case basis, or for certain services and not others. Regardless of the physician's acceptance or non-acceptance, Medicare will pay only its portion of the allowable charge.

Congress provides incentives to increase the number of healthcare providers signing participating agreements with Medicare. One such incentive is a five percent higher fee schedule for PAR providers than for non-PAR providers.

Let's look at a quick example involving Nancy and Jerry. Nancy receives her services at a PAR provider, while Jerry sees a non-PAR provider who accepts assignments from Medicare. We will discuss the differences in the provider payment, as well as what is the patient's responsibility!

Nancy is seen by Dr. Thompson, who is a PAR provider. The physician fee for her services is $180. Medicare's fee schedule allows $105 for this service, which means Dr. Thompson will write off (or not collect) $75. Of that $105, Medicare will pay 80 percent, which is $84.00. The remaining 20 percent or $21 is the patient's responsibility. Between the two, Dr. Thompson receives $105 for the service.

Jerry, on the other hand, is seen by Dr. West, who is a non-PAR provider accepting assignments from Medicare. The physician fee for Jerry's service is also $180, and Dr. West will write off the $75 above the allowable amount. A non-PAR provider will receive 5 percent less than the allowable amount. First, determine how much the 5 percent less would be by multiplying $105 by 5 percent, and you'll get $5.25. The allowable amount for a non-PAR provider is $99.75. Now, Medicare will pay 80 percent of that amount, which is $79.80. The patient is also only responsible for 20 percent of the 5 percent less, so $19.95 is the patient's responsibility.

The non-PAR provider will only receive $99.75 for the service, while the PAR provider receives the full allowable amount of $105.

	PAR	Non-Par
Provider Fee	$180	$180
Fee Schedule Amount	$105	$105
Medicare Allowable Amount	$105	$99.75 [105 - (105 X 5%) = 99.75]
Medicare Payment (80%)	$84 [105 x 80% = 84]	$79.80 [99.75 x 80%]
Patient Responsibility	$21 [105 x 20%= 21]	$19.95 [99.75 x 20% =19.95]

Finally, if a patient goes to a non-participating physician who doesn't accept Medicare's allowable percentage, the patient can be responsible for 115 percent. The allowable amount is still 5 percent less than the allowable amount [105 – (105 x 5%) = 99.75]. However, you'll multiple the allowable amount by 115% [99.75 x 115% = 114.71] before you apply the 80/20 Medicare payment. Medicare will pay 80 percent or $91.77 while the patient is responsible for $22.94. In this case, the physician will collect $114.71 for the services.

Preauthorization

Many insurance carriers that have contracted with Medicare will require preauthorization on some procedures. Some of these procedures are on a mandatory list, and others are chosen by the regional carrier that will require preauthorization. If you do not obtain preauthorization for a procedure that requires it, benefits will be denied.

When it is not possible to obtain preauthorization for the medical care and services rendered, immediate approval can be obtained by a telephone call to the regional office. Be sure to make a note of the date the authorization was given, the name of the person with whom you spoke and any verbal authorization number the regional office gave you.

The state regional office can give you a complete list of services and procedures that require preauthorization.

Medicare Preauthorization

Some of the procedures that require preauthorization are:

- Cataract extractions
- Cholecystectomy
- Joint replacements
- Coronary artery bypass graft
- Inguinal hernia repair
- Bunionectomy
- Hysterectomy

Advance Beneficiary Notice

When administering care for a Medicare patient, the provider may recommend procedures that Medicare does not cover. These items can include routine physicals, some screening tests, hearing aids, dental care, dentures, routine foot care, cosmetic surgery, some vaccinations and comfort items. In these cases, Medicare requires that providers inform patients that the service is not a part of their coverage. This helps patients to make informed decisions regarding their care.

Here, Medicare requires the use of an **Advance Beneficiary Notice** (**ABN**) that informs the patient of the procedure and explains why it is not covered. The patient can then either decide to receive the service and consent to payment, or decide not to receive the service. After reaching a decision, the patient must then sign the form.

Review the following example of an ABN.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Reference: https://www.cms.gov/BNI/02_ABN.asp.

There are four types of Medicare coverage that you will study:

Part A—Hospital Coverage
Part B—Medical Insurance
Part C—Medicare Advantage Plans
Part D—Prescription Drug Plan

Medicare Part A

Medicare Part A helps pay for medically necessary inpatient care in a general hospital, skilled nursing facility care, home health care, hospice care and blood (during a covered stay). Medicare Part A is financed by the Social Security payroll withholding tax paid by workers and their employers. In general, Medicare Part A covers the following:[7]

- Hospital care
- Skilled nursing facility care
- Hospice
- Home health services

Medicare Part A (Hospital Insurance) Summary of Benefits Based on Data for 2013			
Services	**Benefit**	**Medicare Pays**	**Patient Pays**
Hospitalization	First 60 days	All but $1184	$1184
	61st - 90th day	All but $296 per day	$296 per day
	91st - 150th day	All but $592 per day	$592 per day
	Beyond 150 days	$0	All costs
Skilled nursing facility care	First 20 days	All costs	$0
	21st - 100th day	All but $148 per day	$148 per day
	Beyond 100 days	$0	All costs
Home health	Unlimited, if care medically necessary	All costs for services	$0
		80% of durable medical equipment costs	20% of durable medical equipment costs
Hospice care	Terminally ill with an expectancy of only six outpatient months to live	All but a small copayment for outpatient drugs and inpatient respite care	Balance
Blood service	Unlimited, if medically necessary	All but first three pints per year	First three pints per year unless patient arranges for replacement blood donation

Reference: http://www.medicare.gov

Medicare Part B

Medicare Part B helps pay for a wide range of medical services and supplies that Medicare Part A does not cover. **Medicare Part B** helps pay for medical expenses, clinical laboratory services, home health care, outpatient hospital treatment and blood, if medically necessary. Medicare Part B is financed by monthly premiums that people who choose to enroll in the program pay, and typically covers the following:[8]

- Clinical research
- Ambulance services
- Durable medical equipment
- Mental health
- Limited outpatient prescription drugs.

Medicare Part B (Medical Insurance) Example of Benefits Based on Data for 2013			
Services	**Benefit**	**Medicare Pays**	**Patient Pays**
Medical expenses	Unlimited, if medically necessary	80% of approved amount after $147 deductible; and	$147 deductible and 20% of Medicare approved amount
		50% of approved amount for most outpatient mental health services	50% for outpatient mental health services
Laboratory services	Unlimited, if medically necessary	Generally, 100% of Medicare covered lab services	Nothing for services
Home health care	Unlimited, if Medicare requirements are met	100% of approved amount; 80% of Medicare-approved amount for durable medical equipment	Nothing for services; 20% of Medicare-approved amount for durable medical equipment
Outpatient hospital services	Unlimited, if medically necessary	80% of approved amount for the doctor, or the remainder after the copayment for other services	20% of approved amount for the doctor, or the copayment for other services
Blood service	Unlimited, if medically necessary	80% of approved amount starting with 4th pint	First three pints plus 20% of approved amount for additional pints unless patient arranges for donation of replacement blood

Reference: http://www.medicare.gov

Medicare Part C

Medicare Advantage Plan, or **Medicare Part C**, is a plan that Medicare-approved private companies offer. Medicare pays a fixed amount for care every month to the companies offering Medicare Advantage Plans. These companies must follow the rules Medicare sets, although the out-of-pocket costs and referral rules may vary depending on each private company.

There are several different types of Medicare Advantage Plans available:

- Health Maintenance Organization (HMO) Plans—Patients can only see providers in the plan's network and must get referrals from the primary care doctor to see a specialist.
- Preferred Provider Organization (PPO) Plans—Patients can see providers on the network's list, or can go to providers not on the list, at an additional cost. Referrals are not necessary.
- Private Fee-for-Service (PFFS) Plans—Patients may see any provider that will accept terms of the policy's payment.
- Special Needs Plans (SNP)—These plans are limited to people with specific diseases or characteristics. The plans tailor their benefits, provider choices and drug formularies (lists of covered drugs) to best meet the specific needs of the groups they serve.[9]

Medicare Part D

In 2006, Medicare implemented a program that includes prescription drug coverage; this program is called **Medicare Part D**. The program does not cover all costs associated with prescription drugs, but assists in yearly out-of-pocket expenses. Coverage for Medicare Part D may include a monthly premium, yearly deductible and copayments.

Medicare doesn't directly provide this coverag; instead, private insurance companies from each state provide coverage. As a result, participants choose a plan that best serves their needs. Although each plan varies in premiums and copayments, the general coverage and costs are as follows:[10]

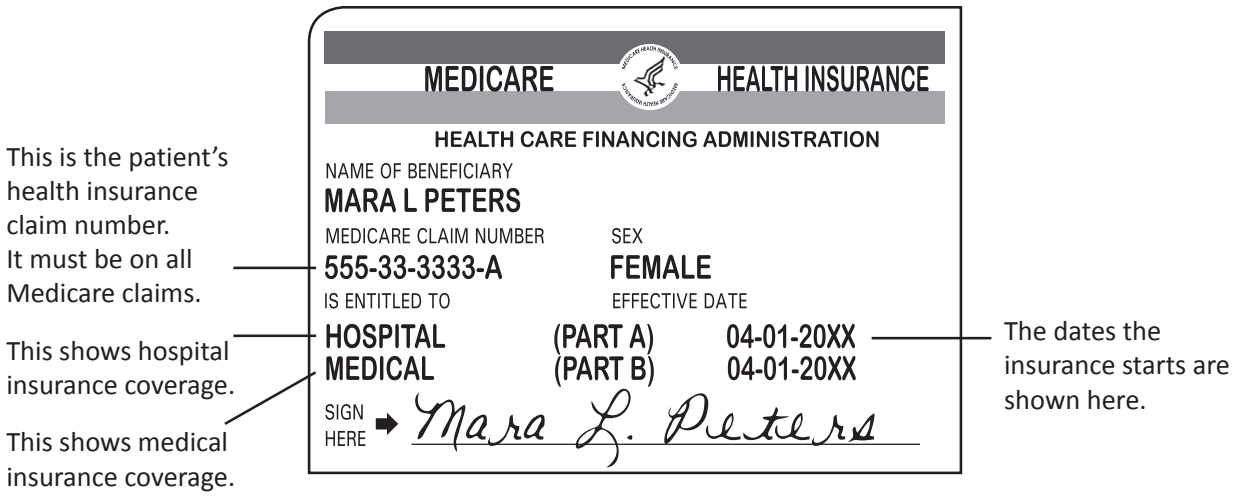
- A monthly premium that varies by plan (higher-income consumers pay more).
- A deductible may apply.
- Coinsurance is the amount consumers pay for each prescription after the deductible has been met.

Additional financial help is available for those with low incomes. For those qualified, the deductible is waived, the premium is waived and the copayments are reduced.

Identification Card

The Medicare patient identification card lists all the information that you, as a healthcare document specialist, need from the patient.

The card is red, white and blue. Cards issued after 1990 are plastic. The Medicare card lists the type of coverage (Part A, Part B or both) and the length of time Medicare has covered the patient. The card also lists a claim number, which is the policy number.



Some of the common beneficiary codes are:

A	Primary claimant (wage earner)
B	Aged wife, age 62 or over
B1	Aged husband, age 62 or over
C1-C9	Child—includes minor, student or disabled child
D	Aged widow, age 60 or over
D1	Aged widower, age 60 or over

For more information on the meanings of letters that follow the Medicare claim number, go to the official Web site of the U.S. Social Security Administration, at http://ssa-custhelp.ssa.gov.

Fiscal Agents and Fiscal Intermediaries

Fiscal agents are organizations under contract with the government to handle claims from physicians and other suppliers of services covered under Medicare Part B. **Fiscal intermediaries** are organizations under contract with the government to handle claims from hospitals, skilled nursing facilities, long-term care facilities and home health agencies.

Step 9: Supplemental Insurance

People often have unique insurance needs. In this section, you'll explore several types of supplemental insurance, including Medigap and Medi-Medi.

Medicare coverage is often not enough for many patients. Because of this, people sometimes buy supplemental insurance for Medicare. This coverage is usually purchased from a third-party private insurance company and, because it fills the gaps in Medicare, it is called **Medigap**.

Medigap and other specialized insurance policies pay for the expenses that are not covered by Medicare Parts A and B. Supplemental policies do not duplicate Medicare coverage. Insurance companies that offer supplemental Medicare policies must comply with federal government standards.

The physician receives Medigap and other supplemental insurance benefit payments directly. When a patient has Medigap insurance, you'll submit the claim to Medicare. From there, Medicare will send the claim on to the Medigap carrier.

There are also times when Medicare is considered a supplemental carrier. Here are some situations that indicate that Medicare is supplemental.

Medicare as a Supplemental Carrier

Medicare is the supplemental carrier when:

- The patient is covered by an employer's group health plan or spouse's insurance.
- The services or treatments are for a work-related illness or injury covered by workers' compensation.
- No-fault liability insurance covers the services or treatments (in the case of an automobile accident, for example).

Medi-Medi

Medicare and Medicaid both cover some patients, and this is called **Medi-Medi**. You will submit claims for Medi-Medi patients to Medicare first. Then, these claims are automatically processed by Medicaid once Medicare completes its processing.

You've covered a lot of detailed information in this section. Let's pause to complete a Practice Exercise.

Step 10: Practice Exercise 4-2

Determine the term(s) to complete each sentence, and write your answers on scratch paper.

1. **Medicare is a(n) _____ funded health insurance program.**
2. **Medicare Part A covers _____ hospital care and services.**
3. **Medicare Part B covers _____ services and supplies not covered by Medicare Part A.**
4. **_____ policies pay for expenses not covered by Medicare Parts A and B.**
5. **Supplemental insurance policies do not duplicate _____ coverage.**
6. **Supplemental insurance benefits are paid directly to the _____.**
7. **Claims for Medi-Medi patients are submitted to _____ first.**
8. **Medicare Part _____ assists with the yearly out-of-pocket prescription expenses.**
9. **ABN stands for _____.**

Step 11: Review Practice Exercise 4-2

Check your answers with the answers at the back of this book. Correct any mistakes you may have made.

Step 12: Lesson Summary

The Centers for Medicare & Medicaid Services administers federally funded, state-run Medicaid and CHIP programs, as well as Medicare. Each state's Medicaid program must meet minimum standards set forth by the federal government. CHIP covers children that aren't eligible for Medicaid and can't afford private insurance.

Medicare Part A is free for eligible recipients and covers hospitalization charges. Medicare Part B is available for an additional premium and covers physician's services, inpatient and outpatient services and supplies. Medicare Part C offers several different types of plans, while Medicare Part D assists with prescription expenses.

Some people also have supplemental insurance coverage, referred to as Medigap. Medi-Medi patients are patients who are covered by both Medicaid and Medicare.

In the next lesson, you'll wrap up learning about healthcare programs by exploring military insurance, workers' compensation and COBRA. You can't move on just yet—first, you need to complete the following Quiz that covers private insurance and managed care, as well as Medicaid, CHIP and Medicare. You'll do great!

Step 13: Quiz 2

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Endnotes

1 *Centers for Medicare & Medicaid Services Home page*. Centers for Medicare & Medicaid Services. Web. 15 October 2013.

2 *CMS Regional Offices*. Centers for Medicare & Medicaid Services, 4 Feb. 2012. Web. 15 October 2013.

3 Do I qualify for Medicaid? Healthcare.gov. Web. 15 October 2013.

4 *Medicaid and the Children's Health Insurance Program*. Medicaid.gov. Web. 15 October 2013.

5 *Medicaid and the Children's Health Insurance Program*. Medicaid.gov. Web. 15 October 2013.

6 *Overview*. Centers for Medicare & Medicaid Services, 14 Dec. 2012. Web. 15 October 2013.

7 What does Medicare Part A cover? Medicare.gov. Web. 15 October 2013.

8 What does Medicare Part B cover? Medicare.gov. Web. 15 October 2013.

9 *Your Guide to Medicare Special Needs Plans (SNPs)*. Centers for Medicare & Medicaid Services, 3 Nov. 2002. Web. 15 October 2013.

10 Medicare 2013 costs at a glance. Medicare.gov. Web 15 October 2013.

Lesson 5
Military Insurance, Workers' Compensation and COBRA

Step 1: Learning Objectives for Lesson 5

When you have completed the instruction in this lesson, you will be trained to:

- Discuss the types of military insurance, including the terminology and coverage.
- Explain TRICARE options, the eligibility requirements and services covered.
- Describe CHAMPVA and the eligibility requirements for coverage.
- Describe the format of military identification cards.
- Describe workers' compensation and its features.
- Differentiate between workers' compensation and disability insurance.
- Describe the purpose of COBRA.

Step 2: Lesson Preview

You've come a long way! You've learned about private insurance and managed care. You studied the various insurances CMS provides. Now, it's time to turn our attention to special insurance situations. In this section, you'll learn about the different types of military insurance, as well as how workers' compensation differs from disability insurance. We'll wrap up the lesson by introducing you to coverage obtained when you are unemployed. After you finish this lesson, you'll be ready for the next step in your healthcare profession—medical terminology. Let's get started!

Step 3: Military Insurance

The **Civilian Health and Medical Program of the Uniformed Services** (**CHAMPUS**) was established in 1966 to provide healthcare coverage for the families of members of the uniformed services. CHAMPUS was developed to control the rising costs of healthcare coverage and to standardize healthcare benefits. Many changes have taken place in the military healthcare system in the past several years. The most important of these changes is the transition from CHAMPUS to the *TRICARE* healthcare system. Although this transition has officially taken place, you may still see references to CHAMPUS in your work as a healthcare document specialist.

Today, the Department of Defense healthcare program, known as **TRICARE**, provides healthcare coverage for medical services, medications and dental care for military families, retirees and their families and survivors.[1] As its name suggests, TRICARE has three options: *TRICARE Standard*, *TRICARE Extra* and *TRICARE Prime*. In addition, TRICARE has a program for Medicare eligible military retirees known as *TRICARE for Life*. Finally, *CHAMPVA* is healthcare for families of veterans with permanent, service-connected disabilities. You will learn about each of these shortly.

With these programs, the service member is called the **sponsor** and can be active-duty, retired or deceased. The family members are the **beneficiaries**. In the past, sponsors were not covered because medical services were provided on the military base on which the sponsor was stationed. However, due to defense budget cutbacks, some military bases have closed their medical facilities. Now, some service members *are* covered by TRICARE, but only if their base does not provide medical services.

Terminology

Just as managed care has terminology specific to it, you'll encounter some terminology specific to military insurance. Understanding the terminology will make your job as a healthcare document specialist much easier, but it is not necessary to memorize the terms. Any time you need information, you'll use your resources. This applies to the Quizzes in the program, as well as in your career.

Authorized Provider—A physician, hospital, clinic or supplier who has applied and been approved to provide medical care and supplies. Authorized providers must have a state license and a national organization accreditation. Medicare-certified providers are considered TRICARE-authorized providers as well. TRICARE will only share the cost of healthcare costs from authorized providers.

Catastrophic Cap—An annual upper limit a family will have to pay for TRICARE Standard covered services in any fiscal year. The catastrophic cap for families of active duty service members is $1,000. All others have a catastrophic cap of $3,000. The catastrophic cap applies only to allowable charges for covered services.[2]

Cost-share—The percentage paid by the patient enrolled in TRICARE Standard and Extra of the allowable charges for health care for each claim. Cost-share depends on the sponsor's status (active or retired) in the service. Cost-share is based on the allowable charge regardless of what the provider actually bills and is paid after the patient has paid the annual deductible.

Deductible—The amount the patient enrolled in TRICARE Standard and Extra must pay each fiscal year before TRICARE begins sharing the cost (cost-share) of medical health care. The deductible is separate from and in addition to the cost-share amounts. For most enrollees, the deductible is $150 per person or $300 per family per fiscal year from October 1 through September 30.

Defense Enrollment Eligibility Reporting System (**DEERS**)—A computerized data bank that lists all active and retired military members as well as their dependents. DEERS lists active and retired service members automatically. The military sponsor is responsible for enrolling all family members and should maintain the status of family to process claims quickly and accurately.

Network Provider—The physician who provides medical care and services to TRICARE beneficiaries under the TRICARE Extra program at contracted rates.

Nonavailability Statement (**NAS**)—A certification from the uniformed service hospital that the procedure the patient is seeking is not available at the military facility. NAS is required for all beneficiaries who live near a military care facility but are seeking nonemergency treatment at a civilian physician or hospital.

Participating Providers—This term refers to healthcare providers that participate in TRICARE. A participating provider accepts the TRICARE allowable charge as the full fee for the care the patient receives. A participating provider files the claims for all TRICARE-eligible patients. Individual providers can participate on a visit-by-visit basis. Hospitals that participate in Medicare must also participate in TRICARE Standard for inpatient care by law. For outpatient care, hospitals may or may not participate. Providers who do not participate in the TRICARE program may bill for their normal charges. The law states that those nonparticipating physicians may not charge more than 15 percent above the TRICARE Standard allowable charge.

Services Covered

Military insurance provides a wide range of healthcare options; program guidelines determine how each service is covered. The covered services include hospitalization, maternity services, skilled nursing facilities and treatment for mental illness and alcoholism.

Hospitalization services include semiprivate room, general nursing, surgical services, drugs and medications, anesthesia, laboratory tests, x-rays and radiology services, necessary medical supplies, blood and blood products.

Maternity services include prenatal and postnatal care, and hospital and professional services.

Skilled nursing facility services include semiprivate rooms; regular nursing services; physical, occupational and speech therapy; drugs furnished by the facility; and necessary medical supplies.

Treatment for mental illness and alcoholism includes up to 150 days in a residential treatment center for mental illness and a total of 28 days per year for alcoholism rehabilitation.

You should contact the Health Benefits Advisor at the nearest military facility to obtain a current copy of the CHAMPVA and TRICARE handbooks for guidelines in your region. The Health Benefits Advisor will also be able to give you the name of a fiscal intermediary in your region. A fiscal intermediary is an organization that contracts with the government to handle CHAMPVA and TRICARE claims. Fiscal intermediaries usually have three-year contracts. Be sure you have up-to-date information for the fiscal intermediary in your region. Having the correct information makes filing claims much easier. You can also go to the following Web site to learn more about TRICARE: www.tricare.mil.

TRICARE

TRICARE offers three levels of coverage—TRICARE Standard, Extra and Prime. There are advantages and cost variances to each type of coverage. The medical codes you determine for each patient's case serve an additional, critical purpose. These codes enable government health agencies to track and research life-threatening illnesses, such as various types of cancer, heart disease and AIDS. Your important role as a healthcare document specialist helps save lives!

TRICARE Eligibility

TRICARE is a healthcare program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration.

The following beneficiaries are eligible for TRICARE medical coverage:

1. Husbands, wives and unmarried children of active-duty or retired service members.
2. Husbands and wives who have not remarried and unmarried children of active-duty or retired service members who have died.
3. Husbands, wives and unmarried children of reservists who are ordered to active duty for more than 30 consecutive days or of reservists who die on active duty.
4. Unmarried children up to age 21, including stepchildren, who are adopted by the sponsor.
5. Former spouses of active or retired military who were married to a service member who had performed at least 20 years of creditable service.
6. Dependents placed in the custody of a service member by a court or recognized adoption agency.
7. Active-duty service members—only if the military base on which they are stationed does not provide medical services.

Note: For TRICARE purposes, children are unmarried people under the age of 21. A child that is a full-time student may also be covered up to the age of 26.

TRICARE Standard

TRICARE Standard is the fee-for-service option that gives beneficiaries the opportunities to see any TRICARE-authorized provider. This is the most flexibile of the TRICARE options. Beneficiaries are responsible for cost shares and deductibles for care that are covered under TRICARE Standard. TRICARE Standard is widely available, offers the broadest choice of providers and has no enrollment fee. The downside to this option is that the beneficiaries may have to do their own paperwork and file their own claims.

Providers who participate in TRICARE will accept the **TRICARE allowable charge** (**TAC**) as the full fee for services they render. However, non-participating providers may charge up to 15 percent above the TAC for their services, and TRICARE Standard beneficiaries are financially responsible for these additional charges.

TRICARE Extra

TRICARE Extra is a PPO-type option and provides healthcare services on a visit-by-visit basis. TRICARE Extra doesn't require enrollment or an annual fee but does have an annual deductible and cost sharing. Eligible persons can seek care from a provider who is part of the network, get a discount on services, and have reduced cost-share, usually five percent less than TRICARE Standard. Providers who participate in TRICARE Extra have agreed to accept the TAC as the full fee for the care they provide. In the TRICARE Extra program, when patients receive care from a TRICARE Extra network provider, a discount on cost sharing is applied, and patients don't have to file their own claims.

TRICARE Prime

TRICARE Prime is an HMO-type option and is currently the least costly healthcare option offered through TRICARE. Eligible persons must enroll for a year at a time and agree to seek health care from the network of healthcare providers, hospitals and clinics. When enrolled in TRICARE Prime, a **primary care manager** (**PCM**) is chosen or assigned. The PCM will provide and coordinate all healthcare needs; the first contact must be the PCM when a patient needs care.

TRICARE Services

The following chart provides a breakdown of the costs of deductibles, enrollment fee and charges for each TRICARE option.[3] Note that junior enlisted ranks (E-1 through E-4) are the backbone of the military workforce. These are the new recruits and technicians learning their particular job. Noncommissioned and senior noncommissioned ranks of E-5 through E-9 are the more senior enlisted; they are technical experts and entry-level management ranks that perform jobs that require a higher degree of experience or education.

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductible	None	$150/individual or $300/family for E-5 & above; $50/$100 for E-4 and below	$150/individual or $300/family for E-5 & above, $50/$100 for E-4 and below
Annual Enrollment Fee	None	None	None
Civilian Outpatient Visit	No cost	15% of negotiated fee	20% of allowed charges for covered service
Civilian Inpatient Visit	No cost	Greater of $25 or $14.35/day	Greater of $25 or $14.35/day
Civilian Inpatient Behavioral Health	No cost	Greater of $20/day or $25/admission	Greater of $20/day or $25/admission
Civilian Inpatient Skilled Nursing Facility Care	$0 per diem charge per admission	$11/day ($25 minimum) Charge per admission	$11/day ($25 minimum) Charge per admission

TRICARE fees and charges

TRICARE for Life

TRICARE for Life (**TFL**) is TRICARE's Medicare-wraparound coverage available to *all* Medicare-eligible TRICARE beneficiaries, regardless of age or place of residence, provided they have Medicare Parts A and B.[4]

The programs TRICARE offers were originally available to members only until the age of 65. At that point, TRICARE members switched to Medicare coverage, but then had the burden of larger deductibles and coinsurance payments. In addition, Medicare doesn't pay for overseas health care, so military families in foreign countries often had to go without coverage once members reached age 65. Thus, Congress developed TRICARE for Life as somewhat of a supplement to Medicare to ease the strain of insurance costs for military families. The plan usually covers deductibles, coinsurance and other charges that Medicare does not pay, as long as the charges qualify.

Today, many retired military personnel consider TRICARE for Life an attractive option for their families because declining Medicare coverage for those who are age 65 and older often means annual increases in insurance plan premiums. In addition, seniors older than age 65 may face penalty charges for each year that they opt out of Medicare.

For example, if a 65-year-old person accepts Medicare this year, it may cost $70 per month. However, if she declines Medicare coverage this year but chooses to accept it five years from now, there may be a 10 percent increase in cost per year—which makes the monthly payment much higher! This can be a hardship for seniors on fixed incomes. Therefore, TRICARE for Life may be a good option for retired military personnel who struggle to pay the high cost of healthcare services.

CHAMPVA

A **veteran** is a person who has served in a uniformed service for the United States, who is no longer in the service and who has received an honorable discharge. In 1973, the Veterans Health Care Expansion Act created **Civilian Health and Medical Program of the Veterans Administration** (**CHAMPVA**), which provides health care for families of veterans with permanent, service-connected disabilities.

The following beneficiaries are eligible for CHAMPVA medical coverage as long as they are not eligible for benefits through the TRICARE program and not eligible for Medicare Part A upon reaching age 65.

1. Active-duty military retirees
2. Husbands, wives and unmarried children of a veteran with total, permanent and service-related disability
3. Husbands, wives and unmarried children of a veteran who died as the result of a service-related disability, or who at the time of death was rated permanently and totally disabled from a service-connected condition
4. Husbands, wives and unmarried children of a service person who died in the line of duty while on active duty

Although very similar to TRICARE in terms of benefits, it is important to note that CHAMPVA is a separate program, distinctly different from the TRICARE options. Determination of eligibility, the authorization of benefits and the processing of claims are the sole responsibility of the Veterans Affairs Health Administration Center in Denver, Colorado.

Identification Cards

To receive TRICARE or CHAMPVA benefits, patients must have a valid identification card. Individuals who are eligible for TRICARE Standard or TRICARE Extra are required to have a Uniformed Services (military) identification card. Individuals who enroll in TRICARE Prime receive a TRICARE Prime identification card. CHAMPVA enrollees have a special card, as well.

The cards are color coded as follows:

- Active-duty sponsor—green
- Active-duty and retirees' family members—tan
- Active-duty Reserve sponsors and family members—red
- Retirees—blue

All military identification cards include the following: a digital photograph of the card owner, the beneficiary's name and date of birth, sponsor's name and relationship to the beneficiary, the date the card was issued and the expiration date of the card. The "medical" block on the back of the card includes whether the cardholder is eligible for medical care from military or civilian sources. Always make copies of the front and back of the identification card, and place these copies in the patient's medical record. Make copies at each physician visit. Look at the following example cards.

Uniformed Services Sample ID Cards

Ready for a break? Let's pause and complete a quick Practice Exercise to cover what you learned.

Step 4: Practice Exercise 5-1

Select the best answer from the choices provided, and write your answers on scratch paper.

1. **The program that provides managed healthcare coverage for military service families is called _____.**
   a. DEERS
   b. HCFA
   c. TRICARE
   d. CHAMPVA

2. **The program that provides health care for the families of veterans with permanent, service-related disabilities is called _____.**
   a. CHAMPVA
   b. TRICARE
   c. DEERS
   d. HCPCS

3. **_____ is a PPO-type option and provides healthcare services on a visit-by-visit basis.**
   a. TRICARE Standard
   b. TRICARE Extra
   c. TRICARE Prime
   d. CHAMPVA

4. **When enrolled in TRICARE Prime, a _____ is assigned or chosen for the beneficiary.**
   a. fiscal agent
   b. DEERS manager
   c. health care manager (HCM)
   d. primary care manager (PCM)

5. **The database listing people eligible for TRICARE is called _____.**
   a. the HCFA System
   b. Defense Enrollment Eligibility Reporting System, DEERS
   c. TRICARE Reporting System
   d. TRICARE Enrollment Eligibility Reporting System, TEERS

6. **_____ is an HMO-type option and is the least costly of the TRICARE options.**
   a. TRICARE Standard
   b. TRICARE Prime
   c. TRICARE Extra
   d. CHAMPUS

7. **Ms. Jones has a tan identification card, which means she is a(n) _____.**
   a. retiree
   b. active-duty Reserve sponsor
   c. active-duty family member
   d. active-duty sponsor

Step 5: Review Practice Exercise 5-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6: Workers' Compensation

The first workers' compensation laws were established in 1911. These new laws allowed *employees* who were injured on the job to receive medical care without first taking their employers to court. An **employee** is a person who is hired to work for another.

Workers' compensation, also known as work comp, provides coverage to employees and their dependents if the employees suffer a work-related *accident* causing injury, illness or death. An **accident** is described as an unplanned or unexpected happening causing injury, illness or death not due to any fault of the employee.

Two sets of laws govern workers' compensation: *federal compensation laws* and *state compensation laws.* **Federal compensation laws** cover miners, maritime workers and civilian employees of the federal government. **State compensation laws** cover employers and employees within each state. State compensation laws vary from state to state.

The **Office of Workers' Compensation Programs** (**OWCP**) of the United States Department of Labor administers coverage of the federal workers' compensation laws. This office oversees three federal programs. They are:

- Federal Coal Mine Health and Safety Act, referred to as the Black Lung Benefits Act—This program provides benefits to coal miners.
- Longshoremen's and Harbor Workers' Compensation Act—This provides benefits for private and public employees who work on the sea nationwide.
- Federal Employees Compensation Act, FECA—It covers on-the-job injuries that are classified as *traumatic injuries* or *occupational illnesses*.

Workers' Compensation

The two types of on-the-job injuries covered by FECA are described as:

- Traumatic injury—an injury caused by a specific event or series of events during a single workday. Falling off a ladder and breaking an arm is an example of a traumatic injury.
- Occupational illness—a condition caused by continued exposure to the workplace. Respiratory trouble due to dust inhaled for years in a mine is considered an occupational illness.

State workers' compensation programs provide coverage for people who are not federal employees—most employees within each state. Programs vary from state to state, so it is important to become familiar with the regulations that apply to your state. You can obtain this information by contacting your state's workers' compensation office, board or commission.

State workers' compensation programs fall into four types of coverage:

1. State compensation fund: In the case of a state compensation fund, the state is the insuring body. Employers pay a premium to the state. The state then insures the employees who are covered by the plans and pays benefits based on the law established by the state.
2. Employer Self-insured Programs: Employers with sufficient capital can set up a fund to cover expenses incurred by job-related accidents or illnesses. State regulations require a percentage of capital be set aside for the fund.
3. Private Commercial Workers' Compensation Programs: In this case, a private health insurance program meeting state-determined guidelines provides the workers' compensation coverage.
4. Combination Programs: In some states, employers can have a combination of state-funded, private or self-insured plans. These plans are put together in packages to best suit the needs of the business and its employees.

Classification of On-the-Job Injuries

To qualify for workers' compensation benefits, the worker is required to have an **on-the-job injury**, which means the employee incurred an injury while doing the expected duties of the position or a disorder that links to the employment of the worker, such as carpal tunnel syndrome.

On-the-job injuries are categorized into four case classifications:

- **Medical claims with no disability** are on-the-job injuries that are easily treated, and the employee is expected to return to work within a short duration of time.
- **Temporary disability** includes claims where the employee is expected to be unable to work for a period of time while he recuperates from his injuries. Typically, coverage includes lost wages and the cost associated with the health care. The employee is expected to return to work although he may not be able to hold his previous position.
- **Permanent disability** is an on-the-job injury that involves the permanent disability of the employee. The physician determines the level of the employee's impairment once the patient has reached a plateau on her ability to recover. This can range from partial disability to full disability. The physician will assign a percentage from one percent to 100 percent, with a 100 percent meaning the employee will no longer be able to work. Benefits include the medical care, lost wages and an indemnity (compensation for a loss) for the disability.
- **Death of a worker** is obviously the most serious of the categories. In the case where the employee is killed during the course of employment, a benefit is paid to the worker's dependents based on the wages earned by the employee at the time of death. Benefits paid for a death are also referred to as double indemnity.

Patient Records

An established patient might come to see the physician for a workers' compensation-covered injury. A separate file must be set up for all workers' compensation activities. Do not include any of the workers' compensation items in the patient's medical record. This helps keep records accurate, and it separates job-related injuries from injuries unrelated to the job. Workers' compensation is the primary carrier for job-related injuries. As a result, insurance companies will refuse claims that are covered by workers' compensation.

Step 7: Disability Insurance

When a person is unable to work, she can be eligible for disability benefits. Unlike workers' compensation, people with disability insurance need not suffer job-related injuries or illnesses to be eligible for coverage.

The federal government, some states and some private insurance carriers offer disability insurance programs. Payroll deductions typically pay for disability insurance. For a program to cover a person with a disability, the disability needs to be a *legal disability*, rather than a *medical disability*.

A **medical disability** is a condition that disables the person, such as a severe back injury. A **legal disability** is one that meets the requirements of the particular program. For example, in the Social Security Disability program, a legal disability is one that prevents the worker from doing *any* work, and the condition is expected to last for a year or more or to cause the worker's death.

As a healthcare document specialist, you won't have to actually file claims with disability insurance carriers, but you might have to assist in putting records together to enable the patient to file. You must have written permission from the patient to release this information to anyone, including insurance companies.

Disability Insurance

You may have to assemble the following records for a patient who is filing a claim with a disability insurance carrier:

- The patient's medical history
- Clinical symptoms
- Treatment provided
- A prognosis for the patient (the physician's prediction of how the patient's condition will be in the future)
- Any other applicable reports

Step 8: Consolidated Omnibus Budget Reconciliation Act

The **Consolidated Omnibus Budget Reconciliation Act** (**COBRA**) was designed to provide health insurance coverage to those who become unemployed either voluntarily or involuntarily and to those who no longer qualify for health insurance benefits because of a reduction in hours. Persons who have been fired for gross misconduct are not eligible to participate. COBRA is also available to the dependents and the spouse of the employee in the case of a divorce or the death of the employee.

In order to qualify, an employee must have participated in a group health plan provided by his place of employment. The coverage is available for 18 months. In the case of divorce or death, the dependents and the spouse are eligible for coverage for 36 months. The premiums for COBRA are determined by the total premium of the health insurance plan provided by the place of employment, including the employer's contribution and the employee's contribution, plus a service fee of two percent.

Generally, coverage under COBRA will be the same as the coverage provided by the group insurance plan provided by the employer. For example, if the employee was receiving dental coverage from their place of employment, the employee may also elect to continue to receive that same coverage while participating with COBRA.

Participants will have an insurance card providing billing information. As with any insurance, it's important to make a copy of the card front and back.

Ready for another Practice Exercise before we wrap up the lesson? Let's go!

Step 9: Practice Exercise 5-2

Determine the correct term(s) to complete each statement, and write your answers on scratch paper.

1. **A(n) _____ is described as an unplanned or unexpected happening causing injury or death not due to any fault of the employee.**

2. **_____ is available to the dependents and the spouse of the employee in the case of a divorce or the death of the employee.**

3. **A(n) _____ is a condition that disables the person.**

4. **_____ includes claims where the employee is expected to be unable to work for a period of time while he recuperates from his injuries.**

5. **Employers with sufficient capital can set up a fund to cover expenses incurred by job related accidents or illnesses called _____.**

6. **The Black Lung Benefits Act provides benefits to _____.**

Step 10: Review Practice Exercise 5-2

Check your answers with the answers at the back of this book. Correct any mistakes you may have made.

Step 11: Lesson Summary

This lesson introduced you to several special insurance programs that provide specific types of coverage. Let's review them before moving on.

TRICARE is the Department of Defense's regional managed care program. CHAMPVA provides healthcare coverage for families of veterans who have permanent, service-connected disabilities and families of veterans who have died because of a service-connected disability.

Workers' compensation provides coverage to employees and their dependents if the employees suffer a work-related injury, illness or death. It's important to note that all other insurance companies will refuse a claim that is covered by workers' compensation. You must determine if an injury is work-related and if it is, you must file with workers' compensation first.

Disability insurance programs cover people who are unable to work because of legal disabilities. Although you won't have to file claims with disability insurance carriers, you might have to help a patient file by assembling the appropriate records.

Finally, COBRA is health insurance coverage for those who are unemployed and those who no longer qualify for benefits due to a reduction in hours.

You learned a lot of information about insurance in the past few lessons. In the next lesson, we'll shift gears a bit, so you can explore what all those medical terms mean. That's right, you'll be able to decipher what doctors say by studying medical terminology. First, it's time to complete another Quiz.

Step 12: Quiz 3

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Endnotes

1 *Benefits—TRICARE*. Military Advantage. Web. 15 October 2013.

2 *Costs*. TRICARE. Web. 15 October 2013.

3 *TRICARE Prime Overview*. Military Advantage. Web. 15 October 2013.

4 *TRICARE for Life*. TRICARE. 22 Nov. 2011. Web. 15 October 2013.

Lesson 6
Introduction to Medical Terminology

Step 1: Learning Objectives for Lesson 6

When you have completed the instruction in this lesson, you will be trained to:

- Differentiate among root words, combining vowels, prefixes and suffixes.
- Define *root word,* and describe how the term is used.
- Define combining forms and compound words.
- Form terms with prefixes, suffixes and root words.

Step 2: Lesson Preview

So far in this course you learned about the day-to-day procedures in healthcare settings. You also saw how medical professionals work together as a team. You became familiar with the basics of insurance, and the various types of insurance coverages available. Hopefully these lessons also taught you that medicine is a very rewarding field. You will experience its satisfactions and live up to its challenges every day that you work as a healthcare document specialist. And you know that skilled healthcare professionals are in high demand. Doctors, hospitals and clinics all need qualified healthcare document specialists. In fact, many such positions remain unfilled due to a lack of qualified candidates. Most employers look for healthcare professionals who have schooling and experience, and with the training you receive in this program, you can count on learning everything you need to know about this medical field. Finding the position you want should be a snap!

In the next three lessons, you're going to focus on one very important part of medicine—its language. Doctors, nurses and other healthcare personnel communicate in specialized terms that, at first, might sound like a foreign language. You've no doubt overheard medical conversations in your own visits to the doctor. As a healthcare document specialist, you'll hear medical terminology in daily conversation. More importantly, you'll use this knowledge as you review medical records for diagnoses and procedures. Once you determine the correct diagnoses and procedures, you'll research those terms in your coding manuals to find the correct medical code. Just think—you'll soon be a medical terminology guru! What used to sound like a foreign language will someday become as familiar as your everyday conversation.

Fear not—learning medical terminology is a lot easier than learning a foreign language. Medical terms can be broken down into easy-to-understand parts. In this lesson, we will introduce you to your new language—the language of medicine. In these next few lessons, you'll learn the building blocks you'll need so that you can break down any medical term. We'll discuss *root words*, *prefixes* and *suffixes* and explain how these word parts come together to form medical terms. Throughout the lesson, be sure to have your flashcards handy as you will need to consult them as you study the following material, do the Practice Exercises and take the Quiz.

Step 3: Learning about Word Parts

Medical terms may appear to be long and complicated, but they actually consist of small word parts. Even the longest medical term can be broken down into small parts that are easily understood. Once you become familiar with the individual word parts, medical terminology becomes easier.

Understanding the various word parts will help you recognize medical terms. It will help you look up the terms in a medical dictionary to confirm correct spellings and meanings.

You will learn about each of these word parts, one at a time, in a simple, logical and easy-to-understand sequence. This will make it easier for you to spell and understand the longest and most complicated terms.

In this lesson, you will learn the name of each type of word part used in medical terminology.

Word Parts

Words are all around us. You use them every day to communicate. You use long words and short words, complex words and simple words. And there always will be words that are new to you. As a healthcare document specialist, you often will be faced with medical terms. These terms might seem complex at times, but you can simplify them. In every sentence you speak, every letter you write, the words are constructed of parts. These parts provide clues to the words' meanings. Because you know this, you can break words down and figure out their meaning from their word parts.

Look at these words you already know:

telephone

microwave

television

microscope

telescope

It's easy to split these words into parts:

telephone = tele + phone

microwave = micro + wave

television = tele + vision

microscope = micro + scope

telescope = tele + scope

You see that some of these words contain some of the same parts. *Tele/* is in three of the words. *Telescope* and *microscope* both have the word part /*scope*.

So you see, words can be divided into smaller parts called **word parts**, and they are very important in learning medical terminology. Word parts are like building blocks. A child can take a dozen building blocks and make many different things, combining the blocks in different ways. The same is true of word parts. Many different words can be formed from a few word parts.

Step 4: Root Words

The foundation for all words is the root word. The **root word** is the basic component of the terms used to communicate. Many simple words contain only a root word without any other word parts.

book

read

joy

cook

drive

Word parts are used with root words to make new and different words. This is usually done by adding either a prefix or a suffix. A **prefix** is a word part added to the beginning of a root word. Conversely, a **suffix** is a word part added to the end of a root word.

When other word parts are added to root words, a new word is formed, and this new word means something slightly different. Below are some new words that were formed from the root words previously mentioned. A prefix or suffix has been added to each root word. Remember, a prefix is a word beginning. A suffix is a word ending.

booklet	a little book
reread	to read again
joyful	having the quality of joy
cooked	to cook sometime in the past
driver	a person who drives

In addition to prefixes and suffixes, different root words come together to form new words. Words made up of two or more root words are called **compound words**. Here are some examples:

book + shelf = bookshelf

drive + way = driveway

news + paper = newspaper

Understanding word parts helps in understanding new words—even long and complicated words.

You may not know the word *recalculate*. But if you know what *calculate* means, and you know what the prefix *re/* means, then you know that *recalculate* means *to calculate again*.

In fact, you probably have made up some new words yourself just by making new combinations of word parts.

Let's review the word parts. Think of these word parts as the building blocks of medical terms.

Word Parts

Root Word	The root word is the foundation or cornerstone of the word.
Prefix	A prefix is attached to the beginning of a root word to change its meaning.
Suffix	A suffix is attached to the end of a root word to change its word form or meaning.

Now let's take the basic concept of word parts and apply it to medical terms.

Step 5: Medical Terms

Medical terms may appear to be long and complicated, but even the longest medical term can be broken down into small, easy-to-understand parts. Once you become familiar with the individual word parts, medical terminology becomes easy. Try to look at medical terms like little puzzles. You're putting together different pieces (root words, prefixes and suffixes) to form complete words.

Understanding some essential word parts will help you recognize medical terms. You will learn about each of these word parts, one at a time, in a simple, logical, easy-to-understand sequence. This will make it very easy for you to spell and understand even the longest and most complicated terms.

The Combining Vowel

Many medical terms contain a fourth word part, which is the *combining vowel*. The **combining vowel** joins a root word to other word parts.

Here is an example of how the combining vowel is used. As you can see, not all terms have all four parts.

Medical Term	Root Word	Combining Vowel	Suffix
dermatology	dermat/ means *skin*	o	/logy means *the study of*

- Dermatology means the study of skin.

Next, you'll see two more medical terms that show examples of word parts. These are compound words because they contain more than one root word.

Medical Term	Prefix	Root Word	Combining Vowel	Root Word	Suffix
neonatologist	neo/	nat/	o	log/	/ist
	means *new*	means *birth* or *born*		means *the study of*	means *one who specializes in*

- A neonatologist is one who specializes in the study of the newborn.

If you use a different prefix, you will have the following term:

Medical Term	Prefix	Root Word	Combining Vowel	Root Word	Suffix
perinatologist	peri/	nat/	o	log/	/ist
	means *around*	means *birth* or *born*			

- A perinatologist is someone who specializes in the study of the fetus and newborn (the time around the birth).

These are two types of doctors you may find yourself working for as a healthcare document specialist!

You've just started the journey of medical terminology and have a good understanding of the basic concepts of word parts. You know that medical terms can be broken down into easy-to-understand pieces called word parts. The foundation for all words is the root word, which is the basic component of the terms we use to communicate. Finally, you've learned about the combining vowel that joins a root word to another word part.

In the next section, we'll explore root words, prefixes and suffixes in more detail. You're probably excited to move to the next step, but first let's review what you know so far about medical terminology.

Tip

If you have access to a computer and the Internet, you can use an online medical dictionary to look up terms. An online medical dictionary can be found at http://www.online-medical-dictionary.org/. Feel free to check it out!

Step 6: Practice Exercise 6-1

Determine the term(s) to complete each sentence, and write your answers on scratch paper.

1. **The foundation word part of a medical term is called a(n) _____.**
2. **The word part that is attached to the end of a term is a(n) _____.**
3. **In a medical term, a prefix is found at the _____.**
4. **The word part that joins a root word and another word part is a(n) _____.**
5. **The word part that is attached to the beginning of a term is a(n) _____.**
6. **In a medical term, a suffix is found at the _____.**
7. **A suffix is attached to the word part called the _____.**
8. **A prefix is attached to the word part called the _____.**
9. **A combining vowel combines a word part and a(n) _____.**
10. **In the term *dermat/o/logy*, the word part /*o*/ is called a(n) _____.**

Step 7: Review Practice Exercise 6-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 8: Root Words

As you previously learned in this lesson, word parts are the building blocks for all words, including medical terms. Up to this point, word parts were described in a general manner. Now we will take a closer look at **root words**—the foundation of all words.

You will find many of the root words in this lesson familiar because they are used in everyday English, as well as in medical terminology. The words covered in this lesson are the most common of all medical root words.

You may have wondered why medical terms are so long and complicated. Well, it's because these terms have very definite meanings. In medicine, one complicated word takes the place of four or five common words so that doctors can communicate exactly what they mean to other healthcare professionals. This prevents misunderstandings that can interfere with the patient's care.

For example, the words abdomen and stomach may mean the same thing to you, but they have different meanings in the healthcare profession. Because of this, doctors use different words for the *stomach* and the *abdomen*. You will learn the root words for these and other parts of the body in this lesson and in lessons to come.

Doctors and other healthcare professionals use special medical terms because they know it's important to communicate precise information about a patient's condition. As you learn to build words, you will be building your professional skills. You will be an important link in the healthcare team. Without you, this patient information would not make it to the insurance companies in the correct format, meaning that your colleagues may not get properly reimbursed for their expertise and services.

The medical codes you determine for each patient's case serve an additional, critical purpose. These codes enable government health agencies to track and research life-threatening illnesses, such as various types of cancer, heart disease and AIDS. Your important role as a medical coding specialist helps save lives!

The Functions of Root Words

There are three interesting facts about root words.

Facts About Root Words

- Root words are the foundation of a medical term.
- Root words name body parts or body functions that the terms represent.
- Most medical terms have at least one root word.

Look at some examples of root words:

Root Word	English Meaning
neur/	nerve
gastr/	stomach
scop/	examine
log/	study of
cardi/	heart
path/	disease

These root words are in the medical terms that follow. Even though you may not know the meaning of the medical term, you know the meaning of the root word you saw just a moment ago.

neuritis	inflammation of nerves
gastritis	inflammation of the stomach
microscope	an instrument to examine small things
logic	a method of studying an area of thought
cardiac	relating to the heart
pathology	the process of the study of disease

Compound Words as Root Words

Some terms have two or more root words in them, which are called **compound words**. In the examples that follow, you will use the same root words you used previously.

Compound word	Meaning
neuropathy	a disease process of nerves
gastroscope	an instrument to examine the stomach
cardiologist	one who studies the heart
pathologist	one who studies disease

In the examples, notice that the combining vowel "o" was used to join the two root words.

Combining Forms of Root Words

Root words sometimes can be awkward to pronounce. That is why you may see the combining vowel—usually the letter /o/—between the root word and other word parts. The combination of the root word and the combining vowel is called the **combining form**. Look at the combining forms for the root words you saw previously.

Root Word	Combining Form	English Meaning
neur/	neur/o	nerve
gastr/	gastr/o	stomach
scop/	scop/o	examine
log/	log/o	study of
cardi/	cardi/o	heart
path/	path/o	disease

In this course, each new root word you learn will be in its combining form.

Root Word + Combining Vowel = Combining Form

When studying root words, you have three goals:

- Remember what the root word sounds like. When you are transcribing, you hear words, but you do not see them. Be sure you remember what a root word sounds like on a sound file.
- Pronounce and spell the root word correctly. Look at how the combining form is divided. What letter is the combining vowel? (It will usually be an /o/.)
- Learn the meaning of the root word.

Take out your Course One Flashcards. You'll see that you have several pages, printed on both sides, with perforation lines dividing the flashcards.

- Each flashcard is numbered and has a Side A and a Side B. Side A shows a medical term or word part. Side B shows that term's meaning.
- Tear your flashcards along the perforation lines. We recommend you rubberband all the flashcards for a given lesson together.
- It's a good idea to carry one or two bundles of flashcards around with you, in your purse or your pocket. That way, you'll be able to review your terms whenever you have a few moments.

Now it's time to begin learning some common medical root words.

Step 9: Pronounce New Root Words

Follow these steps to learn how to pronounce root words.

Audio Exercise

a. Take out your Set 1 flashcards. Find flashcard 1-1. Access the audio for Set 1.

b. Listen to each root word as it is pronounced. After you hear each root word, pause the audio player.

c. Look at the root word and practice pronouncing it out loud several times until you can pronounce it correctly and easily. Turn the flashcard over and read the meaning of the root word. Continue with all the terms in Set 1.

d. Next, begin with the Set 1 flashcards and play the audio track again. This time, pronounce each root word in order but do not stop the player after each term. As you pronounce each root word, look at it on the flashcard. Listen to your own pronunciation of each root word. If you mispronounce one, put a check mark next to it.

e. Next, listen again and practice the root words you mispronounced. Be sure you can pronounce each root word clearly and easily. After you have finished pronouncing all of the root words for Set 1, move on to the next step.

f. Practice the root words you mispronounced by listening again. Be sure you can pronounce the root words clearly and easily.

Step 10: Write New Root Words

Follow these steps to learn how to write root words.

a. Using your Set 1 flashcards again, look at the first root word and say it out loud. Write this root word on blank paper. Be sure to include the slash (/) when you write the term, just like you see it on the flashcard.

b. Turn the card over to Side B and read the meaning out loud. Write the meaning on your blank paper, beside the root word. Writing these root words and meanings will help you learn them more easily. Do this for each flashcard for Set 1. After you have pronounced and written each root word, learn the meanings of these word parts in the next exercise.

Step 11: Learn Root Word Meanings

Follow these steps to learn root word meanings.

a. Take out your Set 1 flashcards. Pronounce each root word out loud. Before you look at the meaning, see if you can remember it. Check yourself by turning the flashcard over to see the meaning. Do this for each flashcard.

b. Now turn all the flashcards over, so you are looking at Side B. Read the meaning for the first root word out loud. Before turning the card over, try to say the medical term that goes with that meaning. Check yourself by turning the card over to Side A and reading the root word.

c. Practice with the flashcards several times until you are familiar with the root words and their meanings. It's not necessary to memorize all the root words now. You will find that you begin to memorize medical terms as you use them throughout this program. Remember to keep your flashcards in order even after you're finished with an activity so you can refer back to them easily. You may use your flashcards for all Practice Exercises and Quizzes. However, the time you spend reviewing the terms now will mean less time spent looking them up later.

A Note About Flashcards

You will use the flashcards from each lesson throughout this course and in the later courses. Save them after you finish each lesson or course. Take good care of them because you'll use them in your career.

Step 12: Practice Exercise 6-2

Part I

For each root word listed, write the meaning on scratch paper. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you looked up on the flashcards.

Root Words

1. **append/o, appendic/o**
2. **arthr/o**
3. **derm/o**
4. **muc/o**
5. **hydr/o**
6. **norm/o**
7. **neur/o**
8. **lith/o**
9. **therm/o**
10. **path/o**

Part II

For each meaning listed, write the correct root word on scratch paper. Be sure to include the slash and the combining vowel. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you looked up on the flashcards.

Meanings

11. **lung**
12. **small intestine**
13. **life**
14. **liver**
15. **giving rise to**
16. **muscle**
17. **pressure**
18. **cut into**
19. **kidney**
20. **blood**

Step 13: Review Practice Exercise 6-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Review your flashcards again, giving extra attention to items circled in the Practice Exercise.

Step 14: Prefixes

Now that you've learned about root words, let's learn about another word part—prefixes. If you consider the root word to be the boxcar on a train, the prefix is the engine, and the suffix is the caboose. You know that prefixes are added in front of root words while suffixes are added at the end of root words.

A prefix changes the meaning of a medical term. While the root word names a body part or body function, the prefix gives additional information about the medical term.

Facts About Prefixes

- A prefix gives additional information about a medical term.
- A prefix usually tells where, when or how.

Let's take a look at some examples of prefixes and their meanings. Notice that prefixes do not have combining vowels.

Prefix	Meaning
peri/	surrounding
brady/	slow
tachy/	fast
micro/	small, tiny
a/	without, absent

Now let's learn more about prefixes.

Facts About Prefixes

- A prefix does change the meaning of the whole medical term.
- A prefix does not change the meaning of a root word.

In the following list, you see medical terms made from some of the root words you studied earlier. Notice that while the prefix changes the meaning of the term, the prefix does not change the meaning of the root word. (Don't worry about the vowel endings on the root words for now. This will be explained shortly.)

Medical Term	Meaning
renal	relating to the kidney
perirenal	relating to surrounding the kidney
cardia	heart
bradycardia	slow heart
tachycardia	fast heart
glossa	tongue
macroglossa	large tongue
gastric	relating to the stomach
hypogastric	relating to below the stomach
leukocytosis	condition of white cells
aleukocytosis	condition of absence of white cells

Fact About Prefixes

Many terms do not begin with a prefix.

A prefix is attached to the root word. If there is no prefix, the first word part you will see is the root word. Look at these examples.

perirenal	starts with prefix
renal	starts with root word

Remember, a prefix only tells *where*, *when* or *how*. A root word tells *what*.

How do you tell if the beginning of the word is a prefix or a root? Well, one way is to see what happens when you remove the first word part. Look at the following example. You saw these terms a moment ago. The root word here means heart.

Medical Term	Meaning
cardia	heart
bradycardia	slow heart

When you take the prefix *brady/* away, the meaning of the term changes from slow heart to heart. However, the meaning of the root, *heart*, doesn't change, so you know that *brady/* is a prefix.

Facts About Prefixes and Root Words

- If you take away a prefix, you take away only the where, when or how.
- If you take away a root word, you have taken away the what—the basic meaning of the term.

Look at the next example. This term is a compound word. The "what" is a *white cell*. A white cell is one kind of cell—it is not a red cell or a liver cell. Look what happens to the meaning of the term when you remove one of the two root words that make up the compound word.

Medical Term	Meaning
leuk/o/cyt/osis	condition of white cells
cyt/osis	condition of cells

When the root word *leuk/o* is removed, the meaning of the term changes from *white cells* to simply *cells*. The term *cyt/osis* means a condition of any kind of cells: red cells, white cells, liver cells and so on. The "what" of the term changed from *white cells* to *cells*. Therefore, *leuk/o* is a root word.

For now, all the prefixes you learn are followed by a slash. Look at these examples.

brady/ micro/ peri/

In addition, all the root words you learn have a slash between the root and the combining vowel. Look at these examples.

cardi/o leuk/o cyt/o

Step 15: Pronounce New Prefixes

Follow these steps to learn how to pronounce prefixes.

Audio Exercise

a. Take out your Set 2 flashcards. Find the first flashcard. Access your audio for Set 2.

b. Listen to each prefix as it is pronounced. After you hear each prefix, put the player on pause.

c. Look at the prefix and practice pronouncing it out loud several times until you can pronounce it correctly and easily. Turn the flashcard over and read the meaning of the prefix. Continue with all the terms in Set 2.

d. Next, begin with the Set 2 flashcards and play the audio track again. This time, pronounce each prefix in order but do not stop the player after each term. As you pronounce each prefix, look at it on the flashcard. Listen to your own pronunciation of each prefix. If you mispronounce one, put a check mark next to it.

e. Next, listen again and practice the prefixes you mispronounced. Be sure you can pronounce each prefix clearly and easily. After you have finished pronouncing all of the prefixes for Set 2, move on to the next exercise.

f. Practice the prefixes you mispronounced by listening again. Be sure you can pronounce the prefixes clearly and easily.

Step 16: Write New Prefixes

Follow these steps to learn how to write prefixes.

a. Using your Set 2 flashcards again, look at the first prefix and say it out loud. Write this prefix on blank paper. Be sure to include the slash (/) when you write the term, just like you see it on the flashcard.

b. Turn the card over to Side B and read the meaning out loud. Write the meaning on your blank paper, beside the prefix. Writing these prefixes and meanings will help you learn them more easily. Do this for each flashcard for Set 2. After you have pronounced and written each prefix, learn the meanings of these word parts in the next step.

Step 17: Learn Prefix Meaning

Follow these steps to learn prefix meanings.

a. Take out your Set 2 flashcards. Pronounce each prefix out loud. Before you look at the meaning, see if you can remember it. Check yourself by turning the flashcard over to see the meaning. Do this for each flashcard.

b. Now turn all the flashcards over, so you are looking at Side B. Read the meaning for the first prefix out loud. Before turning the card over, try to say the medical term that goes with that meaning. Check yourself by turning the card over to Side A and reading the prefix.

c. Practice with the flashcards several times until you are familiar with the prefixes and their meanings. It's not necessary to memorize all the prefixes now. You will find that you begin to memorize medical terms as you use them throughout this program. Remember to keep your flashcards in order even after you're finished with an activity so you can refer back to them easily. You may use your flashcards for all Practice Exercises and Quizzes. However, the time you spend reviewing the terms now will mean less time spent looking them up later.

Step 18: Practice Exercise 6-3

Part I

For each prefix listed, write the meaning on scratch paper. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you looked up on the flashcards.

Prefixes

1. **a/**
2. **ec/, ecto/**
3. **infra/**
4. **peri/**
5. **hypo/**
6. **micro/**
7. **dia/**
8. **epi/**
9. **hyper/**
10. **intra/**

Part II

For each meaning listed, write the correct prefix on scratch paper. Be sure to include the slash. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you looked up on the flashcards.

Meanings

11. **under, inferior to**
12. **half**
13. **against, opposed**
14. **all, every**
15. **away from**
16. **between**
17. **slower than usual**
18. **gross, large**
19. **again, back**
20. **behind, back**

Step 19: Review Practice Exercise 6-3

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Review your flashcards again, giving extra attention to items circled in the Practice Exercise.

Step 20: Suffixes

Jason, an at-home medical transcriptionist for a local heart center, tries to decipher a term on a physician's note. Background conversation and the physician's mumbling are making it difficult for Jason to correctly identify the term. He pauses and replays the sound clip several times trying to catch the word.

After replaying the sound file a couple more times, Jason catches the last part of the word, "centesis." "Hmm," he thinks to himself. "I still can't catch the first part; what is the physician saying?" Jason thinks back to learning about prefixes, root words and suffixes in his training.

"Maybe I can figure out the word based on the word parts and the context," he thinks. Jason reads the few sentences before the unknown word and discovers that the physician is discussing a heart procedure. From his training, he knows that "cardi/o" means heart. Jason wonders if the muffled word is "cardiocentesis." He looks up the word in a medical dictionary and determines the word means "surgical puncture of the heart."

Jason plays the sound clip one more time to see if he found the correct word. "That's it!" Jason exclaims. He flags the word for the physician to review because Jason doesn't want to assume he has the correct word. Then Jason continues to transcribe the rest of the report.

Sometimes medical transcription involves a bit of detective work, as you'll discover in later lessons. In this example, Jason's knowledge of word parts helped him solve the mystery of the unknown word. Knowing word parts will help you break down medical terminology and may help you decipher unknown words.

In this section, you'll tackle the last word part—suffixes. Let's get started!

A **suffix** is the word part that is attached to the end of a root word.

Why use suffixes? A suffix can change the word form or the meaning of a term. The word form tells you how the word functions in the sentence. Word forms also are referred to as parts of speech.

Two important parts of speech are the *noun* and the *adjective*.

A **noun** is the name of a person, place or thing. An **adjective** is a word that describes a noun. Here's an example.

The	**green**	**candle**	has	a	**distinct**	**smell**.
	adjective	noun			adjective	noun

The words *candle* and *smell* are nouns because they name a person, place or thing. The words *green* and *distinct* are adjectives because they describe nouns.

Some root words can function as both nouns and adjectives. All you have to do is change the suffix. Here's an example.

Noun	**Adjective**
courage	courageous

Compare these two sentences:

Courage is an important quality for a soldier to have.
The **courageous** man saved the boy's life.

In the first sentence, *courage* is a noun. It is a thing, a quality. In the second sentence, the word *man* is the noun, and the word *courageous* describes the man, making *courageous* an adjective.

Look at these examples of medical terms that can be changed from nouns to adjectives just by changing the suffix.

Noun	**Adjective**
cardi/a	cardi/ac
gastr/ia	gastr/ic
muc/us	muc/ous
neur/osis	neur/al

Fact About Suffixes

A suffix can change a root word to a noun or an adjective.

The suffix determines whether a word is a noun or an adjective. Suffixes that make a word a noun are called **noun suffixes**. Suffixes that make a word an adjective are called **adjective suffixes**. No matter what root word they are joined to, a noun suffix always changes the word into a noun, and an adjective suffix makes the word an adjective.

Here is a table of some common medical suffixes. Notice that some of the suffixes are noun suffixes, and some are adjective suffixes. Many noun suffixes don't really have a meaning. They are just used to show that the word is a noun.

Suffix	Noun or Adjective	Meaning
/y	noun	the process of
/a	noun	(no meaning)
/ia	noun	condition
/us	noun	(no meaning)
/osis	noun	condition
/ac	adjective	relating to
/ic	adjective	relating to
/ous	adjective	relating to
/al	adjective	relating to

When you learn suffixes later in this lesson, the flashcard will tell you which are noun suffixes and which are adjective suffixes.

Did you notice that many of the suffixes have the same meaning? If they have the same meaning, how do you know which one to use? Well only certain suffixes and certain root words can be combined. For example, each root word generally can be combined with only one adjective ending. *Cardi/o* is joined with */ac* to form cardiac. *Cardi/o* is never joined with */ic*, */al* or */ous*. The words cardiic, cardial and cardious do not exist.

In the next few lessons, you not only will be learning individual word parts but also complete medical terms—both nouns and adjectives.

Often a *root word* + *suffix* combination can itself be used as a word ending. You can think of this as a **combined suffix**. For example:

path/o + /y = /pathy

The combined suffix */pathy* can be joined to many other words.

cardiopathy myopathy neuropathy

These combined suffixes will be written on your flashcards as regular suffixes, but if you look closely, you'll be able to see the *root word* + *suffix* combination. Look at these examples.

Root Word	+	Suffix	=	Combined	Meaning
path/o	+	/y	=	/pathy	process of disease (noun)
path/o	+	/ic	=	/pathic	relating to a disease (adjective)
megal/o	+	/y	=	/megaly	process of enlargement (noun)
megal/o	+	/ic	=	/megalic	relating to enlargement (adjective)
cardi/o	+	/a	=	/cardia	heart (noun)
cardi/o	+	/ac	=	/cardiac	relating to the heart (adjective)

Before you move on, let's pretend for a moment that you know the term *cardiopathy*, which means heart disease, but you aren't sure if cardiopathy is in fact the correct spelling—you suspect it may be spelled cardiapathy instead. So what should you do? Well, simply pull out your flashcards and research the term, or search for the term with an online dictionary. Your research will confirm that the term is spelled *cardiopathy*!

Fact About Suffixes and Root Words

Most root words need either a noun suffix or an adjective suffix at the end of them.

Most root words can't stand alone as complete words—they need a suffix at the end of them. But like everything else in life, there are exceptions. For some root words, you don't need a suffix of any kind to form a complete word. These roots already are complete words. By dropping the combining vowel, these root words stand alone. They also work as suffixes themselves.

Listed are three examples of root words that don't need a suffix.

Root Word	Suffix (Noun)	Meaning
gram/o	/gram	picture, record, tracing
graph/o	/graph	machine that creates a tracing or recording
derm/o	/derm	skin

In this course you will be given more noun and adjective suffixes. Whenever you learn a new term, look to see which suffixes are used with which roots. That way you will begin to recognize which roots and suffixes belong together.

Now, let's learn how to pronounce suffixes.

Step 21: Pronounce New Suffixes

Follow these steps to learn how to pronounce suffixes.

Audio Exercise

a. Take out your Set 3 flashcards. Find the first flashcard. Access the audio for Set 3.

b. Listen to a suffix as it is pronounced. After you hear each suffix, put the player on pause.

c. Look at the suffix and practice pronouncing it out loud several times until you can pronounce it correctly and easily. Turn the flashcard over and read the meaning of the suffix. Continue with all the terms in Set 3.

d. Next, begin with the Set 3 flashcards and play the audio track again. This time, pronounce each suffix in order but do not stop the player after each term. As you pronounce each suffix, look at it on the flashcard. Listen to your own pronunciation of each suffix. If you mispronounce one, put a check mark next to it.

e. Next, listen again and practice the suffixes you mispronounced. Be sure you can pronounce each suffix clearly and easily. After you have finished pronouncing all of the terms for Set 3, move on to the next exercise.

f. Practice the terms you mispronounced by listening again. Be sure you can pronounce the terms clearly and easily.

Step 22: Write New Suffixes

Follow these steps to learn how to write suffixes.

a. Using your Set 3 flashcards again, look at the first suffix and say it out loud. Write this suffix on blank paper. If necessary, be sure to include the slash (/) when you write the term, just like you see it on the flashcard.

b. Turn the card over to Side B and read the meaning out loud. Write the meaning on your blank paper, beside the suffix. Writing these suffixes and meanings will help you learn them more easily. Do this for each flashcard for Set 3. After you have pronounced and written each term, learn the meanings of these suffixes in the next step.

Step 23: Learn Suffix Meanings

Follow these steps to learn suffix meanings.

a. Take out your Set 3 flashcards. Pronounce each suffix out loud. Before you look at the meaning, see if you can remember it. Check yourself by turning the flashcard over to see the meaning. Do this for each flashcard.

b. Now turn all the flashcards over, so you are looking at Side B. Read the meaning for the first suffix out loud. Before turning the card over, try to say the suffix that goes with that meaning. Check yourself by turning the card over to Side A and reading the term.

c. Practice with the flashcards several times until you are familiar with the suffixes and their meanings. It's not necessary to memorize all the terms now. You will find that you begin to memorize medical terms as you use them throughout this program. Remember to keep your flashcards in order even after you're finished with an activity so you can refer back to them easily. You may use your flashcards for all Practice Exercises and Quizzes. However, the time you spend reviewing the terms now will mean less time spent looking them up later.

Step 24: Practice Exercise 6-4

Part I

For each suffix listed, write the meaning on scratch paper. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you looked up on the flashcards.

Suffixes

1. **/ectomy**
2. **/gram**
3. **/logy**
4. **/ist**
5. **/megaly**
6. **/stasis**
7. **/ac**
8. **/meter**
9. **/ism**
10. **/oid**

Part II

For each meaning listed, write the correct suffix on scratch paper. Be sure to include the slash. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you looked up on the flashcards.

Meanings

11. **condition**
12. **inflammation**
13. **pathologic condition**
14. **disease process**
15. **pain**
16. **look at**
17. **withdrawing fluid**
18. **go**
19. **instrument to see with**
20. **throughout the blood**

Step 25: Review Practice Exercise 6-4

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Review your flashcards again, giving extra attention to items circled in the Practice Exercise.

Step 26: Lesson Summary

Understanding how to "decipher" medical terminology is a special link to becoming an effective healthcare document specialist. This knowledge will allow you to find the correct diagnosis and procedure code, which provides healthcare professionals with the information they need to get properly reimbursed. Although medical terms might seem complex, you now know that you can simplify them by breaking them down into word parts and then figuring out the meanings of the parts. Word parts are like building blocks because many different words can be formed from a few word parts.

The foundation for all words is the root word, the basic component of terms. The root word names the body part or body function that the term represents. Most medical terms have at least one root word.

We use word parts together with root words to make new and different words. This is usually done by adding either a prefix or a suffix. Prefixes are word parts added to the beginning of a root word. A prefix gives additional information about a medical term, and a prefix usually tells where, when or how. A prefix does not change the meaning of a root word—but a prefix does change the meaning of the whole medical term. A suffix is a word part added to the end of a root word. The suffix determines whether a word is a noun or an adjective. Most root words need either a noun suffix or an adjective suffix at the end of them. Combining vowels are word parts that join a root word to another word part. Combining vowels make terms easier to pronounce.

It's important that you understand word parts as a healthcare document specialist. While this lesson may have strained your brain a little more than the previous ones, you've now learned about the building blocks you'll need to "build" many medical terms! The Practice Exercises in this lesson are important. If you skipped any or struggled to complete some of them, take a few moments to go back and work on them again. Doing so will prepare you for the upcoming Quiz and build upon your medical foundation of knowledge.

Step 27: Quiz 4

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Just for Fun

After a long day of helping people, most health professionals take a break to smile and have fun. Having fun after working hard has four benefits.

- It relieves stress.
- It exercises your face muscles.
- It isn't fattening.
- It is free.

If anything else in this world gave you these four benefits, you'd take as much of it as you could get. So every once in a while we'll take a fun break—just like this.

Some *Just for Fun* pages are for enjoyment. Some will tell you interesting things about language and the medical field. Some will give you a warm smile.

Most people use words that come from Greek and Latin every day. Here are some examples.

Greek	Latin
telephone	plumber
chemistry	alibi
therapy	medium
skeleton	honor

The English language has more ways to say something than any other language. That is because it contains words from so many languages. In fact, there are a lot of words in English that come from French. Here are some examples.

French

humility

liberty

image

The English language also uses words that are Anglo-Saxon. They are usually three or four letters long. When you use a "four-letter word," you are probably using an Anglo-Saxon word. Look at these examples of common three- and four-letter words.

Anglo-Saxon

cat

dog

free

Medicine has been around a long time. The word parts you are learning come from Greek and Latin.

A long time ago, no one in England spoke English. The peasants spoke Anglo-Saxon. Peasants couldn't read or write. They could only speak their language. It was very simple. Speaking Anglo-Saxon meant you hadn't been to school and didn't have much in the way of gold and diamonds, or even food, for that matter. Anglo-Saxon words became our everyday words.

The only people who were educated were the clergy. They read and wrote Latin. They studied Greek when they wanted to do something really exciting. Therefore, anyone who spoke Latin or Greek was considered educated. As science developed, scientists used Latin and Greek so everyone would know they were educated. Greek and Latin words became our professional terms.

In 1066, the French invaded England. The French ruled England and owned the land. The French language gained importance. Eventually French words became our elegant words.

After many years, the English language grew from these roots. That's why in English today, there are usually three words (at least) for everything. If you consider where the different words come from, you can see why different words for the same thing may sound everyday, scientific or elegant. Look at these examples.

Anglo-Saxon	Latin or Greek	French
fire	conflagration	blaze
job	profession	affair
happy	felicitous	joyous
behind	posterior	derriere

Today, by choosing different words, English can still sound everyday, professional or elegant. Don't be afraid of long words. You soon will learn easy, step-by-step ways of breaking them down to the building blocks you have learned. In this section, you are learning the building blocks. In future sections, you will learn what the terms mean. Soon you will be using medical terms like a professional because you will be a professional.

Lesson 7
Dividing and Combining Medical Terms

Step 1: Learning Objectives for Lesson 7

When you have completed the instruction in this lesson, you will be trained to:

- Divide common medical terms into parts, and provide the meaning of each part.
- Properly combine prefixes, root words and/or suffixes to form medical terms that describe certain diagnoses and procedures.
- Determine the meanings of root words, prefixes and suffixes.

Step 2: Lesson Preview

So far, you have learned the word parts that fit together to form medical terms: prefixes, root words and suffixes. In this lesson you'll learn how to take complete terms and divide them. You'll also learn how to combine word parts correctly to create new terms.

You may recall the train example in the last lesson—the root word is the boxcar, the prefix is the engine and the caboose is the suffix. When you divide medical terms, you can look at the entire train and determine the prefix, suffix and root word. This is important because you sometimes will be faced with unfamiliar terms. If you can look at an unfamiliar word and divide it properly, you then can determine its meaning based on the word parts.

As a healthcare document specialist, you might review medical records that don't have the correct medical term spelled out for you. It will be your job to determine the exact procedure or diagnosis from the medical records. Without those key terms coded, which you'll soon learn how to do, the providers for whom you work could not get reimbursed by insurance companies for their time and expertise. You are the link between the healthcare provider and her salary! This lesson shows you how to take "plain English" descriptions and combine word parts to form the correct medical term. As you read this lesson, keep in mind that you are learning both the meanings of and how to assemble words.

Remember that you are not expected to memorize every term. The more familiar you are with your terminology, the quicker and easier it will be to complete some of your tasks as a healthcare document specialist. On the job, your knowledge about word parts will help you with your terms, and you will use a medical dictionary as needed. For now, complete your Practice Exercises and concentrate on reviewing your flashcards and listening to pronunciations when you have an opportunity. You will soon be confident in your medical terminology skills.

Throughout this lesson, be sure to have your flashcards handy as you will need to consult them as you study the following material, do the Practice Exercises and take the Quiz. Your knowledge of medical terms will make you a valuable resource in the medical field—you will be able to communicate effectively with healthcare providers and insurance companies. Now, let's get started!

Step 3: Dividing Medical Terms

You have learned about word parts—the building blocks of medical terms—and you can identify these building blocks in medical terms. By dividing these terms into their word parts, you can recognize new or complicated medical terms. Then you can look them up in a dictionary more easily and spell them correctly.

Fact About Dividing Words

When you are looking for the word parts in a medical term, read from the end of the term to the beginning. This simple technique lets you "see" word parts more easily.

Let's look at the following example.

thermometer

If you read from the end of the word, the first word part you see is the suffix *meter*. Draw a slash to the left of *meter*.

thermo/meter

Continue reading from right to left. Next you see an *o*. This may be a combining vowel. Put in another slash. Continue reading from right to left. You see the root word *therm*.

therm/o/meter

Now give the meaning of thermometer starting with the suffix.

Word Part Starting with End of Word	Meaning
/meter	instrument to measure
o	(combining vowels have no meaning)
therm/	heat

A thermometer is an instrument to measure heat.

The following example further shows you how to divide a medical term, reading from end to beginning, to find the meaning.

Word Part Starting with End of Word	Meaning
/partum	childbirth
post/	after

Postpartum means after childbirth.

Word Part Starting with End of Word	Meaning
/plasty	restore through surgery
o	(combining vowels have no meaning)
maxill/	upper jaw

Maxilloplasty means restoring the upper jaw through surgery.

Of course, whenever you are pronouncing a term, you should read from the beginning of the term to the end, just as you would read any new word in English.

Consonants, Vowels and the Role They Play

When you divide medical terms it is important to remember that a **consonant** is any letter of the alphabet except *a*, *e*, *i*, *o*, *u* and, for the purposes of working with medical terms, *y*.

Fact About Dividing Medical Terms

When a suffix begins with a consonant, there is a combining vowel between the root word and the suffix.

Let's take a look at a few examples.

Term with Suffix Beginning with Consonant	Meaning
cardi/o/**gram**	tracing of the heart
thromb/o/**plasty**	surgical repair of a blood clot
thorac/o/**centesis**	withdrawing fluid from the chest
gastr/o/**tomy**	incision into the stomach

Because all the suffixes in these examples begin with a consonant, the combining vowel is used. (Did you notice in these examples that dividing slashes (/) were placed between each word part?)

Fact About Dividing Words

When the suffix begins with a vowel, there is no combining vowel between the root word and the suffix.

You already learned that **vowels** are the letters *a*, *e*, *i*, *o* and *u*. Also, *y* is considered a vowel when working with medical terms. Let's look at some examples.

Term with Suffix Beginning with Vowel	Meaning
arthr/**algia**	pain in joints
hemat/**oma**	blood tumor (lump)
bi/**opsy**	look at living (tissue)
cardi/**ac**	relating to the heart
cardi/o/path/**y**	disease of the heart

As you can see, the combining vowel was not used in the terms above before the suffix. The last term, *cardiopathy*, ends with the suffix /*y*. The suffix /*y* follows this vowel rule because it acts like a vowel here.

Fact About Dividing Words

There is a combining vowel between two root words in a compound word.

As you learned, a compound word has two or more root words in it. Look at these examples. Notice the combining vowel between the root words. Also notice that the combining vowel remains even if the second root word begins with a vowel.

Compound Word with Combining Vowel	Meaning
cardi/o/**log**/ist	heart specialist
gastr/o/**enter**/o/**logy**	study of the stomach and bowels
therm/o/**meter**	instrument to measure heat

A Little Practice

Let's get a little practice in dividing medical terms. Look for word parts in the examples that follow. Read each term from the end of the term—from right to left. Put in slashes between word parts. Pay special attention to whether or not a combining vowel is present. Be careful. Not every *o* is a combining vowel, so use your flashcards if you need help.

perirenal

hemostasis

neuritis

hepatitis

cranium

pararenal

appendectomy

paraneural

cardiology

hepatomegaly

Here is how you should divide these terms. Either way is correct as the combined suffix does not always need to be divided.

peri/ren/al

hem/o/stasis

neur/itis

hepat/itis

crani/um

para/ren/al

append/ectomy or append/ec/tom/y

para/neur/al

cardi/o/logy or cardi/o/log/y

hepat/o/megaly or hepat/o/megal/y

Now give the meaning of these terms. Start at the end of the term and work to the left. Write the meaning on scratch paper. (The meaning you give doesn't have to be exactly the same as the one provided. We will use the meanings from your flashcards.)

peri/ren/al

hem/o/stasis

neur/itis

hepat/itis

crani/um

para/ren/al

append/ectomy

para/neur/al

cardi/o/logy

hepat/o/megaly

The meanings for each of the previous terms are listed here:

peri/ren/al	around (surrounding) the kidney
hem/o/stasis	control (hold in) blood
neur/itis	inflammation of nerve(s)
hepat/itis	inflammation of the liver
crani/um	(structure of the) skull
para/ren/al	beside (beyond) the kidney
append/ectomy	(the process of) removal of the appendix
para/neur/al	relating to beside a nerve
cardi/o/logy	(the process of) the study of the heart
hepat/o/megaly	(the process of) enlargement of the liver

The words "the process of" are enclosed in parentheses because they usually are left off when the word is defined in common speech. For example, *hepatomegaly* commonly is defined as enlargement of the liver, not the *process of enlargement of the liver*.

Now that you know the meaning of hepatomegaly, just for fun, would you like to see what code you would assign for congenital hepatomegaly?

Q44.7 Hepatomegaly

See how a medical term is translated into a diagnostic code? This code would be entered on the medical claim form required for the insurance company. Without it, the insurance company processing the medical claim would not know what is wrong with the patient. A healthcare document specialist's job is very important!

Word Meanings

People who work in the medical field often use shorter and simpler meanings of words to save time. As you become more familiar with medical terms, you probably will use simpler meanings also. Sometimes a simpler meaning of a word can be formed by reading the word from beginning to end.

Compare these simpler meanings that were given by an experienced healthcare document specialist to the meanings derived from word parts.

Term	Meaning Derived from Word Parts	Simpler Meaning
thermometer	instrument to measure heat	heat-measuring instrument
paraneural	relating to beside a nerve	next to a nerve
cardiology	the study of the heart	heart specialty
hepatomegaly	enlargement of the liver	liver enlargement

For now, simply start at the end of a word that is new to you. This will help you look for word parts that you recognize and help you give meanings for word parts. This is the easiest way to find word parts and give meanings. As you become more familiar with various word parts, feel free to use simpler meanings.

Now let's examine a few word parts and their meanings. Remember, you may use your flashcards to find word part meanings, and as you learn more word parts, dividing medical terms will become easier!

Word Part	Meaning
bi/	two
/malacia	softening
syn/, sym/	together with
gynec/o	female
sarc/o	nongland tissue, flesh
vit/o	living, alive
chem/o	chemical, drug
meta/	change, beyond
maxill/o	upper jaw
nect/o	bind
/oma	tumor, mass

Before you move on to your first Practice Exercise for this lesson, examine the two boxes that follow. The boxes list common prefixes and suffixes and their meanings. This information will help you as you divide and combine terms.

Prefix	Meaning
a/, an/	absence of, without, no, not
ante/	before
con/	with
contra/	opposite, against
dia/	across, apart, complete knowledge, through
endo/	within, in, inner
post/	after
pro/, pros/	before, forward, in front of
re/	back, behind
sub/	under, below
trans/	across, through, over, beyond

Suffix	Meaning
/al	relating to, pertaining to
/algia	pain
/ectomy	removal, excision
/gnosis	about the patient's condition
/gram	recording, picture
/ic	relating to, pertaining to
/itis	inflammation
/logy	study of
/osis	abnormal condition
/scopy	process of visual examination

Step 4: Practice Exercise 7-1

Part I

On scratch paper, divide each medical term that follows by putting slashes between the word parts, including between root words and combining vowels. Remember, you don't have to divide a combined suffix. For example, *cardi/o/logy* and *cardi/o/log/y* are both correct. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you had to look up on the flashcards. The first word is divided for you.

Part II

Next to each medical term you divided in Part I, write the meaning. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you had to look up on the flashcards. The first answer is provided to get you started.

	Medical Terms	
1.	**cardi/o/megaly**	**enlargement of the heart**
2.	**acromegaly**	
3.	**macroglossia**	
4.	**histology**	
5.	**arthritis**	
6.	**splenomegaly**	
7.	**aleukocytosis**	
8.	**thoracocentesis**	
9.	**gastrectomy**	
10.	**pulmonary**	

Step 5: Review Practice Exercise 7-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Review your flashcards again, giving extra attention to items circled in the Practice Exercise.

Step 6: Pronounce New Word Parts

Follow these steps to learn how to pronounce new word parts.

Audio Exercise

a. Take out your Set 4 flashcards. Access the audio for Set 4.

b. Listen to a word part as it is pronounced. After you hear a word part, pause the player.

c. Look at the word part and practice pronouncing it out loud several times until you can pronounce it correctly and easily. Turn the flashcard over and read the meaning of the word part. Continue with all the terms in Set 4.

d. Next, begin with the Set 4 flashcards and play the audio track again. This time, pronounce each word part in order but do not stop the player after each term. As you pronounce each word part, look at it on the flashcard. Listen to your own pronunciation of each word part. If you mispronounce one, put a check mark next to it.

e. Next, listen again and practice the word parts you mispronounced. Be sure you can pronounce each word part clearly and easily. After you have finished pronouncing all of the terms for Set 4, move on to the next step.

f. Practice the terms you mispronounced by listening again. Be sure you can pronounce the terms clearly and easily.

Step 7: Write New Word Parts

Follow these steps to learn to write new word parts.

a. Using your Set 4 flashcards again, look at the first term and say it out loud. Write this term on blank paper. Be sure to include the slash (/) when you write the term, just like you see it on the flashcard.

b. Turn the card over to Side B and read the meaning out loud. Write the meaning on your blank paper, beside the term. Writing these word parts and meanings will help you learn them more easily. Do this for each flashcard for Set 4. After you have pronounced and written each term, learn the meanings of these word parts in the next exercise.

Step 8: Learn Word Part Meanings

Follow these steps to learn word part meanings.

a. Again, take out your Set 4 flashcards. Pronounce each flashcard term out loud. Before you look at the meaning, see if you can remember it. Check yourself by turning the flashcard over to see the meaning. Do this for each flashcard.

b. Now turn all the flashcards over, so you are looking at Side B. Read the meaning for the first term out loud. Before turning the card over, try to say the medical term that goes with that meaning. Check yourself by turning the card over to Side A and reading the term.

c. Practice with the flashcards several times until you are familiar with the word parts and their meanings. It's not necessary to memorize all the terms now. You will find that you begin to memorize medical terms as you use them throughout this program. Remember to keep your flashcards in order even after you're finished with an activity so you can refer back to them easily. You may use your flashcards for all Practice Exercises and Quizzes. However, the time you spend reviewing the terms now will mean less time spent looking them up later.

Step 9: Practice Exercise 7-2

Part I

For each word part listed, write the meaning on scratch paper. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you had to look up on the flashcards.

Word Parts

1. **carcin/o**
2. **ox/o**
3. **laryng/o**
4. **cerebr/o**
5. **/genesis**
6. **axill/o**
7. **/penia**
8. **/tome**
9. **/tomy**
10. **/oma**

Part II

For each meaning, write the proper word part on scratch paper. Be sure to include the slash. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you looked up on the flashcards.

Meanings

11. **self**
12. **run**
13. **chemical, drug**
14. **with**
15. **change, beyond**

16. **rib**
17. **female**
18. **lower jaw**
19. **brain**
20. **many**

Step 10: Review Practice Exercise 7-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Review your flashcards again, giving extra attention to items circled in the Practice Exercise.

Step 11: Practice Exercise 7-3

Part I

On scratch paper, divide each medical term that follow by putting slashes between the word parts, including between root words and combining vowels. Remember, you don't have to divide a combined suffix. For example, *cardi/o/logy* and *cardi/o/log/y* are both correct. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you had to look up on the flashcards. The first word is divided for you.

Part II

Next to each medical term you divided in Part I, write the meaning. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you had to look up on the flashcards. The first answer is provided to get you started.

	Medical Terms	
1.	**oste/o/malacia**	**softening of bone**
2.	**sarcoma**	
3.	**carcinoma**	
4.	**connect**	
5.	**maxillary**	
6.	**laryngitis**	
7.	**vital**	
8.	**costal**	
9.	**craniotome**	
10.	**chemotherapy**	

Step 12: Review Practice Exercise 7-3

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Review your flashcards again, giving extra attention to items circled in the Practice Exercise.

Step 13: Combining Medical Terms

Combining word parts to form medical terms is just the reverse of dividing medical terms into word parts.

When you learned to divide medical terms, you gained the skill of recognizing long or complicated terms by dividing them into their word parts. Sometimes when doctors dictate, a term may be unclear or incorrect. If you know how to combine word parts, you can put together the correct medical term from its everyday English meaning. This is the reason for learning how to combine medical terms.

Knowing just a few word parts allows you to combine them into many different medical terms. Look at this example of the number of new terms you can form each time you add a new word part to your list.

Word Parts Learned and Terms You Can Form			
Root Words:			
	gastr/o	cyst/o	splen/o
Suffixes:			
/ic	gastric	cystic	splenic
/itis	gastritis	cystitis	splenitis
/ectomy	gastrectomy	cystectomy	splenectomy
			gastrosplenic
Prefixes:			
epi/	epigastric	epicystitis	episplenitis
peri/	perigastric	pericystic	perisplenitis
		pericystitis	

Let's see now. You only needed to learn eight word parts to build 16 medical terms! Not bad. Just stick to the steps and before you know it, you will have learned many word parts the easy way. Word parts, like nickels and dimes, add up fast.

Would you like to see another example of a medical term that is coded? How about gastritis? A patient visits the doctor because he has a stomachache. After examination and testing, the doctor diagnoses him with acute gastritis. You know that the meaning of gastritis is inflammation of the stomach. That sounds painful!

K29.00 Acute gastritis without bleeding

Isn't it fun to see how what you are learning about combining medical terms will later help you assign diagnostic and procedure codes? Keep working hard!

Consonants, Vowels and the Role They Play

Let's go over the important things to remember when combining medical terms. These rules will help you when combining most Latin terms.

Fact About Combining Word Parts

Use a combining vowel between a root word and a suffix that begins with a consonant.

Look at these examples of terms built from their English meanings. Each suffix begins with a consonant. That's why the combining vowel was used.

Meaning	Term with Suffix Beginning with Consonant	Combined Term
tracing of the heart	= cardi/o + /**gram**	= cardi/o/gram
surgical repair of a blood clot	= thromb/o + /**plasty**	= thromb/o/plasty
to cut into the stomach	= gastr/o + /**tomy**	= gastr/o/tomy

Facts About Combining Word Parts

- Do not use a combining vowel between a root word and a suffix that begins with a vowel.
- Do not use a combining vowel between a prefix and a root word.

Look at these examples. The combining vowel is not used.

Meaning	Term with Suffix Beginning with Vowel	Combined Term
blood tumor (lump)	= hemat/o + /**oma**	= hemat/oma
look at living (tissue)	= bi/o + /**opsy**	= bi/opsy
relating to the heart	= cardi/o + /**ac**	= cardi/ac

Fact About Combining Word Parts

Use a combining vowel between two root words in a compound word even when the second root word begins with a vowel.

Look at the following examples. The combining vowel is used between two root words. All of the root words are in boldface type.

Meaning	Compound Word	Combined Term
heart specialist	**cardi**/o/**log**/ist	cardiologist
instrument to measure heat	**therm**/o/**meter**	thermometer
study of the stomach and intestines	**gastr**/o/**enter**/o/logy	gastroenterology
relating to water electrical activity	**hydr**/o/**electr/ic**	hydroelectric

When dividing and combining terms in this course, it's helpful to identify the prefixes and suffixes in addition to the root words. For example:

Meaning	Prefix	Root(s)	Suffix	Medical Term
control blood		hem/o	/stasis	hemostasis
relating to around kidney	peri/	ren/o	/al	perirenal
enlargement of the liver		hepat/o	/megaly	hepatomegaly
inflammation of vessels		angi/o	/itis	angiitis
removal of the spleen		splen/o	/ectomy	splenectomy

Read from the beginning of the term to the end when you are pronouncing a term you have created. And remember, read from the end of the term to the beginning when you are checking the meaning of a term you have created.

Now, let's reinforce what you've learned so far with a few Practice Exercises.

Step 14: Practice Exercise 7-4

For each set of word parts, combine the parts into a medical term using the rules you learned in this lesson. Write the medical term and the meaning on scratch paper.

Word Parts

1. **gastr/o**
   enter/o
   /logy
2. **oste/o**
   /malacia
3. **laryng/o**
   /scope
4. **carcin/o**
   /oma
5. **sarc/o**
   /oid
6. **muc/o**
   /ous
7. **thromb/o**
   /osis
8. **hepat/o**
   /ic
9. **peri/**
   col/o
   /itis
10. **pulmon/o**
    /ic

Step 15: Review Practice Exercise 7-4

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 16: Practice Exercise 7-5

In this Practice Exercise, you will divide the terms and give their meanings. Follow these steps:

a. On scratch paper, make slashes to divide the terms into word parts. Like this: cardi/o/log/ist
b. Write the meaning of the word next to the word. Like this:
cardi/o/log/ist one who specializes in studying the heart
c. You may refer to your flashcards if you need to.

Medical Terms

1. **chemist**
2. **craniotomy**
3. **laryngectomy**
4. **endoderm**
5. **perihepatic**
6. **thrombitis**
7. **subhepatic**
8. **retrogastric**
9. **myeloid**
10. **myopathy**
11. **venous**
12. **natal**
13. **kleptomania**
14. **neurosis**
15. **electric**
16. **arterial**
17. **cystic**

Step 17: Review Practice Exercise 7-5

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 18: Pronounce New Word Parts

Follow these steps to learn how to pronounce new word parts.

Audio Exercise

a. Take out your Set 5 flashcards. Access the audio for Set 5.

b. Listen to a word part as it is pronounced. After you hear a word part, pause the player.

c. Look at the word part and practice pronouncing it out loud several times until you can pronounce it correctly and easily. Turn the flashcard over and read the meaning of the word part. Continue with all the terms in Set 5.

d. Next, begin with the Set 5 flashcards and play the audio track again. This time, pronounce each word part in order but do not stop the player after each term. As you pronounce each word part, look at it on the flashcard. Listen to your own pronunciation of each word part. If you mispronounce one, put a check mark
next to it.

e. Next, listen again and practice the word parts you mispronounced. Be sure you can pronounce each word part clearly and easily. After you have finished pronouncing all of the terms for Set 5, move on to the next step.

f. Practice the terms you mispronounced by listening again. Be sure you can pronounce the terms clearly and easily.

Step 19: Write New Word Parts

Follow these steps to learn to write new medical terms.

a. Using your Set 5 flashcards again, look at the first term and say it out loud. Write this term on blank paper. Be sure to include the slash (/) when you write the term, just like you see it on the flashcard.

b. Turn the card over to Side B and read the meaning out loud. Write the meaning on your blank paper, beside the term. Writing these word parts and meanings will help you learn them more easily. Do this for each flashcard for Set 5. After you have pronounced and written each term, learn the meanings of these word parts in the next exercise.

Step 20: Learn Word Part Meanings

Follow these steps to learn the meanings of word parts.

a. Take out your Set 5 flashcards. Pronounce each flashcard term out loud. Before you look at the meaning, see if you can remember it. Check yourself by turning the flashcard over to see the meaning. Do this for each flashcard.

b. Now turn all the flashcards over, so you are looking at Side B. Read the meaning for the first term out loud. Before turning the card over, try to say the medical term that goes with that meaning. Check yourself by turning the card over to Side A and reading the term.

c. Practice with the flashcards several times until you are familiar with the word parts and their meanings. It's not necessary to memorize all the terms now. You will find that you begin to memorize medical terms as you use them throughout this program. Remember to keep your flashcards in order even after you're finished with an activity so you can refer back to them easily. You may use your flashcards for all Practice Exercises and Quizzes. However, the time you spend reviewing the terms now will mean less time spent looking them up later.

Step 21: Practice Exercise 7-6

Part I

On scratch paper, write the meaning for each word part that follow. Use your flashcards for items that you don't know. Circle any items you looked up on the flashcards.

Word Parts

1. **lapar/o**
2. **pneum/o**
3. **ana/**
4. **/physis**
5. **/pnea**
6. **bronch/o**
7. **cutane/o**
8. **mort/o**
9. **psych/o**
10. **phob/o**

Part II

Write the correct word part for each meaning that follow on scratch paper. Be sure to include the slash. Use your flashcards for items that you don't know. Circle any items you looked up on the flashcards.

Meanings

11. **break down, dissolve**
12. **bad, labored**
13. **nose**
14. **bear**
15. **secrete**
16. **ear**
17. **eye**
18. **kidney**
19. **tonsils**
20. **flow**

Step 22: Review Practice Exercise 7-6

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Review your flashcards again, giving extra attention to any items circled in the Practice Exercise.

Step 23: Lesson Summary

Previously, you saw that medical terms are constructed of root words, prefixes and suffixes. By learning these word parts, you can divide a medical term into its word parts and derive its meaning. You can take an unfamiliar medical term, separate its root word from any prefixes or suffixes, and determine what that word means. This is important because you cannot—and should not—memorize every single medical term healthcare providers use. But you can learn to divide and combine medical terms, and this skill will enable you to become a competent, professional healthcare document specialist. You'll be able to break up unfamiliar medical terms so that you can look them up in your medical dictionary and coding manuals to determine the correct spelling and meaning.

Now don't get discouraged if you found this lesson a little challenging. The Practice Exercises in this lesson are important. If you skipped any or struggled to complete some of them, go back and work on them again. Doing so only will help you with the upcoming Quiz. Thousands of men and women have successfully graduated from our programs, and we want you to be one of these success stories! If you need a helping hand, call your instructor. And remember that we offer support even after you graduate and as you advance in your new career.

Step 24: Quiz 5

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Lesson 8
Medical Abbreviations, Symbols and Special Terms

Step 1: Learning Objectives for Lesson 8

When you have completed the instruction in this lesson, you will be trained to:

- Recognize common medical abbreviations.
- List and explain common symbols.
- Describe eponyms and acronyms.
- Differentiate between terms that sound alike.
- Determine terms that are opposites.
- Convert singular medical terms to plurals, and recognize medical plurals.

Step 2: Lesson Preview

Imagine you run into a good friend who has a hard time keeping in touch with his family. When you ask him, "Did you write that e-mail to your brother?" he shakes his head no. Now look closely at the question you asked. The sentence, "Did you write that e-mail to your brother?" illustrates the complexity of the English language.

Your question contained three *sound-alikes*—the words *you*, *write* and *to* sound the same as other words (*ewe*, *right* or *rite*, and *too* or *two*). *Sound-alikes*, *medical plurals* and *opposites* are just three types of medical terms we'll cover in this lesson. *You* (not *ewe*) also will learn some common medical *abbreviations* and *symbols*.

As a healthcare professional, you will often encounter terms that may sound or look alike, such as hypertension and hypotension. Not only do these terms sound alike, but they're also opposites. Hypertension refers to high blood pressure, and hypotension refers to low blood pressure. It will be your job to determine if the term you see is, indeed, the correct term. Additionally, as you'll soon find out, healthcare providers use many abbreviations and symbols. It seems only natural since many medical terms are long and complex! If you are familiar with these abbreviations and symbols, you'll easily be able to convert them into the correct medical terms so that you can code them properly.

It's amazing how much you already know about medical terminology from the previous two lessons. This new information will allow you to build on that knowledge and understand all the facets of your new career in the healthcare profession. Healthcare providers will appreciate your knowledge. So let's get started with this lesson about special terms!

Step 3: Abbreviations

Doctors frequently use shortened versions of longer words or phrases. These shortened versions of words and phrases are called **abbreviations**. Abbreviations are extremely useful to a doctor because they save valuable time. However, abbreviations are not helpful unless you, the healthcare document specialist, can determine the names for the procedures the doctor performed. Because it is important to be completely accurate, doctors and hospitals get together and produce lists of approved abbreviations—abbreviations they all agree on and understand.

Abbreviations in Hospitals

The Joint Commission is an independent, not-for-profit organization that regulates hospitals and other healthcare facilities. Hospitals are required by The Joint Commission to keep a list of acceptable abbreviations and their meanings. Only the accepted abbreviations may be used in the medical records for that hospital.

Office Records

The rules for abbreviations are more relaxed for the records in individual offices. However, any bills or insurance forms that are typed must follow the hospital's list of abbreviations.

Doctors

Doctors sometimes have their own personal abbreviations. As a healthcare document specialist, you will need to learn these personal abbreviations. This will help you communicate more effectively with your clients or employer.

Pharmacies

Lists of medications and treatments that a pharmacy prepares are included in the medical bill, and they appear on the insurance forms filed by the doctor's office or hospital. Usually Latin abbreviations are used for these medications and treatments.

On your flashcards, beside each Latin lower case abbreviation you will see the full Latin phrase. You will not need to learn the Latin words—just the punctuation and the everyday meaning.

Step 4: Learn Abbreviations

Follow these steps to learn how to write abbreviations.

a. Using your Set 6 flashcards, look at the first term and say it out loud. Write this term on blank paper.

b. Turn the card over to Side B and read the meaning out loud. Write the meaning on your blank paper, beside the term. Writing these abbreviations and meanings will help you learn them more easily. Do this for each flashcard in Set 6. After you have pronounced and written each term, learn the meanings of these abbreviations in the next exercise.

Step 5: Meanings of Abbreviations

Follow these steps to learn how to write abbreviations.

a. Take out your Set 6 flashcards. Pronounce each flashcard term out loud. Before you look at the meaning, see if you can remember it. Check yourself by turning the flashcard over to see the meaning. Do this for each flashcard.

b. Now turn all the flashcards over, so you are looking at Side B. Read the meaning for the first term out loud. Before turning the card over, try to say the abbreviation that goes with that meaning. Check yourself by turning the card over to Side A and reading the term.

c. Practice with the flashcards several times until you are familiar with the abbreviations and their meanings. It's not necessary to memorize all the terms now. You will find that you begin to memorize medical terms as you use them throughout this program. Remember to keep your flashcards in order even after you're finished with an activity so you can refer back to them easily. You may use your flashcards for all Practice Exercises and Quizzes. However, the time you spend reviewing the terms now will mean less time spent looking them up later.

Step 6: Practice Exercise 8-1

For each abbreviation or acronym that follow, write the meaning on scratch paper. Do all the items you know first. Then, use your flashcards for items that you don't know. Circle the items you had to look up on the flashcards.

Abbreviation/Acronyms

1. **CO_2**
2. **mg**
3. **O_2**
4. **n.p.o.**
5. **NBS**
6. **EBV**
7. **kg**
8. **TPR**
9. **IM**
10. **q.n.s.**
11. **b.i.d.**
12. **DOB**

13. **Dx**

14. **IV**

15. **stat**

16. **q.a.m.**

17. **GB**

18. **Sx**

19. **Rx**

20. **FUO**

Step 7: Review Practice Exercise 8-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Pay particular attention to any items you have circled.

Step 8: Slang

There are two types of *slang* you may encounter in the medical field—medical slang and English slang.

Medical Slang

Medical slang words are informal abbreviations for longer medical terms. For example *sedimentation rate* is called *sed rate*. The *laboratory* is the *lab*. Doctors use medical slang frequently for the same reason they use abbreviations—to save time.

Fact About Medical Slang

If you encounter slang on a medical form, use the full term the slang represents. For example: If the doctor wrote, "The patient was prepped for appy," you would know to code for an appendectomy.

Some medical slang terms are used so frequently that they become accepted medical terms. Exam and prep are two examples of this.

Let's tie this in to a previous lesson on medical insurance. What code would you use for appendectomy? An appendectomy is a surgical procedure and is coded from a different manual than a diagnosis. The code would look like this:

44950 Appendectomy

This code would be entered on the claim form to tell the insurance company exactly what procedure the doctor performed for the patient. Remember, the diagnosis is the reason the patient sees the doctor, and the procedure is what the doctor decides to do to help the patient.

English Slang

English slang words are highly informal words not often used in professional writing.

Facts About English Slang

Obscene or offensive statements are never put in any medical report, including patient files, insurance forms and patient charts, unless the patient is being quoted (in this case, use quotation marks around the quoted statement). If the patient is not being quoted, the offensive or obscene statement would be deleted.

- Correct: The patient said, "I fell down and hurt my ass."
- Incorrect: The patient is a pain in the ass. (Leave out this entire sentence.)

Step 9: Write Slang Terms

Follow these steps to learn how to write slang terms.

a. Take out your Set 7 flashcards. Look at each slang term and say it out loud. Write each slang term on blank paper.

b. Turn the flashcard over and read the meaning out loud. Write the meaning beside each slang term. Writing these slang terms and meanings will help you learn them more easily. Do this for each term for Set 7. After you have pronounced and written each term, learn the meanings of these slang terms in the next step.

Step 10: Learn Slang Term Meanings

Follow these steps to learn slang term meanings.

a. Take out your Set 7 flashcards. Pronounce each slang term out loud. Before you look at the meaning, see if you can remember it. Check yourself by turning the flashcard over to see the meaning. Do this for each term for Set 7.

b. Now turn your Set 7 flashcards over so you can see the meanings of the slang terms. Read each meaning out loud. Before you look, see if you can remember the slang term that goes with that meaning. Check yourself by turning the flashcards over to see the slang terms. Do this for each term in Set 7.

c. Practice with the flashcards several times until you are familiar with the slang terms and their meanings. It's not necessary to memorize all the terms now. You will find that you begin to memorize slang terms as you use them throughout this program. Remember to keep your flashcards in order even after you're finished with an activity so you can refer back to them easily. You may use your flashcards for all Practice Exercises and Quizzes. However, the time you spend reviewing the terms now will mean less time spent looking them up later.

Step 11: Practice Exercise 8-2

Match the slang words with the medical terms for which they stand. Write your answers on scratch paper.

1.	**sibs**	a. medications
2.	**prep**	b. nullipara, woman with no deliveries
3.	**meds**	c. pathology
4.	**ab**	d. siblings, brothers and sisters
5.	**exam**	e. abortion
6.	**path**	f. primipara, woman with one previous birth
7.	**appy**	g. temperature
8.	**primip**	h. prepare, preparation
9.	**nullip**	i. appendectomy, appendicitis
10.	**temp**	j. examination

Step 12: Review Practice Exercise 8-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 13: Symbols

The **symbols** used in medicine are no different from those used in everyday life. When you use symbols, you must be sure the symbol is well known. To give you a better understanding of which symbols are acceptable, we will go through the main rules you need to remember.

Facts About Using Symbols

- When you use symbols, do not leave a space between the symbol and the numeral.
- However, do leave a space between a numeral and the symbol x. This symbol means "by" in dimensions, as in 6 x 9.
- In addition, you do leave a space between the numeral and degree sign but do not leave a space between the degree sign and the C or F.

Let's take a look at the following list of symbols, what they mean, and how they are used.

Symbol	Meaning	Example
°C	degrees Celsius	32 °C
°F	degrees Fahrenheit	98.6 °F
&	and (between capital letters only)	D&C
x	times, by	x 3 days, 2 x 3 x 5
+	plus (urine; reflexes)	3+
:	ratio; ___ to ___	1:2
/	per, vision test	2/day; 20/20
/	over (blood pressure)	120/80
–	minus, ___ to ___ (range), through	–2, 4–5, II–XII
-	suture size	3-0 (000) silk
#	number	#16 Fr, #3-0 silk

Step 14: Practice Exercise 8-3

Write the appropriate symbol for each term on scratch paper. You may refer to the list of symbols in Step 13.

1. **temperature (Celsius or Fahrenheit)**
2. **number**
3. **suture size**
4. **over (blood pressure)**
5. **and (between capitals)**
6. **minus**
7. **vision**
8. **ratio**

Step 15: Review Practice Exercise 8-3

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 16: Special Terms

In medical terminology, just as in the rest of the English language, there are *special terms* that have specific rules. These **special terms** include proper nouns and other capitalized words, sound-alikes and opposites. Now you will discover which words require special treatment, such as capitalization. You also will learn about two special classes of terms: *eponyms* and *acronyms*.

Eponyms

In addition to the medical terms you learned to combine and divide in previous lessons, medical reports contain other information, such as laboratory test results, special medical abbreviations and the names of medical equipment and procedures. Often these words include **proper names**—brand names or the names of people. You must capitalize proper names.

It was the custom in the past to use a person's name to identify the medical inventions or discoveries. The kinds of things named for people include:

- a new disease; a symptom or sign of disease
- an anatomical structure
- a new instrument, test or examination method

An **eponym** is a term that is formed from a person's name. The person's name is given to the name of his or her discovery or invention to indicate that person did the research and made the discovery. One example is *Bell palsy*.

Fact About Eponyms

An eponym has two parts:

1. The person's name as an adjective.
2. The type of invention or discovery as a noun.

Eponym Adjective	Eponym Noun	Meaning
Bell	palsy	facial paralysis
Pott	clamp	surgical instrument
Chiba	needle	long biopsy needle
McBurney	point for the appendix	examination location
Kaposi	sarcoma	unusual skin cancer

Because an eponym includes a person's name, you won't be able to divide it into medical word parts. You do, however, capitalize the proper name in the term, but not the noun.

If you use an eponym frequently enough, you probably will memorize how it is spelled. Otherwise, you will have to look in a medical dictionary for the proper spelling of eponyms.

Because it is difficult to remember the meanings of eponyms, it is becoming less common for medical discoveries or inventions to be named for people. It is now considered more professional to use a properly combined medical term rather than an eponym. Nonetheless, doctors use eponyms frequently.

Brand Names

In the past, an eponym told you the name of the person who took credit for a discovery or an invention. Some names of medical products indicate that a company owns the patent for an invention or discovery. **Brand names** are like eponyms because they demonstrate who discovered the procedure, diagnosis or disease. The kinds of new brand name eponyms you see today are for the following:

- a genetic cell line or tissue culture product
- equipment or instruments
- drugs or therapy methods

Don't worry if you can't pronounce some eponyms. All you need to be able to do is to find the correct spelling in the dictionary. Before you move on to *acronyms*, let's take one more look at some common eponyms.

Common Eponyms

Babkin reflex

Cantor tube

Charcot syndrome

Colles fracture

Cooley anemia

Epstein-Barr virus

Erb palsy

Gordon reflex

Halsted suture

Hodgkin disease

Hodgkin sarcoma

Kaposi sarcoma

Laennec cirrhosis

Legg disease

McBurney point

Miller-Abbott tube

Pauley point

West Nile virus

Acronyms

An **acronym** is a word formed using the initials from a group of words or from word parts. Here are some acronyms you probably already know:

Acronym	Stands for
IRS	Internal Revenue Service
USA	United States of America
DMV	Department of Motor Vehicles

Acronyms are a special kind of abbreviation. Doctors use acronyms because they save time. Instead of writing the very long names of some diseases and procedures, the doctor simply uses the acronym. Here are some examples of some common medical term acronyms.

Medical Term or Phrase	Acronym
cardiopulmonary resuscitation	CPR
complete blood count	CBC
electrocardiogram	EKG or ECG

Acronyms are formed by taking the first letter of each word in a phrase or by taking the first letter of the word parts. For example, FTD stands for **F**lorist **T**elegraph **D**elivery, and NG stands for **n**asogastric. Not every word in the phrase has to be represented in the acronym. Small, nonessential words are usually omitted. For example, EENT stands for eye, ear, nose *and* throat.

Acronyms usually are pronounced by saying the letters one by one. However, if the letters of the acronym spell a word or can be pronounced as a word, then the acronym may be pronounced as if it were a word. Let's take a look at a few examples.

Acronym	Pronounced
EEG	Say the letters—Ee-ee-gee
ELISA	Pronounce the word—El-ee-sah

In fact, some acronyms that are pronounced like words actually become words if they are used often enough. The word laser began as an acronym for the phrase Light Amplification by Stimulated Emission of Radiation. No one bothers to say the whole phrase anymore because laser is an accepted word. The same is true of the word scuba, which stands for self-contained underwater breathing apparatus.

Fact About Acronyms

Write acronyms in capital letters with no periods or spaces between the letters. For example, CBC stands for complete blood count, and NSVD stands for normal spontaneous vaginal delivery.

When you hear a new acronym, to find out what it stands for, be sure to look it up. This helps you write, type and spell acronyms correctly. Most common acronyms can be found in a medical dictionary.

Step 17: Practice Exercise 8-4

Let's practice forming acronyms. Listed are complete medical phrases. Write the correct acronym for each phrase on scratch paper. Notice how the acronym is formed by taking the initials of the words or word parts in the phrase.

Medical Phrases

1. **blood urea nitrogen**
2. **white blood count**
3. **Venereal Disease Research Laboratory**
4. **rheumatoid arthritis**
5. **human immunodeficiency virus**
6. **Physician's Desk Reference**
7. **(The) pupils (are) equal, round (and) reactive (to) light (and) accommodation**
8. **electr/o/encephal/o/gram**
9. **eye, ear, nose (and) throat**
10. **intra/muscular**

Step 18: Review Practice Exercise 8-4

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 19: Pronounce Acronyms

Follow these steps to learn how to pronounce acronyms.

Audio Exercise

a. Take out your Set 8 flashcards. Find the first flashcard. Access the audio for Set 8 flashcards.

b. Listen to an acronym as it is pronounced. After you hear an acronym, put the player on pause.

c. Look at the acronym and practice pronouncing it out loud several times until you can pronounce it correctly and easily. Turn the flashcard over and read the meaning of the acronym. (You do not need to memorize the meaning of an acronym—only be able to form it and look up its meaning on the flashcard.) Continue with all the terms in Set 8.

d. Next, begin with Set 8 flashcards and play the audio track again. This time, pronounce each acronym in order but do not stop the player after each term. As you pronounce each acronym, look at it on the flashcard. Listen to your own pronunciation of each acronym. If you mispronounce one, put a check mark next to it.

e. Next, listen again and practice the acronyms you mispronounced. Be sure you can pronounce each acronym clearly and easily. After you have finished pronouncing all of the acronyms in Set 8, move on to the next step.

f. Practice the terms you mispronounced by listening again. Be sure you can pronounce the terms clearly and easily.

Step 20: Sound-alikes and Opposites

Two types of word pairs occasionally may present challenges for the healthcare document specialist. They are *homophones* and *antonyms*.

Homophones (Sound-alikes)

At the beginning of this lesson, we called the words "to" and "too" sound-alikes. Well, the more technical term for words that sound alike is **homophone**. These words are not spelled alike, and they have different meanings, but when homophones are pronounced, they sound the same. The English language is full of homophones. Look at these examples:

- principle—principal
- seen—scene
- two—too
- meddle—medal

As you can see, each of these four pairs of words looks different, but they sound the same. As you work with medical records, doctors and insurance companies, be careful that you distinguish between homophones when you hear information. You certainly wouldn't want to meddle in the business's principle scene when you really needed to know if the principal had seen the medal. Okay, so that's a stretch, but you get the idea!

Antonyms (Opposites)

Antonyms are words or word parts that have opposite meanings. Sometimes these words sound similar to each other, which can cause problems for someone with no training. Let's take a look at these two antonyms:

- hypotension (low blood pressure)
- hypertension (high blood pressure)

In your work as a healthcare document specialist, make sure the terms you see used make sense. Did the doctor mean what he wrote? If you have a question, call the doctor's office and check. Insurance companies will deny claims for inaccurate codes!

Consider the following situation. If you know that normal blood pressure is 120/80, which term below is correct?

- The patient has *hypertension* with a blood pressure of 90/60.
- The patient has *hypotension* with a blood pressure of 90/60.

In this context, *hypotension* is correct because 90/60 is lower than 120/80.

The codes for hypotension and hypertension are different. You can see by the following example how important it is to pay attention to the medical terms and interpret the information in the coding manuals correctly.

I95.9 Hypotension

I10 Hypertension

Step 21: Practice Exercise 8-5

Some of the more common antonym pairs follow. You already practiced their meanings with your flashcards. Write the meaning of each term on scratch paper. Refer back to your flashcards if you need to do so.

1. **micro/**
   macro/
2. **ante/**
   retro/
3. **pre/**
   post/
4. **hypo/**
   hyper/
5. **eu/**
   dys/
6. **con/**
   contra/
7. **tachy/**
   brady/
8. **ana/**
   cata/
9. **ab/**
   ad/

10. **infra/**
    supra/

11. **/malacia**
    /sclerosis

12. **a/**
    (*not using this prefix is the antonym*)

13. **endo/**
    ecto/

Step 22: Review Practice Exercise 8-5

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 23: Medical Plurals

Many medical terms follow special medical plural rules. Some medical words even have two plural forms, one which follows the normal English rule and one which follows the medical rule. When there are two ways to make a medical term plural, generally doctors use English rules when dictating reports for patients or other non-medical people, and they use medical rules when reports go to other doctors or into the medical chart. Since medical plurals and English plurals sound very different, it will be easy for you to tell which rule the doctor is following.

Medical Rules for Plurals

In some cases, medical plurals are formed by changing suffixes. In other cases, letters in the root word must be changed in addition to changes in the suffix. The following chart shows you how to form medical plurals. Follow this chart to form medical plurals.

Ending With	Change To	Example
/um	/a	medi/um—medi/a (mee-dee-uh)
/us	/i	calcul/us—calcul/i (cal-cue-lie)
/a	/ae	lamin/a—lamin/ae (lam-in-ee)
/is	/es	diagnos/is—diagnos/es (dy-ag-no-seez)
/itis	/itid/es	arthr/itis—arthr/itid/es (ar-thrit-a-deez)
i/on	i/a	criteri/on—criteri/a (cry-teer-ee-ah)
ax	ac/es	thorax—thorac/es (thore-a-seez)
ix	ic/es	cervix—cervic/es (serv-eh-seez)
ex	ic/es	index—indic/es (in-deh-seez)
yx	yc/es	calyx—calyc/es (kay-luh-seez)

Step 24: Practice Exercise 8-6

In this exercise, let's practice forming plurals using the medical rules you just learned and some of the terms you used previously in this course. All of the terms in this Practice Exercise follow the medical plural rules we gave you. You do not need a dictionary to do this exercise.

Look at each word and write the medical plural of each word on scratch paper.

Singular Medical Terms

1. **synthesis**
2. **centrum**
3. **vena**
4. **nervus**
5. **ganglion**

Step 25: Review Practice Exercise 8-6

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 26: Lesson Summary

Congratulations! You've almost completed the last of three lessons that have introduced you to the language of medicine—medical terminology you need to effectively and professionally perform your job as a healthcare document specialist. You learned about word parts (root words, prefixes and suffixes), and how to divide and combine a medical term and derive its meaning using its word parts. In this lesson, you discovered how to use abbreviations and symbols in your work. This lesson also presented information about such special medical terms as eponyms, acronyms, homophones (sound-alikes), antonyms (opposites) and plurals.

Now that you have learned the essential building blocks of medical terminology, you're one step closer to your goal of becoming a healthcare document specialist. All of this knowledge will make your healthcareer career that much easier. You'll be able to figure out and research complex or unfamiliar medical terms, abbreviations and symbols so that you can transcribe and edit reports and assign the correct code to medical records. Remember that healthcare providers view those codes as extremely valuable information. Without them, without you, healthcare providers could not get reimbursed. Nor could government healthcare agencies track serious or terminal illnesses, which in turn leads to research funding dollars that help save lives!

Are you ready to move on? Take a few moments to review your lesson, and good luck on the Quiz!

Step 27: Quiz 6

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Lesson 9
Ethics and Legal Issues

Step 1: Learning Objectives for Lesson 9

When you have completed the instruction in this lesson, you will be trained to:

- Explain the importance of confidentiality in the healthcare profession.
- Describe the concept of ethics.
- Outline the main purposes of the federal HIPAA regulations.
- Explain fraud, and determine some common fraudulent situations that you must avoid.
- Explain the development of and need for Recovery Audit Contractors.
- Discuss the basic ideas surrounding liability and malpractice, including insurance coverage.

Step 2: Lesson Preview

Legal issues include confidentiality and ethics—concepts you need to keep in mind always. No matter how well you do your job as a healthcare document specialist, you must also be ethical. A big part of that code of ethics is ensuring that a patient's private health information remains private.

Patients depend on workers in the healthcare field to protect their privacy from creditors, employers, insurers and others. If an employer learns of a potential employee's family history of diabetes, would the employer refuse to hire the person? Would a life insurance company that learned of a client's transfer to hospice care find a loophole to terminate coverage? Questions like these are certainly on the minds of many people today.

Step 3: Confidentiality

Do you remember the last time that you went to the doctor? Even if it was just a regular check up, you wouldn't want your doctor to discuss your appointment at dinner with his friends, would you? As a healthcare professional, you have access to many medical records. It is essential that you understand that these records are *confidential*.

When something is **confidential**, it means that it is kept secret. Confidentiality goes hand in hand with *ethics*, which will be detailed shortly. You have learned a bit about medical records, and you've probably guessed that because of their sensitivity, these records are confidential. That means you can only release them to authorized persons. A medical facility must consider a wide range of factors to ensure confidentiality of patient records. These factors include:

- hiring trustworthy, responsible staff;
- ensuring information stored on computerized systems is secure and available only to authorized individuals; and
- having standardized, secured procedures in place for transferring patient information within the facility, between facilities and to outside individuals.

Guidelines for Confidentiality of Medical Records

Beginning with the people it employs, a hospital, physician's office or other healthcare facility must ensure that sensitive patient information is only accessible to reliable people. It's important that all the policies and procedures that relate to confidentiality and release of all medical records be written down and available for reference.

Review the following security procedures that help ensure confidentiality of medical records and information:

- Employees are prohibited from working on records of acquaintances.
- New employees are required to sign confidentiality pledges before they can access confidential information, and a system must be in place to ensure that such statements are signed.
- Security procedures are in place for accessing medical record storage areas that aren't under continuous supervision by authorized staff.
- All computerized patient information must only be accessible with a unique password, and information system users must not share their passwords.
- A written plan is developed to deal with suspected breaches of confidentiality.
- All physicians who use the computer system should agree, in writing, to keep their ID codes confidential and be responsible for authenticating their dictation.

Guidelines for Faxing Medical Records

In addition to following the guidelines previously mentioned, it is important to guard against unauthorized access to records in situations where a fax machine is used. Even if the information is sent to an authorized person, it is possible for someone else to receive the information. Procedures that help ensure the confidentiality of faxed medical records include the following:

- Always follow the rules set out by the provider or client with whom you are working. If there is a policy that prohibits sending records by fax, then do not do it. If there are no such restrictions, follow the next guideline.

- Always have an original release form on file before sending any patient records via fax. Do not accept a faxed copy of a patient release form; although the form appears to be signed, you have no way of knowing if that signature is valid because you are looking at a copy of the form and not the form itself.
- Send faxes only to a secure fax machine. This means you have to verify with the receiving person that the fax either will be picked up immediately or that the fax is in a secure area away from people who are not authorized to see what you are sending.
- Never send sensitive test information via fax. This includes HIV and pregnancy test results.
- Always use a fax cover sheet. The cover sheet must list your name, company name, telephone number, fax number and the number of pages sent.

Now that you have a better understanding of the sensitivity of medical records, let's talk about being ethical.

Step 4: Medical Ethics

Medical ethics include confidentiality, accuracy, integrity and completeness of medical records and the proper storage of these records. Medical ethics also involve guarding against fraud and misleading claims.

Being ethical means that you strive to do what's right and that you are dependable and trustworthy. As a healthcare document specialist, you will have access to confidential information regarding patients, physicians, insurance companies and government insurance programs. Handling this information correctly and appropriately establishes your credibility and level of professionalism. To work in the medical field, you must maintain your credibility and have a very high level of professionalism.

Most organizations have a **code of ethics**, which is a document that outlines specific ethical guidelines. This statement usually is posted where it easily can be read and lists specific behaviors and efforts that members or employees are expected to uphold. A code of ethics helps the employees of a company know what is expected of them but also helps patients or consumers relax and know that they are dealing with a credible, responsible office or business. Take a look at the sample code of ethics from the American Academy of Professional Coders that follows.

Code of Ethical Standards

Commitment to ethical professional conduct is expected of every AAPC member. The specification of a Code of Ethics enables AAPC to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members. This document establishes principles that define the ethical behavior of AAPC members. All AAPC members are required to adhere to the Code of Ethics and the Code of Ethics will serve as the basis for processing ethical complaints initiated against AAPC members.

AAPC members shall:

- Maintain and enhance the dignity, status, integrity, competence, and standards of our profession.
- Respect the privacy of others and honor confidentiality.
- Strive to achieve the highest quality, effectiveness and dignity in both the process and products of professional work.
- Advance the profession through continued professional development and education by acquiring and maintaining professional competence.
- Know and respect existing federal, state and local laws, regulations, certifications and licensing requirements applicable to professional work.
- Use only legal and ethical principles that reflect the profession's core values and report activity that is perceived to violate this Code of Ethics to the AAPC Ethics Committee.
- Accurately represent the credential(s) earned and the status of AAPC membership.
- Avoid actions and circumstances that may appear to compromise good business judgment or create a conflict between personal and professional interests.

Adherence to these standards assures public confidence in the integrity and service of medical coding, auditing, compliance and practice management professionals who are AAPC members.

Failure to adhere to these standards, as determined by AAPC's Ethics Committee, may result in the loss of credentials and membership with AAPC.

Source: AAPC Code of Ethics: http://www.aapc.com/AboutUs/code-of-ethics.aspx 4 September 2013

Confidentiality and ethics go hand in hand with the *Health Insurance Portability and Accountability Act*, which you'll learn about next. You'll learn who must abide by the act, the details of the act and how the act applies to you as a healthcare document specialist.

Step 5: Health Insurance Portability and Accountability Act

In 1996, Congress enacted the **Health Insurance Portability and Accountability Act** (**HIPAA**). This bill has two main objectives. The first objective is **portability**, which is to ensure the continuation of health insurance coverage for workers and their families during times of job change or loss. The second, **accountability**, is to increase the effectiveness of the healthcare system while protecting health data integrity, confidentiality and availability, as well as preventing fraud and abuse.

The **Health Information Technology for Economic and Clinical Health** (**HITECH**) **Act**, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology.[1] HIPAA (as modified by the HITECH Act of 2009) requires compliance to privacy standards and security in the maintenance and electronic exchange of administrative and financial healthcare information.

Many experts call HIPAA the most sweeping healthcare legislation in years. Its provisions touch nearly everyone who works in health care. Providers, payers and clearinghouses—anyone who deals with confidential patient information is affected.

The different sections of HIPAA are known as **titles**. It is Title II, Subtitle F that is probably the most important to the healthcare professional. This part is called the *Administrative Simplification Compliance Act.* When healthcare professionals talk about HIPAA and being HIPAA compliant, they are usually referring to this section. The **Administrative Simplification Compliance Act** (**ASCA**) sets up nationally consistent regulations in four main areas:

- Transaction and Code Sets Standards
- Privacy Standards
- Security Standards
- Unique Identifier Standards

You'll examine each of these standards in more detail and explain how it affects you as a healthcare document specialist, but first let's look at who must follow HIPAA regulations.

Covered Entities

Those that must follow HIPAA regulations are called *covered entities*. **Covered entities** include health plans, healthcare clearinghouses and healthcare providers who transmit any health information in electronic form. A healthcare professional who is a member of the covered entity's workforce is also known as a covered entity.

However, a healthcare document specialist who is, for example, an independent medical transcriptionist providing transcription services to a physician is not a covered entity, but a *business associate*. A **business associate** is a person that performs, or assists in the performance, of a function or activity involving the use or disclosure of individually identifiable health information. This includes claims processing or administration, data analysis, utilization review, quality assurance, billing, benefit management and practice management.[2] The contract between a covered entity and a business associate must contain specific elements describing the permitted and required uses of protected health information. A sample business associate contract can be found at the Department of Health and Human Services Web site at www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html.

Now that you know who must comply with HIPAA, let's look at the rules that covered entities and their business associates must follow. Keep in mind that when covered entities are referred to, it's assumed that business associates are included in the rule, as well, due to the contract between covered entities and business associates.

Transaction and Code Sets Standards

According to HIPAA, a **transaction** is an *electronic* exchange involving the transfer of information between two parties for a specific purpose.[3] A transaction is **electronic** if it is transmitted with an electronic medium, which includes Internet, Extranet, leased lines, dial-up lines and private networks. Information physically moved from one location to another with storage media, such as magnetic tapes, disks or CDs, is also considered an electronic transaction. Telephone voice response or faxback systems are not electronic transactions, according to HIPAA.

Transaction and Code Sets Standards simply outline the format and codes used for electronic transmissions. At one time, there were about 400 formats for electronic health claims being used in the United States. This lack of standardization made it difficult and expensive to develop and maintain software to process claims. Today, it's required that all covered entities doing business electronically use the same transactions and code sets. Let's look at the standard code sets first.

Under HIPAA, specific code sets were adopted for diagnoses and procedures to be used in all healthcare transactions. These code sets include *HCPCS* (ancillary services/procedures), *CPT* (physician services/procedures), *CDT* (dental terminology), *ICD-9* (diagnoses and hospital inpatient procedures), *ICD-10-CM* (diagnosis), *ICD-10-PCS* (inpatient procedures) and *NDC* (National Drug Codes). You'll become more familiar with the *HCPCS*, *CPT* and *ICD-10-CM* coding manuals later in the healthcare document specialist program. For now, it's just important to know that these are the recognized code sets used in the industry.

Now, let's look at the standard transactions. You've learned about the CMS-1500 and UB-04 claim forms; however, when claim information is transmitted electronically, it's not submitted in the same format as you see on the paper claim. **Electronic data interchange** (**EDI**) is the electronic transfer of information in a standard format between trading partners. Basically, EDI is the process of the healthcare document specialist submitting a claim electronically in a standard format to an insurance company for reimbursement for the provider's services. Here is an example of a claim submitted to an insurance carrier for Robert Daly seen at the Medical Care Center:[4]

Header
ST*978*123456~
BLB*0012*00*Z98765*20120801*1800~
Loop 100A – Submitter Name
NM1*27*2*MEDICAL CARE CENTER******97*0665544004
Loop 1000B – Receiver Name
NM1 BLUE CROSS OF NE *****97*12000~
Loop 2000A – Service provider Name for Medical Care Center
NM1*92*1*MEDICAL CARE CENTER*****12*0665544004
REF*2J*121212~
Loop 2010BA – Subscriber (Patient) for Robert Daly
NM1*DALY*ROBERT*
N3*1920 JOHNSON BLVD
N4*YOURTOWN*CO*80000~
D8*20000212*M**

Wow! That looks like gibberish, doesn't it? As a healthcare document specialist, it's not your responsibility to understand, describe or maintain this information. You simply need to know that the claim information you send to an insurance carrier is not transmitted in the same format as the paper CMS-1500 or UB-04 claim forms but in a standard form that HIPAA requires.

Finally, it's helpful to recognize the terminology associated with these electronic transactions. Since October 16, 2003, all healthcare businesses that submitted claims electronically have been required to use version 4010. In 2012, **version 5010** replaced version 4010 with improvements, such as correcting technical issues, accommodating new business needs and eliminating inconsistencies in reporting requirements.

All of this technical information may seem overwhelming to you. However, keep in mind that it's not the specifics that you need to know, but the big picture. There are standards in the healthcare industry. These standards define the codes you use, the forms you complete and how information is submitted electronically. You may hear the term 5010 in your work, and now you know that 5010 refers to the current standard version of electronic transmissions!

Privacy Rule

The HIPAA **Privacy Rule** establishes national standards to protect individuals' medical records and other personal health information that applies to covered entities.[5] The Privacy Rule addresses the use and disclosure of a patient's *protected health information*. **Protected Health Information** (**PHI**) is individually identifiable health information, or information that can be used to identify an individual, that is held or transmitted by a covered entity or its business associate in any form, whether electronic, paper or oral.[6] We'll be talking about protected health information a lot in this section, as it's the foundation of the privacy rule.

HIPAA requires that covered entities provide patients a **notice of privacy practices**, which is a form that defines how the provider can use PHI. A notice of privacy practice in plain language that describes the following is necessary.[7]

- How the covered entity may use and disclose PHI about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of PHI.
- Whom individuals can contact for further information about the covered entity's privacy policies.

In addition, the notice must include an effective date, and providers are required to provide the notice on a patient's first visit.

The basic principal of the Privacy Rule is to define and limit the circumstances in which PHI may be used or disclosed by covered entities. This rule allows healthcare providers to obtain a **consent**, or written permission, to use or disclose a patient's health information for treatment, payment and healthcare operations, often referred to as TPO. Written *authorization* is required for any use or disclosure of PHI that is not for TPO or not otherwise specified in the Privacy Rule.

Authorization to disclose information forms must contain:

- A specific description of the health information that will be used
- The name or specific identification of the person or people to whom the healthcare facility may disclose the information
- The name or specific identification of the person or people who are authorized to use the information
- An expiration date that pertains to the individual or purpose of the disclosure of the health information
- A statement of a person's right to rescind the authorization in writing
- A statement that outlines the exceptions to the right to rescind
- A statement that outlines how a person may rescind the authorization right
- A statement that the Privacy Rule would no longer protect health information that the recipient redisclosed, even if authorization disclosed it previously
- The individual's signature and the date

The following results in an invalid authorization:

- The expiration date on the authorization to disclose information has passed
- The authorization to disclose information form is not completely filled out

- The authorization to disclose information form lacks one or more required elements
- The authorization to disclose information form covers more than one request
- The healthcare facility knows the patient or the patient's legal representative has rescinded authorization
- The healthcare facility knows that some or all of the information in the form is false

There are only two instances in which the patient may *not* rescind authorization to disclose healthcare information: when the person or people to whom the healthcare facility disclosed the information have already taken action or when the authorization was given so that a patient could receive insurance coverage, and the insurance company contests a claim under the policy.

The Privacy Rules states that healthcare providers must make reasonable efforts to use, disclose and request the *minimum necessary* amount of PHI needed to accomplish the purpose of the authorization. **Minimum necessary** limits unnecessary or inappropriate access to and disclosure of PHI. Let's look at an example to clarify this point.

A healthcare document specialist that processes the billing for Weston Medical Clinic does not require the entire documentation (medical record) to submit a claim. The patient name and insurance information, as well as the medical codes, are needed for the healthcare document specialist to create a claim for the reimbursement process. Meanwhile, a healthcare document specialist working as a medical transcriptionist does not need to know the patient's insurance information; she just needs to know who the patient was, when the service was performed and what the provider did during the service.

So, aside from our previous example, how does the Privacy Rule affect you as a healthcare document specialist? Well, in your healthcare profession, you probably won't be checking for consents or authorization, but you do need to protect the patient's medical record. Look at the following scenarios, and think about how the healthcare document specialist should have handled each situation differently.

> Elizabeth is a healthcare document specialist who does medical coding from home. Elizabeth's home office is in the living room of her townhome. She begins her day by connecting to an EHR to pull the dictation that was transcribed the previous day. As she's working on assigning codes, Elizabeth's neighbor, Alice, knocks on the door. Elizabeth invites Alice in the living room for a cup of coffee. Forgetting to log off of the EHR, Elizabeth runs to the kitchen to make the coffee. While alone in the living room, Alice notices the name of a co-worker on the screen. Her curiosity gets the best of her, and Alice inches closer to read the details on the screen.
>
> Patrick visited his doctor for depression. Patrick was surprised when John, a casual acquaintance, asked about his health. During the conversation, John revealed that his wife, Susan, does the medical billing for Patrick's doctor and noted the diagnosis when processing the claim.

Both scenarios are violations of the Privacy Rule. It's important that you, as the healthcare document specialist, keep the patient's protected health information private. After all, consider how you would feel if you were the patient in one of these examples!

Security Rule

While the Privacy Rule focuses on protected health information in general, the Security Rule deals with electronic protected health information (ePHI). The **Security Rule** establishes a national set of security standards for protecting health information that is held or transferred in electronic form. This rule does not apply to PHI transmitted orally or in writing.[8] Prior to HIPAA, no formal security standards or requirements existed for protecting health information. As technology evolved, computers became standard in the healthcare profession, allowing medical information to become more mobile and efficient, but also increasing the potential security risk. Computer hackers and viruses can wreak havoc on computer systems; they can corrupt files, make information public and change critical data.

The Security Rule has two primary purposes:

- Require appropriate security safeguards to protect ePHI that may be at risk.
- Promote access and use of ePHI while protecting an individual's health information.

Specifically, HIPAA notes: *A covered entity must have in place appropriate administrative, technical and physical safeguards to protect the privacy of protected health information.* This includes any intentional or unintentional use or disclosure of ePHI. HIPAA requires each covered entity to assess its own security needs and implement the measures that best meet those needs. Administrative, physical and technical concerns must be examined when these entities protect privacy. This doesn't mean that every employee must now have top-secret clearance. Some changes can be simple. For example, a good security step is to ensure that unauthorized people cannot view computer monitors and faxed pages. Other security measures are more complicated, such as using proper electronic data *encryption*. **Encryption** means the electronic information is put into a coded form while transmitted. The encrypted electronic information cannot be understood without the appropriate decryption equipment. Take a look at the example that follows.

Patient: Alyssa Turner
MRN: 12345678
DOB: 12-12-1962

Current Medications:

Lipitor	20 mg daily
Clonidine	0.17 mg q.h.s.
Synthroid	1.7 mcg daily

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In your career as a healthcare document specialist, you will have access to protected health information. While electronic health records provide ease of access, you must have in place appropriate administrative, technical and physical safeguards to protect the privacy of protected health information. How will you do this? Passwords, key cards and encryption are a few ways.

Healthcare organizations must control access to their files. A small physician's office might simply provide passwords for its personnel to meet this requirement. The healthcare document specialist working from home could log onto the computer system to access billing and coding information with her password, while the nurse practitioner at the office could renew prescriptions and view and modify health histories with her password.

In a large hospital, the access requirements have a more complex set of tools. Key cards might be used for personnel to access particular rooms that house information databases within the multi-building complex. A security officer might view daily printouts that detail who accessed certain files with their passwords. She also might require password changes every few months. The feature of the security standards may vary to ensure that compliance is economically feasible for organizations of every shape and size.

Using encryption software is a simple safeguard for a healthcare document specialist to ensure patient privacy. When PHI is encrypted, even if a hacker is able to gain access to medical records, he won't be able to read or interpret the information. The patient's privacy is protected because a key is required to unscramble the information.

Let's look at the final standard in the Administrative Simplification Compliance Act, which is the Unique Identifier Standard.

Unique Identifier Standard

The **Unique Identifier Standard** establishes the implementation specifications for obtaining and using the standard unique health identifier for health care providers. At this time, there are two standards when it comes to unique identifier: the *Employer Identification Number* and the *National Provider Identifier.*

In 2002, HIPAA adopted the **Employer Identification Number** (**EIN**), which was issued by the Internal Revenue Service (IRS) to identify employers on standard transactions, which includes CMS-1500 and UB-04 claims, as well as all electronic transmissions of claims. The billing provider includes his EIN on the claim to be used for 1099 taxable income reporting purposes. We will discuss the EIN in more detail when you learn to complete the claim forms in this program.

HIPAA mandated the adoption of a standard unique identifier for healthcare providers in 2007. The **National Plan and Provider Enumeration System** (**NPPES**) collects identifying information on healthcare providers and assigns each a unique National Provider Identifier (NPI). The NPI regulation seeks to eliminate multiple identifiers. At one time, insurance carriers, such as Medicare and Medicaid, assigned identifiers for providers to submit with claims. These identifiers were known as UPIN OSCAR and PIN. The identifiers were not standardized, resulting in one provider having multiple identification and billing numbers. These legacy numbers complicated the claims submission processes and resulted in the assignment of the same identification number to different health care providers by different health plans.

According to CMS, the **NPI** is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. Once assigned, NPI is associated with the same provider forever; it will not change, regardless of job or location changes.

The use of standard identifiers is expected to ease the administrative challenges associated with all aspects of patient healthcare records. These challenges include documentation, maintenance and billing requirements. These standard identifiers will allow the various entities within the healthcare system to most effectively and efficiently perform their respective financial, clinical, preventive and research functions. To put it simply, a healthcare entity can devote more time to its own particular business and patients and less to general paper pushing when using an NPI.

Now that you have a better understanding of the standards associated with the Administrative Simplification Compliance Act, let's look at what happens when patient privacy is **breached**, which means there was a violation or infraction of a standard.

Breach of Privacy

What happens when there is an intentional or unintentional use or disclosure of ePHI? The HITECH Act requires covered entities to provide notification in the event of a breach of *unsecured* protected health information. **Unsecured** means the information hasn't been encrypted. For instance, if a computer hacker gained access to patient information that hasn't been encrypted, the practice would have to inform all patients and the Department of Health and Human Services (HHS) of that breach. In some cases, the practice is also required to notify the media. However, if the ePHI is encrypted, patients do not need to be notified.

Following are two examples of data breach notifications. The first is a notice from TRICARE posted to its Web site alerting the public of the breach. The second is a news article, also notifying the public of the breach, as required by HIPAA.

> Letters are being mailed from Science Applications International Corporation (SAIC) to affected military clinic and hospital patients regarding a data breach involving personally identifiable and protected health information (PII/PHI). On Sept. 14, 2011, SAIC reported the loss of backup tapes containing electronic health care records used in the military health system (MHS) to capture patient data from 1992 through Sept. 7, 2011 in San Antonio area military treatment facilities (MTFs), including filling pharmacy prescriptions and other patients whose laboratory workups were processed in these same MTFs, even if the patients were receiving treatment elsewhere. The data may include Social Security numbers, addresses and phone numbers, and some personal health data such as clinical notes, laboratory tests and prescriptions. There is no financial data, such as credit card or bank account information, on the backup tapes. ref: http://www.tricare.mil/breach/old.htm

This breach affected nearly 5 million patients, making it the largest medical data breach since the HHS began tracking incidents in 2009.

> On May 14, 2012 federal prosecutors charged one of the hospital's medical technicians with violating the Health Insurance Portability and Accountability Act, or HIPAA. Prosecutors say that over a 17-month period Laurie Napper used her position at the hospital to gain access to patients' names, addresses and Medicare numbers in order to sell their information. ref: http://www.kaiserhealthnews.org/Stories/2012/June/04/electronic-health-records-theft-hacking.aspx

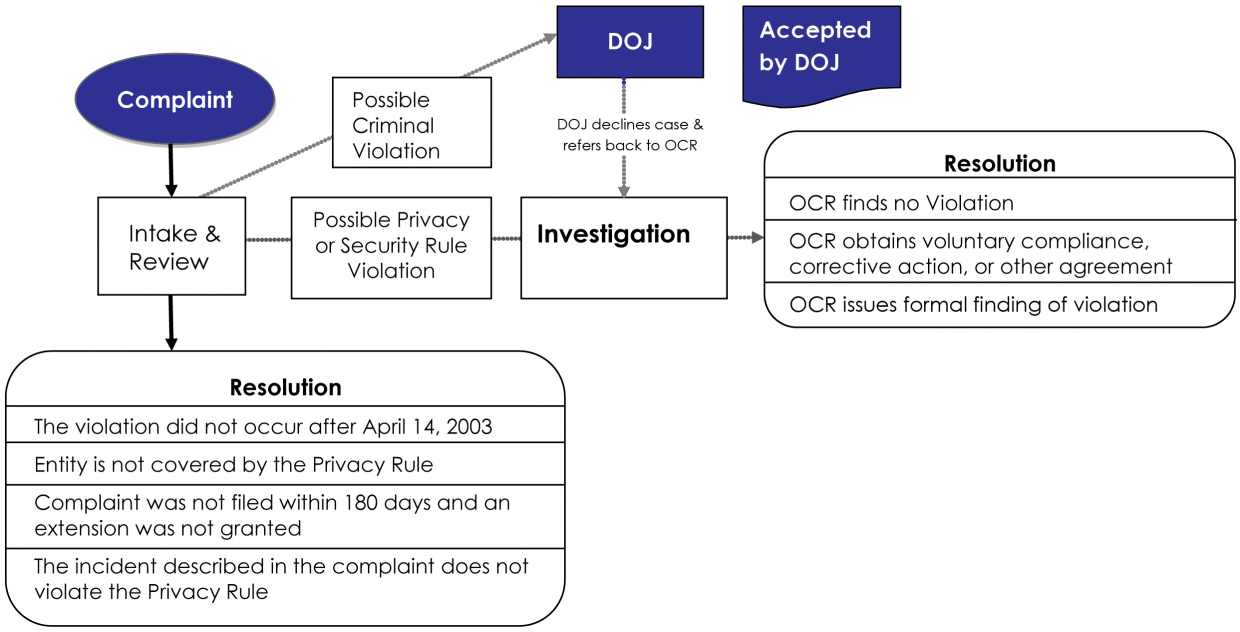
The first case was an example of an unintentional breach of ePHI, while it was clearly an intentional violation in the second.

Now, let's look at the organization that has the right to enforce, audit, fine and charge covered entities for violations of HIPAA, such as those you just examined.

Office for Civil Rights

HIPAA and HITECH are administered by the HHS in the Office of the Civil Rights (OCR). The OCR enforces the Privacy and Security Rules by investigating complaints and conducting compliance reviews, as well as performing education and outreach to foster compliance with the rules' requirements. Since the compliance date in April 2003, HHS has received more than 71,849 HIPAA complaints. The OCR has resolved 91 percent of complaints received (more than 65,460). The OCR has investigated and resolved more than 16,708 cases by requiring changes in privacy practices and other corrective actions by the covered entities. Of the remaining complaints, 8,514 were investigated, and no violation was found; 40,238 complaints were resolved through closure of cases that were not eligible for enforcement because the entity wasn't covered under the Privacy Rule, the complaint was not filed in a timely fashion or the incident described wasn't in violation of the Privacy Rule.

HIPAA Privacy & Security Rule Compliant Process



Ref: http://www.hhs.gov/ocr/privacy/hipaa/enforcement/process/index.html

Let's look at those complaints that were resolved through investigation and enforcement. If the evidence indicates that the covered entity was not in compliance, the OCR will attempt to resolve the case with the covered entity by obtaining voluntary compliance, corrective action and/or a *resolution agreement*.[9] A **resolution agreement** is a contract signed by HHS and a covered entity in which the covered entity agrees to perform certain obligations (e.g., staff training) and make reports to HHS, generally for a period of three years.[10] The HHS monitors the covered entity during these three years to ensure that the entity is in compliance with the obligation.

According to the OCR, most Privacy and Security Rule investigations are concluded to the satisfaction of the OCR. However, if the covered entity does not take action to resolve the matter in a way that is satisfactory, the OCR may decide to impose *civil money penalties* (*CMPs*) on the covered entity. Under the HITECH Act, mandatory penalties have been and will be imposed for *willful neglect*. According to HIPAA, **willful neglect** means conscious, intentional failure or reckless indifference to the obligation to comply with the administrative simplification provision violated. **Civil money penalties** for willful neglect can extend up to $250,000, with repeat or uncorrected violations extending up to $1.5 million.

You've learned a lot in this section! You studied the basics of HIPAA and the HITECH Act. You know the standards associated with the Administrative Simplification Compliance Act and understand how they apply to your career as a healthcare document specialist. And you found that the OCR has the right to enforce, audit, fine and charge covered entities for violations of HIPAA.

The last section about the violations of HIPAA may have seemed a bit daunting, but it's important to know that there will be ramifications for willful neglect. However, the key is remembering to act in an ethical manner and keep patient information private. As a healthcare document specialist, you know not to share a chart note you've transcribed earlier that day with your family during dinner. You understand that coding a chart of a close friend isn't the best idea; it should be coded by someone else! And you would never share your neighbor's billing troubles with another neighbor. These safeguards will keep you from breaking any of the rules you've just learned about! Now, let's pause for a quick review.

Step 6: Practice Exercise 9-1

Determine the term(s) to complete each sentence, and write your answers on scratch paper.

1. **The two main objectives of HIPAA are _____ and _____.**
2. **_____ are healthcare professionals who transmit any health information in electronic form.**
3. **The _____ addresses the use and disclosure of patients' health information.**
4. **TPO stands for _____, payment and healthcare _____.**
5. **The Security Rule does not apply to PHI transmitted _____.**
6. **_____ is issued by the Internal Revenue Service (IRS) to identify employers on standard transactions.**
7. **The _____ is a 10-position, numeric identifier that does not carry other information about healthcare providers.**
8. **The term _____ refers to a violation or infraction of a standard.**
9. **When protected health information is unsecured it means the information hasn't been _____.**
10. **A conscious, intentional failure or reckless indifference to the obligation to comply with the administrative simplification provision is _____.**

Step 7: Review Practice Exercise 9-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 8: Fraud and Abuse

One of the government's top priorities is to eliminate healthcare *fraud*. Unfortunately, investigations of fraud and abuse are on the rise. **Fraud** occurs when inaccurate information is used to wrongfully gain compensation. Fraud is a crime. In the medical field, this often can occur in the medical record itself. For example, a patient's insurance coverage becomes effective June 15. The patient receives service from a provider on June 1. The medical record is altered to indicate the date of service as June 20 to allow the treatment to be covered by insurance. This is fraud.

To guard against fraud, you must do one simple thing: Be accurate. Don't be tempted to change information on medical records if that information already is correct. If you do change correct information, you are committing fraud, and the consequences can be severe.

The U.S. General Accounting office estimates that $1 out of every $10 spent on Medicare and Medicaid is lost to fraud and abuse. With the increasing costs associated with health care, the reduction of fraud and abuse has become a point of focus for CMS.

Fraud examples:

- Billing for services or supplies that were not provided
- Altering claims to obtain higher payments
- Soliciting, offering or receiving a kickback, bribe or rebate
- Provider providing services for fictitious patients
- Using another person's Medicare card to obtain medical care

Abuse examples:

- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Breach of the Medicare participation or assignment agreements
- Improper billing practices including billing Medicare when Medicare is not primary

Fraud and abuse can be reported to the federal Office of Inspector General, OIG. This governing body then makes a decision as to the penalty. The penalty can be monetary, criminal, administrative or a combination of any of the three. The Office Inspector General is also responsible for notifying the state intermediaries of any new scams.

As a healthcare document specialist, you need to be sure you are coding properly, that you are not billing for medically unnecessary services, that the Medicare patient is who she says she is and that you are using an appropriate fee schedule. Keep in mind you are human and may make a mistake from time to time. Medicare is not after you; they are looking for those who are purposely defrauding the system.

Preventing Fraud and Abuse

The **Federal False Claims Act** (**FCA**) was signed into law in 1863 by Abraham Lincoln and is the basis for prosecution of healthcare fraud and abuse claims. The FCA prohibits anyone from presenting a false or fraudulent claim to be paid by the government, using a false record or statement to conceal or avoid paying money to the government or conspiring to defraud the government.

The FCA was not originally intended to investigate healthcare providers, but in recent years, this has become increasingly necessary, as well as very costly. In 1986, Ronald Reagan signed amendments into law that significantly strengthened the government's ability to successfully prosecute for fraud. Damages increased from double to triple, and the FCA was extended to include unintentional misconduct.

To prevent fraud and abuse, many healthcare providers have created corporate *compliance plans*. **Compliance plans** are formalizations of processes that identify, investigate and prevent violations in various healthcare services.

In addition, the government has created model compliance plans for hospitals and clinics. These include structure, standards, oversight, education, monitoring and enforcement.

Insurance rates increase when an insurance company pays fraudulent claims. When codes are not correct, the insurance company will not pay the correct amount, which delays doctors' payments and leads to increased healthcare costs. Thus, insurance companies often try to collect damages when they discover fraudulent claims.

Consequences of Committing Fraud

Fraud is a crime and, therefore, punishable by law. If the fraud was intentional and systematic, and if the effects of the fraud were far-reaching, the justice system can impose harsh penalties, including jail time.

The criminal side of fraud is only half of the picture. There are also civil consequences to fraud. Fraud affects us every day. When insurance companies pay fraudulent claims, rates increase unnecessarily. Insurance companies often try to collect damages when they discover fraudulent claims. These damages include *compensatory damages* and *punitive damages*.

Compensatory damages are damages directly related to the fraud. For example, if a claim submitted to an insurance company with charges for $700 worth of procedures that were not performed, the civil courts might award the insurance company $700 in compensatory damages. Compensatory damages represent the compensation a *plaintiff* receives from a *defendant* for the actual damage caused (in our example, $700 in overcharges). The **plaintiff** is the person who files the claim and initiates a lawsuit, while the **defendant** is the person named in the claim or charged with the crime. However, if the insurance company feels the fraud was intentional or perhaps negligent, it might ask for punitive damages.

Punitive damages are damages awarded to the plaintiff to punish the defendant and, theoretically, deter the defendant from repeating the fraud in the future. Punitive damages can far exceed compensatory damages. In our $700 example above, a court might award punitive damages for five times that amount ($3,500) if the fraud was intentional. Punitive damages are awarded above and beyond any compensatory damages. That means our original $700 judgment has now swelled to $4,200! This is a high cost for a lapse in judgment. In addition, whoever committed the fraud is responsible for paying all damages.

Doctors and other healthcare professionals can be liable for damages in some situations, whether their actions were intentional or not. To help protect healthcare professionals, insurance companies offer a variety of liability insurance coverage.

Step 9: Liability Insurance

When you drive a car, you run the risk of being in an accident. Obviously, you don't set out to intentionally hit another car, but accidents happen. To protect yourself and the other drivers on the road, you carry some form of automobile insurance. No doubt you've heard of people being awarded thousands of dollars by courts for damages suffered in accidents. If you have insurance, then your insurance company pays for these damages. (After all, that's what insurance is for.) If you aren't covered by insurance, then you pay the entire amount!

Doctors and other healthcare professionals can be covered by medical liability insurance. The physician you work with usually carries this insurance. In case there are damages suffered as a result of an accident or negligence, the insurance covers the doctor, the doctor's staff and anyone the doctor contracts with for services relating to the practice.

In the medical world, physicians are legally responsible for their actions, as well as the actions of their employees and anyone they contract with for services relating to their practice. This protects you, the healthcare document specialist, as long as you stay within the scope of your duties, which means as long as you are doing the job you were hired to do. However, if you knowingly submit fraudulent claims or break the law in some other manner, you are liable, and insurance won't cover you. Let's look at two situations.

Example 1 While working on a complex claim, Julia accidentally transposes two numbers, causing an error that results in overpayment by the insurance company.

Example 2 Hillary works with Dr. Gregg. Dr. Gregg hands her a bill and says, "Don't use the surgical package code. I never do because I get more money if I code everything separately." Hillary does as Dr. Gregg asks.

Which example represents fraud? The answer is Example 2. When Hillary knowingly goes along with Dr. Gregg, she is submitting claims she realizes are false. This should be reported, not complied with. How do insurance companies catch fraudulent claims? They conduct company-auditing procedures.

Insurance Audits

Insurance companies guard very closely against fraud. Even with safeguards, some fraudulent claims sneak through. However, through *insurance audits*, many of these claims are caught. An **insurance audit** is a thorough review by the insurance company of a claim and all related documentation. Auditors compare and search the records for inconsistencies and alterations.

What triggers an insurance audit? Well, the insurance company might find the claim suspicious or notice that the doctor files an unusual number of similar claims. On the other hand, the patient might bring a questionable claim to the attention of the insurance company.

Many insurance companies encourage their clients to review medical records and bills to ensure that the procedures listed were performed and the diagnosis is accurate. If a patient has a question, the insurance company has a toll-free number to call for that purpose. If there is an overcharge on a claim that a patient notified the insurance company about, that patient usually gets some kind of cash reward from the insurance company. This encourages patients to review their records.

As a healthcare document specialist, you may be interested in an auditing position. Auditing ensures medical necessity, correct coding and compliance. The knowledge you learn in this program will provide you the skills for an entry-level position.

Step 10: Recovery Audit Contractors

According to the OIG, it is estimated that $16.4 billion in improper payments and error rates were made in 2000.[11] The Medicare Modernization Act of 2003 created a three-year project to recover Medicare overpayments and identify underpayments. The three-year project focused on California, Florida, New York, South Carolina and Massachusetts. In March 2008, the program ended with more than $1.03 billion recovered from improper payments. Approximately 96 percent of the improper payments were overpayments collected from providers, and the remaining four percent were underpayments paid to providers.[12]

The Tax Relief and Health Care Act of 2006 expanded this project to all 50 states, creating a permanent and nationwide program by 2010. CMS contracted **Recovery Audit Contractors** (**RACs**) to recover overpayments. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they collect from providers.[13] RACs may review the last three years of provider claims for the following types of services: hospital inpatient and outpatient, skilled nursing facility, physician, ambulance and laboratory, as well as durable medical equipment.

In 2011, CMS reported that it has collected more than $313 million in Medicare overpayments through its recovery audit program since October 2009.14 However, RAC decisions can be appealed. Look at the following report:

> The Centers for Medicare & Medicaid Services (CMS) has released appeals data for Medicare fee-for-service Recovery Audit Contractors (RACs). For claims originating in fiscal year 2011 (Oct. 1, 2010-Sept. 30, 2011), providers appealed 56,620 repayment demands, over 6.25 percent of the 903,372 claims with overpayment determinations. Of these, 24,548 (43.4 percent) were decided in providers' favor. Approximately 2.7 percent of all claims with overpayment determinations were overturned on appeal. Reference: http://www.aapcps.com/news-articles/RAC-appeals-won.aspx

As with liability concerns, there are several legal concerns to consider when working with medical records. Let's take a closer look.

Step 11: Legal Concerns

The legal system in the United States is very complex. Attorneys study it for years and still may not understand everything there is to know about law. While we will cover some of the basic concepts regarding medical records and the law, you should always consult an attorney if you have to deal with the legal system. By doing so, you receive expert advice from someone who knows the system. This section gives you an overview of some very basic concepts, which will enable you to effectively communicate with other medical professionals.

Subpoenas

A **subpoena** is a legal document issued by the court requiring the person named on the subpoena to appear in court or to supply certain documents or both. A subpoena can authorize the legal release of confidential medical records.

A subpoena cannot be mailed. Instead, it is served personally by an authorized person. If you are served with a subpoena and fail to respond, you can be arrested and charged with a crime. A subpoena is a legal document and must never be ignored.

When you follow the directions contained in the subpoena, you have **complied** with it. To comply with a subpoena for medical records, you generally have a specified amount of time to produce the records. You make copies of the appropriate records, and supply the copies to whoever is named on the subpoena. Usually, this is an attorney.

If you receive a subpoena to testify, it means you must appear at the designated court on the assigned day and time. You cannot be late, and you cannot ignore the subpoena. Sometimes you are paid for your time, and the fee is included with the subpoena. Remember not to get angry with the person serving the subpoena. The server is usually neutral, not involved with the case at all and "just doing a job."

When a subpoena is issued, it usually means someone is headed to court and needs the medical records for a case. Sometimes, however, disputes don't end up in court. Instead, they may be heard in *arbitration*.

Arbitration

Arbitration is an alternative to a court of law. In **arbitration**, two disputing parties meet with an **arbitrator**, or a person chosen to decide a dispute or settle differences. Each party tells its side of the situation, and the arbitrator issues a ruling. In **binding arbitration**, the ruling is final and must be obeyed. In **nonbinding arbitration**, the ruling is merely a suggestion from an objective person. Many contracts now specify that disputes must be settled in binding arbitration rather than in court. Arbitration is much less expensive and usually resolves problems faster than the court system.

Medical Testimony

If arbitration is not an option, or if someone insists on going to court, then people may have to provide *testimony*. **Testimony** is the sworn statements of witnesses and experts given while on the witness stand in court. Witnesses give statements under an oath of truth, and people who lie during testimony can be charged with **perjury**, a serious crime.

In medical cases, doctors are sometimes called to testify. Often, doctors testify as expert witnesses—people who know about the circumstances surrounding a case, but not necessarily about the case itself. For example, imagine a trial involving physical evidence, such as DNA. The DNA is analyzed and the results brought to court. The side presenting the evidence might have an expert talk about DNA in general. That expert is someone who knows about DNA but has no other connection to the case. This person is an expert witness.

Now it's time to review what you've learned about fraud and abuse with the following Practice Exercise.

Step 12: Practice Exercise 9-2

Determine the correct term(s) to complete each sentence, and write your answers on scratch paper.

1. **As a healthcare professional, you cannot release any medical information unless it is to an authorized person because the information is _____.**
2. **Ethical guidelines are often spelled out in a document called a _____.**
3. **You should _____ fax sensitive test information.**
4. **Damages directly related to fraud are termed _____ damages.**
5. **The _____ prohibits anyone from presenting a false or fraudulent claim to be paid by the government.**
6. **Fraud includes inaccurate information that is used to wrongfully gain _____.**
7. **Fraud and abuse can be reported to the _____.**
8. **A(n) _____ is a thorough review by the insurance company of a claim and all related documentation.**
9. **_____ are paid on a contingency fee basis, receiving a percentage of the improper payments they collect from providers.**
10. **A(n) _____ can authorize the legal release of confidential medical records.**
11. **A(n) _____ is a person chosen to decide a dispute or settle differences.**
12. **When a person lies during testimony, he can be charged with _____.**

Step 13: Review Practice Exercise 9-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 14: Lesson Summary

We covered a lot of information in this lesson. Ethics and credibility are interwoven like threads in a rug. When you are in business, whether it is your own or someone else's, you must always keep a strong code of ethics foremost in your mind. If you follow the principles of these ethics, you can relax and do your job. You have credibility. People can count on you.

Privacy and security are major concerns as more and more healthcare data is transmitted and maintained electronically. The Health Insurance Portability and Accountability Act is, in part, is federal legislation that governs health information in electronic form. Here, legal and ethical issues are joined. As a healthcare document specialist, you must be sure that you follow strict guidelines in protecting the confidentiality of the patient information entrusted to you. A signed patient consent, obtained by the physician, permits you to release information for purposes of treatment, payment and healthcare operations. You must not make any other release of information unless the patient has provided a signed authorization allowing such release.

Even the most ethical person can make a mistake. Mistakes can be covered by liability insurance carried by the physician with whom a person works. Fraud, however, is an intentional misrepresentation of facts. Fraud usually is committed to try to gain more money or some other undeserved benefit. Fraud is illegal. When illegal acts are committed or if two parties have a disagreement that cannot be settled, the legal system might come into play.

The legal system, as you've learned, settles disputes and upholds laws. Subpoenas are often used to present all the facts. A subpoena is a document that is served to a person who is in possession of vital information. This information might be in the form of medical records, or it might be in the form of expertise in the field. If you are in charge of records that are listed on a subpoena, you should make sure you are authorized to release the records to the appropriate party, and then you may do so.

Arbitration is used when two parties disagree and cannot settle their disagreement. Binding arbitration means the arbitrator's decision is final and must be followed. In nonbinding arbitration, the decision of the arbitrator is treated as a suggestion. Finally, you learned that sometimes a physician has to go to court to provide medical testimony.

The next lesson details the parts of the medical record and describes the importance of documentation. Are you ready to move on? Great!

Endnotes

1 HITECH Act Enforcement Interim Final Rule. U.S. Department of Health & Human Services. Web. 29 October 2013.

2 HIPAA.com. Web. 29 October 2013.

3 Transaction & Code Set Standards. CMS.gov. Web. 29 October 2013.

4 Data Standards Committee. Public Health Data Standards Consortium, 2013. Web. 29 October 2013.

5 The Privacy Rule. U.S. Department of Health & Human Services. Web. 29 October 2013.

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7 Covered Entities. U.S. Department of Health & Human Services. Web. 29 October 2013.

8 Understanding Health Information Privacy. U.S. Department of Health & Human Services. Web. 29 October 2013.

9 HIPAA Enforcement. U.S. Department of Health & Human Services. Web. 29 October 2013.

10 HIPAA Enforcement. U.S. Department of Health & Human Services. Web. 29 October 2013.

11 *Centers for Medicare & Medicaid Services' Use of Medicare Fee-for-Service Error Rate Data To Identify and Focus on Error-Prone Providers*. Department of Health & Human Services, 7 Oct. 2010. Web. 15 October 2013.

12 *Recovery Audit Contractors (RAC)*. American Health Information Management Association. Web. 15 October 2013.

13 *Recovery Audit Contractor (RAC) Program*. American Hospital Association. Web. 15 October 2013.

14 *CMS collects $162 million in overpayments in first three months of 2011*. Modern Healthcare. Web. 15 October 2013.

Lesson 10
Medical Records

Step 1: Learning Objectives for Lesson 10

When you have completed the instruction in this lesson, you will be trained to:

- Explain the parts of a medical record.
- Describe the importance of documentation in medical records.
- Identify two types of medical records formats.
- Explain how healthcare personnel manage medical records.

Step 2: Lesson Preview

In this lesson, you'll learn about the various parts of a medical record, which contains all of a patient's medical history related to that provider. The medical record includes charts, notes and information to identify the patient, support the diagnosis or reason for the appointment, justify the treatment and accurately document the results. The record also contains past and present illnesses and treatments. Every aspect of a patient's treatment at a healthcare facility is documented in this record. In other words, the medical record provides a complete picture of the health care the patient has received.

Do you remember the example with Dr. Green in that first lesson? At the end of the patient's appointment, Dr. Green dictated his notes about the encounter. In this lesson, you'll discover the type of documentation providers use, as well as commonly used narrative formats. Finally, you'll review good recording practices to ensure success in your future profession. So let's get started by discussing the aspects of a medical record.

Step 3: Medical Records

Think back to your last visit at a doctor's office. You've probably been asked to fill out a new patient questionnaire in a doctor's waiting room, but you may not be familiar with the contents of a medical record. Let's clear up some of these mysteries.

The most common parts of a medical record include: The *questionnaire*, *registration/admission* form, *consent for treatment* form, *patient history* form, *plan of treatment* form and *progress report* form. Let's take a moment to discuss each of these briefly, as well as look at a few examples.

Questionnaire

A medical record is generated when a patient receives medical care. This record usually begins its life as a questionnaire or patient data sheet. The **questionnaire** asks about a patient's medical history, insurance coverage and other important facts. Let's take a look at an example questionnaire.

Patient Data Sheet

Patient Name: Date: _____
Last: _____ First: _____ MI: _____
Street/P.O.: _____ City/State: _____ Zip Code: _____
Sex: M ☐ F ☐ Birthdate: _____ SS #: _____
Patient Home Phone: _____ Patient Work Phone: _____
Primary Care Physician: _____

Bill To: (Head of Household If Different From Above Information)
Last Name: _____ First: _____ MI: _____
Birthdate: _____ SS #: _____
Street/P.O.: _____ City/State: _____ Zip Code: _____
Work Phone: _____ Home Phone: _____
Head of Household Place of Employment: _____
Message Phone: _____

Primary Insurance Coverage:
Company: _____
ID #: _____ Group #: _____

2nd Insurance Coverage: (If applicable) _____
ID #: _____ Group #: _____

Spouse: (If applicable)
Last: _____ First: _____ MI: _____
Birthdate: _____ SS #: _____
Place of Employment: _____ Work Phone: _____

Children: (If a patient or will be a patient at this clinic, please list) Sex
Last: _____ First: _____ MI: ___ M ☐ F ☐ Birthdate: _____
Last: _____ First: _____ MI: ___ M ☐ F ☐ Birthdate: _____
Last: _____ First: _____ MI: ___ M ☐ F ☐ Birthdate: _____
Last: _____ First: _____ MI: ___ M ☐ F ☐ Birthdate: _____

In case of emergency and I am unavailable, you have my permission to treat any of the members of my family as necessary.

Signature: _____ Date: _____

Registration/Admission

The **registration/admission** form is used to record important information, such as the patient's name, address and insurance information. This form may be completed every time a patient sees the provider, or the practice may keep one on file and update it as necessary.

ADMISSIONS/DISCHARGE RECORD

Last Name	First Name	Middle Name	Maiden Name	Soc Sec No	Room No	Admitting No
Schmidt	Bonnie				2	10043

Address	City	State	Zip Code	Phone	Sex	Marital Status
1810 Bluegrass Dr	Springtown	Co	80002	9705559041	M (F)	(M) S

Age-Yrs	Birth Date Mo	Day	Year	Birthplace	Race and Ethnicity	Religion
	06	25	1952	MD	☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ Hispanic ☒ White ☐ Other	NA

Occupation	Employer or Employer of Spouse	Address of Employer-Phone
Graphic Artist	Kain Graphics	1924 Main St Springtown CO 9705556001

Name of Spouse	Address if Other than Above	Birthplace
Richard Schmidt	Same	CO

Notify in Case of Emergency	Relationship	Address	Phone
Richard Schmidt	Spouse	Same	Same

Name of Father	Birthplace	Maiden Name of Mother	Birthplace
NA	NA	NA	NA

Name of Blue Cross and/or Blue Shield Plan	Group No.	Contact No.	Effective Date	Subscriber Dependents
NA				☐ Family Member Comprehensive ☐ Coverage

Other Hospitalization Insurance	Cert. Or Policy No.	Group No.	Effective Date	Medicare No.
Health Services Inc.	560-1113	208	0101xx	NA

Consent for Treatment

Whenever a patient agrees to a suggested treatment, the patient must complete a consent for treatment form. The **consent for treatment form** includes a statement indicating the patient has been informed of the treatment plan, including possible side effects and negative outcomes. The patient signs the form, indicating agreement to the treatment and awareness of all possible consequences resulting from the treatment.

Complete & Compassionate OB/GYN Care
Consent To Treatment

Please **PRINT** this form and **BRING** it with you to your appointment.

Patient Name: Merrilee Fox Date of Birth: 5/4/1949

Social Security No.: _____ Today's Date: 0329XX Time: 1:00 am / (pm)

I, Merrilee Fox (the _____ of _____), hereby voluntarily consent to outpatient care at Complete & Compassionate OB/GYN Care, P.A., encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physicians' assistants, medical assistants, or their designees as is necessary in the medical staff's judgement.

Release of Information: (a) I authorize Complete & Compassionate OB/GYN Care, P.A. to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care. (b) I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Complete & Compassionate OB/GYN Care, P.A.

This form has been explained to me and I fully understand this *Consent To Treatment* and agree to its contents.

Comments:

_____

_____

Signature of Patient or Person Authorized to consent for patient: Merrilee Fox

Signature of Witness who explained the contents of this "Consent to Treatment" form:

Rebecca Poe

****

If the patient is a minor or is unable to consent, please complete the following:

- **A.** Patient is a minor and is _____ years of age.
  Name of Father _____ Name of Mother _____
- **B.** Patient is unable to consent because _____
  _____

Signature of Closest Relative or Legal Guardian: _____

Relationship: _____ Witness to Signature: _____

Patient History

When a patient sees a provider for the first time or hasn't seen a particular doctor for a long period of time, the patient is asked to fill out a patient history form. The **patient history** contains critical questions regarding the patient's health history. The patient's responses to these questions enable the provider and medical staff to give the patient the best possible care.

Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your express written consent. Thank you very much for taking the time to fill our this lengthy form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit.

General:

Name: Merrilee Fox	Birthdate: 5/4/1949	SS #:
Date of your last complete physical exam? 2/9/XX	Date of your last chest X-ray? unknown	
Date of your last cholesterol screening? 2/9/XX	Date of your last dental exam? 3/10/XX	
Date of your last eye exam? 3/1/XX	Date of your last sigmoidoscopy? 2002	

Women:	**Men:**
Date of last mamogram? 9/29/XX	Date of last PSA?
Date of last pap smear? 2/9/XX	Date of last rectal/prostate exam?

Immunizations: unknown			
Measles - Mumps - Rubella (MMR)	Date:	Pneumonia	Date:
Tetanus and diptheria toxoids (Td)	Date:	Hepatitis B	Date:
		Influenza	Date:

Past Medical History: (check those that apply)

	AIDS or HIV +		Chicken pox		Measles		Rheumatic Fever
	Blood or Plasma Tranfusions		Epilepsy		Mumps		Scarlet Fever
	Cancer		Infectious Mononucleosis		Polio		Whooping Cough

Hospital / Surgical History:

Illness or Operation	Date	Illness or Operation	Date
1) Bunionectomy	1990	4)	
2)		5)	
3)		6)	

Allergies:

Please list any drug, food, contact or environmental substances to which you have had an allergic or bad reaction.

Medications:

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them.

1) Vitamin C	4)	7)
2) Multi-Vitamin	5)	8)
3)	6)	9)

Social History:

Occupation: Clerk			Marital Status: M		
Do you execise regularly? (YES) NO	What type? Walking		How often? 3 times/wk		
I have never smoked. (YES) NO	I currently smoke packs per day.		I have smoked for years.		
I formerly smoked but stopped in: (list year)			Do you wear seat belts?	YES	NO
Do you use other forms of tobacco? YES NO	Do you use illicit drugs? YES (NO)		Do you drink alcohol?	YES	(NO)
How often/how much?	How often/how much?		How often/how much?		
Do you have any risk factors for HIV infection? YES (NO)	Have you ever been exposed to anyone with tuberculosis?			YES	(NO)
Have you had excessive exposure to sun because of your work or recreation?				YES	(NO)
Are you currently experienceing unusual stress? YES (NO)	Explain:				
Are there any environmental risks involved in your job or home environment? YES (NO)	Explain:				

Family History:

		Relationship			Relationship			Relationship
	Anemia			Epilepsy		✓	High cholesterol	Mother
	Asthma			Glaucoma			Kidney disease	
	Obesity			Leukemia			Thyroid disease	
	Cancer			Depression			High blood pressure	
	Diabetes		✓	Heart disease	Mother		Alcohol problems	
✓	Stroke	Mother		Lung disease			Bleeding Tendency	

Present Age or Age of Death:	Mother: 80	Father: 90
Sibling #1 N/A	Sibling #2	Sibling #3

Women Only: Menstrual Period Onset:	Regular? YES NO	Date last period began:
Age at menopause: 48	Difficulty with periods? YES NO	Specify:
Pregnancies: No. of children:	Born Alive: 2 Cesarean:	Premature: Stillborn: Miscarriages:
Describe complications:		

Please check all conditions you currently have or have had:

General Questions
- Weight loss
- Weight gain
- Change in sleep patterns
- Change in activity capacity

Neurologic and Psychiatric
- Anxiety
- Headaches
- Depression
- Meningitis
- Paralysis
- Seizure
- Stroke
- Tingling
- Tremors
- Memory Loss
- Fainting spells, dizziness
- Head injuries
- Blackouts or near blackouts
- Change in sensation anywhere on your body
- Localized weakness or numbness

Ears, Eyes, Nose & Throat
- ✓ Hay fever
- Glaucoma
- Polyps
- Allergy
- Cataracts
- Goiter
- Hoarseness
- Double vision
- Gum problems
- Eye problems
- Ear Infections
- ✓ Glasses/contacts
- Hearing Loss
- Ear discharge/pain
- Frequent nosebleeds
- Ringing in your ears
- Sinus infecti
- Swollen glands

Cardiovascular
- Angina
- Chest pain
- Leg cramps
- Murmurs
- Ankle swelling
- Awakening at night short of breath & getting out of bed
- Cardiac catheterization
- Cold hands or feet
- Congenital heart defects
- Dizziness when standing up quickly
- Heart attacks
- Heart failure
- High or low blood pressure
- Irregular heart rate
- Purple fingers or lips
- Leg pain that resolves with rest
- Heart palpitations
- Varicose veins

Respiratory
- Pleurisy
- Wheezing
- Asthma
- Breathlessness when lying flat
- Prolonged cough
- Coughing up blood
- Emphysema
- Shortness of breath
- Tuberculosis
- Pneumonia
- Frequent infections (bronchitis)

Skin
- Abscess
- Dandruff
- Acne
- Oily skin
- Boils
- Rashes
- Hives
- Dry skin
- Lumps
- Psoriasis
- Jaundice
- Athlete's foot
- Excessive body odor
- Excessive sweating
- Fungal infections
- Nail problems
- Moles- irregular
- Moles - change/new

Kidneys & Urinary Tract
- Blood in urine
- Brown urine
- Dribbling after urination
- Painful urination
- Excessive thirst
- Involuntary urination/incontinence
- Urinating frequently (day)
- Urinating frequently (night)
- Urine hesitancy
- Weak flow
- Frequent bladder infections
- Kidney disease
- Kidney stone

Endocrine
- Diabetes
- Sickle cell
- Abnormal body hair
- Changes in skin texture
- Cold intolerance
- Heat intolerance
- History of "borderline" diabetes
- Increased loss of hair
- Rheumatism
- Thyroid disease

Male & Female
- Painful sexual intercourse
- Loss of sexual interest
- Unprotected sex
- Groin itching
- Sexually transmitted diseases

Males Only
- Hernia
- Sterility
- Bloody ejaculation
- Inability to complete intercourse
- Lump on testicle
- Penile discharge
- Premature ejaculation
- Problems maintaining or keeping an erection
- Prostate disease
- Sores on penis or warts
- Testicular pain
- Testicular swelling

Musculoskeletal
- Anemia
- Arthritis
- Back pain
- Bursitis
- Gout
- Joint aches
- Neck pain
- Tendinitis
- Abnormal Blood Counts
- Blood clots in legs/lungs
- Bone Marrow Biopsy
- Easy Bleeding
- Easy bruising
- Joint swelling
- Morning stiffness
- Muscle aches

Gastrointestinal
- Diarrhea
- Gallstones
- Reflux
- Vomiting
- Ulcers
- Heartburn
- Hepatitis
- Indigestion
- Abdominal pain
- Anal fissures
- Black tarry stools
- Vomiting blood
- Constipation
- Nausea
- Problems swallowing
- Hiatal Hernia
- Intestinal obstruction
- Liver disease
- Hemorrhoids
- Red blood after bowel movements

Females Only
- D + C
- Hot flashes
- Hernia
- Fibroids
- Abn. bleeding between cycles
- Abnormal pap smear
- Bleeding after intercourse
- Complications w/ pregnancy
- PMS
- Endometriosis
- Heavy bleeding during cycles
- Discharge from breast
- Ovarian cysts
- Pelvic Inflammatory Disease
- ✓ Postmenopausal symptoms
- Vaginal discharge
- Vaginal Dryness
- Vaginal warts

Provider Notes

Provider Signature Mary Fields **Date** 0329XX

Plan of Treatment

The provider records the orders given to the patient regarding treatment on the **plan of treatment form**. In our example, the physician's instructions are for discharging the patient. Completion of this form helps establish a plan for recovery and provides the patient with clear instructions to follow.

PATIENT DISCHARGE INSTRUCTIONS

DATE 04-13-XX

MEDICATIONS / SUPPLIES — TO BE TAKEN AT HOME

NAME	DOSAGE	HOW OFTEN	WHAT FOR
Flexeril	10 mg	2 times/day	muscle spasms
Advil	200 mg	4-6 hrs as needed	pain relief
Calcium	600 mg	2 times/day	assist bone healing

ALLERGIES

ACTIVITY LEVEL

- ☐ NO RESTRICTIONS
- ☒ STAIR CLIMBING limited
- ☐ LIFTING _____ POUNDS
- ☒ AUTOMOBILE DRIVING when cast is removed
- ☐ CONTACT YOUR PHYSICIAN FOR SPECIFIC ACTIVITY INSTRUCTIONS
- ☐ OTHER _____

SPECIAL INSTRUCTIONS

- HOME TESTING _____
- ☐ EARLY MORNING WT. _____
- ☐ URINE TESTING _____
- ☐ STOOL TESTING _____
- ☒ OTHER see below

DIET

- ☐ NO RESTRICTIONS
- ☒ 1200 CALORIE, AS PER DIET SHEET
- ☐ _____ CALORIE, DIABETIC, AS PER DIET SHEET
- ☐ _____ GM SODIUM (SALT) RESTRICTED, AS PER DIET SHEET
- ☐ CONTACT YOUR PHYSICIAN FOR SPECIFIC INSTRUCTIONS
- ☒ OTHER 6-8 glasses of water/day

OTHER INSTRUCTIONS

Elevate leg above level of heart for first 48 hours.
Move joints above and below cast regularly as instructed.
Apply ice pack over fracture site for first 24 hours.
Call physician if increasing pain, discoloration of toes, swelling, burning or tingling occur.

APPOINTMENTS

Fracture and cast to be checked in 7 days.

APPROVED BY

Fran E. Fractures, MD 04-13-XX
M.D. SIGNATURE DATE

FORM COMPLETED BY F E F (I HAVE READ AND UNDERSTAND THE PHYSICIAN'S INSTRUCTIONS)

Bonnie Brokenbone 4/13/XX
DATE

Progress Report

As a treatment plan moves along, or as a patient's condition changes, the information is recorded on the **progress report** form. Providers use this form to chart changes of all kinds in their patients' conditions. Changes can include worsening conditions as well as improvements. Every patient has a progress report form.

MED. RECORD NO.: 040202 **BIRTH DATE** **SEX**

PATIENT NAME: RALPH POLLACK

ADDRESS

PROGRESS NOTES

DATE	DEPARTMENT	
9/24/XX	**MEDICINE**	
		S - Laboratory studies completed to confirm UTI and to rule out pyelonephritis and prostatic carcinoma.
		O - Urinalysis: Specific gravity 1.030, pH 7.4, negative for protein, glucose and ketones. Microscopic: No RBCs, WBCs or casts seen. Creatinine 1.0, BUN 13, WBC 10.6 with normal differential, acid phosphatase 0.5, prostate specific agglutinins 2.2. Urine culture positive for Enterobacter resistant to ampicillin and Keflin.
		A - Urinary tract infection secondary to Enterobacter. No evidence of pyelonephritis or prostate carcinoma from serologic or urine testing.
		P - Urology consultation.
		Dilip Patel, MD

The Flow of Medical Information

Health professionals use the medical record to provide patient information for the different segments of the patient's care. The record helps the various practitioners involved in treating the patient to communicate with one another. It's not necessary for a doctor to individually speak with each healthcare professional. The medical record keeps the current healthcare providers abreast of the patient's treatment and progress. In addition, the record depicts for future providers an accurate picture of the patient's previous care. It enables one doctor who takes over for another to continue to treat the patient without interrupting care.

Another important use of the medical record is for reimbursements. The patient's medical record supplies information so the patient and third-party payers can be
billed for services and expenses. The medical record substantiates laboratory tests, medications and other services listed on an insurance claim.

The medical record serves other purposes as well. It's a legal business record for the healthcare provider. It gives the patient documentation for legal claims, such as the extent of injuries from an auto- or work-related accident. The record can be used to analyze and review the quality of patient care. It also can be used for research and education or for healthcare facility planning and market research. In addition, medical records help determine problems that the healthcare delivery system needs to address, such as increases in the occurrence of heart disease or breast cancer.

Medical records were first kept in hospitals. Now, virtually every healthcare provider maintains such records because complete files are necessary to verify medical expenses, validate the healthcare provided and meet government requirements. Although the format of the medical records may differ, all records contain similar information. The information that follows summarizes the purpose of the information that medical records provide.

Medical Records:

- Identify the patient
- Record results of tests and treatments
- Justify diagnoses and treatments
- Offer information to all providers involved in the patient's care
- Detail the patient's previous care for future providers
- Maintain a record of services for billing third-party payers
- Provide the healthcare facility with a legal business record
- Provide tools for evaluating patient care
- Provide documentation for study and research
- Give healthcare providers data for planning delivery of services and marketing

It's time to pause for a Practice Exercise to review what you've learned.

Step 4: Practice Exercise 10-1

Choose the best answer from the choices provided, and write your answers on scratch paper.

1. **A medical record _____.**
   a. is generated when a patient receives medical care
   b. usually begins its life as a questionnaire or patient data sheet
   c. provides a complete picture of the health care the patient has received
   d. all of the above

2. **Which of the following is NOT an important use of a medical record? _____**
   a. It's a legal business record for the healthcare provider.
   b. It can be used for research and education.
   c. It can be used to train doctors.
   d. It's used for reimbursement.

3. **_____ justify diagnoses and treatments and detail the patient's previous care for future providers.**
   a. Flow charts
   b. Admissions records
   c. Encounter forms
   d. Medical records

4. **The format used and kinds of information recorded in each medical record is _____ from one facility to another.**
   a. similar
   b. exactly the same
   c. very different
   d. often lost when the record is transferred

Step 5: Review Practice Exercise 10-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

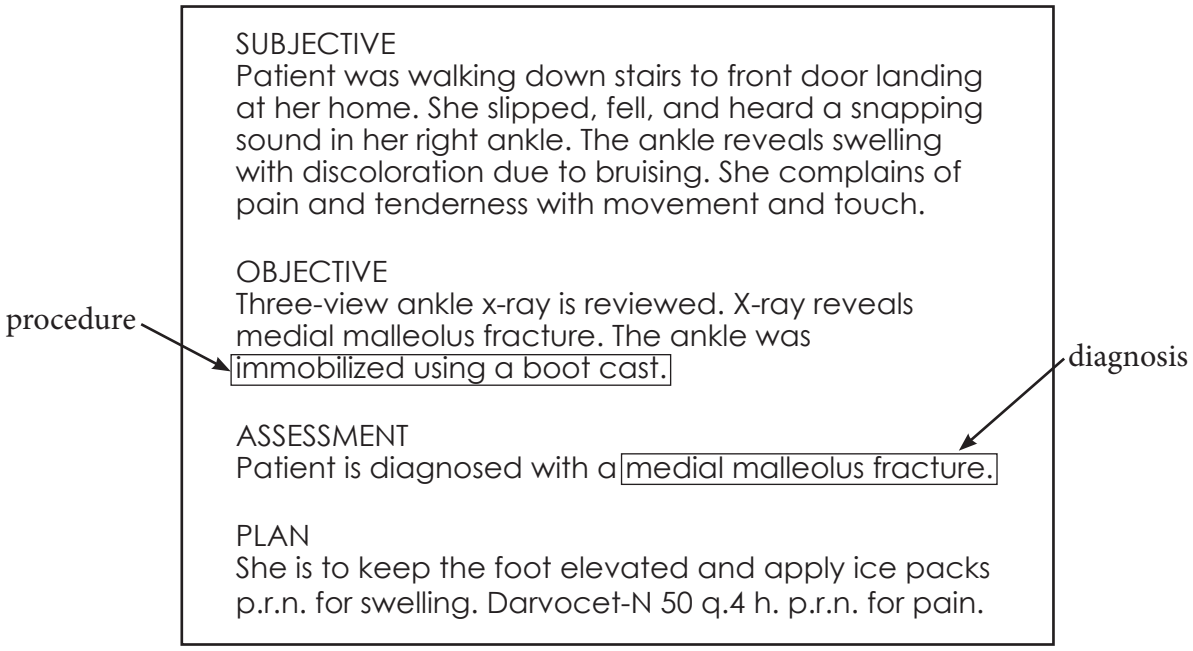
Step 6: Documentation

You know that medical records serve as a valuable source of communication. In fact, medical records act as an important resource for legal protection, financial reimbursement, education, quality assurance and medical research.

As a healthcare document specialist, you'll use a doctor's dictation to transcribe documentation. **Documentation** is the written record of the services that the provider performs. You see, patients are charged for services received based on what the physician documents. When the physician dictates the diagnosis and procedure for the medical records, these eventually end up on the medical bill.

A physician's dictation substantiates the charges on the medical bill. Because dictation records diagnoses and procedures, it contains a lot of the information that ends up on medical bills. This is the information you will use to assign the correct medical codes for reimbursement purposes.

Look at the following example of dictation that notes the diagnosis and procedure of Becky Johnson's physician visit.



Don't worry if you didn't understand everything in the previous example. Just remember that the diagnosis, or problem, and procedure, or what was done about the problem, are what you will use to assign codes.

Physician documentation has another important function; it represents a database for reimbursement decisions for Medicare, Medicaid, third-party insurance coverage and workers' compensation payments. If services are provided but not documented, the healthcare provider will not be reimbursed. In other words, *if it's not documented, it didn't happen.* Let's take a look at a quick example.

Dr. Green biopsies a skin lesion on a patient's face and removes two skin tags. A biopsy means to remove and examine a living tissue sample. Dr. Green documents the biopsy but fails to document the removal of the skin tags. The insurance company receives a claim indicating both procedures and then requests the medical record to confirm the procedures performed. But remember, the doctor only documented the biopsy. Because Dr. Green failed to document the removal of the skin tags, the insurance company only will reimburse for the biopsy procedure. Ah! Not a pleasant outcome for the doctor! However, as a healthcare document specialist, you'll be trained to notice that the physician left off the procedure in his dictation.

Let's look at another example—this one also illustrates the importance of documentation. A new patient comes to a local clinic with a complaint of ear pain. The physician takes the patient's history, and she then performs an exam. After the patient leaves, the doctor dictates the service; however, she is interrupted and ends the dictation after documenting the patient's history.

This dictation goes to the healthcare document specialist. She transcribes the dictation and then reads the dictation to apply codes and notes the incomplete documentation. In this case, the healthcare document specialist will contact the physician to correct this error. Later in this lesson when you learn how to handle medical records, you'll discover the proper procedures healthcare professionals use to correct an error.

So as a healthcare document specialist, you can see how important the accuracy of documentation—written and verbal—is to everyone working in the healthcare field. Now let's move on to study the different types of documentation and narrative formats you may encounter in your daily work.

Types of Documentation

The type and format of a physician's *dictation* vary among facilities, but all dictation contains the date and time the entry was written, the patient's complaint, the problem and what the physician did during the service.

Study the following sample of a history and physical transcribed report.

Name: Yasuyo Mora
#030601
Dr Anne Jones

HISTORY AND PHYSICAL EXAMINATION

HISTORY

CHIEF COMPLAINT
Exacerbation of CLL and lymphoma.

HISTORY OF PRESENT ILLNESS
This is a 78-year-old Asian woman who presented with symptoms of chronic lymphocytic leukemia and was treated with chemotherapy. She went into complete remission and then relapsed into a lymphomatous state. She has received chemotherapy on an intermittent basis. The last chemotherapy was 3 months ago. Now she is seen in the office because of increasing general malaise, leukocytosis, weight loss, cough, multifocal adenopathy and right pleuritic chest pain. History of prior aortic aneurysm repair.

REVIEW OF SYSTEMS
Appetite and weight have been poor. Denies nausea, abdominal pain or changes in bowel habits. No genitourinary or musculoskeletal complaints.

PHYSICAL EXAMINATION
GENERAL: Skin was normal in color and turgor.
HEENT: Head: Normocephalic. Mouth: Good dental hygiene.
NECK: The neck is supple, but there is submandibular adenopathy.
CHEST: The chest is clear to percussion and auscultation. The heart has regular sinus rhythm without murmurs or gallops.
ABDOMEN: Abdomen is soft and nontender with inguinal and femoral adenopathy. There is no hepatosplenomegaly. There is fullness in the left iliac fossa.

IMPRESSION
Exacerbation of chronic lymphocytic leukemia, lymphomatous type.

PLAN
Admit to hospital for chemotherapy including VP-16, Oncovin, bleomycin and methotrexate.

_____
Anne Jones, MD

D: 02/04/20XX
T: 02/04/20XX
AJ:MT

Commonly Used Narrative Formats

Providers use a common dictation format with some variations, of course. Now that you have seen a history and physical report, let's take a look at another type of medical report format, the SOAP report (also called the chart note). Aside from the loosely structured traditional narrative, this frequently used format is identified by the acronym—SOAP.

The **SOAP** format stands for subjective, objective, assessment and plan. If you see dictation that includes something like "SUBJECTIVE, Patient has no burning on urination...," then the provider is using a SOAP format.

- **S**ubjective means the patient's point of view or complaint.
- **O**bjective refers to the clinical findings.
- **A**ssessment is the examiner's diagnosis based on the clinical findings.
- **P**lan refers to the doctor's order.

You might encounter other dictation formats, as well. For example, you might see dictation with the following headings:

- **CC**, which stands for chief complaint and is the same as Subjective in the SOAP format.
- **Px**, which stands for physical examination and is the same as Objective in the SOAP format.
- **Dx**, which stands for diagnosis and is the same as Assessment in the SOAP format.
- **Rx**, which stands for prescription and is the same as Plan in the SOAP format.

Before you move on, let's look at an example of SOAP dictation:

PROBLEM
Acute chest pain.

SUBJECTIVE
The patient has long-standing osteoporosis and rheumatoid arthritis, under treatment with prednisone 40 mg p.o. daily. Yesterday she experienced the onset of severe left chest pain in the left midaxillary line. She has had pleuritic pain and dyspnea since that time. There is no history of trauma. In addition, there is pain in the right ankle.

OBJECTIVE
There is pinpoint tenderness in the midaxillary line over ribs 4-6. There is 3/5 limitation of motion of right ankle secondary to pain. Inversion-eversion motion 3/5. The femoral, popliteal, posterior tibial, dorsalis pedis pulses are full and equal bilaterally. The Achilles tendon reflexes are equal bilaterally. There is pronation deformity of the right ankle and minimal swelling of the right ankle. The tibiotalar joint appears to be well maintained. The taloscaphoid area has more swelling.

ASSESSMENT
1. Rule out spontaneous rib fractures secondary to prednisone therapy.
2. Rheumatoid arthritis with destructive disease of the subtalar joint.
3. Osteoporosis.

PLAN
Rib series and rib taping if fractures are present. Bone survey with attention to the right ankle and foot. Orthopedic consultation for evaluation of right ankle and foot.

_____
Ryo Miyamoto, MD

D: 12/20/20XX
T: 12/20/20XX
RM:JEF

Step 7: The Business of Managing Medical Records

Different medical facilities manage medical records in various ways—each method is designed to promote *good recording practices*. **Good recording practices** include those activities and procedures that the healthcare professionals do to ensure that a patient's medical record is *legible*, *understandable*, *timely*, *error free* and *reproducible*. Let's look more closely at the medical-records-handling elements that are likely to affect you as a healthcare document specialist.

Good Recording Practices

Every medical record must be:

- **Legible**. The doctor might have to rewrite the entry if key elements of a written health record actually cannot be deciphered. This action should be reserved for only the critical elements of the health record, and the request must be made very diplomatically. If the illegible part of the record has been documented legibly elsewhere, or is clear on the dictation, no rewrite should be requested.
- **Understandable**. For medical records to be understandable, abbreviations and arrangement of forms in the medical record must be consistent with the medical facility's standards and procedures. Everyone on the medical staff should know the facility's rules for the use of abbreviations in the medical record. In fact, personnel should have an official list of acceptable abbreviations and their meanings.
- **Timely**. Timeliness of entries is critical to the accuracy of the health record. The medical record must be coded in a timely manner, and the bill must be submitted in a reasonable amount of time. This way if information is lacking or incorrect, the sooner it gets to the provider, the sooner the situation can be remedied.
- **Error free**. How errors are corrected is extremely important in terms of patient care, as well as for legal purposes. When an error is made in the medical record, several protocols should be taken.
- **Reproducible**. A medical record must be correctly formatted and clear. Medical records may be copied, microfilmed or even scanned electronically for storage. Consequently, handwritten entries must be made in black ink, and computer-generated reports must be reproducible.

Let's look at the protocols for correcting an error in a medical record.

Correcting a Written Medical Record

- The entry should be crossed out with a single line.
- The source of the error should be noted, such as indicating that the entry pertains to another patient or noting another specific reason for the error.
- The initials of the person making the correction should be noted.
- The date and time the error was discovered should be noted.

Let's look at an example of how an error would be corrected on a written medical record. The original dictation indicates the arm was cut. It was discovered the leg, not the arm, was cut. The dictation would be corrected as follows. You'll see the initials of the person making the corrections at the top of the record, with the time in military format and the date.

JL, 1547,
12/07/XX

SUBJECTIVE
Jeff complains of a 3.5 cm wound on his ~~arm~~ leg that he received while cutting wood.

OBJECTIVE
Superficial wound measuring approximately 3.5 cm. The wound is cleaned and then repaired with a simple closure.

ASSESSMENT
The patient is diagnosed with a 3.5 cm simple ~~arm~~ leg laceration.

PLAN
Patient to watch for signs of infection such as redness or oozing. He is to return in a week for the removal of the sutures.

Correcting an Electronic Health Record

Correcting an error in an EHR should follow the same basic principles as correcting a written medical record. The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated. When correcting or making a change to an entry in an EHR, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted. In situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected.

Well, now you have an idea of what types of documentation you'll primarily use to "get your facts" on each patient. Don't worry if you didn't recognize some of the terminology in the reports; you'll continue to add to that knowledge throughout your program and throughout your career!

Step 8: Practice Exercise 10-2

Choose the best answer from the choices provided, and write your answers on scratch paper.

1. **_____ is/are an important resource for legal protection, financial reimbursement, education, quality assurance and medical research.**
   a. Nursing notes
   b. Encounter forms
   c. Dictation
   d. Medical records

2. If services are provided but not documented, reimbursement to the healthcare provider _____.

a. will not be a problem
b. will not occur
c. probably will be delayed indefinitely
d. will be provided only if the coder signs off on the documentation

3. Which of the following is NOT contained in all dictation?

a. The nurse's notes on the diagnosis and procedure
b. The patient's complaint
c. What the physician did during the service
d. The date and time the entry was written

4. _____ means the patient's point of view or complaint.

a. Assessment
b. Objective
c. Subjective
d. Evaluation

5. _____ stands for diagnosis and is the same as assessment in the SOAP format.

a. Dx
b. Rx
c. CC
d. Px

6. Which of the following is NOT one of the good recording practices mentioned in this lesson?

a. Organization
b. Timely
c. Error free
d. Reproducible

7. _____ medical records means the use of abbreviations and arrangement of forms in the medical record is consistent with the medical facility's standards and procedures.

a. Reproducible
b. Timely
c. Understandable
d. Error free

Step 9: Review Practice Exercise 10-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 10: Lesson Summary

In this lesson, you learned how important doctor dictation and accurate documentation are to medical records. You know that you, the healthcare document specialist, will use doctor dictation to ensure that providers get reimbursed for the services they provide. We also talked about the different types of documentation, and you studied examples of documentation and narrative formats that you might encounter in your work.

You know how essential it is that all medical facilities have standardized processes and procedures in place to ensure that patient healthcare records are legible, understandable, timely, error free and reproducible.

Congratulations! You are ready to take the final Quiz in this course, which covers medical records and legal issues! Once you have completed the Quiz, you'll be ready to tackle the next course in your Healthcare Documentation Program. You're doing great!

Step 11: Quiz 7

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Course One
Healthcare Documentation Program
Answer Key

Lesson 1

Practice Exercise 1-1

1. The **a. office manager** is usually the first person in the doctor's office to see a patient.

2. When the patient tells the doctor what's wrong, the information is called the **c. chief complaint**.

3. An outstanding claim is one that **d. hasn't been paid yet**.

4. Describe the five basic responsibilities of a healthcare document specialist.

    1. **Transcribe/Edit Dictation.**

       As a healthcare document specialist, you will create dictation by transcribing digital voice files into dictation, or by editing text that has been created by computer software systems.

    2. **Code Dictation.**

       Once the dictation is complete, the healthcare document specialist will read the dictation to determine the diagnoses and procedures that apply. Reference manuals are used to assign codes to represent the diagnoses and procedures.

    3. **Complete and Submit Insurance Claim Forms.**

       Using the codes obtained from the reference manuals, as well as patient and physician information, you will complete and submit the appropriate insurance claim form.

    4. **Follow Up on Claims and Bills.**

       After you submit the insurance claim form, you might need to contact the insurance company regarding the claim. You might also need to follow up with patients to secure payment.

    5. **Secondary Insurance Claims and Patient Billing.**

       After the primary insurance carrier has paid its share of the bill, if the patient has secondary insurance, you will submit a bill to the secondary carrier. If the patient does not have secondary insurance, then the patient may be responsible for paying whatever remains after the primary carrier has paid.

Practice Exercise 1-2

1. A healthcare document specialist should exhibit three personal qualities: **professionalism**, **presentation** and **adaptability**.

2. The **image** you project is important.

3. Handling several responsibilities at once is termed **multi-tasking**.

4. **Adaptability** is the ability to be modified or changed.

5. Explain the most important character traits of a successful healthcare professional.

   1) Curiosity and Drive—includes a true interest in the field, a constant desire keep up with the ever-changing field and willingness to keep an open mind and learn new skills.

   2) Warmth and Confidence—includes an appreciation for the satisfaction of caring for others, as well as being courteous, pleasant and able to put a patient at ease.

   3) Organizational and Professional Skills—includes the ability to handle several responsibilities at once, make lists of things to do, keep charts and other paperwork organized and prioritize.

Lesson 2

Practice Exercise 2-1

1. **a. Insurance** is a contract between an individual or group and an insurance company.

2. The payments from the insured person or group that are collected by the carrier are known as **c. premiums.**

3. The second-party payer is the **c. physician**.

4. The amount of money an individual must pay before insurance benefits begin is called the **a. deductible.**

5. The process of notifying an insurance company before hospitalization, surgery or tests is called **b. preauthorization**.

Practice Exercise 2-2

1. When an insurance company pays for medical services, it **d. reimburses** either the insured or the provider.

2. A form used by some doctors that contains the most common procedures performed by that doctor is called a(n) **c. encounter form**.

3. A patient may simply make a copayment for a visit and then the **a. provider bills the insurance company for the remainder of the bill**.

4. An error on the claim form may **a. delay** reimbursement.

4. When you write a code on an insurance form, you are **b. coding** that entry.

6. Diagnosis codes are contained in the **c. *ICD-10-CM*** manual.

Practice Exercise 2-3

1. Managed care gives insurance providers a basis for **b. predicting** healthcare costs.

2. **b. Managed care coverage** limits the patient's freedom to choose doctors.

3. HMO stands for **c. health maintenance organization**.

4. The program that provides managed healthcare coverage for military service families is called **c. TRICARE**.

5. The program that provides health care for the families of veterans with permanent, service-related disabilities is called **CHAMPVA**.

6. A(n) **accident** is described as an unplanned or unexpected happening causing injury or death not due to any fault of the employee.

7. Medicare is a(n) **federally** funded health insurance program.

8. Medicare Part A covers **medically necessary** hospital care and services.

9. Medicare Part B covers medical **services and supplies**

10. An advance payment for coverage of potential services is termed **premiums**

11. Private insurance carriers operate **for profit** and can raise rates at will.

12. The insured is also known as the **subscriber**

Lesson 3

Practice Exercise 3-1

1. The insured is often called the **subscriber**.
2. A(n) **private insurance** carrier operates for profit and can raise rates at will.
3. A(n) **policy** describes the subscriber's benefits and coverage.
4. Advance payment for coverage of potential services is known as **prepay**.
5. A(n) **identification card** lists vital information that allows completion of claim forms.

Practice Exercise 3-2

1. One of the first managed care systems covered workers building the Grand Coulee Dam in **d. 1938**.
2. Managed care gives insurance providers a basis for **b. predicting** healthcare costs.
3. HMO stands for **c. health maintenance organization**.
4. PPGs are **a. physician provider** groups.
5. HSA stands for **b. health savings account**.

Lesson 4

Practice Exercise 4-1

1. There are **a. 10** CMS regional offices.
2. Medicaid was officially established in **d. 1965**.
3. Although **d. Medicaid and CHIP** is/are financed by state and federal governments, it is/they are run by each state.
4. Medicaid recipients each receive ID cards or coupons that note **b. his/her classification of eligibility**.
5. **c. Preauthorization** for specific services, or the review of proposed treatment for appropriateness by Medicaid, is required by some states.
6. Which statement is NOT true of the Children's Health Insurance Program? **a. CHIP was created in 1965.**

Practice Exercise 4-2

1. Medicare is a(n) **federally** funded health insurance program.
2. Medicare Part A covers **medically necessary** hospital care and services.
3. Medicare Part B covers **medical** services and supplies not covered by Medicare Part A.
4. **Medigap** policies pay for expenses not covered by Medicare Parts A and B.
5. Supplemental insurance policies do not duplicate **Medicare** coverage.
6. Supplemental insurance benefits are paid directly to the **physician**.
7. Claims for Medi-Medi patients are submitted to **Medicare** first.
8. Medicare Part **D** assists with the yearly out-of-pocket prescription expenses.
9. ABN stands for **Advance Beneficiary Notice**.

Lesson 5

Practice Exercise 5-1

1. The program that provides managed healthcare coverage for military service families is called **c. TRICARE**.
2. The program that provides health care for the families of veterans with permanent, service-related disabilities is called **a. CHAMPVA**.
3. **b. TRICARE Extra** is a PPO-type option and provides healthcare services on a visit-by-visit basis.
4. When enrolled in TRICARE Prime, a **d. primary care manager** (**PCM**) is assigned or chosen for the beneficiary.
5. The database listing people eligible for TRICARE is called **b. Defense Enrollment Eligibility Reporting System, DEERS**.
6. **b. TRICARE Prime** is an HMO-type option and is the least costly of the TRICARE options.
7. Ms. Jones has a tan identification card, which means she is a(n) **c. active-duty family member**.

Practice Exercise 5-2

1. A(n) **accident** is described as an unplanned or unexpected happening causing injury or death not due to any fault of the employee.

2. **COBRA** is available to the dependents and the spouse of the employee in the case of a divorce or the death of the employee.

3. A(n) **medical disability** is a condition that disables the person.

4. **Temporary disability** includes claims where the employee is expected to be unable to work for a period of time while he recuperates from his injuries.

5. Employers with sufficient capital can set up a fund to cover expenses incurred by job related accidents or illnesses called **Employer Self-insured Programs**.

6. The Black Lung Benefits Act provides benefits to **coal miners**.

Lesson 6

Practice Exercise 6-1

1. The foundation word part of a medical term is called a(n) **root word**.

2. The word part that is attached to the end of a term is a(n) **suffix**.

3. In a medical term, a prefix is found at the **beginning**.

4. The word part that joins a root word and another word part is a(n) **combining vowel**.

5. The word part that is attached to the beginning of a term is a(n) **prefix**.

6. In a medical term, a suffix is found at the **end**.

7. A suffix is attached to the word part call the **root word**.

8. A prefix is attached to the word part called **the root word**.

9. A combining vowel combines a word part and a(n) **root word**.

10. In the term *dermat/o/logy*, the word part */o/* is called a **combining vowel**.

Practice Exercise 6-2

Part I

	Root Words	Meanings
1.	append/o, appendic/o	**appendix**
2.	arthr/o	**joint**
3.	derm/o	**skin**
4.	muc/o	**mucus**
5.	hydr/o	**water, fluid**
6.	norm/o	**proper, rule**
7.	neur/o	**nerve**
8.	lith/o	**stone**
9.	therm/o	**heat**
10.	path/o	**disease**

Part II

	Meanings	Root Words
11.	lung	**pulmon/o**
12.	small intestine	**enter/o**
13.	life	**bi/o**
14.	liver	**hepat/o**
15.	giving rise to	**gen/o**
16.	muscle	**my/o**
17.	pressure	**tens/o**
18.	cut into	**secti/o**
19.	kidney	**ren/o**
20.	blood	**hem/o, hemat/o**

Practice Exercise 6-3

Part I

	Prefixes	Meanings
1.	a/	**without, absent**
2.	ec/, ecto/	**outside, outer**
3.	infra/	**inferior to, below**
4.	peri/	**around, surrounding**
5.	hypo/	**decreased, below**
6.	micro/	**small, tiny**
7.	dia/	**through**
8.	epi/	**upon, in addition**
9.	hyper/	**increased, above**
10.	intra/	**within**

Part II

	Meanings	Prefixes
11.	under, inferior to	**sub/ or infra/**
12.	half	**hemi/**
13.	against, opposed	**anti/**
14.	all, every	**pan/**
15.	away from	**ab/**
16.	between	**inter/**
17.	slower than usual	**brady/**
18.	gross, large	**macro/**
19.	again, back	**re/**
20.	behind, back	**retro/**

Practice Exercise 6-4

Part I

	Suffixes	Meanings
1.	/ectomy	**removal**
2.	/gram	**picture, record, tracing**
3.	/logy	**study of**
4.	/ist	**one who does**
5.	/megaly	**enlargement**
6.	/stasis	**control, hold in**
7.	/ac	**relating to**
8.	/meter	**distance measure, instrument to measure**
9.	/ism	**situation, process, condition**
10.	/oid	**like**

Part II

	Meanings	Suffixes
11.	condition	**/ia**
12.	inflammation	**/itis, /itic**
13.	pathologic condition	**/osis**
14.	disease process	**/pathy**
15.	pain	**/algia**
16.	look at	**/opsy**
17.	withdrawing fluid	**/centesis**
18.	go	**/grade**
19.	instrument to see with	**/scope**
20.	throughout the blood	**/emia, /hemia**

Lesson 7

Practice Exercise 7-1

	Medical Terms	Meanings
1.	cardi/o/megaly	**enlargement of the heart**
2.	acr/o/megaly	**enlargement of the extremities (tips)**
3.	macro/gloss/ia	**condition of a large (gross) tongue**
4.	hist/o/logy	**study of tissue**
5.	arthr/itis	**inflammation of the joint**
6.	splen/o/megaly	**enlargement of the spleen**
7.	a/leuk/o/cyt/osis	**condition of the absence of white cells**
8.	thorac/o/centesis	**withdrawing fluid from the chest**
9.	gastr/ectomy	**removal of the stomach**
10.	pulmon/ary	**relating to the lung**

Practice Exercise 7-2

Part I

	Word Parts	Meanings
1.	carcin/o	**cancer of the gland tissue**
2.	ox/o	**oxygen**
3.	laryng/o	**voicebox, larynx**
4.	cerebr/o	**brain**
5.	/genesis	**creating**
6.	axill/o	**armpit**
7.	/penia	**lack of, decrease, poor**
8.	/tome	**cutting instrument**
9.	/tomy	**cut into or slice**
10.	/oma	**tumor, mass**

Part II

	Meanings	Word Parts
11.	self	**auto/**
12.	run	**/drome**
13.	chemical, drug	**chem/o**
14.	with	**con/**
15.	change, beyond	**meta/**
16.	rib	**cost/o**
17.	female	**gynec/o**
18.	lower jaw	**mandibul/o**
19.	brain	**cerebr/o**
20.	many	**poly/**

Practice Exercise 7-3

	Medical Terms	Meanings
1.	oste/o/malacia	**softening of bone**
2.	sarc/oma	**tumor or mass of nongland tissue**
3.	carcin/oma	**cancer tumor or mass of gland tissue**
4.	con/nect	**bind with**
5.	maxill/ary	**relating to the upper jaw**
6.	laryng/itis	**inflammation of the voicebox**
7.	vit/al	**relating to living, alive**
8.	cost/al	**relating to the rib(s)**
9.	crani/o/tome	**cutting instrument for the skull**
10.	chem/o/therapy	**treatment with chemicals**

Practice Exercise 7-4

	Word Parts	Medical Terms	Meanings
1.	gastr/o enter/o /logy	**gastroenterology**	**study of the stomach and small intestine**
2.	oste/o /malacia	**osteomalacia**	**softening of bone**
3.	laryng/o /scope	**laryngoscope**	**instrument used to see the voicebox**
4.	carcin/o /oma	**carcinoma**	**cancer tumor or mass of gland tissue**
5.	sarc/o /oid	**sarcoid**	**like nongland tissue**
6.	muc/o /ous	**mucous**	**relating to mucus**
7.	thromb/o /osis	**thrombosis**	**pathologic condition of having a clot**
8.	hepat/o /ic	**hepatic**	**relating to the liver**
9.	peri/ col/o /itis	**pericolitis**	**inflammation of the tissue surrounding the colon**
10.	pulmon/o /ic	**pulmonic**	**relating to the lung**

Practice Exercise 7-5

	Medical Terms	Meanings
1.	chem/ist	**one who specializes in chemicals**
2.	crani/o/tomy	**cut into the skull**
3.	laryng/ectomy	**removal of the voicebox**
4.	endo/derm	**within the skin or inside tissue**
5.	peri/hepat/ic	**relating to around the liver**
6.	thromb/itis	**inflammation of a clot**
7.	sub/hepat/ic	**relating to under the liver**
8.	retro/gastr/ic	**relating to behind the stomach**
9.	myel/oid	**like the bone marrow or spinal cord**
10.	my/o/pathy	**muscle disease**
11.	ven/ous	**relating to a vein or the veins**
12.	nat/al	**relating to birth**
13.	klept/o/mania	**obsession with stealing**
14.	neur/osis	**pathologic condition of the nerves**
15.	electr/ic	**relating to electrical activity**
16.	arteri/al	**relating to an artery**
17.	cyst/ic	**relating to a sac of fluid or bladder**

Practice Exercise 7-6

Part I

	Word Parts	Meanings
1.	lapar/o	**abdomen**
2.	pneum/o	**air, gas, lung air sacs**
3.	ana/	**positive, up**
4.	/physis	**grow**
5.	/pnea	**breathing**
6.	bronch/o	**airway tubes in lung**
7.	cutane/o	**skin surface**
8.	mort/o	**death**
9.	psych/o	**mind**
10.	phob/o	**fear**

Part II

	Meanings	Word Parts
11.	break down, dissolve	**/lysis, lytic**
12.	bad, labored	**dys/**
13.	nose	**rhin/o**
14.	bear	**/phoria**
15.	secrete	**/crine, crin/o**
16.	ear	**ot/o**
17.	eye	**ophthalm/o**
18.	kidney	**nephr/o**
19.	tonsils	**tonsill/o**
20.	flow	**/rrhea**

Lesson 8

Practice Exercise 8-1

	Abbreviation/Acronyms	Meanings
1.	CO_2	**carbon dioxide**
2.	mg	**milligram**
3.	O_2	**oxygen (gas)**
4.	n.p.o.	**nothing by mouth**
5.	NBS	**normal bowel sounds**
6.	EBV	**Epstein-Barr virus**
7.	kg	**kilogram**
8.	TPR	**temperature, pulse and respiration**
9.	IM	**intramuscular**
10.	q.n.s.	**quantity not sufficient**
11.	b.i.d.	**two times a day**
12.	DOB	**date of birth**
13.	Dx	**diagnosis**
14.	IV	**intravenous**
15.	stat	**at once**
16.	q.a.m.	**every morning**
17.	GB	**gallbladder**
18.	Sx	**symptoms**
19.	Rx	**treatment, prescribe**
20.	FUO	**fever of unknown origin**

Practice Exercise 8-2

1.	sibs	**d.**	**siblings, brothers and sisters**
2.	prep	**h.**	**prepare, preparation**
3.	meds	**a.**	**medications**
4.	ab	**e.**	**abortion**
5.	exam	**j.**	**examination**
6.	path	**c.**	**pathology**
7.	appy	**i.**	**appendectomy, appendicitis**
8.	primip	**f.**	**primipara, woman with one previous birth**
9.	nullip	**b.**	**nullipara, woman with no deliveries**
10.	temp	**g.**	**temperature**

Practice Exercise 8-3

1.	temperature (Celsius or Fahrenheit)	**o**
2.	number	**#**
3.	suture size	**-**
4.	over (blood pressure)	**/**
5.	and (between capitals)	**&**
6.	minus	**–**
7.	vision	**/**
8.	ratio	**:**

Practice Exercise 8-4

	Medical Phrases	Acronyms
1.	blood urea nitrogen	**BUN**
2.	white blood count	**WBC**
3.	Venereal Disease Research Laboratory	**VDRL**
4.	rheumatoid arthritis	**RA**
5.	human immunodeficiency virus	**HIV**
6.	Physician's Desk Reference	**PDR**
7.	(The) pupils (are) equal, round (and) reactive (to) light (and) accommodation	**PERRLA**
8.	electr/o/encephal/o/gram	**EEG**
9.	eye, ear, nose (and) throat	**EENT**
10.	intra/muscular	**IM**

Practice Exercise 8-5

1. micro/ **small, tiny**
   macro/ **gross, large**
2. ante/ **before**
   retro/ **behind, back**
3. pre/ **before**
   post/ **after, past**
4. hypo/ **decreased, below**
   hyper/ **increased, above**
5. eu/ **normal, even, good**
   dys/ **bad, labored**
6. con/ **with**
   contra/ **opposite, against**
7. tachy/ **faster than usual**
   brady/ **slower than usual**
8. ana/ **positive, up**
   cata/ **negative, down**
9. ab/ **away from**
   ad/ **toward, near**
10. infra/ **inferior to, below**
    supra/ **above, superior to**
11. /malacia **softening**
    /sclerosis **hardening**
12. a/ **without, absent**
    (not using this prefix is the antonym)
13. endo/ **within**
    ecto/ **outside, outer**

Practice Exercise 8-6

	Singular Medical Terms	Medical Plurals
1.	synthesis	**syntheses**
2.	centrum	**centra**
3.	vena	**venae**
4.	nervus	**nervi**
5.	ganglion	**ganglia**

Lesson 9

Practice Exercise 9-1

1. The two main objectives of HIPAA are **portability** and **accountability**.
2. **Covered entities** are healthcare professionals who transmit any health information in electronic form.
3. The **Privacy Rule** addresses the use and disclosure of patients' health information.
4. TPO stands for **treatment**, payment and healthcare **operations**.
5. The Security Rule does not apply to PHI transmitted **orally or in writing**.
6. **Employer Identification Number** (**EIN**) is issued by the Internal Revenue Service (IRS) to identify employers on standard transactions.
7. The **NPI** is a 10-position, numeric identifier that does not carry other information about healthcare providers.
8. The term **breached** refers to a violation or infraction of a standard.
9. When protected health information is unsecured it means the information hasn't been **encrypted**.
10. A conscious, intentional failure or reckless indifference to the obligation to comply with the administrative simplification provision is **willful neglect**.

Practice Exercise 9-2

As a healthcare professional, you cannot release any medical information unless it is to an authorized person because the information is **confidential**.

2. Ethical guidelines are often spelled out in a document called a **code of ethics**.

3. You should **never** fax sensitive test information.

4. Damages directly related to fraud are termed **compensatory** damages.

5. The **Federal False Claims Act (FCA)** prohibits anyone from presenting a false or fraudulent claim to be paid by the government.

6. Fraud includes inaccurate information that is used to wrongfully gain **compensation**.

7. Fraud and abuse can be reported to the **Office of Inspector General**.

8. A(n) **insurance audit** is a thorough review by the insurance company of a claim and all related documentation.

9. **RACs** are paid on a contingency fee basis, receiving a percentage of the improper payments they collect from providers.

10. A(n) **subpoena** can authorize the legal release of confidential medical records.

11. A(n) **arbitrator** is a person chosen to decide a dispute or settle differences.

12. When a person lies during testimony, he can be charged with **perjury**.

Lesson 10

Practice Exercise 10-1

1. A medical record **d. all of the above**.

2. Which of the following is NOT an important use of a medical record? **c. It can be used to train doctors.**

3. **d. Medical records** justify diagnoses and treatments and detail the patient's previous care for future providers.

4. The format used and kinds of information recorded in each medical record is **a. similar** from one facility to another.

Practice Exercise 10-2

1. **d. Medical records** is/are an important resource for legal protection, financial reimbursement, education, quality assurance and medical research.

2. If services are provided but not documented, reimbursement to the healthcare provider **b. will not occur**.

3. Which of the following is NOT contained in all dictation? **a. The nurse's notes on the diagnosis and procedure**

4. **c. Subjective** means the patient's point of view or complaint.

5. **a. Dx** stands for diagnosis and is the same as assessment in the SOAP format.

6. Which of the following is NOT one of the good recording practices mentioned in this lesson? **a. Organization**

7. **c. Understandable** medical records means the use of abbreviations and arrangement of forms in the medical record is consistent with the medical facility's standards and procedures.