



Medical Claims and Billing Specialist

Instruction Pack 1

Lessons 1-7

Explore the possibilities

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Medical Claims and Billing Specialist

Instruction Pack 1

- Lesson 1: Welcome to the Exciting World of
Medicine and Medical Claims**
- Lesson 2: The Third-party Payer: How
Insurance Works**
- Lesson 3: Handling Claims**
- Lesson 4: Private Insurance and Managed
Care Programs**
- Lesson 5: Medicaid and Medicare**
- Lesson 6: Military Insurance, Workers'
Compensation and COBRA**
- Lesson 7: Medical Terminology—Word Parts**

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Lesson 1

Welcome to the Exciting World of Medicine and Medical Claims



Step 1 Learning Objectives for Lesson 1

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
 - Describe a medical bill and its important characteristics.
 - Describe an encounter form, and discuss how it is used.
 - Explain the basic administrative activities in a medical office.
 - Determine the role of the medical claims specialist (you!).



Step 2 Lesson Preview

- ❑ Medical claims is an exciting and expanding medical field. You will work with people who save lives! Currently, employment opportunities in the medical claims and billing field are increasing throughout the country. This course will give you the skills you need to find the job YOU are looking for. And at U.S. Career Institute, we will continue to help you after you graduate. We offer graduate assistance to every student who completes our courses. We will counsel you on marketing yourself, as well as preparing yourself 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 have completed the course and are working in the field, U.S. Career Institute is dedicated to your success.

Your course is 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! As you go through the first few lessons, you'll notice that they always share the same basic order.



You selected a booming and lucrative career—medical claims and billing!

You will always have Learning Objectives and a Lesson Preview first. From there, you will read new material and then take a Practice Exercise—a self-graded review. 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.

Typically, you will take a graded quiz once you complete a lesson. This quiz highlights what's important in the course. 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 find the right answer rather than memorizing the material.

If you have questions about any part of the course, feel free to call an instructor. We are here to make your trip through this material enjoyable and rewarding.

In this first lesson, you'll explore part of the routine in a medical office—the new patient questionnaire and patient encounter form. Then, you'll learn about many more activities that occur in the medical office every day. You'll look at a typical day in a medical office, so you can see these activities from the points of view of both the front office professional and the medical claims specialist.

This course also provides you with an understanding of the medical biller's role in electronic billing. You will become familiar with common software used to submit insurance claims through an electronic clearinghouse for maximum reimbursement. U.S. Career Institute will guide you through every step of the medical claims and billing process.

Now, remember how we talked about the step-by-step nature of this course? Let's move on to Step 3.



Step 3 Welcome to Your Career as a Medical Claims and Billing Specialist!

- You chose a great profession for your career. The healthcare industry is booming, and it needs eager, qualified professionals. This is especially true for medical claims and billing specialists.

Employment in health care is growing rapidly for two reasons. The number of people in older age groups will grow faster than the total population. This increase is due to rising life expectancies and continual advances in medical technology. In addition, healthcare costs continue to climb, which means more doctors want to get paid, which means more job opportunities for you—the medical claims and billing specialist!

Obviously, the medical claims and billing subject interests you—that's why you enrolled in this course. Think of how you will help people—patients, physicians and medical office personnel. As a medical claims specialist, you serve as the liaison between each of these people and the many insurance companies that they work with. You'll perform work that's fun and challenging!

What Does a Medical Claims and Billing Specialist Do?

As a medical claims specialist, you work with medical bills, which help doctors and other healthcare providers get paid for their services. Medical claims and billing specialists complete insurance forms necessary to collect payment from insurance companies. These specialists know that the doctor doesn't get paid unless the form is completed and filed correctly. Billing specialists have training in medical terminology, medical records handling and some basic coding. We'll discuss this in greater detail later.

The first portion of this section introduces you to medical bills. You also will learn about charges for medical care, and explore how doctors and insurance companies figure these charges. You'll see how a bill is generated from a patient's first contact all the way through processing and payment. Finally, we'll show you a common document in many doctors' offices, hospitals and other medical care facilities—the patient encounter form. Ready to dive in? Let's go!

What is a Medical Bill?

Have you seen a medical bill? More than likely, you have seen one at some point. A patient generates a **medical bill** when she receives medical care, which usually begins its life as a questionnaire. Think back to the last time you went to a new doctor—you probably filled out a **new patient questionnaire**. The form asks you about your medical history, insurance coverage and other important facts. Let's look at an example questionnaire.

Patient Data Sheet		Date: _____
Patient Name:		
Last: _____ First: _____ MI: _____		
Street/P.O. _____ City/State _____ Zip Code _____		
Sex: M <input type="checkbox"/> F <input type="checkbox"/> 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)		
Last: _____ First: _____ MI: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/> Birthdate _____
Last: _____ First: _____ MI: _____		M <input type="checkbox"/> F <input type="checkbox"/> Birthdate _____
Last: _____ First: _____ MI: _____		M <input type="checkbox"/> F <input type="checkbox"/> Birthdate _____
Last: _____ First: _____ MI: _____		M <input type="checkbox"/> F <input type="checkbox"/> 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: _____

Medical Claims and Billing Specialist

After you complete this form, the front office professional takes it and any applicable insurance information. Then, she enters the information into the office's database—usually on a computer—to create your medical file. The **medical file** contains all your medical history related to that doctor and his or her office. For example, if you go to Dr. Johnson for a physical every year, your medical history file at his office contains all the information from all of your previous visits. This information includes your physical condition, any diagnoses made and treatments provided.

How does all of this apply to the medical claims and billing specialist? In order to do a good job, the medical claims and billing specialist needs access to complete and accurate medical files. You'll use these documents in your new career to generate bills and insurance claims. **Medical claims** are invoices that list all procedures performed, any diagnoses made, all medicines administered and any other office charges. The **diagnosis** refers to what the doctor believes is wrong with the patient. The **procedures** refer to the doctor's treatment for the patient. All of these items cost the doctor's office, hospital or clinic money, which is why the medical provider must charge the patient for visits. When all this information is correct on the bill, the patient or insurance company pays all benefits due without worrying about overcharges. In addition, the clinic, office or hospital won't be underpaid, which happens when medical procedures are mistakenly left out of a patient's file.



Once you complete your questionnaire and return it to the front office professional, she creates your medical file.

The Lifecycle 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. 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 assistant. What you've done is start the life cycle of the **medical bill**. The assistant at the desk enters your information into the office computer. The computer may then produce a *patient encounter form* for your doctor to use. Usually a **patient encounter form** lists many types of procedures, from office visits to physical exams to x-rays to immunization. Based on the information you provided on the questionnaire, the assistant has the computer print your name, billing address, insurance company and policy number on the encounter form. Then when you go back to the examination room, your encounter form is part of the medical file the doctor works with as she examines you. Please note, in this course, the encounter form shows the *medical codes* that you need to complete a claim form. **Medical codes** are codes assigned to procedures and diagnoses that can occur during a patient's medical visit. Diagnostic codes for diagnoses and procedure codes for procedures performed.

Lesson 1—Welcome to the Exciting World of Medicine and Medical Claims

On the encounter form on the following page, you will see different levels listed under the heading *Office Service*. These levels indicate whether you are a new or established patient and the amount of care involved in your office visit—that is, the amount of history-taking, physical examination and decision-making required.

After your examination, the doctor notes the procedures she performed on the encounter form. Usually, there is more than one procedure. For example, she might check the *Level II, Established Patient* procedure and the *Immunizations and Injections—Influenza* procedure if you needed a flu shot. The noted items tell the office assistant what to charge you or your insurance company for your visit.

Now that your medical bill exists, what happens to it next? It's time to process the bill. Let's learn more!

Processing the Bill

Once the bill exists, it goes through several steps on its way to being paid. There are three common ways a patient and medical facility handle bills for medical care:

1. The insurance company requires the patient to pay the entire bill at the time of service before leaving the medical facility. Then, the patient submits a claim to the insurance company for reimbursement.

or

2. The patient pays a **co-payment** (a flat amount, such as \$20 or \$25) before leaving the medical facility. Then, the doctor's office bills the patient's insurance company by submitting a claim for the remainder of the bill.

or

3. The patient pays nothing up front, and the medical facility submits a claim to the patient's insurance company for the bill. Then, once the insurance company reimburses the doctor's office for the covered charges, the doctor's office sends a bill to the patient for the remaining costs that insurance did not cover.

Medical Claims and Billing Specialist

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

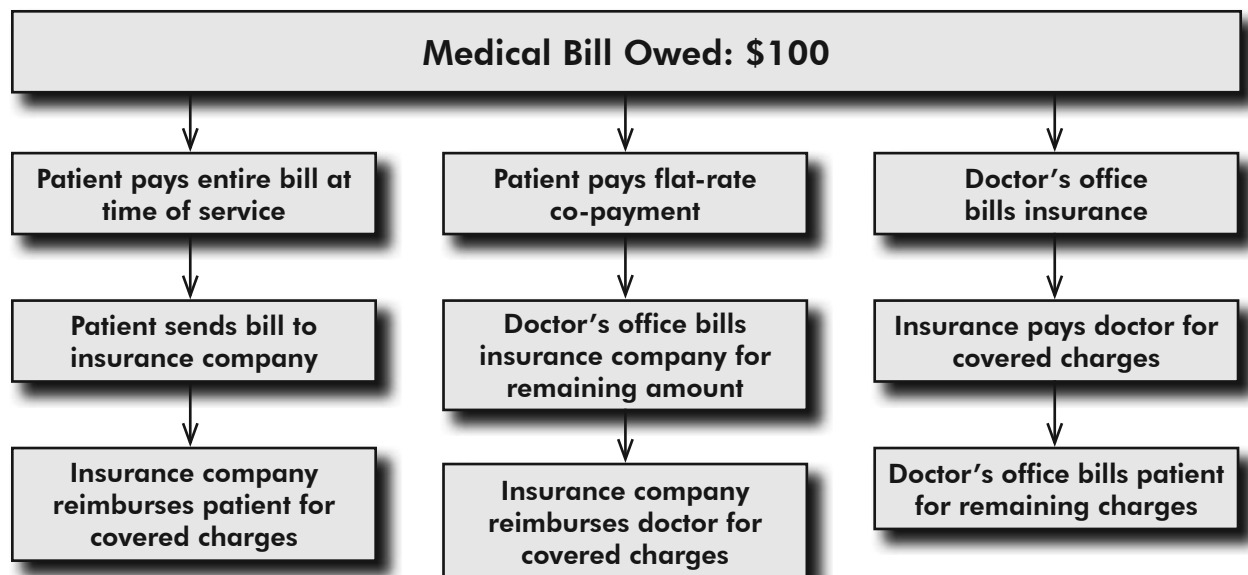
If, as the patient, you have to pay the entire bill on the day of your treatment, then, generally, it is up to you to send the bill to your insurance company. Your doctor's office is not obligated to submit claims to an insurance company unless it has a contract with that company or the federal government requires it—as is the case for Medicare and Medicaid. However, the doctor's office 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 office billing your insurance company is that when you pay at the time of service, the insurance company pays you directly.



You'll process bills differently depending on how the patient pays.

If the doctor's office bills your insurance company first, then usually you leave the office without paying any of the bill. The insurance company receives the doctor's request for payment and pays the covered amount, which varies according to your policy. Then, after the doctor 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 doctor would receive \$80 from the insurance company and bill you the remaining \$20.

When the insurance company pays for services, whether it pays you directly or the doctor's office, it is *reimbursing* either you or the office. **Reimbursement** is the process of paying someone back for services already performed.



A big part of the medical claims and billing specialist's role is to submit **insurance claims**—the bills to insurance companies that request payment in accordance with the appropriate insurance policies. Some medical claims and billing specialists work in doctors' offices, hospitals or clinics. Others work at home or for outside claims services. This course will give you the knowledge to be accurate and thorough—two essential qualities of a good medical claims and billing specialist—no matter where you decide to work.

The Importance of Being Accurate and Thorough

When the medical billing specialist correctly fills out and submits claims, payments come quickly, and the doctors are happy.

As a medical claims specialist, you might double-check bills as they come through your service. Usually, this means checking to be sure that the diagnosis matches the treatment or 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. Medical billing specialists can increase doctors' collections by as much as 10 percent to 15 percent! That's why medical claims and billing specialists play such an important role in the healthcare industry.

When bills include mistakes, they delay payments a month or more, delay processing and cost the doctor in denied claims, resubmission costs and reduced payments. Doctors need accurate medical claims specialists—like you—which is one of the great aspects of this career. Medical claims and billing specialists enjoy job security because people will *always* need doctors, and doctors will *always* need to bill 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!

Let's take a closer look at a typical day in a medical office.



Step 4 Everyday Procedures for the Front Office Professional

- ❑ To understand how a medical claims specialist gets information to do her job, you need to understand how people gather this material in the medical office. This information includes patient data and insurance company information, as well as doctor's procedures, diagnoses and other actions.

To illustrate the puzzle pieces, let's take a look at a typical day in a medical office. First, we'll examine the point of view of the first person a patient sees when she arrives for an appointment—the front office professional.

A Day in the Life of the Front Office Professional

Barbara is a front office professional for Mountain View Clinic, a busy family medical clinic. This clinic has five doctors—Dr. Hansen, Dr. Yates, Dr. Rivera, Dr. Gregg and Dr. Westlake. Barbara is responsible for tracking patients as they arrive and check in for their appointments. Each doctor sees about 15 patients a day. Barbara’s appointment book contains a different page for each doctor’s schedule. Barbara arrives at 7:30 a.m. ready to begin her day!



Let's meet Barbara—the office manager for a busy family medical clinic.

Barbara begins with the 8 a.m. appointments.

8:00 a.m.	Dr. Hansen	Mr. Anderson
	Dr. Yates	Mr. Burgess (new patient)
	Dr. Rivera	Ms. Smith
	Dr. Gregg	Mrs. Jones (new patient)
	Dr. Westlake	Mr. Wood

Each of the five doctors has a bright-and-early patient appointment scheduled. By 7:55 a.m., four of the five patients are in the waiting room. Two are new patients at the clinic, so they fill out the new patient questionnaire for the office. The other two are established patients. One established patient is seeing Dr. Rivera, and the other is seeing Dr. Westlake. Barbara pulls the medical files for each of these established patients. The medical files are manila folders with coded tabs according to the patients’ last names. Then Barbara prints an encounter form for each patient and attaches it to each folder. She places these two files in the “Patient to See” stacks for each doctor’s nurse.

After a few minutes, the two new patients bring up their completed questionnaires. Barbara creates the medical files for these two patients. This means she makes a new folder for each of them, codes each appropriately and places a copy of the questionnaire in each new folder. Then she takes the original questionnaire and types the information from it into her computer. So, now there are two files for these patients—one in the computer and one on paper. After she has entered on the computer the information about the two patients, she tells the computer to print out an encounter form for each of them. Barbara clips the encounter forms to the appropriate folders and then distributes them—one goes to Dr. Yates’s nurse and the other to Dr. Gregg’s nurse.

It is now 8 a.m., but one appointment hasn’t arrived yet. At 8:04 a.m., Barbara receives a call from the missing patient, Mr. Anderson. He has car trouble and can’t keep his appointment. Barbara assures Mr. Anderson that he can reschedule his appointment. As she talks to him, she opens the appointment book and looks at Dr. Hansen’s calendar. Dr. Hansen can see him either the next day at 9 a.m. or the following Wednesday at 8:15 a.m. The man chooses next Wednesday, and Barbara records the appointment.

By 8:06 a.m., all four of the other appointments are back in the examination rooms. The 8:30 a.m. patients start to arrive. The routine is similar, except this time all five arrive. They are all established patients, so Barbara pulls their files, prints out encounter forms and distributes the folders to the correct nurses.

Now it is 8:15 a.m., and Dr. Yates is finished with his 8 a.m. appointment—a man named Jim Burgess. Mr. Burgess walks out of the examination room and hands the encounter form to Barbara. Barbara looks at the procedures on the bill the doctor circled and quickly fills in an amount next to each one. She totals the bill—\$187—and has Mr. Burgess sign it. He has medical insurance, so the medical office will send the bill to the insurance company without him paying an initial co-payment or the entire amount of the bill. Therefore, Mr. Burgess signs the bill to give the insurance company permission to pay the clinic directly and returns it to Barbara. Barbara then rips off the back copy for Mr. Burgess. As Mr. Burgess picks out a free lollipop from the basket on the counter, Barbara quickly files the completed and signed encounter form in her “To Submit, Current” file.

Dr. Yates’s nurse has returned Mr. Burgess’s file. Barbara retrieves it and places it in the “To Be Updated” basket—the place where files that must have new action recorded are placed. The folders in this basket need the doctors’ dictation before a *medical transcriptionist* can transcribe them. A **medical transcriptionist** transcribes doctors’ dictated notes into an accessible format. To transcribe this information, the MT calls a phone line that contains a voice record of the doctor’s dictation. When the transcriptionist finishes the doctor’s dictation from this morning, the transcribed notes for Mr. Burgess will go into his medical file. Then Barbara will file Mr. Burgess’s file with the other medical files.

Barbara’s day goes on like this from 8 a.m. until she leaves at 5 p.m. During that time, she is continually checking in patients, entering new questionnaires on the computer, creating files, retrieving files, completing encounter forms and scheduling and rescheduling appointments.

Now, let’s look at the same activities from the perspective of the medical claims and billing specialist.



Step 5 The Medical Claims and Billing Specialist’s Daily Routine

- ❑ Joann, the claims specialist for Mountain View, deals mostly with insurance companies and patients who have already received treatment.

Joann starts the day by going through the claims that are still outstanding—that is, bills that haven’t been paid yet. For this clinic, most of these outstanding claims are still 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.



Joann starts her day with the claims that need insurance payments.

Medical Claims and Billing Specialist

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 doctor's office. 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 goes to work with the individual claims (those that have a balance due from the patient).

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

Finally, Joann is ready to work on bills received during yesterday's clinic activity. In Mountain View, the billing office is one day behind the reception area—the medical claims specialist works on Tuesday's bills on Wednesday, Wednesday's on Thursday and so on. Joann spends most of the remainder of the day checking encounter forms for correct diagnoses and treatments. She catches one mistake where the doctor diagnosed chest pain but had noted *Blood Sugar* instead of *EKG*. (The two laboratory tests are next to each other on the form). She contacts the physician to make the necessary change. Joann also checks the encounter form for complete patient information—name, address, chart number, insurance company and policy number.

After making sure all the information is correct, Joann arranges the encounter forms according to each patient's insurance company. Medicare goes in one folder, a particular private insurance in another and so on. The claims, which will be based on the encounter forms, must be sent to the correct insurance companies.

Joann first bills the **primary carrier** for each claim. As the name suggests, this is the insurance company that is billed first. It is *primarily* responsible for that patient's charges. There can be secondary and **tertiary**, or third, insurance companies. Joann bills the secondary insurance company after the primary carrier has paid its share of a bill. Finally, Joann bills the tertiary carrier after the secondary carrier has paid.

After sorting through all the encounter forms and dividing them according to primary carriers, Joann goes through each stack and removes the office copy of each encounter form. She files the office copies. Then she transfers the information on each encounter form to an insurance claim form, most commonly a CMS-1500. You will learn how to fill out this form later in the course.

Lesson 1—Welcome to the Exciting World of Medicine and Medical Claims

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																								
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1)																													
(Medicare #) (Medicaid#) (Sponsor's SSN) (Member ID #) (SSN or ID) (SSN) (ID)																																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE										4. INSURED'S NAME (Last Name, First Name, Middle Initial)														
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)														
CITY STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY STATE																								
ZIP CODE TELEPHONE (Include Area Code)					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					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 <input type="checkbox"/> NO <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH SEX M <input type="checkbox"/> F <input type="checkbox"/>														
b. OTHER INSURED'S DATE OF BIRTH SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? Place (State) _____ YES <input type="checkbox"/> NO <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME														
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										c. INSURANCE PLAN NAME OR PROGRAM NAME														
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, return to and complete item 9 a-d.</i>														
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.										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 _____ DATE _____										SIGNED _____																								
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM _____ TO _____																								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM _____ TO _____																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>																								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. _____ 3. _____ 2. _____ 4. _____										22. MEDICAID 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 EMG					C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					E. DIAGNOSIS POINTER					F. \$CHARGES G. DAYS UNITS H. EPSDT FAMILY I. ID. QUAL. J. RENDERING PROVIDER ID.#														
1.																																		
2.																																		
3.																																		
4.																																		
5.																																		
6.																																		
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					28. TOTAL CHARGE \$ _____					29. AMOUNT PAID \$ _____					30. BALANCE DUE \$ _____				
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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #														
SIGNED _____ DATE _____										a. _____					b. _____					a. _____					b. _____									

CMS-1500 form is the most commonly used insurance claim form.

Medical Claims and Billing Specialist

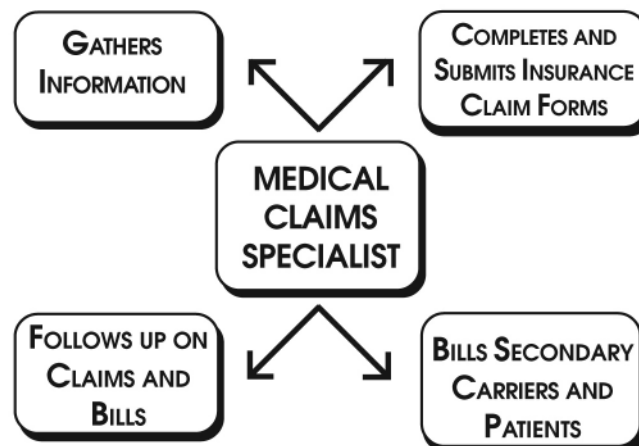
By 4:30 p.m., Joann has organized, processed and packaged the claims she has gone through today. They go out to their respective insurance companies, and the clinic waits for payment.

Now that you have an idea of what a medical claims and billing specialist does every day, let's review some general responsibilities.



Step 6 The Responsibilities of the Medical Claims Specialist

- As a medical claims specialist, you have four basic responsibilities:
 1. **Gather Information.** As a medical claims specialist, you will gather all pertinent information. Usually, this means using the encounter form (or other type of medical bill) to find out everything you need to fill out an insurance claim form.
 2. **Complete and Submit the Insurance Claim Form.** After checking the encounter form for accuracy, you then will use the bill to complete and submit the appropriate insurance claim form.
 3. **Follow Up With Insurance Companies and Patients.** After you submit the insurance form, you might need to contact the company regarding the claim. As a result, it is important you keep a copy of the claim so you can track down answers to any questions the insurance company might have. You might also have to follow up with patients to secure payments.
 4. **Secondary Insurance Claims and Patient Billing.** After the primary carrier has paid its share of the bill, if the patient has secondary insurance, you need to bill that 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.



Now that you've learned more about the medical claims and billing specialist's responsibilities, let's look at another aspect of your job—confidentiality.



Step 7 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 medical claims specialist, you have access to many people's medical records. The records might be in the form of encounter forms, billing statements, claims or even complete medical files. It is essential that you understand that these records are confidential.

What does *confidential* mean? **Confidential** means *secret*. The term originated from a Latin word meaning *with trust*. Your client entrusts you with someone's medical records. This means that unless your client gave you authorization, you cannot reveal information from those records to anyone under any circumstances. You can release the required information to complete the insurance claim form for the insurance company because the patient authorizes you to do so. However, you cannot release any information that doesn't normally appear on the insurance form unless you are given permission. You cannot "volunteer" information to the insurance company.

You must not break this confidentiality requirement. This means you can't tell your best friend about someone's medical records. You can't tell your neighbor. You can't tell another doctor. A person's medical records are the property of that person and the attending physician (the examining doctor) *only*. Claims specialists who violate this confidential arrangement quickly lose credibility and clients. You'll learn more about confidentiality later in the course when we discuss HIPAA—the Health Insurance Portability and Accountability Act (HIPAA), which protects patients' privacy of personal health information.

Our discussion of confidentiality may sound harsh. However, confidentiality is such an important subject that we want to clarify it early in the course. Now that you have this information, you can prepare yourself ahead of time for this crucial requirement.

As you can see, the medical claims and billing specialist occupies an important position in the medical field, and the field provides many opportunities for you. By understanding and fulfilling your responsibilities, you are acting professionally and gaining valuable credibility. With these professional qualities and your accredited training, you'll develop the ultimate in job security!

Now, let's pause and complete a quick Practice Exercise.



You'll keep medical records confidential as a medical claims and billing specialist.

Step 8 Practice Exercise 1-1

For questions 1 through 10, select the best answer from the choices provided.

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

2. **The medical claims specialist is responsible for ____.**
 - a. transcribing the doctor's taped notes
 - b. filling out and submitting insurance claim forms
 - c. examining patients
 - d. scheduling patients

3. **A ____ usually begins its life as a questionnaire.**
 - a. statement of medical transaction
 - b. medical bill
 - c. generated user interface document
 - d. patient-doctor relationship account

4. **A preprinted 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. patient encounter form
 - d. claim form

5. **A patient may simply make a co-payment for a visit and then the ____.**
 - a. doctor's office bills the insurance company for the remainder of the bill
 - b. doctor's office considers the remainder of the bill uncollectible
 - c. patient sends a bill to the insurance company
 - d. doctor's office sends out a full bill to the patient in 10 days' time

6. The front office professional in a medical facility typically has to ____.
- a. take patient temperatures
 - b. check in arriving patients
 - c. write patient prescriptions
 - d. transcribe doctor dictation
7. The insurance company that is billed first is called the ____ carrier.
- a. secondary
 - b. primary
 - c. claims
 - d. first-payment
8. 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
9. An error on the claim form will ____ reimbursement.
- a. delay
 - b. not impact
 - c. speed up
 - d. improve
10. As a medical professional, you cannot release any information that doesn't normally appear on the insurance form unless you are given permission because ____.
- a. you aren't a doctor
 - b. the insurance company has the information
 - c. of confidentiality
 - d. you don't have access to that information

 **Step 9** **Answers to Practice Exercise 1-1**

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



Step 10 Lesson Summary

- ❑ As you now know, the medical claims and billing profession is an integral part of the medical field. Without an accurate medical claims and billing specialist, doctors can face delayed and denied claims from insurance companies.



The medical office is a busy place, and it's a place where you can make a difference as a medical claims and billing specialist!

That's why good medical claims and billing specialists enjoy job security and earn the kind of money that they do. Doctors earn more money when they have an effective medical claims and billing specialist!

Medical facilities often use a document called a patient encounter form to easily record procedures they perform on patients. The encounter form is a list of the most common procedures a doctor performs. The doctor notes the name of the procedure performed, and this enables office staff to determine the correct cost for that patient's treatment. For the medical claims specialist, the encounter form provides an easy-to-read bill to process quickly for submission of payment.

There are three common ways a patient and medical facility handle bills for medical care. First, the insurance company may require the patient to pay the entire bill at the time of service before leaving the medical facility. Then, the patient submits a claim to the insurance company for reimbursement. Second, the patient may pay a co-payment (a flat amount, such as \$20 or \$25) before leaving the medical facility. Then, the doctor's office submits a claim to the patient's insurance company for the remainder of the bill. Third, the patient may pay nothing at the time of service, and the medical facility submits a claim to the patient's insurance company for the bill. Then, once the insurance company reimburses the doctor's office for covered charges, the doctor's office sends a bill to the patient for the remaining balance.

Lesson 1—Welcome to the Exciting World of Medicine and Medical Claims

Whenever a medical facility works with medical bills, it is essential that those bills are accurate. A good medical claims specialist double-checks to make sure that all patient and doctor information is correct. This helps ensure timely payments in the appropriate amounts for all procedures.

The medical office is a busy place! Many activities go on every day in healthcare facilities in addition to direct medical care. Patients check in, schedule appointments and pay bills. The medical claims and billing specialist files insurance claims for the medical facility. A claims specialist must deal with insurance companies, correctly fill out insurance forms and effectively follow up with insurance carriers and individuals.

Because of the sensitive nature of medical records, they are confidential. The medical claims and billing specialist must respect the confidentiality rule and never give out information without first getting proper permission. There is no greater violation in the medical records field than giving out confidential information to someone not authorized to receive it.

This lesson introduced you to some important aspects of medical claims and billing. You'll explore each of these concepts in detail in later lessons. Every lesson prepares you for the next. Remember, your course explains concepts in easy-to-understand language with plenty of examples to show you exactly what to do and how to do it. Nothing is left to chance! And remember, if you ever need help, just call your U.S. Career Institute instructor, who will give you the guidance you need. We can't wait to see you succeed as a medical claims and billing specialist! Congratulations on taking the first step!

Let's complete the following quiz. Remember, you can refer to your course materials if needed. Good luck!



Step 11 Mail-in Quiz 1

- Follow the steps to complete the quiz.
 - a. Be sure you've mastered the instruction and the Practice Exercises that this quiz covers.
 - b. Mark your answers on your quiz. Remember to check your answers with the lesson content.
 - c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.
 - d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your quiz online.
 - e. Submit your answers to the school via mail, e-mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 1

For questions 1 through 15, select the best answer from the choices provided. Each item in this quiz is worth 6.67 points.

1. **A ____ is a document that is generated when a patient receives medical care.**
 - a. statement of medical transaction
 - b. medical bill
 - c. generated user interface document
 - d. patient-doctor relationship account

2. **The first step in the lifecycle of a medical bill occurs when the ____.**
 - a. patient fills out a questionnaire at the doctor's office, clinic or hospital
 - b. patient makes a follow-up appointment
 - c. initial payment is received
 - d. account is fully paid

3. **Typically, the questionnaire a patient fills out at the medical facility contains ____.**
 - a. nothing of interest to a medical claims specialist
 - b. the doctor's home telephone number
 - c. questions about the patient's medical history and insurance coverage
 - d. a privacy policy

4. **Some doctors' offices use a(n) ____, which is a form that contains the most common procedures performed by that doctor.**
 - a. account-easing document
 - b. easy-accounting bill
 - c. encounter form
 - d. claim form

5. **When an insurance company pays for medical services, it ____ the appropriate party (either the insured or the medical office).**
 - a. gerrymanders
 - b. processes
 - c. collects from
 - d. reimburses

Lesson 1—Welcome to the Exciting World of Medicine and Medical Claims

- 6. If an insurance company pays 80 percent of a claim of \$100, the patient is responsible for _____ percent of the bill.**
 - a. 20
 - b. 10
 - c. 80
 - d. 100

- 7. As a medical claims and billing specialist, it is your responsibility to _____ for the doctors you work for.**
 - a. schedule appointments for
 - b. examine patients
 - c. submit insurance claims
 - d. determine each patient's diagnosis and appropriate treatment

- 8. Two essential qualities of a good medical claims specialist are _____.**
 - a. tenacity and toughness
 - b. accuracy and thoroughness
 - c. understanding and free-spiritedness
 - d. being argumentative and unlikable

- 9. The insurance company that is billed after the primary carrier has paid is called the _____ carrier.**
 - a. back-up
 - b. held-back
 - c. second-hand
 - d. secondary

- 10. The most commonly used insurance form is called the _____.**
 - a. CMS-1500
 - b. CMS-1000
 - c. Common Carrier Insurance Form (CCIF)
 - d. Primary Carrier Claim Form (PCCF)

- 11. A medical bill might be outstanding because the _____.**
 - a. clinic isn't waiting for the insurance payment
 - b. patient paid the balance because he does not have insurance
 - c. insurance company only pays quarterly
 - d. insurance company has paid, but there is still a balance due for the patient to pay

Medical Claims and Billing Specialist

12. **Paying someone for services already performed is ____.**
- a. claims processing
 - b. completing an encounter
 - c. reimbursement
 - d. always an insurance company's responsibility
13. **After the primary carrier has paid its share of the bill, the claims specialist should then ____.**
- a. close the file as "uncollectible"
 - b. re-bill the primary carrier for the remaining amount
 - c. bill the tertiary carrier
 - d. bill the secondary carrier, if there is one, or the patient if there is not
14. **The medical claims specialist uses ____ to gather patient information.**
- a. an informal survey
 - b. an insurance salesperson
 - c. the encounter form or other medical bill
 - d. the doctor
15. **Essentially, confidential means ____.**
- a. secret
 - b. you can release the information to anyone
 - c. you can tell your neighbor about it
 - d. information

Congratulations

You've completed Lesson 1.



Don't wait for your quiz results to continue with Lesson 2.

Lesson 2

The Third-party Payer: How Insurance Works



Step 1 Learning Objectives for Lesson 2

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
 - Explain what insurance is.
 - Define the terms common to most insurance carriers.
 - Determine the types of insurance programs available today.



Step 2 Lesson Preview

- ❑ Did you know that most people in America qualify for some sort of medical insurance? This explains why the career you've chosen— medical claims and billing specialist— continues to grow...and why the pay is so good! In fact, billers who work with physicians can expect more than 16 percent growth in this field over the next several years according to the Bureau of Labor and Statistics. Imagine the job opportunities you'll have in this exciting profession!

Let's take a look at some of the types of medical insurance you'll work with. In addition to the various government programs available, hundreds of private companies provide medical insurance. Fortunately, a few common threads tie all insurance companies together, for example, the terminology used and the forms required. These common threads will make your job as a medical claims specialist easier. In Lesson 2, we will introduce you to the language of the insurance world. You will find out about providers and payers. You'll learn about deductibles, co-payments, premiums and schedules of benefits.

After that, we'll move into the different programs available. You'll be introduced to the various insurance programs, from government insurance programs such as Medicare and Medicaid to the managed care approaches of the HMOs and PPOs. Chances are you've heard of many of these terms and programs. If you haven't, fear not! We'll cover them here and also in more detail in later lessons.



Most people in America qualify for some sort of medical insurance, and billers who work with physicians can expect more than 16 percent growth in this field during the next several years.



Step 3 Insurance

- ❑ The terms *medical insurance* and *health insurance* and *healthcare coverage* or some other similar phrase all refer to the same thing. **Medical insurance** is a contract between an insurance company (carrier) and an individual or a group—the **insured**. This contract (the 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—they are paid 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 their services. Every insurance company requires an itemized list of procedures, pharmaceuticals and other materials before they pay benefits. Every procedure has its own code, and different insurance companies and plans all have their own forms and specific requirements. This is where you, as a medical claims and billing specialist, enter the picture. When you've completed this course, you can prepare medical claims for doctors' and hospital bills in the form necessary to meet the standards of insurance companies and government agencies.

But first, you need to know the language insurance carriers and medical claims specialists use to communicate. In the next section, you will learn some of this language.



Step 4 Common Insurance Terms

- ❑ Liz is a receptionist for Dr. Grant. She is great at making appointments and keeping track of patients. Yesterday, Dr. Grant's claims specialist was out sick, and the doctor asked Liz to check on some insurance information for him. He asked her to compare the explanation of benefits for three different patients and see how much each patient needed to pay. Then he asked if any of the three had a co-payment that hadn't been made yet. Finally, he asked Liz to check the explanation of benefits to see if any of the three patients had met their deductibles yet.

Liz knows English very well, but this all sounded like another language. She dug through some insurance forms, but she 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 claims specialist returned.

Imagine you were Liz. Could you ask someone from an insurance company questions (and understand the answers)? In this section, we will cover some basic insurance concepts that will help you function intelligently when you run across insurance terminology.



Would you be able to ask someone from an insurance company questions and understand the answers?

Provider

The **provider** is the person or organization that provides medical services. For example, doctors are providers.

Claim Form

The **claim form** is the document that the medical claims specialist fills out in order to submit an insurance claim to an insurance carrier. The most common insurance forms are the CMS-1500 and CMS-1450 forms. The CMS-1450 is also referred to as the UB-04.

Deductible

The amount of money an individual must pay before insurance benefits begin is called the **deductible**. Usually a policy will pay nothing of the first \$250, \$500 or \$1,000 of medical charges and then will pay a percentage of everything above that amount every year.

On the explanation of benefits, any amount that is “applied to deductible” is a covered charge that is subtracted from your total deductible amount. The insurance carrier does not pay any money on “applied to deductible” charges. For example, imagine that you, a patient, have a medical policy that has a \$250 deductible and, after the deductible is paid, 80 percent coverage. So far this year, you have spent \$200 of your own money on medical care, and that medical care has been defined as covered under your insurance policy. For the insurance company to begin to pay 80 percent of your covered medical care costs, you must still pay out \$50 more for covered charges. After you have met the \$250 deductible, your medical insurance benefits will begin, and the carrier will pay 80 percent of each claim you submit for covered charges for the rest of the year.

Co-payment

A **co-payment** is a flat amount of money paid by the patient. For example, many policies have a co-payment for prescription drugs or office visits to a doctor. That means every time a person fills a prescription or visits the doctor, it costs her no more than her co-payment, but she must pay that co-payment every time she fills a prescription or goes to the doctor. Some policies require co-payments even after the deductible has been met. Other policies have no deductible, but a co-payment is required every time any type of medical care is received. Co-payments are paid immediately at the time of service.

Reasonable and Customary

The phrase **reasonable and customary (R&C)** refers to price guidelines used by insurance carriers for different procedures. Usually a carrier will only pay up to the maximum on its reasonable and customary fee, regardless of the actual cost of a procedure to the patient. For example, if a patient has knee surgery and the doctor charges \$1,000, the insurance company compares that fee to its reasonable and customary scale. If the R&C scale gives a \$900 limit for that particular procedure, then the patient may be responsible for the extra \$100 depending on the agreement the physician has with the insurance company. The physician may accept the R&C scale amount. Fees that exceed the reasonable and customary scale are *disallowed* by the carrier.

Many private insurance carriers have adopted the reasonable and customary guidelines for their coverage. Many government insurance programs also use reasonable and customary guidelines.

Explanation of Benefits

The **explanation of benefits (EOB)** is a document that explains how much the insurance company paid and how much it disallowed (charges that exceed reasonable and customary charges are disallowed). Let's look at two samples of EOBs.

Provider Name: Dr. Neda Dayoff				Dates of Service: 01/03/20XX		
Type of Service	Submitted Charge	Disallowed Charge	Allowable Charge	Applied to Deductible	Balance Due	Amount Due From Carrier
Office Visit	100.00	9.00	91.00	20.00	71.00	80%-56.80

The insurance company sends an explanation of benefits every time you submit a claim. Even if the carrier is paying nothing on the claim, it will still send this form explaining why. In the example above, the insurance carrier is paying \$56.80 of a \$100.00 charge. That means the patient is responsible for \$20.00 to meet the deductible and \$14.20 for the 20 percent due from the insured. The patient may also be responsible for the \$9.00 disallowed charge, depending on the insurance policy. As a medical claims specialist, you can see how valuable the explanation of benefits is.

Lesson 2—The Third-party Payer: How Insurance Works

Let's look at a line-by-line explanation of this EOB:

Bill from Dr. Neda Dayoff:	\$ 100.00	Amount due to the doctor for medical care and services.
Disallowed charge:	– 9.00	Amount that exceeds the reasonable and customary price scale; the patient may be responsible for this amount.
Allowable charge:	91.00	Maximum amount that the insurance carrier will cover for the services.
Applied to deductible:	– 20.00	Amount of the charges that was applied to the patient's deductible. If the patient's deductible has been met, this item will be blank or read "zero." In this case, the deductible is met after this last \$20 payment.
Amount due from carrier:	\$ 56.80	Amount paid by the insurance carrier to the doctor. In this case, the insurance company agreed to pay 80 percent of the remaining charges.

Provider Name: Dr. Neda Dayoff				Dates of Service: 01/03/20XX		
Type of Service	Submitted Charge	Disallowed Charge	Allowable Charge	Co-payment	Balance Due	Amount Due From Carrier
Office Visit	100.00	9.00	91.00	20.00	71.00	71.00

In this second example, the insurance carrier will pay \$71.00 of the \$100.00 charge. That means the patient is responsible for the \$20.00 co-payment. A co-payment is a flat amount paid by the patient for a doctor visit, usually made at the time of the visit. As in the first example, the patient may be responsible for the disallowed charge, depending on the insurance policy.

Don't worry about the specifics of the EOB. Remember, these first lessons serve as a general introduction to the basic areas of the medical claims and billing field. You will learn about each of these concepts in greater detail later in the course.

Step 5 Practice Exercise 2-1

Select the best answer for each question.

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

Medical Claims and Billing Specialist

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. Charges that exceed the reasonable and customary scale of a policy are _____ by the carrier.
 - a. disallowed
 - b. paid anyway
 - c. always applied toward the deductible
 - d. allowed

4. If the insurance company is paying nothing on a claim, you _____.
 - a. do not receive an explanation of benefits
 - b. still receive an explanation of benefits
 - c. sometimes receive an explanation of benefits
 - d. know that all charges are above what are considered reasonable and customary

Using the following explanation of benefits example, answer questions 5 through 7.

Provider Name: Dr. Ima Fization				Dates of Service: 05/15/20XX		
Type of Service	Submitted Charge	Disallowed Charge	Allowable Charge	Co-payment	Applied to Deductible	Amount Due From Carrier
Office Visit	79.00	14.00	65.00	10.00	0.00	55.00

5. How much does the insured owe (not including the co-payment, which has already been paid)? In this case, the patient is responsible for the disallowed charge. _____.
 - a. \$14.00
 - b. \$55.00
 - c. \$10.00
 - d. \$52.00

6. Since there is \$0.00 applied to the deductible, _____.
 - a. the deductible has already been met
 - b. the submitted charge was too low to require an amount applied to deductible
 - c. the co-payment covers the deductible
 - d. disallowed charge covers the deductible

7. What is the amount that exceeds the reasonable and customary price scale? _____
- \$79.00
 - \$65.00
 - \$14.00
 - \$55.00

Using the following explanation of benefits example, answer questions 8 through 10.

Provider Name: Dr. Lief Saver				Dates of Service: 09/10/20XX		
Type of Service	Submitted Charge	Disallowed Charge	Allowable Charge	Co-payment	Applied to Deductible	Amount Due From Carrier
Pys Therapy	147.00	26.00	121.00	20.00	67.00	34.00

8. How much does the insured owe (not including the co-payment, which has already been paid)? In this case, the patient is not responsible for the disallowed charge. _____
- \$121.00
 - \$87.00
 - \$67.00
 - \$93.00
9. What is the maximum amount the insurance carrier will cover for this particular service? _____
- \$147.00
 - \$26.00
 - \$121.00
 - \$34.00
10. What is the amount that exceeds the reasonable and customary price scale? _____
- \$26.00
 - \$121.00
 - \$67.00
 - \$34.00

Step 6 Answers to Practice Exercise 2-1

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



Step 7 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.

Government Insurance

Unless otherwise noted, these programs are administered by the federal government.

Medicare

Medicare is a federal health plan covering people age 65 and older and people with disabilities.

Medicaid

Medicaid is a state-sponsored insurance program for low-income people who otherwise wouldn't be able to afford health insurance.

HCFA (Health Care Financing Association) was established in 1977 to administer the Medicare and Medicaid programs. It is part of the Department of Health and Human Services of the federal government. HCFA has in recent years changed its name to **CMS** (Centers for Medicare & Medicaid Services) and should now be referred to as CMS.

TRICARE

TRICARE provides medical coverage for families of the various "uniformed" government services. It also covers retired military personnel and their families and the families of military personnel killed in active duty. TRICARE has three options, which offer different levels of care: TRICARE Standard, TRICARE Extra and TRICARE Prime. TRICARE Standard was once known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). You will still occasionally see references to this older name in your work as a claims specialist.

CHAMPVA

CHAMPVA (Civilian Health and Medical Program of the Veterans Administration) is the program that covers veterans with permanent, service-related disabilities. It also covers their dependents, and in the event the service member dies from a service-related disability, CHAMPVA covers the family.

Workers' Compensation (Workers' Comp)

Workers' comp, a *state-run program*, pays the medical bills for people with job-related illnesses or injuries.

In addition to the preceding government programs, there are also many private insurance companies. These private insurance companies can be divided into two categories: traditional and managed care.

Private, Traditional Insurance

Twenty-five years ago, the traditional insurance concept was the only one around. The traditional insurance concept basically could be described as the following.

The insurance company contracted with an individual to pay her medical bills based on a **fee-for-service** concept—that is, whatever the physician or medical provider charged was the amount on which the insurance company based its reimbursement.

Private insurance companies are in business to earn profits. They pay out benefits, but also take in much more in premiums.

Managed Care

As healthcare costs skyrocketed, many businesses that held group insurance policies for their employees began looking for ways to save money while still providing excellent healthcare coverage. The solution was *managed care*.

Born in the 1980s, managed care introduced the concepts of **Health Maintenance Organizations (HMOs)** and **Preferred Provider Organizations (PPOs)**. In both HMOs and PPOs, there are groups of doctors who contract with the organization to charge set amounts for procedures. The patient cannot be charged an additional fee (beyond a co-payment that might be in the patient's policy).

In HMOs, patients pay a fixed periodic rate (monthly, quarterly or annually). The patients then receive whatever health care they need, but they must see a physician or medical provider who is part of that HMO. HMOs encourage their members to practice preventive health care, often paying for routine physicals and tests designed to catch signs of illness before the person actually becomes sick. The patient is assigned a *primary physician* when she joins the HMO. This primary physician then oversees that patient.

PPOs contract with many doctors who agree to charge rates according to the PPO scale. These doctors are not “employed” by the PPO. Instead, they are independent offices, hospitals and clinics that have joined the PPO. When policy holders in a PPO go to a medical provider who is not part of the PPO network, that policy holder will see a large reduction in benefits.



Step 8 Lesson Summary

- Just as the medical claims and billing specialist is an integral part of the medical world, medical insurance is a necessary part of America's health care. Insurance coverage comes from both government and private sources. Regardless of what company provides the coverage, all insurance companies use a specific language to refer to different insurance concepts. You've already become familiar with some of these terms; and you'll continue to learn more as you progress through your course.

The different insurance programs available fall into three categories: government, traditional and managed care. Government programs such as Medicare, TRICARE and CHAMPVA are managed by the federal government. Medicaid and workers' comp are managed by state governments. In managed care, HMOs and PPOs contract with groups of doctors to provide care at certain set amounts. These types of healthcare programs were developed to help control the rising cost of medical care in America.

Keep in mind that this lesson was a brief overview of insurance programs and how insurance works. You'll learn the details of each concept in later lessons. You also will see the important role you'll play in the filing of insurance claims. Your employer will depend on you to submit the proper documentation to insurance companies and federal agencies for reimbursement so that he or she can benefit financially and avoid fraud charges. The specialized training you get in these lessons will make you and those for whom you work successful! Let's complete a quiz before we move on to the next lesson about handling claims.

✉ **Step 9 Mail-in Quiz 2**

- ❑ Follow the steps to complete the quiz.
 - a. Be sure you've mastered the instruction and the Practice Exercises that this quiz covers.
 - b. Mark your answers on your quiz. Remember to check your answers with the lesson content.
 - c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.
 - d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your quiz online.
 - e. Submit your answers to the school via mail, e-mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 2

Select the best single answer for each of the following items. Each item in this quiz is worth 5 points.

1. **When an insurance carrier pays for medical treatment based on a policy, it is paying ____.**
 - a. premiums
 - b. a co-payment
 - c. benefits
 - d. HMOs
2. **The ____ is a document that explains how much the insurance company paid on a claim.**
 - a. explanation of benefits
 - b. insurance statement
 - c. insurance policy
 - d. PPO

For items 3 through 6, match the insurance program with its description.

- | | |
|------------------|--|
| 3. ____ Medicare | a. program that covers veterans with permanent, service-related disabilities and their families |
| 4. ____ Medicaid | b. a state-sponsored insurance program for low-income people |
| 5. ____ TRICARE | c. a federal health care plan covering people age 65 and older and people with disabilities |
| 6. ____ CHAMPVA | d. provides medical coverage for active duty and retired members of the various uniformed government services and their families |

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For questions 7 through 11, select the best answer from the choices provided.

7. **A state-run program that pays the medical bills for people with job-related injuries or illnesses is called ____.**
 - a. PPO
 - b. Medicaid
 - c. workers' compensation
 - d. managed care

8. **The traditional insurance company paid out benefits based on a(n) ____ concept.**
 - a. managed care
 - b. HMO
 - c. PPO
 - d. fee-for-service

9. **Managed care was born in the 1980s ____.**
 - a. because doctors wanted more authority over fees
 - b. in response to rising healthcare costs
 - c. in response to doctors' wishes for better insurance service
 - d. because employers wanted more comprehensive and expensive insurance policies

10. **HMO stands for ____.**
 - a. Hired Medical Organization
 - b. Hired Medical Officer
 - c. Health Maintenance Organization
 - d. Health Maintenance Operation

11. **PPO stands for ____.**
 - a. Preferred Provider Organization
 - b. Policy Protection Operation
 - c. Premium Protection Operation
 - d. Preferred Premium Operation

Lesson 2—The Third-party Payer: How Insurance Works

For items 12 through 15, match the term with its definition.

- | | |
|---|---|
| <p>12. ____ Provider</p> <p>13. ____ Deductible</p> <p>14. ____ Co-payment</p> <p>15. ____ Reasonable and customary</p> | <p>a. An amount of money an individual must pay before insurance benefits kick in</p> <p>b. Refers to price guidelines used by insurance carriers for different procedures</p> <p>c. A flat amount of money paid by the patient every time a medical service is performed</p> <p>d. A person or organization that provides medical services</p> |
|---|---|

Using the following explanation of benefits example, answer questions 16 through 20.

Provider Name: Dr. Liv Nogood				Dates of Service: 05/29/20XX		
Type of Service	Submitted Charge	Disallowed Charge	Allowable Charge	Co-payment	Applied to Deductible	Amount Due From Carrier
Lab	29.00	7.00	22.00			
Lab	55.00	18.00	37.00			
Lab	86.00	16.00	70.00			
Totals	170.00	41.00	129.00	20.00	0.00	109.00

16. How much does the insured owe (not including the co-payment, which has already been paid)? In this case, the patient is not responsible for the disallowed charge. ____
- a. \$0.00
 b. \$61.00
 c. \$129.00
 d. \$20.00
17. What is the maximum amount the insurance carrier will cover for the services? ____
- a. \$170.00
 b. \$129.00
 c. \$109.00
 d. \$41.00

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18. What is the amount that exceeds the reasonable and customary price scale? _____
- a. \$129.00
 - b. \$109.00
 - c. \$41.00
 - d. \$0.00
19. According to the EOB, this patient's deductible _____.
- a. has not been met
 - b. has been met
 - c. is \$20.00
 - d. is \$250.00
20. The co-payment is _____ and is paid by the _____.
- a. \$10.00/doctor's office
 - b. \$15.00/patient
 - c. \$20.00/carrier
 - d. \$20.00/patient

Congratulations

You've completed Lesson 2.



Don't wait for your quiz results to continue with Lesson 3.

Lesson 3

Handling Claims



Step 1 Learning Objectives for Lesson 3

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
 - Describe the preauthorization requirement many insurance companies have.
 - Explain how diagnostic and procedure codes apply to insurance.
 - Handle the follow-up claims procedures.



Step 2 Lesson Preview

- ❑ As you know, insurance knowledge is a critical part of your new career as a medical claims and billing specialist. In such a short time, you've built an insurance foundation of knowledge; it won't be long before you're an insurance guru! In this lesson, we'll cover a few more factors that affect coverage and reimbursement: preauthorization, diagnostic coding and procedure coding.

As a medical claims and billing specialist, you'll support physicians, clinics, hospitals and patients. You've timed your new career perfectly, too! The demand for medical claims and billing specialists continues to grow as our population ages and the number of health practitioners increases. Search on the Internet or thumb through your local phone book to get an idea of just how many physicians work in your area. Then figure that each physician sees from 10 to 20 patients per day, most of whom will need a claim processed. As you can see, you'll have endless opportunities as a medical claims and billing specialist!

Let's move on to learn a bit about preauthorization requirements and how they affect you, the claims and billing specialist.



The demand for medical claims and billing specialists continues to grow.



Step 3 The Preauthorization Requirement

- 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. If he doesn't notify his insurance company *before* he enters the hospital, the company will reduce 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.

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, usually a loved one or even the hospital, to notify the insurance company within 24 hours of hospitalization.

Although the insurance company sometimes denies a claim just because preauthorization was not received, usually the company simply reduces the amount it will pay for that claim.



Step 4 Diagnostic Codes

- ❑ After a hospital stay, tests and other procedures, the medical claims specialist needs to fill out a claim form. These forms, which you will fill out later in this course, require special codes. These codes are based on the diagnosis made and procedures performed. They are called *diagnostic codes* and *procedure codes*. When you write a code on an insurance form (or bill or patient's chart), you are **coding** that entry.

When you look at the CMS-1500 form, you can see that there are many **fields** (sections) to be filled in. One of the most important fields is Field 21—*Diagnosis or Nature of Illness or Injury*. In this field, you must enter some crucial information. But what information? Do you write in the doctor's diagnosis? No. You must use a diagnostic code.

Diagnostic codes are numbers that identify the physician's opinion about what's wrong with the patient (his diagnosis). These codes are not random numbers. There is a system to them. That system is called the **International Classification of Diseases (ICD)**. ICD codes are used by hospitals, doctors, offices and medical claims specialists. Whether the patient has a viral infection, a broken leg, food poisoning or any other illness or injury, you can properly code the condition. Insurance companies require a proper diagnostic code to identify the doctor's diagnosis.

Often a patient is suffering from more than one symptom. In this case, multiple diagnoses may apply. The doctor will determine a primary diagnosis—usually the main cause of the symptoms or the main health problem. When you code, you always enter the **primary diagnosis** code first.

When there is more than one diagnosis made, the ones that aren't primary are called **concurrent conditions**. That means these conditions happen at the same time as the primary diagnosis and might affect how the patient recovers.

Medical Claims and Billing Specialist

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										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										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED										7. INSURED'S ADDRESS (No., Street)									
CITY										8. PATIENT STATUS										CITY									
STATE										Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										STATE									
ZIP CODE										Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										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)									
a. INSURED'S DATE OF BIRTH										b. OTHER INSURED'S DATE OF BIRTH										b. AUTO ACCIDENT?									
b. EMPLOYER'S NAME OR SCHOOL NAME										c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT?									
c. INSURANCE PLAN NAME OR PROGRAM NAME										d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?										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.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.										SIGNED _____ DATE _____										SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										FROM _____ TO _____									
19. RESERVED FOR LOCAL USE										17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)										20. OUTSIDE LAB?										22. MEDICAID RESUBMISSION CODE									
1. _____										YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES										ORIGINAL REF. NO.									
2. _____										23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE									
3. _____										FROM MM DD YY TO MM DD YY										B. PLACE OF SERVICE									
4. _____										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)									
5. _____										F. \$CHARGES										E. DIAGNOSIS POINTER									
6. _____										G. DAYS UNITS										H. EPSDOT FAMILY									
25. FEDERAL TAX I.D. NUMBER										SSN EIN										I. ID. QUAL.									
26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT?										J. RENDERING PROVIDER ID. #									
28. TOTAL CHARGE										YES <input type="checkbox"/> NO <input type="checkbox"/>										NPI									
29. AMOUNT PAID										30. BALANCE DUE										\$									
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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #									
SIGNED _____ DATE _____										a. _____ b. _____										a. _____ b. _____									

Field 21 is filled in with crucial information—the doctor's diagnosis.

We will cover diagnostic coding concepts later in the course. Now, let's look at procedure coding.



Step 5 Procedure Coding

- Diagnosis coding is not the only kind of coding you will do. If you look at the portion of the CMS-1500 form below, you will see Field 24D—a column for *Procedures, Services or Supplies*. This column is divided into two halves. The first half is labeled *CPT/HCPCS* and the second is labeled *Modifier*. This is where you write down the code for the **procedures** (and modifiers of those procedures, if any), or treatments and tests, the doctor performed.

Procedures and modifiers are listed in Field 24D. The procedure codes given here indicate that an established patient made an office visit and was given an influenza immunization.

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	FROM MM DD YY	TO MM DD YY	CPT/HCPCS	MODIFIER												
1.	:	:	:	:	:	:			99212	:	:	:	:	:	:	NPI
2.	:	:	:	:	:	:			90658	:	:	:	:	:	:	NPI
3.	:	:	:	:	:	:			90460	:	:	:	:	:	:	NPI
4.	:	:	:	:	:	:				:	:	:	:	:	:	NPI
5.	:	:	:	:	:	:				:	:	:	:	:	:	NPI
6.	:	:	:	:	:	:				:	:	:	:	:	:	NPI

Remember, you might be called upon to double-check bills as they come through your service. Usually double-checking means making sure the diagnosis matches the procedures. Insurance companies use box 24D to check the procedures and make sure they are consistent with the diagnosis. If they aren't consistent, reimbursement from the insurance company will be delayed or may be reduced.

Like diagnoses, procedures have their own numerical language. The language of procedure codes is either the *Current Procedural Terminology* (CPT) or the *Healthcare Common Procedure Coding System* (HCPCS—pronounced “Hick-Picks”). CPT codes are the first level of HCPCS codes. CPT coding is the most commonly used set of procedure codes. The CPT codes, produced annually by the American Medical Association, are divided into six sections.

CPT Procedure Code Divisions

Evaluation and Management

Anesthesiology

Surgery

Radiology

Pathology and Laboratory

Medicine

Most procedures the doctor performs will have a code. You will enter the correct code in the correct column of the CMS-1500 form. We'll show you exactly how to find this code later on. For now, all you need to know are the fields that codes go in on the CMS-1500 form.

Step 6 Practice Exercise 3-1

Select the best answer for each question.

- 1. 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

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

Complete the following items as directed.

3. The doctor confirmed that Jerry Smith has acute bronchitis. The diagnostic code is found in which field on the CMS-1500 claim form? _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
19. RESERVED FOR LOCAL USE		17b.	NPI	FROM TO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)		20. OUTSIDE LAB?		\$CHARGES						
1. _____		<input type="checkbox"/> YES <input type="checkbox"/> NO								
2. _____		22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.						
3. _____		23. PRIOR AUTHORIZATION NUMBER								
4. _____										
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
FROM TO				CPT/HCPCS MODIFIER						
MM DD YY	MM DD YY									
1.										NPI
2.										NPI
3.										NPI
4.										NPI
5.										NPI
6.										NPI

4. Georgia Whitham just had an appendectomy. The procedure code is found in which field on the following CMS-1500 claim form? _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
19. RESERVED FOR LOCAL USE		17b.	NPI	FROM TO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)		20. OUTSIDE LAB?		\$CHARGES						
1. _____		<input type="checkbox"/> YES <input type="checkbox"/> NO								
2. _____		22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.						
3. _____		23. PRIOR AUTHORIZATION NUMBER								
4. _____										
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
FROM TO				CPT/HCPCS MODIFIER						
MM DD YY	MM DD YY									
1.										NPI
2.										NPI
3.										NPI
4.										NPI
5.										NPI
6.										NPI

Step 7 Answers to Practice Exercise 3-1

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

Step 8 Claims Follow-up

- ❑ As a medical claims specialist, you will often work with insurance companies. Whether you are in your home, a medical office, clinic or hospital, or work for an insurance review company, you will communicate with insurance companies every day. This communication includes filling out and filing claim forms, providing necessary additional information, recording payments and, often, following up with letters and telephone calls.

Through this course you will gain the excellent customer service skills necessary when dealing with insurance companies as well as clients and patients. You will learn how to explain charges, handle criticism, give and receive feedback, be assertive and communicate effectively without becoming confused as someone asks you questions.

So let's look at some tips to help you be an efficient medical claims specialist as you interact with insurance companies.

Communicating Effectively with Insurance Companies

- ✓ The two ways to contact an insurance company are: (1) directly or (2) through a field representative.
- ✓ When you contact an insurance company regarding a claim, be sure to include a copy of the claim or at least the patient's name, chart number, date of service, policy number, and the doctor's provider ID.
- ✓ When you call an insurance company about a problem, be polite and courteous and try to solve the problem. If you need questions answered, ask them!
- ✓ When you write to an insurance company, be concise—get to the point. The faster the insurance company knows what you need, the faster it can process your request.
- ✓ When you inquire about a claim that has not been paid within the 30-day payment period, you can bring this to the insurance company's attention by: (1) sending a short letter to the company; (2) calling on the telephone; or (3) rebilling the company by submitting a copy of the original bill and writing "SECOND BILLING" on the top.

There are many reasons an insurance company might not pay on a claim within the 30-day payment period. There might be errors on the CMS-1500 form. The insurance company might have paid the patient (expecting the patient to pay the doctor). Regardless of the reason, if you notify the insurance company, then it can relay the reason for nonpayment to you. At the very least, you should receive an explanation of benefits (EOB) form.

If this process fails to solve the problem, you can trace an insurance claim. To **trace**, or track down, a claim, you send a memo to the insurance company with this information on it:

1. Name of Insured
2. Chart Number
3. Policy Number
4. Date of Service
5. Procedures Performed

This information lets the insurance company trace a particular claim. Traces are useful when you are trying to locate an individual claim.

What do you do if you receive an explanation of benefits that you believe is wrong? Perhaps the insurance company denied coverage for an individual based on a pre-existing condition, for example.

The **appeal** is a letter from the provider to the insurance company explaining why the EOB is incorrect and asking the company to review it again.

If the insurance company decides that a procedure is experimental or investigational and therefore not covered by a policy, the doctor can also appeal that decision. The doctor can request a peer review. A **peer review** is a review of the procedures done by that doctor. The review is done by a group of unbiased, objective doctors who determine if the procedure was appropriate and, if so, the amount of reasonable compensation for the procedure.



The information that you track down on an insurance claim will be useful to the insurance company as it traces the claim.



Step 9 Lesson Summary

- ❑ You now have a foundation to stand on in the world of insurance and coding. Insurance is very important in the medical field. Insurance companies have many regulations, including preauthorization requirements, follow-up procedures and an appeals process. It is essential that you, as a medical claims specialist, keep up to date with these procedures and requirements.

You're nearly halfway through Pack 1. Keep up the good work! In the next lesson, you'll get a taste of private and group healthcare programs. Let's complete the following quiz and keep going!



Step 10 Mail-in Quiz 3

- ❑ Follow the steps to complete the quiz.
 - a. Be sure you've mastered the instruction and the Practice Exercises that this quiz covers.
 - b. Mark your answers on your quiz. Remember to check your answers with the lesson content.
 - c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.
 - d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your quiz online.
 - e. Submit your answers to the school via mail, e-mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 3

Select the best single answer for each of the following items. Each item in this quiz is worth 5 points.

1. **If preauthorization is required, but the insurance company is not notified, the insurance company _____.**
 - a. bills the doctor for the cost of the extra paperwork involved
 - b. might reduce reimbursement
 - c. pays more
 - d. any of the above

2. **In order to review hospitalizations, surgeries and to reduce fraud, the insurance company _____.**
 - a. can require preauthorization
 - b. might contract with a third-party oversight company
 - c. increases benefits for fraudulent claims
 - d. both a and b are correct

3. **If an insurance company authorizes a hospital stay of five days and the patient stays seven days (not due to any medical necessity), then the _____.**
 - a. patient must pay for the extra two days
 - b. hospital allows the patient to stay for free for the extra two days
 - c. insurance carrier pays for the extra two days
 - d. insurance agent must pay a penalty

4. **Numbers based on the diagnosis made and procedures performed are called _____.**
 - a. codes
 - b. checks
 - c. HMOs
 - d. terms

5. **The diagnosis code is entered in field _____ of the CMS-1500 form.**
 - a. 31
 - b. 1
 - c. 21
 - d. 24A

6. **Codes that identify the physician's opinion about what's wrong with a patient are called _____ codes.**
 - a. procedure
 - b. diagnosis
 - c. HCPCS
 - d. Medicare

7. **ICD stands for _____.**
 - a. International Coding Decimals
 - b. International Coding Disorders
 - c. International Classification of Diseases
 - d. Internal Classification of Disorders

Medical Claims and Billing Specialist

8. If a patient is suffering from more than one symptom, the doctor will determine a _____, usually the main cause of the symptoms or the main health problem.
- primary diagnosis
 - concurrent condition
 - concurrent diagnosis
 - primary prognosis
9. HCPCS stands for _____.
- Honorary Coding Procedures Common System
 - Healthcare Common Procedure Coding System
 - Health Care Primary Coding System
 - Hired Care Primary Coding System
10. CPT stands for _____.
- Colorado Procedure Tests
 - Corporate Procedure Terminology
 - Current Primary Tests
 - Current Procedural Terminology

For items 11 through 13, match the coding term with its definition or description.

- | | |
|-----------------|--|
| 11. _____ ICD | a. codes produced annually by the American Medical Association |
| 12. _____ CPT | b. pronounced "Hick-Picks" |
| 13. _____ HCPCS | c. diagnosis codes |

Select the best single answer for each of the following items.

14. When you trace an insurance claim, you should send the _____ to the insurance company.
- name of the insured
 - date of service
 - procedures performed
 - all of the above
15. If an insurance company denies a claim, the _____.
- decision is final
 - doctor can appeal the decision
 - doctor can request a peer review
 - both b and c are correct

For questions 16 and 17, use the following form.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? \$CHARGES						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER										
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.	MM DD YY	MM DD YY		CPT/HCPCS	MODIFIER					NPI
2.										NPI
3.										NPI
4.										NPI
5.										NPI
6.										NPI

16. An encounter form shows a patient was diagnosed with intermediate coronary syndrome. In which field will you enter the diagnosis code on the CMS-1500 claim form?
- 19
 - 21
 - 24D
 - 24E
17. A patient has a biopsy done on her lip. In which field will you enter the procedure code on the CMS-1500 claim form? _____
- 19
 - 24C
 - 24D
 - 24E

Select the best single answer for each of the following items.

18. As a claims specialist, you discover that Juanita Rodriguez’s insurance company has not reimbursed the doctor’s office for her bill, and 37 days have elapsed since you submitted the claim. You should _____ the insurance company.
- write a letter to
 - call
 - submit a second claim to
 - any of the above

Medical Claims and Billing Specialist

19. Doctor Feelgood performs laboratory tests for his patient, Will Siesta. The claims specialist will code these tests as _____ codes.
- modifier
 - diagnosis
 - procedure
 - CMS
20. Doctor Obie charts that her patient, Sarah Gooding, has a sprained ankle. The claims specialist will code this as a _____.
- modifier
 - diagnosis
 - procedure
 - CMS

Congratulations

You've completed Lesson 3.



Don't wait for your quiz results to continue with Lesson 4.

Lesson 4

Private Insurance and Managed Care Programs



Step 1 Learning Objectives for Lesson 4

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
 - Explain characteristics of private and group healthcare insurance programs.
 - Describe the concept of the prepaid insurance provider.
 - Explain the histories of several managed care programs.
 - Describe managed care terms such as *co-payment*, *capitation* and *fee schedule*.
 - Understand the different managed care programs, including HMOs, PPOs, point of service (POS) plans and physician provider groups (PPGs).



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, like HMOs and PPOs, are becoming a very popular alternative to the once-traditional fee-for-service approach to health care. This lesson will discuss private insurance concepts and expand on the basics of managed care programs by covering the history of HMOs (health maintenance organizations) and PPOs (preferred provider organizations), as well as introducing you to several other managed care programs. These other managed care programs operate in ways similar to HMOs or PPOs. Overall, you will review co-payments, fee schedules and many other concepts in the managed care world.



People have many health insurance options.



Step 3 Private and Group Health Insurance

- According to CMS's data, our nation's health expenditures equal more than \$1.1 trillion per year! That's quite a sum. Two of the reasons for this is that people are living longer and the population continues to increase. 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 commercial health insurance policy. A **private insurance carrier** offers a variety of healthcare plans that require the subscriber to pay premiums. They operate for profit, meaning they have stockholders who benefit from the profits. Private insurance companies can raise their rates when they need or want to, and they can more easily deny coverage at will.

Facts About Private Insurance Carriers

There are a few inherent facts about private insurance carriers:

- ✓ Private insurance carriers operate for profit, and they have stockholders who benefit from those profits.
- ✓ Private insurance carriers can deny coverage at will. This means that they can determine whether to accept a potential subscriber as a customer.
- ✓ Private carriers 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** is the person who prepays the fee for insurance coverage.

When a subscriber purchases insurance coverage, he purchases a *policy*. An insurance **policy** describes the subscriber's benefits and details of coverage.

Many larger employers offer **group health insurance**. Companies purchase a group health plan that they can 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.

Group health insurance works similarly to private healthcare insurance because a private healthcare insurance company purchases a group policy. One difference with a group policy is that the insurance carrier cannot deny coverage to any of the company's employees, regardless of any pre-existing conditions.

Insurance Contracts

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

There are two types of contracts: service benefit contracts and indemnity benefit contracts. **Service benefit contracts** are plans that have participating physicians—physicians who have agreed to participate in the programs. This contract covers the services themselves, reimbursing the participating physician rather than the subscriber. Subscribers usually receive better benefits by utilizing a participating physician listed in their benefits package or preferred provider directory.

Indemnity benefit contracts cover the actual expenses for providing a service. This type of contract sometimes allows the physician to bill the subscriber for any amount not covered by the insurance company. You will need to check with the insurance company's administrator for contractual details.

Level of Payments

Participating physicians agree to accept a level of payment determined by the insurance company. Review the following three levels of payment.

Facts About Participating Physicians

The following three categories classify payments to participating physicians:

1. **Usual, customary and reasonable** is the amount a physician would normally charge the majority of patients, the fee most physicians in the geographic area charge, and the amount determined to be appropriate for the service or procedure.
2. **Customary maximum** is the fee charged by most physicians in the community.
3. **Fixed fee schedule** is the maximum fee allowed by the insurance company for a specific medical service or procedure.

When a subscriber sees a nonparticipating physician, sometimes insurance companies will pay minimal benefits. However, usually the subscriber receives payment for benefits directly. Therefore, as a medical claims and billing specialist, you need to know which of your doctors are participating physicians for which insurance companies. If a doctor is not a participating physician, the patient must pay the bill and may need to file his own claims to his insurance company.

Medical Claims and Billing Specialist



Step 4 Insurance Basics

- When you file an insurance claim, you will usually use the CMS-1500 claim form. In some cases, individual programs might have its own forms, although they are all similar to the CMS-1500 form.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

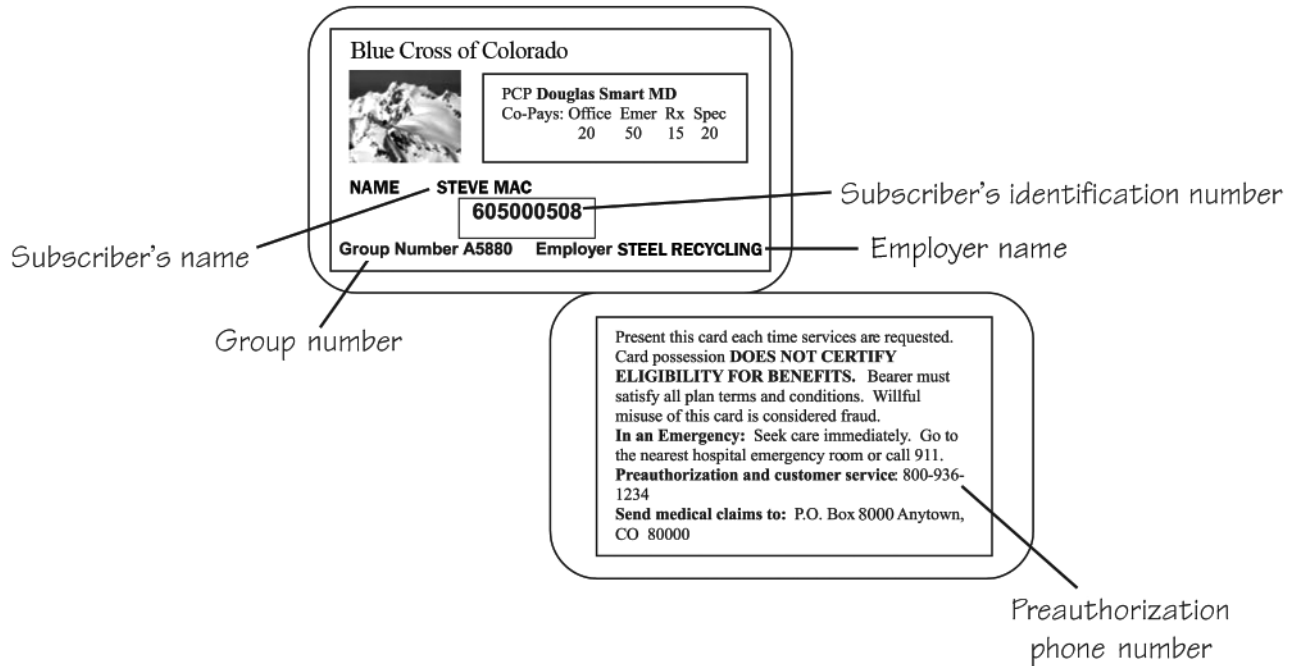
<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE (Medicare #)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										7. INSURED'S ADDRESS (No., Street)									
3. PATIENT'S BIRTH DATE										6. PATIENT RELATIONSHIP TO INSURED									
8. PATIENT STATUS										11. INSURED'S POLICY GROUP OR FECA NUMBER									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE									
14. DATE OF CURRENT ILLNESS OR INJURY OR PREGNANCY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY										20. OUTSIDE LAB?									
24. A. DATE(S) OF SERVICE										22. MEDICAID RESUBMISSION CODE									
25. FEDERAL TAX I.D. NUMBER										23. PRIOR AUTHORIZATION NUMBER									
26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT?									
28. TOTAL CHARGE										29. AMOUNT PAID									
30. BALANCE DUE										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS									
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH#									

CMS-1500 claim form

Identification Cards

Every person subscribing to a private insurance carrier has 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 keep a photocopy of the front and back of each subscriber's ID card on file.



Sample ID Card

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

- Subscriber's name
- Subscriber's identification number
- Group name
- 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.

Time Limits

After you have filled out the claim, you need to file it before the deadline established by individual insurance companies. This deadline varies from carrier to carrier, but for many, you must file the claim within a 30-day deadline. Whatever the time limit, the **timely filing guideline** is the deadline for filing a claim. Each carrier has its own timely filing guideline.

Filing a claim within the timely filing guideline is essential. If you do not file in time and the claim is late, then the carrier may not pay anything on the claim. In addition, the physician cannot bill the patient for the services. You can see that if you miss the deadline, the carrier usually denies the claim altogether, which results in no payment for the physician (and many headaches for you!). There can be some exceptions to this rule, but the circumstances must be extremely unusual for a carrier to consider waiving the timely filing guideline.

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 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, co-payment amounts and the amount paid on each individual claim.

The physician bills the patient for amounts applied to the patient's deductible, any co-payment 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.

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

BLUE CROSS OF COLORADO

Date: 04/10/XX

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

Policy: STEEL RECYCLING

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

STEVE MAC
 1823 KERRY COURT
 YOURTOWN, CO 80000

Patient: FRAN MAC

Number: 605000508

Explanation of Payments:

Claim Number	Provider/Type of Service	Date of Service From - Through	Billed Charges	Disallowed Amount		Deductible	Co-pay/ Co-Ins	Total Reimbursement Amount
					*			
66355912	Douglas Smart MD*							
	99212	0317XX-0317XX	50.00	6.48	9		20.00	23.52
	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	Deductible and out of pocket expenses for 03/17/XX-03/17/XX
		Co-payment \$20.00
		Non-covered amount \$15.48
Front Range Family Care	47.52	Total Patient Responsibility \$20.00

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

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

Medical Claims and Billing Specialist

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

Step 5 Practice Exercise 4-1

For questions 1 through 8, match the definition with the correct term.

- | | |
|--|------------------------------------|
| 1. _____ Operates for profit and can raise rates at will | a. Fixed fee schedule |
| 2. _____ The amount a physician would charge the majority of patients and the amount determined to be appropriate for the service or procedure | b. Prepay |
| 3. _____ Allows the physician to bill the subscriber for any amount not covered by the insurance company | c. Policy |
| 4. _____ Describes the subscriber's benefits and coverage | d. Customary maximum |
| 5. _____ The fee charged by most physicians in the community | e. Private insurance carrier |
| 6. _____ Advance payment for coverage of potential services | f. Service benefit contract |
| 7. _____ Plan that has participating physicians | g. Indemnity benefit contract |
| 8. _____ The maximum fee allowed for a specific medical service or procedure | h. Usual, customary and reasonable |

Step 6 Answers to Practice Exercise 4-1

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



Step 7 Managed Care

- Previously, you learned how managed care came about to help combat the rising costs of health 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 healthcare costs. Managed care gives insurance companies a basis for predicting these costs by establishing set fees and costs for healthcare services.



Managed care gives insurance companies a basis for predicting healthcare costs.

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. They 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: HMOs and PPOs, as well as point of service (POS) plans and physician provider groups (PPGs).



Step 8 Health Maintenance Organizations (HMOs)

- 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 physicians. 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 denied if a nonparticipating physician 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 service they need. However, all HMO participants are restricted in their choice of doctors.

Medical Claims and Billing Specialist

In order to facilitate treatment, each HMO participant must work through the participant's primary physician. The **primary physician** is a doctor 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.



Step 9 Preferred Provider Organizations (PPOs)

- Although PPOs are similar to HMOs, 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 physician 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 co-payments. 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 co-payment drops. This amount is the total amount paid to that point. For example, if Bill belongs to a PPO with a 20 percent co-insurance up to a \$5,000 threshold limit, then Bill must pay the first 20 percent of every bill until his total of bills is \$5,000. After that, the PPO pays 100 percent of covered charges.

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.



Step 10 Point of Service (POS) Plans

- **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 doctors. As is the case with PPOs, when a nonparticipating doctor or a nonparticipating 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 and integrated into POS plans, make them a nice compromise in managed care.



Step 11 Physician Provider Groups (PPGs)

- ❑ 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 it's cost effective, which enables them to compete with other physicians.



Step 12 Health Savings Accounts

- ❑ The Medicare bill of 2003 put Health Savings Accounts (HSAs) into effect. The bill's creators designed it to help individuals save for future medical expenses on a tax-free basis.

Participants need insurance with high deductible health plans (HDHP) to enroll in Health Savings Accounts (HSA). The participant cannot enroll in any other primary health insurance program including Medicare. Enrollment in dental, optical, disability, and long-term healthcare plans is acceptable. The participant cannot be a dependent on someone else's tax return.

HSA contributions are made on a yearly basis. Individual contributions are \$3,050 and family contributions are \$6,150. The HSA gives the insured the ability to save for their medical expenses on a tax-free basis. The contributions are tax free, the earnings on the savings are tax free, as well as 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 co-payments, co-insurance and deductibles. Once a person is qualified for Medicare, the HSA can pay Medicare premiums.

High Deductible Health Plan

In order to set up an HSA, enrollment in a high deductible health plan (HDHP) is required. An HDHP is a health insurance plan where the insured anticipates paying the first dollar medical expenses, or in other words, the plan includes a very high deductible. For an insurance plan to qualify as a HDHP it must have a deductible of \$1,200 for an individual, or \$2,400 deductible for a family. In general, this deductible applies to all medical expenses including dental, optical, and prescriptions. Some plans continue to cover preventive medicine such as prenatal care, well-child care, immunizations, annual physicals, mammograms, pap smears, etc. For the most part, however, the insured can anticipate paying for his medical care until he meets the deductible.

Billing for an HSA

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

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

It will be difficult for you as the medical billing professional to keep track of the patient's deductible status because the deductible applies to so many services and suppliers. Instead, the physician's office collects payment for services in full. You will then submit a CMS-1500 claim to the appropriate insurance, or submit the claim electronically. This insures that the services apply to the patient's deductible. At some point, you may receive an EOB showing that the patient met her deductible. You will then need to notify the office of the patient's status and if there is an over-payment, the office will need to issue a refund. From the point when the patient meets his deductible, you will continue to submit claim forms as you would for any other insurance.

Ready to apply what you've learned so far? Let's complete a Practice Exercise!

Step 13 Practice Exercise 4-2

For questions 1 through 6, select the best answer from the choices provided.

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. ____ 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

4. HMO stands for ____.
 - a. health-care management organization
 - b. home medical option
 - c. health maintenance organization
 - d. health management organization

5. PPGs are ____ groups.
 - a. physician provider
 - b. patient provider
 - c. preferred physician
 - d. preferred provider

6. HSA stands for ____.
 - a. health service administrator
 - b. health savings account
 - c. home savings account
 - d. health service account

Step 14 Answers to Practice Exercise 4-2

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



Step 15 Managed Care Concepts

- At this point, we have covered a few of the more common managed care programs in the United States. Regardless of which managed care programs you deal with as a medical claims specialist, there are some concepts you will run into. These concepts include preauthorization, peer review organizations, utilization review, capitation and visitation limits.

Imagine that you're starting your first day on the job (or with a new client), and you aren't familiar with the basic concepts of managed care. Your colleague, John, comes up and hands you a stack of files, saying, "Be sure to call these companies and check on preauthorization requirements and PROs." What would you do? If you hadn't taken this course, you could easily mistake what John is saying. For someone unfamiliar with managed care, John might as well be speaking in a foreign language. But, thanks to this course and your diligent work, you probably won't hear terms unfamiliar to you. Consequently, your colleagues and clients won't seem to be speaking in some obscure dialect.



If you understand the concepts of managed care, your colleagues won't seem to be speaking a foreign language.

Preauthorization

In some cases, managed care providers (as well as some fee-for-service plans) require preauthorization. **Preauthorization** is the approval of the managed care provider for certain procedures. Usually, a patient's insurance identification card or managed care membership card will list preauthorization requirements, as well as a telephone number to call for preauthorization. Before the carrier will issue a **preauthorization certificate**, also known as *precertification* or *prior authorization*, it will review the patient's individual case, including the proposed procedure, and then determine if circumstances warrant the procedure. Some examples of situations requiring preauthorization are surgery, magnetic resonance imaging, CAT scans and other expensive diagnostic tests.

It is essential to know whether preauthorization is required in any case. If a patient fails to get the proper preauthorization, the patient's benefits are dramatically reduced or denied.

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 because, 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.

Another way to ensure proper treatment is the *utilization review program*. The **utilization review program** safeguards against unnecessary and inappropriate medical care.

Capitation

An alternative to a fee schedule for services is a fee schedule per patient. Sometimes physicians receive payment according to the number of members of a managed care program the physicians have in their practices. **Capitation** means that a participating physician's reimbursement is based on how many patients the physician sees rather than which services the physician performs.

Visitation Limits

No, the term *visitation limits* doesn't refer to how many visitors a patient can have. It refers to visits to specialists. Many managed care programs set a **visitation limit** on the number of visits to specialists a patient may make or the number of special treatments, such as physical therapy, a patient may have.



Step 16 Working with Managed Care

- As a medical claims and billing specialist, you will work closely with managed care providers to ensure that they properly reimburse the doctors you work for or have as clients.

The Managed Care Quick Reference Card

You will need to set up a system for yourself that helps you keep track of each program's requirements. A simple way to do this is to make a managed care quick reference card for each program. You can keep the "cards" on a computer or in a manual card file.

The **managed care quick reference card** contains vital information for each managed care program used by patients of the doctors you work with. Create a card like the one in the following illustration. Then fill out one card with the name, address and telephone numbers for each plan. In addition to this information, each card should also have the name of your contact person for the plan, co-payment information, preauthorization requirements and a list of participating facilities.

Medical Claims and Billing Specialist

Managed Care Quick Reference Card	
Name	
Address	
Telephone	
Contact Person	
Co-Payment and Deductible Information	
Preauthorization Requirements	
Participating Facilities	
Claim Form	

Managed care quick reference cards help you keep track of managed care programs.

By keeping a managed care quick reference card handy, you will be able to quickly access essential information for each managed care program you deal with. These cards can save you time and help you tremendously.

To find the information you need to have on each card, contact the managed care plans that the doctors you work with use. Some may offer many plans with different information. For these, write "See patient plan" in the co-payment and deductible line. This immediately tells you that the managed care program has different coverage plans.

Use the managed care quick reference card to fill out important information when filing a claim. You also can use it to contact the program if a billing question comes up.

Explanation of Benefits

We covered the explanation of benefits (EOB) earlier in this course. Every claim you submit will result in an EOB, which explains the benefits provided and why benefits weren't provided. Remember to look carefully at the EOB you receive from the managed care program. Everyone makes mistakes, and by reviewing the EOB carefully, you can catch any mistakes that appear.

Be sure to look for such terms as *Not Eligible for Payment* and *Noncovered Charges* or other similar terms. These all indicate a denied claim. If you see a denied claim, be sure to review the situation to make sure the denial is correct. If you have a question, or believe the denial is wrong, then you can appeal the decision.



Review the managed care program's EOB carefully to catch mistakes.

Appealing Benefits

Situations may come up that require you to appeal a benefit decision. The managed care program might have mistakenly denied coverage for a covered procedure. On the other hand, perhaps extenuating circumstances prevented a patient from getting preauthorization. In cases such as these, you may have to write a letter of appeal to the program. You should become familiar with the contact person for each program because you usually start the appeals process by contacting that individual.

Western Plains Insurance

**Explanation of Benefits
THIS IS NOT A BILL**

For Inquiries:

Western Plains Insurance
P.O. BOX 1999
PLAINS, NEVADA 84448-0541
1-800-111-2222

#BWNCQXF
#9999999990000LF3#
ZACHARY S. SMITH
1234 Main Street
Fort Collins, CO 80526

CLAIM NUMBER: 010234XXXXX
DATE RECEIVED: 01/21/20XX
DATE PROCESSED: 01/27/20XX
DATE PAID: 01/27/20XX
PATIENT NAME: Emma Smith
ID NUMBER: R12345678
PATIENT ACCT NO: 390XXXX

SUMMARY OF STANDARD OPTION BENEFITS ON THIS CLAIM						BENEFIT CHECK SENT TO CITY YOUTH CLINIC				
PROVIDER NAME: SANDERS						DATES OF SERVICE: 01/10/20XX - 01/10/20XX				
Type Of Service	Submitted Charges	Negotiated Savings	Noncovered Charges	Exp *	Allowable Charges	Deduct	Coins Copay	Other Coverage	What We Owe	What You Owe
WEL CHILD	65.00	1.95		610	63.05				63.05	
WEL CHILD	33.00	13.81		610	19.19				19.19	
WEL CHILD	12.00	4.94		610	7.06				7.06	
TOTALS	\$110.00	20.70			89.30				\$89.30	

* EXPLANATION OF CODES/REMARKS

610 -- THE COVERED CHARGES EXCEED THE ALLOWABLE CHARGES PROVIDED UNDER THE SERVICE BENEFIT PLAN FOR THESE SERVICES. COVERED CHARGES ARE SUBMITTED CHARGES LESS ANY NONCOVERED CHARGES. BECAUSE THIS PROVIDER IS A PREFERRED OR PARTICIPATING PROVIDER WITH THE LOCAL PLAN, YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE COVERED CHARGES AND THE ALLOWABLE CHARGES. THE DIFFERENCE EQUALS THE NEGOTIATED SAVINGS BETWEEN THE PROVIDER AND THE LOCAL PLAN.

Any resubmission of eligible expenses on this claim must be received no later than December 31 of the calendar year following the date of service or 90 days from the date of the form, whichever is later.

Managed Care Programs and Medicare

An HMO that has a Medicare Part B contract may cover a patient. There are two different Part B Contracts: HMO risk plans and HMO cost plans. Submit claims for HMO risk plans to the HMO plan or the regular Medicare carrier.

Contact the Medicare Managed Care department at your Medicare Regional CMS Operations office for guidelines on submitting claims for Medicare/HMO patients. These guidelines may vary from region to region.

Managed Care Programs and Medicaid

If a Medicaid patient is also enrolled in an HMO or PPO managed care program, submit the claim to the managed care program and not to the Medicaid fiscal agent or intermediary. The capitation method for services to eligible members determines payment.



Step 17 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. Place a copy of the subscribers' insurance identification cards in their medical files. From this copy, you, the medical claims specialist, will find the information you need to file patients' claims.

As healthcare costs increased, insurance companies looked for ways to predict and control costs. One answer they 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 medical claims specialist, you need to become familiar with the requirements of the managed care programs you deal with. In order to do this, you should contact each program and get essential information. Then write this information down on a quick reference card that you can keep handy, whether in a computer file or nearby in a file cabinet. This card will help you as you work through claims for managed care.

Congratulations, you're more than halfway through Pack 1, and you're doing great! In the next lesson, you'll continue to build your foundation of knowledge by exploring Medicaid and Medicare. However, you must complete the following quiz before we can move on. Good luck!

Step 18 Mail-in Quiz 4

- Follow the steps to complete the quiz.
 - a. Be sure you've mastered the instruction and the Practice Exercises that this quiz covers.
 - b. Mark your answers on your quiz. Remember to check your answers with the lesson content.
 - c. When you've finished, transfer your answers to the Answer Sheet. Use only blue or black ink.
 - d. **Important!** Please fill in all information requested on your Answer Sheet or when submitting your quiz via e-mail.
 - e. Submit your quiz to the school via mail, e-mail or fax.

Mail-in Quiz 4

For questions 1 through 10, select the correct word or phrase that best completes each sentence. You'll use all the terms. Each item in this quiz is worth 4 points.

customary maximum	fight rising healthcare costs	PPOs
preferred provider organizations	insurance policy	HMO
reduced or denied	fixed fee schedule	primary physician
threshold limit		

1. **A(n) _____ describes insurance benefits and coverage information.**
2. _____ **is the maximum fee allowed for a specific medical service or procedure.**
3. _____ **is the fee charged by most doctors in the community.**
4. **Managed care started in order to help _____.**
5. **The most popular choice in managed care is the _____.**
6. **If an HMO patient is treated by a nonparticipating physician, the patient's insurance benefits are _____.**
7. **PPO stands for _____.**
8. **The _____ is the doctor in charge of a particular patient in an HMO.**

Lesson 4—Private Insurance and Managed Care Programs

9. One difference between HMOs and PPOs is that members of _____ can choose their own doctors and treatment facilities and still receive benefits.
10. The total amount of bills at which point the co-payment is dropped is called the _____.

For questions 11 through 21, select the correct word or phrase that best completes each sentence. You'll use all the terms.

write a letter	physician provider groups	advance approval for certain procedures
EOB	capitation arrangement	point of service plans
appeal the decision	peer review organizations	Medicare bill of 2003
reduced	number of visits to a specialist	

11. _____ strive to combine the best elements of both HMOs and PPOs.
12. _____ are managed care programs that are owned by the physicians.
13. If a patient fails to get proper preauthorization, the patient's benefits will be _____.
14. _____ examine and ensure quality health care in managed care situations.
15. Preauthorization is the _____.
16. When a physician's reimbursement is based on how many patients the physician sees instead of the services performed, the physician is participating in a(n) _____.
17. Visitation limits refers to the _____ a patient may make.
18. When you see the term disallowed on a document, you should carefully review the _____ to make sure the denial is correct.
19. If you believe the EOB is incorrect, you should _____.
20. If the managed care program mistakenly denies coverage, you may have to _____ of appeal.
21. The _____ was designed to help individuals to save for future medical expenses on a tax-free basis.

Medical Claims and Billing Specialist

For questions 22 through 25, match the term to the correct definition.

- | | |
|--------------|--|
| 22. ____ PPO | a. a group of physicians and hospitals who give plan members discounted health care for plan participants |
| 23. ____ HMO | b. prepaid health plan in which individuals receive medical services from participating physicians |
| 24. ____ PPO | c. members choose their own medical care providers, with care from a participating physician or facility resulting in increased benefits |
| 25. ____ POS | d. groups of physicians who negotiate contracts with employers, insurance companies and other entities in order to provide healthcare coverage |

Medical Claims and Billing Specialist Mail-in Quiz 4

1. Fill in your **student ID** and your **course code** below.

STUDENT ID NUMBER COURSE CODE

2. Be sure your **name** and **address** are filled in below.

3. **Transfer your answers** to this cover sheet.

For School Use Only:
Grade: _____

NAME

ADDRESS

CITY STATE ZIP

U.S. Career Institute
2001 Lowe Street
Fort Collins, CO 80525

CL1

This Space for Instructor Use

↑ Fold on dotted line

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Medical Claims and Billing Specialist

13. _____

14. _____

15. _____

16. _____

17. _____

18. _____

19. _____

20. _____

21. _____

22. _____

23. _____

24. _____

25. _____

Congratulations

You've completed Lesson 4.



Don't wait for your quiz results to continue with Lesson 5.

Lesson 5

Medicaid and Medicare



Step 1 Learning Objectives for Lesson 5

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
 - Describe the Centers for Medicare and Medicaid (CMS).
 - Distinguish between Medicaid and Medicare.
 - Discuss Medicaid and some general guidelines for submitting Medicaid claims.
 - Explain the federal Medicare program.
 - Discuss the two-level HCPCS coding system.
 - Differentiate among Medicaid, Medicare, Medigap and Medi-Medi coverage and procedures.



Step 2 Lesson Preview

- ❑ Although many people have private insurance, a large group of Americans receive some of their health care benefits through government programs. These programs include Medicaid, Medicare, TRICARE and CHAMPVA, as well as workers' compensation and disability. In this lesson, you'll explore Medicaid and Medicare. We will explain how the two programs work and how you will deal with their requirements.

You'll learn about Medicaid, a federal program run by individual states, in the first sections of this lesson, while later sections teach you about Medicare. Medicare is a federally funded program. Each of these government insurance programs has specific requirements regarding claims, eligibility and reimbursement. We will show you those requirements throughout this lesson and explain how to follow them. Ready to get started? Let's go!



Lesson 5 introduces you to government healthcare programs.



Step 3 CMS

- In 1977, the Department of Health and Human Services established the Centers for Medicare and Medicaid Services (CMS), an agency of the federal government, to administer the Medicaid and Medicare programs. In the past, CMS was HCFA (Health Care Financing Administration). Although the name has changed, you may still see references to HCFA.

The headquarters for CMS is in Baltimore, Maryland, with 10 regional offices nationwide. The headquarters is responsible for the two national healthcare programs, Medicaid and Medicare, which provide benefits to more than 75 million beneficiaries. CMS, in conjunction with the Health Resources and Services Administration, also runs the State Children's Health Insurance Program (SCHIP), which covers a large quantity of the almost 10 million uninsured children of the United States.

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.

The 10 regional offices of CMS provide quality customer service and rights to affordable healthcare services. A list of the regional offices, along with the states and territories in each region, appears in the following chart.

CMS Regional Offices

Region I	Boston CMS Regional Office John F. Kennedy Federal Building Room 2325 Boston, Massachusetts 02203-0003	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont
Region II	New York Regional Office 26 Federal Plaza, Room 3811 New York, New York 10278-0063	New Jersey, New York, Puerto Rico and Virgin Islands
Region III	Philadelphia Regional Office The Public Ledger Building 150 South Independence Mall West, Suite 216 Philadelphia, Pennsylvania 19106	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia
Region IV	Atlanta Regional Office Atlanta Federal Center 61 Forsyth Street, S.W. Suite 4T20 Atlanta, Georgia 30303-8909	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee
Region V	Chicago Regional Office 233 North Michigan Avenue Suite 600 Chicago, Illinois 60601	Indiana, Illinois, Michigan, Minnesota, Ohio and Wisconsin
Region VI	Dallas Regional Office 1301 Young Street, 8 th Floor Dallas, Texas 75202	Arkansas, Louisiana, Oklahoma, New Mexico and Texas
Region VII	Kansas City Regional Office Richard Bolling Federal Building 601 East 12 th Street, Room 235 Kansas City, Missouri 64106-2808	Iowa, Kansas, Missouri and Nebraska
Region VIII	Denver Regional Office 1961 Stout Street, Room 522 Denver, Colorado 80294-3538	Colorado, Montana, North Dakota, South Dakota, Wyoming and Utah
Region IX	San Francisco Regional Office 75 Hawthorne Street 4 th and 5 th Floors San Francisco, California 94105	California, Hawaii, Nevada, Arizona, American Samoa, Commonwealth of Northern Marianas Islands and Guam
Region X	Seattle Regional Office 2201 Sixth Avenue MS/RX-40 Seattle, Washington 98121-2500	Alaska, Idaho, Oregon and Washington



Step 4 Medicaid

- ❑ In 1965, Title XIX of the Social Security Act became federal law to establish Medicaid officially. Although Medicaid is a federally mandated program, each state runs its own Medicaid program. Federal and state governments jointly fund the Medicaid programs to assist states in providing adequate medical care to eligible needy persons. Medicaid is the largest government program providing medical and health-related services to those who cannot afford them.

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.

Currently, 49 states have some form of Medicaid. In California, Medicaid is called *Medi-Cal*. Only Arizona does not have a true Medicaid program. Arizona has an alternative, prepaid medical assistance program for low-income persons. Arizona has special permission from the federal government for its unique health care program, which is called the *Arizona Health Care Cost Containment System (AHCCCS)*. This program meets the minimum federal standards, but is based on a different philosophy than traditional Medicaid.

Because Medicaid programs are run by individual states, the requirements for billing vary from state to state. As a medical claims and billing specialist, you will need to contact your state Medicaid administration to get your state's requirements. You can find additional information on your state's program at www.cms.gov.

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.

Who is Eligible for Medicaid?

Although each state has some discretion in determining eligibility requirements for Medicaid recipients, states are required to provide Medicaid coverage to certain **categorically needy** groups of people, such as these:

- Low-income families with children
- Supplemental Social Security Income (SSI) recipients

- Infants born to Medicaid-eligible pregnant women
- Children under age six and pregnant women whose family income is at or below 133 percent of the federal poverty level
- Recipients of adoption assistance and foster care

In addition to the mandatory Medicaid eligibility requirements, states have the option to offer two additional categories of Medicaid recipients: “other” categorically needy recipients and medically needy recipients.

Additional Categorically Needy Groups

The optional **categorically needy** groups share characteristics of the mandatory eligibility groups, but the eligibility criteria are more liberally defined. A few examples of these additional categorically needy groups include the following:

- Certain low-income children who would not otherwise qualify for mandatory Medicaid coverage
- Aged, blind or disabled adults whose incomes are above those requiring mandatory coverage, but are below the federal poverty level
- Low-income, uninsured women who need treatment for breast or cervical cancer

Medically Needy Groups

Another optional group of Medicaid recipients is the *medically needy* or *medically indigent* group. **Medically needy** Medicaid recipients have too much income to qualify for the mandatory or optional categorically needy groups. These people earn enough money to pay for basic living expenses, but they cannot afford medical expenses. Medicaid helps these individuals meet medical costs. Some Medicaid recipients are required to pay a co-payment and/or coinsurance before they can receive state benefits. A **co-payment** is a flat amount, such as \$10, that the insurance policy designates a patient must pay before the patient leaves 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. Some Medicaid recipients must pay a co-payment each month before receiving Medicaid benefits. It is important to obtain the co-payment when the patient is 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. All recipients receive a Medicaid identification card.

Medicaid Identification Cards

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 fifteenth 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, co-payment requirements, or restrictions on the types of services they are eligible to receive. Photocopy the front and the back of each card or coupon for each visit.

Services that Medicaid Covers

According to federal guidelines, all Medicaid programs are required to pay for basic services. The following boxes show the services.

Facts About Medicaid— Required Services for Categorically Needy Recipients

Medicaid programs for the categorically needy must provide the following basic services:

1. Laboratory and x-ray services
2. Inpatient hospital care
3. Outpatient hospital care
4. Physician's care, pediatric and nurse practitioner services, and where legal, midwife services
5. Medical and surgical dental services
6. Family planning services and supplies
7. Home health care
8. Care in a nursing facility
9. Rural health clinic services
10. Health center services
11. EPSDT (Early and periodic screening, diagnosis and treatment)

Number 11 above, *early and periodic screening, diagnosis and treatment (EPSDT)*, benefits children. This program is designed to provide preventive services, early detection and treatment of children whose families receive Temporary Assistance for Needy Families ("TANF," formerly known as welfare). Services include medical history, physical examination, assessment of development and immunization status, screening of anemia, lead absorption, tuberculosis, sickle cell trait and disease and dental, hearing and vision problems.

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING																	
EPSDT CLAIM											INVOICE/PAT. ACCT NUMBER						
1. CLIENT NAME (LAST, FIRST, M.I.)					2. CLIENT ID NUMBER				3. DATE OF BIRTH MO DAY YR			4. SEX <input type="checkbox"/> M <input type="checkbox"/> F					
5. SCREENING						6. OTHER INSURANCE											
N = PERFORMED, NORMAL R = PERFORMED, REFERRED A = PERFORMED, ABNORMAL LEAVE BLANK IF NOT PERFORMED. T = PERFORMED, TREATED						OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO INSURANCE PAID / DENIED <input type="checkbox"/> PAID <input type="checkbox"/> DENIED DATE INSURANCE PAID / DENIED INSURANCE COMPANY NAME/ADDRESS INSURANCE POLICY NUMBER INSURANCE GROUP NUMBER POLICYHOLDER NAME / ADDRESS EMPLOYER NAME											
ITEM NO.	SCREENING ITEMS					RESULTS											
01	MEDICAL HISTORY OBTAINED?																
02	PHYSICAL EXAMINATION?																
03	ASSESSMENTS PERFORMED																
04	VISION																
05	HEARING																
06	DENTAL																
07	DEVELOPMENTAL (PHYS. GROWTH/EMOTIONAL DEV./LEARNING)																
08	NUTRITIONAL/GASTROINTESTINAL																
09	CARDIOVASCULAR/RESPIRATORY																
10	GENITAL/URINARY TRACT																
11	DIABETES																
12	IMMUNIZATION																
13	EDUCATION																
14	OTHER SCREEN																
01	LAB TESTS PERFORMED																
02	HGB/HCT																
03	URINALYSIS																
04	SICKLE CELL																
05	BLOOD LEAD																
06	TB																
07	OTHER LAB																
7. DIAGNOSIS ICD-9-CM DESCRIPTION																	
1	_ _ _ _ _					_____											
2	_ _ _ _ _					_____											
3	_ _ _ _ _					_____											
4	_ _ _ _ _					_____											
IN COLUMN 13, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4																	
8. LINE NO.	9. DATE OF SERVICE MO DAY YR			10. PLACE OF SERVICE	11. PROCEDURE CODES			12. MODIFIER 1 2		13. DIAGNOSIS RELATED P S T			14. UNITS OF SERVICE	15. CHARGES		16. COMMENTS	
01																	
02																	
03																	
04																	
05																	
06																	
07																	
08																	
09																	
10																	
17. NAME PHYSICIAN OR AGENCY					DIAGNOSIS RELATED: RELATE DIAGNOSIS IN FIELD 7 TO PROCEDURE BY REFERRING TO NUMBERS 1, 2, 3, OR 4					21. TOTAL CHARGES			24. RENDERING PROVIDER ID				
18. BILLING PROVIDER ID					22. INS AMOUNT PAID					25. REFERRING PROVIDER ID							
19. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE SIDE)					20. DATE SIGNED			23. NET CHARGE			26. SUPERVISING PROVIDER ID						

FORM # 10018 (REV. 9/98)

In the State of Colorado, providers must file a special EPSDT claim.

Facts About Medicaid— Required Services for Medically Needy Recipients

Medicaid programs for the medically needy must provide these minimum services:

1. Prenatal care and delivery services for pregnant women
2. Outpatient services for children under age 18
3. Home health care
4. Certain services for the mentally retarded

States may choose to increase benefits and cover more services, but they are not required to do so. Additional medical services that may be covered by Medicaid include the following.

Facts About Medicaid— Some Additional Services

Some states cover nonrequired services, such as:

- | | |
|--|--|
| ✓ Ambulance service | ✓ Allergy care |
| ✓ Dental care | ✓ Clinic services |
| ✓ Prescription drugs | ✓ Dermatologic care |
| ✓ Chiropractic care | ✓ Podiatry care |
| ✓ Emergency room care | ✓ Diagnostic, screening,
preventive and rehabilitative
services (physical therapy) |
| ✓ Optometric service,
eyeglasses and eye
refractions | ✓ Psychiatric care |
| ✓ Prosthetic devices | ✓ Private duty nursing |
| ✓ Mental health care | |



Step 5 Filing Medicaid Claims

- As we stated earlier in this lesson, Medicaid is a state-administered program. Therefore, there are many different sets of regulations for Medicaid claims. In order to ensure you follow the correct set, be sure to get and use the Medicaid Handbook for your particular state. This section presents some general guidelines for submitting Medicaid claims.

Physicians who choose to participate in the Medicaid program agree to participate in the entire program of their particular state. Physicians agree to accept as payment in full Medicaid reimbursements for covered services. The physician usually writes off the difference between the fees normally charged by the physician and the amount reimbursed by Medicaid as a loss. If Medicaid does not cover services, however, physicians are within their legal rights to bill patients for payment.

Most Medicaid claims are required to be processed using the CMS-1500 form. You've already seen the CMS-1500 form in previous lessons, and in later lessons you'll learn how to fill it out.

Although the CMS-1500 form is the standard, a few states use a slightly different form. For example, Colorado uses a Medicaid form called the Colorado 1500. All claim forms must conform to very strict standards and will appear very similar to the CMS-1500 claim form. Since Medicaid is a state-administered program, each state's requirements will vary. Be sure to contact your local Medicaid office for guidelines.

Preauthorization

Some states require preauthorization for specific services. **Preauthorization** is the review of proposed treatment by Medicaid in order 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 local Medicaid 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 Medicaid office.

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

Facts About Medicaid—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

Time Limits and Appeals

Whether you are filing a claim or appealing an action taken by Medicaid, you have a limited time to do so. Each state has its own time limit for the submission of a claim. Depending on the state in which you live, the time limit varies from two months to one year from the date that the patient received medical services and/or care. For example, in Colorado the Medicaid claim must be filed within 120 days of the date of service.

When you appeal an action by Medicaid, you have between 30 and 60 days from receipt of the denial to file the appeal, depending on the state. Appeals should include a cover letter and photocopies of the original claim form, any preauthorization forms and the explanation of benefits received. First, the regional fiscal intermediary reviews appeals, and then the Department of Welfare. At each level, an examiner reviews the case and makes a decision.

Time limits on filing claims and appeals prevent “stale” claims and long, drawn-out appeals. Find out your state’s requirements on filing claims and file claims promptly.



States have time limits for claim submission.

Reciprocity

We 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 47 and 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, his home state Medicaid program pays. It is up to the medical claims and billing specialist to request the proper forms from George's home state. In these circumstances, you would contact the Medicaid intermediary in 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.

Explanation of Benefits

When you receive a Medicaid payment, an *explanation of benefits (EOB)* accompanies it. The **explanation of benefits** is a document explaining exactly what actions Medicaid took on a particular claim.

The actions explained in an EOB include approvals, denials, adjustments, suspends and audit/refunds. An **approval** occurs when an original claim or payment is approved for a previously denied claim. The EOB lists all denied claims, or **denials**, and should be researched and resubmitted immediately if necessary. **Adjustments** can occur from overpayments or underpayments, or actions taken from appealed claims. The EOB also lists suspended claims, or **suspends**, and are due to a claim in review or are waiting to receive additional information. **Audit/refund** transactions are miscellaneous transactions due to cost settlements, state audits or refund checks received.

As the medical claims and billing specialist, you should review the Medicaid explanation of benefits one line at a time to understand the reimbursement of benefits for each patient.

Third Party Liability

It is possible for a person who is eligible for Medicaid to have additional health insurance from an insurance plan through an employer or another government program. The other insurance program is the primary carrier in these cases. Medicaid becomes the secondary carrier.

You will file the claim first with the primary carrier. After receiving an explanation of benefits (EOB) from the primary carrier, you will then submit a claim to Medicaid, enclosing a copy of the EOB from the primary carrier.

Let's pause and review what we learned in this section.

Step 6 Practice Exercise 5-1

For questions 1 through 15, select the best answer to complete each sentence.

1. **The Centers for Medicare & Medicaid Services acts as a purchaser of healthcare services for ____ and ____.**
 - a. state governments, the federal government
 - b. Medicaid, Medicare
 - c. Supplemental Security Income (SSI) policies, Medigap policies
 - d. TRICARE, Medicare

2. **There are ____ CMS regional offices.**
 - a. 10
 - b. 12
 - c. five
 - d. four

3. **Medicaid was officially established in ____.**
 - a. 1977
 - b. 1975
 - c. 1968
 - d. 1965

4. **Although ____ is financed by state and federal governments, it is run by each state.**
 - a. CMS
 - b. HCPCS
 - c. Medicare
 - d. Medicaid

5. **____ Medicaid recipients have too much income to qualify for the mandatory or optional categorically needy groups.**
 - a. All
 - b. Veteran
 - c. Medically needy
 - d. Wealthy

6. **The levels of care required by federal law for Medicaid recipients are called ____.**
 - a. mandatory care levels
 - b. minimum standards
 - c. mandatory standards
 - d. maximum standards

7. **Medicaid recipients receive ID cards or coupons, which note ____.**
 - a. their income
 - b. their classification of eligibility
 - c. federal claim guidelines
 - d. minimum standards

8. **Some health insurance programs require the insured to pay a percentage of the cost of covered charges, called ____.**
 - a. preauthorization payments
 - b. a customary fee
 - c. a coverage fee
 - d. coinsurance

9. **The difference between the fees normally charged for a service and the amount reimbursed by Medicaid is usually ____.**
 - a. written off as a loss by the physician
 - b. billed to the patient
 - c. billed to Medicare
 - d. paid by the patient at the time of service

10. **____ 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

11. **From state to state, the time limits for submission of Medicaid claims vary between ____ from the date that the patient received medical services.**
 - a. 30 and 60 days
 - b. three and six months
 - c. 30 and 90 days
 - d. two months and one year

12. Depending on your state, you have between ____ days to file an appeal of an action by Medicaid.
- 60 and 90
 - 30 and 60
 - 30 and 120
 - 60 and 120
13. In most states, Medicaid claims should be submitted using the ____ claim form.
- CMS-1500
 - CA-1
 - Medicaid
 - CMS-1000
14. If a person has other insurance coverage, Medicaid becomes the ____ carrier.
- only
 - tertiary
 - secondary
 - primary
15. When filing a Medicaid claim for a person with a primary carrier, you must include a copy of the ____ from the primary carrier.
- CMS-1500
 - EOB
 - EOMB
 - invoice

Step 7 Answers to Practice Exercise 5-1

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



Step 8 Medicare

- ❑ Medicare is a federally administered, federally funded health insurance program. Medicare is administered by the Centers for Medicare & Medicaid Services (CMS). The Social Security Administration provides information about the program and handles enrollment for eligible individuals.

There are different kinds of Medicare coverage:

- Part A, Hospital Insurance
- Part B, Medical Insurance
- Part D, Prescription Drug Coverage

Medicare Part A is financed by the Social Security payroll withholding tax paid by workers and their employers. Medicare Part B is financed by monthly premiums paid by people who choose to enroll in the program.

Who is Eligible for Medicare?

Medicare beneficiaries are people who meet at least one of the criteria described here.

Facts About Medicare—Who Qualifies?

People who qualify for Medicare must be one or more of the following:

1. Age 65 or older, retired on Social Security, railroad or civil service retirement
2. Blind
3. Disabled and eligible for Social Security disability benefits and, further, belong in one of these categories:
 - a. Disabled workers (any age)
 - b. Disabled widows or widowers of workers who are currently or fully insured through Social Security, civil service, the federal government or the Railroad Retirement Act and whose spouse had qualified for benefits under one of these programs
 - c. Adults disabled as minors (under 18 years of age), whose parents are on or eligible for Social Security
 - d. Children and adults with end-stage renal disease
 - e. Kidney donors

Medical Claims and Billing Specialist

Individuals who apply for Social Security early, at 62 years of age, do not receive Medicare benefits; they are eligible for Medicare Parts A and B when they become 65 years of age. Certain aged or disabled people who do not qualify for Medicare Part A may be able to get it by paying a monthly premium.

Medicare Identification Card

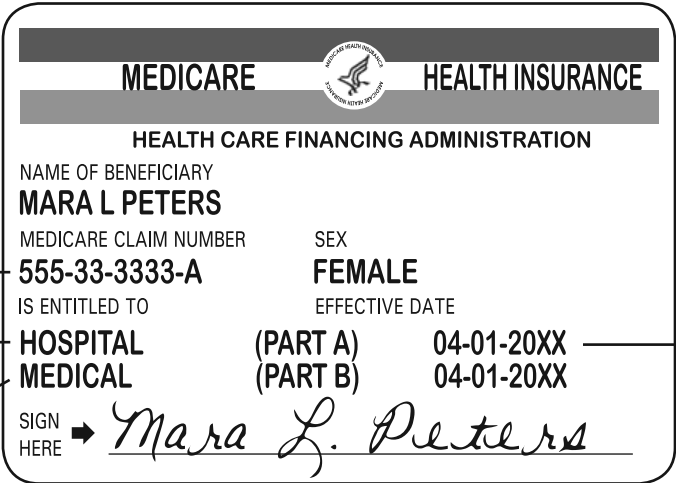
The Medicare patient identification card lists all the information that you, as a claims specialist, need from the patient.

The card is red, white and blue, and 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. Copy the claim number exactly onto the patient's insurance claim form.

This is the patient's health insurance claim number. It must be on all Medicare claims.

This shows hospital insurance coverage.

This shows medical insurance coverage.



IS ENTITLED TO

HOSPITAL	(PART A)	04-01-20XX
MEDICAL	(PART B)	04-01-20XX

The dates the insurance starts are shown here.

SIGN HERE → *Mara L. Peters*

The letters following the Medicare claim number (555-33-3333-A) on the identification card indicate the following:

- | | |
|----|--|
| A | Primary claimant (wage earner) |
| B | Wage earner's number (spouse is 62 years or older) |
| C | Child - includes minor, student or disabled child |
| D | Spouse of deceased wage earner |
| T | Uninsured and entitled only to health insurance benefits |
| HA | Disabled claimant (wage earner) |

Any letters preceding the Medicare claim number (A000-00-0000) on the identification card indicate railroad retirees and such family members as the following:

A	Retired railroad employee
CA	Child
MA	Spouse of retired railroad employee
WA/WD	Widow or widower of deceased employee
WCA/WCD	Widow or widower of retiree with child or disabled child of deceased employee
JA	Widow or widower receiving a joint and survivor annuity



Step 9 Services that Medicare Covers

- Now that you're familiar with Medicare, let's examine some of its services.

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).

Hospital services include a semiprivate room and board, general nursing and other hospital services and supplies.

Skilled nursing facility care includes a semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies. The patient must have been in a hospital for at least three days and entered a Medicare-approved facility.

Home health care includes part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services, if medically necessary.

Hospice care includes pain relief, symptom management and support services for the terminally ill.

Blood is included when furnished by a hospital or skilled nursing facility during a covered stay, if the blood is medically necessary.

Medical Claims and Billing Specialist

Medicare Part A (Hospital Insurance) Summary of Benefits Based on Data for 2011			
Services	Benefit	Medicare Pays	Patient Pays
Hospitalization	First 60 days	All but \$1132	\$1132
	61 st - 90 th day	All but \$283 per day	\$283 per day
	91 st - 150 th day	All but \$566 per day	\$566 per day
	Beyond 150 days	\$0	All costs
Skilled nursing facility care	First 20 days	All costs	\$0
	21 st - 100 th day	All but \$141.50 per day	\$141.50 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 6 outpatient months to live	All but a small co-payment 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

The monetary values are evaluated each year by the federal government and are subject to change.

Medicare Part B

Medicare Part B helps pay for a wide range of medical services and supplies not covered by Medicare Part A. Part B helps pay for medical expenses, clinical laboratory services, home health care, outpatient hospital treatment and blood, if medically necessary.

Medical expenses include physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment and more.

Clinical laboratory services include blood tests, urinalysis, mammograms, Pap smears and more.

Home health care includes part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, if medically necessary.

Outpatient hospital treatment includes services for the diagnosis or treatment of an illness or injury.

Blood is included when furnished by a hospital or skilled nursing facility, if the blood is medically necessary.

Medical Claims and Billing Specialist

Medicare Part B (Medical Insurance) Example of Benefits Based on Data for 2011			
Services	Benefit	Medicare Pays	Patient Pays
Medical expenses	Unlimited, if medically necessary	80% of approved amount after \$162 deductible; and 50% of approved amount for most outpatient mental health services	\$162 deductible and 20% of Medicare approved amount 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 co-payment for other services	20% of approved amount for the doctor, or the co-payment for other services
Blood service	Unlimited, if medically necessary	80% of approved amount starting with 4 th pint	First three pints plus 20% of approved amount for additional pints unless patient arranges for donation of replacement blood

The monetary values are evaluated each year by the federal government and are subject to change.

Medicare Part D

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.

Medicare doesn't directly provide the coverage, but instead by private insurance companies from each state. As a result, participants each choose a plan that best serves their needs. Although each plan varies in premiums and co-payments, the general coverage and costs are as follows:

- A monthly premium ranging from \$8.00 to \$32.00
- A deductible of \$250.00
- After the deductible is met a co-payment ranging from \$5.00 per prescription to 25 percent of the cost of the prescription
- After \$2,250.00 of coverage is provided, 100 percent of the prescription costs are paid by the participant until a cap of \$5,100.00 is reached.
- After the cap of \$5,100.00 has been reached then a co-payment of five percent of the prescription cost is paid by the insured.

Additional financial help is available for those with low incomes. If qualified, the deductible is waived, the premium is waived, and the co-payments are reduced. This allowance was made to cover those patients who previously received drug coverage from Medicaid, and will now be required to switch to Medicare Part D. States will no longer provide drug coverage through Medicaid.



Step 10 Filing Medicare Claims

- ❑ As you now know, Medicare is a federally funded health insurance program administered by CMS. It's now time to look at how to file Medicare claims.

Submit Medicare claims for physician services with the carrier designated for your region. When you file with Medicare, you use the CMS-1500 claim form. Filing Medicare claims is similar to filing claims for other insurance carriers. However, the federal government developed the **Healthcare Common Procedure Coding System (HCPCS)** for the Medicare program. HCPCS consists of two levels:

- Level I CPT codes
- Level II HCPCS codes

We'll talk more about HCPCS coding later, but remember when you are filing Medicare claims, it's important to contact your state Medicare carrier to know what level of procedure codes are required in your state.

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. The National Blue Cross and Blue Shield Association holds the fiscal intermediary contract to handle claims for services covered under Medicare Part A.

Participating Physicians

A physician who agrees to accept payment from Medicare signs a Medicare-participating agreement and agrees to accept assignment on all Medicare claims. A PAR provider is a physician who participates with Medicare and 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** would be whichever charge is the lowest of the following three charges.

- 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.

Physicians do not currently have to accept assignment for Medicare. They 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 the allowable charge.

National Provider Identifier (NPI)

National provider identifier (NPI) is a part of the Health Insurance Portability and Accountability Act. This act requires each physician to apply for a nationally assigned identification number. In the past, each insurance carrier would assign a participating physician a personal identification number (PIN). You can imagine this would be confusing, especially if the physician participated with a number of carriers. NPI simplifies the process by assigning a single national identification number.

The NPI is a 10-digit number assigned by CMS (Centers for Medicare and Medicaid Services). A physician must submit an application to CMS to have a national provider identification assigned. The CMS-1500 and UB-04 claim forms use this number for identification purposes.

The Claim Form

When you file with Medicare, you use the CMS-1500 claim form. Medicare regulations require all physicians who treat Medicare beneficiaries to file the claim form for their patients, whether the physician accepts assignment or not.

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 your local Medicare 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 that was given to you by the Medicare office.

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



Whether or not a physician accepts Medicare assignment, she must file a claim form for any Medicare patients she treats.

Facts About Medicare—Preauthorization

Some of the procedures that require preauthorization are:

- ✓ Cataract extractions
- ✓ Cholecystectomy
- ✓ Joint replacements (hip, shoulder, knee)
- ✓ Coronary artery bypass graft
- ✓ Inguinal hernia repair
- ✓ Bunionectomy
- ✓ Hysterectomy

Time Limits and Appeals

File Medicare claims within one year of the dates of the performed services. This means that if Mary receives services in February 2010, then you must file with Medicare by the end of February 2011. The filing deadline is extended another full year if the service was provided in the last three months of the calendar year. If you fail to file by the deadline, Medicare will deny the claim. Additionally, the physician is liable for significant monetary penalties for failing to file a Medicare claim.

<u>Dates of Service</u>	<u>Last Filing Date</u>
Jan. 1, 2010—Sep. 30, 2010	Jan. 1, 2011—Sep. 30, 2011
Oct. 1, 2010—Dec. 31, 2010	Oct. 1, 2012—Dec. 31, 2012

When you appeal an action by Medicare, you must do so within 60 days of the date you received the notice of denial. Unless you can prove otherwise, Medicare deems that you received the denial notice five days after the date on it. If you should need more than 60 days to file the appeal, you can request more time from the intermediary at the Medicare office. You will be notified in writing of the time granted you.

Explanation of Benefits

When you receive a payment, it's accompanied by an **Explanation of Medicare Benefits (EOMB)**. This form will explain the actions Medicare took on the submitted claim. This form may also be called the Medicare Summary Notice (MSN).

The EOMB includes the amount billed, amount approved, deductible and/or coinsurance that the patient is responsible for, and reductions or denials of charges. Match the code number on the claim with the code number on the back of the EOMB to quickly explain reductions and denials. Reasons for reductions and denials can vary from the fact that the claim was filed after the time limit to the care not being covered. Review this example of an EOMB.

Transamerica Occidental Life **EXPLANATION OF MEDICARE BENEFITS**
Transamerica Occidental Life Insurance Company

*22313 W3276 **FAM PRAC MED** **SEP 19, 20XX**

BENEFICIARY NAME	PERFORMING SUPPLIER	SERVICE	PLACE	PROCEDURE	AMOUNT	AMOUNT	NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	
H.I.C. NO.	CONTROL NUMBER	FROM MO-DAY TO DAY-YR	-TYPE	CODE-MODIFIERS	BILLED	APPROVED					
499-34-1487-A	EX 544458 6246-080-880	08-19 19-XX		71020	61.00	43.30	56	0.00			
L WILSON	EX 149 458-07-7080-A	09-08 08-XX	1 A	90050	28.00	26.00	106	0.00			
M. MIRELE	EX 126 464-40-3930-A	09-05 05-XX	1 E	99000	17.00	3.00	6				
M. MIRELE	EX 915 464-40-3930-A	08-25 25-XX 08-25 25-XX 08-25 25-XX	1 A 1 E 1 E	90070 99000 81000-XL	46.00 10.00 73.00	41.30 3.00 50.05	56 6 209	0.00	8.86	40.78	
R WALL	EX 126 042-16-3112-A	09-08 08-XX 09-08 08-XX 09-08 08-XX 09-08 08-XX 09-08 08-XX 09-08 08-XX 09-08 08-XX	1 A 1 B 1 E 1 A 1 E 1 D 1 A 1 A	90080-22 99210 99000 93000 81000-XL 71020 J0110 A4480	73.00 38.00 17.00 42.00 10.00 61.00 26.00 11.00	61.80 25.00 3.00 42.00 5.75 43.30 3.00 10.00	56 56 6 56 56 56 56 56	0.00	37.62	154.67	
NOTE					EXPLANATION						
209: CLINICAL LABORATORY PROCEDURES WERE PAID AT 100% OF THE APPROVED AMOUNT.											
A NEW LAW HAS REDUCED YOUR MEDICARE PAYMENT BY 1% FOR SERVICES FROM 03/01/XX THROUGH 09/30/XX											
TOTALS					BILLED	APPROVED	CLAIMS	DEDUCTIBLE	COINSURANCE	PAYMENT	
					504.00	316.20	5	0.00	80.94	252.71	

ON QUESTIONS RELATED TO THIS PAYMENT: **No 208044826**

- Date of check and statement.
- Patient's name and Medicare number.
- Number of supplier performing services if not the same as the physician/supplier billing for the services.
- Claim control number. Refer to this number when inquiring about a particular claim.
- Special notation, when applicable. (Here, the Medi-Cal number is listed.)
- Procedure code-modifier. These codes and modifiers describe services rendered as billed by you.
- Reductions or denials of charges can be explained by matching these numbers to the numbered explanations on the back of the EOMB.
- Deductible. This column lists any deductible applied for claims included on this statement.
- Co-insurance. This column lists the 20% co-insurance amount for claims included on this statement.
- Number of claims. This figure represents the total number of claims included on this statement.
- Amount of check. This is the total amount of the check attached and represents payment for all claims included on this statement.
- This is the check number on the payment issued for the claims included on this statement.

Advance Beneficiary Notice (ABN)

When providing care for a Medicare patient, the physician may recommend a procedure that is not covered by Medicare. 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, in order to allow the patient to make an informed decision regarding their care, Medicare requires that the physician inform the patient of the service not being a part of their coverage. Medicare has provided a form called an advance beneficiary notice, ABN. The ABN 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. Once decided, the patient then must sign the form. Review this example of an ABN.

Medical Claims and Billing Specialist

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.

Medicare Preventive Services

Preventive services are procedures that are provided in order to detect the early onset of an illness. Detecting illnesses such as cancers in their early stages save lives and health insurance costs. In recognizing the need for preventive medicine, Medicare provides coverage for a variety of preventive services. Medicare Preventive Services at the time of this printing include the following:

- Initial preventive physical exam
- Blood test for cardiovascular screening
- Test for screening diabetes
- Bone mass measurements
- Cancer screening
- Mammography
- Pap tests
- Pelvic exams
- Prostate exams
- Fecal occult blood tests
- Sigmoidoscopy
- Colonoscopy
- Double contrast barium enema
- Glaucoma screening
- Immunizations
- Nutritional therapy
- Diabetes self-management

Every one of these services has its own requirements, eligibilities and levels of coverage. For example, Medicare provides coverage for a mammogram yearly for any female beneficiary over the age of 40. Pap smears are covered for all low risk females every other year and yearly for those who are in a high-risk category. Services such as bone mass measurements and glaucoma screening require the patient to exhibit risk factors before Medicare will cover these services.

Medical Claims and Billing Specialist

Medicare provides for the first initial preventative physical exam (IPPE) as a person is newly eligible for Medicare. It is known as the “Welcome to Medicare” exam. Beyond this initial exam, Medicare does not cover annual physicals.

If you would like to have more information on all of these services, their requirements, and coverage you may wish to visit the CMS Web site at www.cms.gov.

Medicare Fraud and Abuse

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 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 to notify the state intermediaries of any new scams.

You as a medical billing professional, need to be sure you are coding properly, that you are not billing for medically unnecessary services, that the Medicare patient is who they say they are, 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 looking for you, they are looking for those who are purposely defrauding the system.



Step 11 Supplemental Insurance

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

Medigap or Supplemental Insurance

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. The 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 still bill Medicare as the primary carrier. From there, Medicare will send the claim on to the Medigap carrier. When the explanation of Medicare benefits (EOMB) arrives, it usually has a note that states the claim was sent to the supplemental carrier for any additional benefits.

Many times, you will bill Medicare as the primary carrier. However, there are times when Medicare is considered a supplemental carrier. Here are some situations that indicate that Medicare is the supplemental, rather than the primary, carrier.

Facts About 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).
- ✓ A patient with permanent kidney failure is covered by an employer group health plan.

Medi-Medi (Medicare/Medicaid)

Medicare and Medicaid both cover some patients. People who qualify for Old Age Security assistance benefits, the severely disabled and the blind qualify for both Medicare and Medicaid.

Medical Claims and Billing Specialist

Submit claims for Medi-Medi patients to Medicare first. These claims are automatically processed by Medicaid once Medicare completes its processing. You should follow the Medicaid guidelines for filing claims.



Step 12 State Children's Health Insurance Program (SCHIP)

- The State Children's Health Insurance Program (SCHIP) was initiated in 1998. It is a jointly financed program between the federal government and each individual state. The SCHIP provides healthcare coverage for low-income families who do not qualify for Medicaid.

Each state has its own guidelines and eligibility rules, but in general, the standard requires the insured to be under the age of 19 and the families' earnings to be less than \$36,200 for a family of four. The program generally covers doctor visits, immunizations, hospitalizations, and emergency room visits. In some states, the program also includes dental care.

Let's complete one more Practice Exercise before we wrap up the lesson. Keep up the good work!



Step 13 Practice Exercise 5-2

- For questions 1 through 20, select from the following terms to complete each sentence. You won't use every term.

30	can	Medicaid
federally	two	private insurance companies
60	three	Level II HCPCS codes
state	A	NPI
CMS-1500	one	Advanced Beneficiary Notice
do not	Medigap	EOMB
physician	patient	Medicare
fraud	preventive	Medicare Part D
B	PIN	

1. Medicare is a(n) _____ funded health insurance program.
2. There are _____ kinds of Medicare coverage.

3. Medicare Part _____ covers medically necessary hospital care and services.
4. Medicare Part _____ covers medical services and supplies.
5. The procedure codes for Medicare claims can be Level I CPT codes and _____.
6. A(n) _____ is assigned by CMS for identification purposes.
7. Medicare claims should be submitted using the _____ claim form.
8. Medicare claims should be filed within _____ year(s) from the date the patient received treatment.
9. You have _____ days to appeal a denied Medicare claim.
10. The _____ explains what action Medicare took on a submitted claim.
11. _____ policies pay for expenses not covered by Medicare Parts A and B.
12. Supplemental insurance policies _____ duplicate Medicare coverage.
13. Supplemental insurance benefits are paid directly to the _____.
14. Some patients _____ be covered by both Medicare and Medicaid.
15. Claims for Medi-Medi patients are submitted to _____ first, as the primary carrier.
16. _____ assists with the yearly out-of-pocket prescription expenses.
17. Medicare part D coverage is provided by _____.
18. Billing for services that were not provided is an example of _____.
19. ABN stands for _____.
20. Medicare _____ services are provided to detect the early onset of illnesses.

Step 14 Answers to Practice Exercise 5-2

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

Step 15 Lesson Summary

- The Centers for Medicare & Medicaid Services administers both federally funded Medicare programs and state-run Medicaid programs. Medicaid covers low-income people. Each state's Medicaid program must meet minimum standards set forth by the federal government.

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. As a medical billing specialist, it is important to keep up to date with both Medicaid and Medicare billing procedures. Both programs currently use the CMS-1500 or a similar form for claim submission.

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. We can't move on just yet—first, you need to complete the following quiz. You'll do great!

Step 16 Mail-in Quiz 5

- Follow the steps to complete the quiz.
 - a. Be sure you've mastered the instruction and the Practice Exercises that this quiz covers.
 - b. Mark your answers on your quiz. Remember to check your answers with the lesson content.
 - c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.
 - d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your quiz online.
 - e. Submit your answers to the school via mail, e-mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 5

For questions 1 through 20, select the best answer from the choices provided. Each item in this quiz is worth 4 points.

1. **The main purpose of CMS is to ____.**
 - a. purchase healthcare services for the Medicare and Medicaid programs
 - b. administer healthcare benefits to its beneficiaries
 - c. govern the Department of Health and Human Services
 - d. all of the above

2. **Low-income families with children and infants born to Medicaid-eligible women are examples of ____ recipients.**
 - a. Medicare
 - b. medically needy
 - c. categorically needy
 - d. Social Security Supplemental Income (SSI)

3. **Medically needy Medicaid recipients ____.**
 - a. include SSI recipients
 - b. have too much income to qualify for the categorically needy groups
 - c. must have preauthorization for every visit and service
 - d. include workers of any age who are disabled

4. **Children whose families receive TANF may benefit from Medicaid through a program called ____ that provides preventive services and early detection and treatment.**
 - a. EPSDT (Early and Periodic Screening, Diagnosis and Treatment)
 - b. HS Head Start
 - c. Early Start
 - d. EPFP (Early and Periodic Family Planning)

5. **The ABN form informs the patient of the procedure and why it is ____.**
 - a. covered
 - b. covered but the patient is responsible for the payment
 - c. not covered
 - d. none of the above

6. ____ is the review of proposed treatment by Medicaid to determine whether or not the treatment is appropriate.
- Reciprocity
 - An appeal
 - DHHS review
 - Preauthorization
7. The process of a home state Medicaid program paying a claim for medical services that occur in another state is called ____.
- preauthorization
 - an appeal
 - reciprocity
 - transference
8. The ____ explains the actions Medicaid has taken on a patient's claims.
- explanation of medical benefits
 - explanation of benefits
 - claims review
 - Medicaid claim summary
9. If a patient is eligible for Medicaid and also has additional health insurance, Medicaid becomes the ____ carrier.
- primary
 - secondary
 - tertiary
 - Answer could be any of the above; every claim is unique.
10. Medicare is administered by the ____ government and funded by the ____ government.
- federal, federal
 - federal, state
 - state, federal
 - state, local
11. Medicare Part A pays for ____, and Part B pays for ____.
- physician services, hospital services
 - medical expenses, hospital services
 - clinic services, pharmaceuticals
 - hospital services, medical expenses

- 12. Medicare Part A is financed by ____.**
- a. fiscal agents
 - b. the federal government
 - c. Social Security payroll withholding tax paid by workers and their employers
 - d. monthly premiums paid by enrollees
- 13. Medicare Part B is financed by ____.**
- a. fiscal agents
 - b. the federal government
 - c. Social Security payroll withholding tax paid by workers and their employers
 - d. monthly premiums paid by enrollees
- 14. Medicare preventive services include ____.**
- a. mammography
 - b. glaucoma screening
 - c. nutritional therapy
 - d. all of the above
- 15. The Medicare term ____ charge refers to whichever charge is the lowest of the following: customary charge, prevailing charge and actual charge.**
- a. approved
 - b. intermediary
 - c. case-by-case
 - d. acceptance
- 16. Because Medicaid programs are run by each individual state, the requirements for billing ____.**
- a. vary from state to state
 - b. are the same for every state
 - c. are dictated by the federal government
 - d. are submitted to a federal agency and a state agency
- 17. Medicare fraud is reported to the ____.**
- a. Office of Inspection of fraud
 - b. Office of Inspector General
 - c. Office of Medicare fraud
 - d. Official Inspector General

Medical Claims and Billing Specialist

18. ____ insurance can be purchased to supplement Medicare insurance.
- Medi-Medi
 - Medicaid
 - Medicare Part C
 - Medigap
19. When a patient is eligible for both Medicare and Medicaid, you should submit claims to ____ first.
- Medicare
 - Medicaid
 - the primary insurance carrier
 - Medigap
20. An EOMB is a(n) ____.
- CMS policy that ensures health safety and accountability
 - explanation of Medicaid benefits
 - explanation of Medicare benefits
 - statement of explanation for Medicare Part C

For questions 21 through 25, match the group of people with the healthcare program for which it would be eligible.

21. ____ Those who qualify for TANF a. Medicare
22. ____ Disabled workers b. Medicaid
23. ____ Those who cannot afford care
24. ____ Children and adults with end-stage renal disease
25. ____ Those who are blind; income above federal poverty level

Congratulations

You've completed Lesson 5.



Don't wait for your quiz results to continue with Lesson 6.

Lesson 6

Military Insurance, Workers' Compensation and COBRA



Step 1 Learning Objectives for Lesson 6

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
 - Define the three options of medical coverage offered through TRICARE.
 - Explain CHAMPVA and who is eligible for coverage.
 - Describe workers' compensation and its features.
 - Differentiate between workers' compensation and disability insurance.
 - Determine the steps required for filing claims in special insurance situations.



Step 2 Lesson Preview

- ❑ There are special insurance situations that have specific coverage programs. Families of military personnel, for example, may qualify for either the TRICARE or CHAMPVA programs. Employees injured on the job receive workers' compensation. People who are unable to work in their present job or skill anymore because of an injury often receive benefits from disability insurance.

As a medical claims specialist, you will run into situations such as the ones described above. This lesson gives you the knowledge necessary to complete and file claims for healthcare providers that treat patients who receive benefits through one or more of these special insurance situations. Let's dive in and learn about TRICARE!



The government offers healthcare programs to families of military personnel.



Step 3 TRICARE

- ❑ TRICARE is the name of the Department of Defense (DOD) regionally managed healthcare program for military service families. **TRICARE** provides healthcare options for the families of military service members. These family members are **beneficiaries**. The service member is the **sponsor**, and can be active-duty, retired or deceased.

In the past, TRICARE didn't cover the sponsor (service member) because the sponsor was provided medical services on the military base on which he/she was stationed. However, due to recent 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.

As its name suggests, TRICARE has three options: TRICARE Standard, TRICARE Extra and TRICARE Prime. We will discuss these shortly. First, though, let's discuss CHAMPUS, the forerunner of TRICARE Standard.

CHAMPUS

CHAMPUS, which stands for **Civilian Health and Medical Program of the Uniformed Services**, 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'll still see references to CHAMPUS in your work as a medical claims specialist.



Step 4 CHAMPVA

- ❑ In 1973, the Veterans Health Care Expansion Act created CHAMPVA. **CHAMPVA**, which stands for **Civilian Health and Medical Program of the Veterans Administration**, provides health care for families of veterans with permanent, service-connected disabilities. This includes the families of veterans who have died because of a service-connected disability.

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.

Although very similar to TRICARE Standard in terms of benefits, it is important to note that CHAMPVA is a separate program, distinctly different from TRICARE Standard. 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.



Step 5 Common Words and Terms

- ❑ In order to work with TRICARE and CHAMPVA claims, it is important to understand the meaning of words and terms commonly used.

Authorized Provider

An **authorized provider** is a physician, hospital, clinic or supplier who has applied, and been approved, to provide medical care and supplies. Each state licenses the provider, accredited by a national organization, or meets other standards of the medical community. TRICARE will only share the cost of healthcare costs from authorized providers.

Catastrophic Cap

The **catastrophic cap** is the cost cap or upper limit that patient pays for health care in any fiscal year. The limit for an active-duty family enrolled in TRICARE Prime is \$1,000; for all other enrollees in TRICARE Prime the limit is \$3,000. The limit for eligible TRICARE Standard and Extra families is \$7,500. The catastrophic cap only applies to allowable charges for covered services. There is no cost cap for services that are not covered or for services received from a nonparticipating provider.

Cost-Share

Cost-share is 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

A **deductible** is 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.

DEERS

DEERS stands for **Defense Enrollment Eligibility Reporting System**. DEERS is 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 his or her family members and should maintain the status of his or her family in order to process claims quickly and accurately.



DEERS is a computerized data bank that lists all active and retired military members and any dependents.

Medically Necessary

Medical services or supplies generally accepted to be reasonable and adequate for the diagnosis and treatment of illness or injury are **medically necessary**.

Network Providers

A **network provider** is the physician who provides medical care and services to TRICARE beneficiaries under the TRICARE Extra program at contracted rates.

Nonavailability Statement

The **nonavailability statement**, or **NAS**, is required for all beneficiaries who live near a military care facility but are seeking nonemergency treatment at a civilian physician or hospital. The NAS is certification from the uniformed service hospital that the procedure the patient is seeking is not available at the military facility. People at the nearby military medical facility enter statements electronically into the DEERS computer files. TRICARE and CHAMPVA do not issue nonavailability statements themselves; the military hospitals must do this.

Participating TRICARE Providers

Healthcare providers who participate in TRICARE are also called **participating providers**. 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 his or her TRICARE-eligible patients. Individual providers can participate on a visit-by-visit basis. Hospitals that participate in Medicare must, by law, also participate in TRICARE Standard for inpatient care. 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.

TRICARE Standard Supplemental Insurance

TRICARE Standard Supplemental Insurance is a health benefit plan that supplements TRICARE Standard benefits. Supplemental insurance programs generally pay most or all of the balance due after TRICARE Standard has paid its share of the cost of covered healthcare services and supplies.



Step 6 TRICARE Options

- ❑ As you know, TRICARE has three options: TRICARE Standard, formerly known as CHAMPUS, TRICARE Extra and TRICARE Prime. Let's look at some specifics of each.

TRICARE Standard

TRICARE Standard is the new name for CHAMPUS, although the name "CHAMPUS" isn't completely phased out (for example, the CMS-1500 form still refers to CHAMPUS). As you read, keep in mind that CHAMPUS and TRICARE are one and the same. The name has changed to one of the three policy options: TRICARE Standard, TRICARE Extra or TRICARE Prime.

TRICARE Standard pays a share of the cost of covered healthcare services obtained from authorized civilian hospitals and doctors. There is no enrollment in TRICARE Standard, though eligible persons need enrollment in the DEERS computer data bank.

TRICARE Standard pays for only medically necessary care and services provided by an authorized provider. Costs to the patient include an annual deductible of \$150 per person or \$300 per family, and usually 20 percent cost-share of allowable charges.

TRICARE Extra

The second of the three healthcare options offered is TRICARE Extra. TRICARE Extra is a PPO-type option and provides healthcare services on a visit-by-visit basis. This option features healthcare providers who are part of an organized network and who have agreed to participate in TRICARE for all eligible patients. 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. Physicians who participate in TRICARE Extra have agreed to accept the TRICARE allowable charge or a negotiated fee as the full fee for the care they provide. There is no enrollment in TRICARE Extra, though eligible persons need enrollment in the DEERS computer data bank.

TRICARE Extra pays for only medically necessary care and services provided by an authorized provider. Costs to the patient include an annual deductible of \$150 per person or \$300 per family for outpatient care, and usually 15 percent cost-share of allowable charges.

TRICARE Prime

TRICARE Prime is the final option offered through the DOD managed healthcare program. 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. There is a fee for enrollment for retirees; while TRICARE Prime automatically enrolls active-duty service members. 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 patients need care.

Costs to the patient include an annual enrollment fee and a pre-set co-payment fee. There are no annual deductible or cost-share payments with this option. The patient usually pays a \$12 co-payment for physician services, and \$30 co-payment for emergency services, depending on the sponsor's military status.

Point-of-Service

The point-of-service (POS) option, only for TRICARE Prime enrollees, allows the patient to choose to get TRICARE-covered non-emergency services outside the TRICARE Prime network of providers without a referral from their primary care manager. There is an annual deductible of \$300 per person or \$600 per family under the POS option as well as a cost-share of 50 percent of the TRICARE allowable charge.



Step 7 Eligibility Requirements for TRICARE and CHAMPVA

- Now that you've been introduced to TRICARE and CHAMPVA, let's take a closer look at the eligibility requirements.

TRICARE Eligibility Requirements—Who is Eligible?

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.



TRICARE offers health care for military service members, including the Army, Navy, Air Force and Coast Guard.

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: Children are those unmarried and under the age of 21. A child may also be covered up to the age of 26 if he or she is in school full-time.

Who is Not Eligible for TRICARE?

1. Active-duty service members (unless, as stated above, there are no medical services available on their military base).
2. Dependent parents and parents-in-law.
3. Most persons who are eligible for Medicare Part A.
4. Widow or widower of a service member who remarries.
5. Persons eligible for benefits under CHAMPVA.

Now that you're aware of TRICARE's eligibility requirements, let's look at CHAMPVA's eligibility requirements.

CHAMPVA Eligibility Requirements—Who is Eligible?

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, 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.

Note: Children are those unmarried and under the age of 21. A child may also be covered up to the age of 26 if he or she is in school full time.

Who is Not Eligible for CHAMPVA?

1. Most persons who are eligible for Medicare Part A.
2. Persons eligible for benefits under TRICARE.



Step 8 Identification Cards




- ❑ To receive TRICARE or CHAMPVA benefits, patient 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 family members—tan
- Active-duty Reserve sponsors and family members—red
- Retirees—blue
- Retirees' family members—tan

All military identification cards include the following: a digital photograph of the card owner, the beneficiary's name, 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 file. Make copies at each physician visit. Look at the following example cards.

Lesson 6—Military Insurance, Workers' Compensation and COBRA

ARMED FORCES OF THE UNITED STATES		
		U.S. NAVY ACTIVE 
RANK LT		EXPIRATION DATE INDEF
SIGNATURE <i>SR Douglas R</i>		SOCIAL SECURITY NUMBER 000-00-0001
DOUGLAS JOSEPH R		
GENEVA CONVENTION IDENTIFICATION CARD		

Front

				
DATE OF BIRTH 1982APR16	WEIGHT 150	HEIGHT 5'11"	HAIR COLOR BRN	EYE COLOR BL
DATE OF ISSUE 2005FEB23	BLOOD TYPE A-	GENEVA CONV CATEGORY III		
				
DD FORM 2 (ACTIVE)		FEB05		PROPERTY OF US GOVERNMENT

Sponsor ID card

Back


UNITED STATES UNIFORMED SERVICES		
		EXPIRATION DATE 2009OCT01
		SPONSER SERVICE U.S. ARMY
		SPONSER STATUS/RANK RET / CAPT
		SPONSER SSN 000-00-0001
SOCIAL SECURITY NUMBER 000-00-0002		RELATIONSHIP SP
SIGNATURE <i>Battista Mary D</i>	SPONSER SAMPLE RETIRED	
BATTISTA MARY D		AUTHORIZED PATRONAGE EXCHANGE MWR COMMISSARY
IDENTIFICATION CARD		

Front

Family Member ID card

Back

				
DATE OF BIRTH 1963JUN20	WEIGHT 135	HEIGHT 5'7"	HAIR COLOR BLK	EYE COLOR BR
DATE OF ISSUE 2007AUG23	MEDICAL DIRECT	OFF DATE 2007MAY29	EXP DATE 2008OCT01	
				
DD FORM 1173		OCT03		PROPERTY OF US GOVERNMENT

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE VETERANS ADMINISTRATION (CHAMPVA)	
	POSTMASTER: RETURN TO: CENTRAL CHAMPVA REGISTRY CENTER VAMC DENVER, CO 86220
DEPENDENT OR SURVIVOR	
BENEFICIARY OF VA IDENTIFICATION CARD	
SIGNATURE OF BENEFICIARY (if age 12 or older)	
SAMPLE	

VA FORM 10-7959, DEC 1988

1. NAME OF BENEFICIARY VOID/VOID/VOID	3. SEX X	5. I.D. NUMBER XXXXXXXXXX
2. DATE OF BIRTH XX/XX/XX	4. EXP. DATE XX/XX/XX	6. ISSUE DATE XX/XX/XX
Use the identification number in block 5 when applying for CHAMPVA CLAIMS or for the Fiscal Intermediary. If you have any questions regarding this card, call the CHAMPVA Center at 1-800-331-9935		
		000238

Sample CHAMPVA ID card



Step 9 Services Covered

- ❑ CHAMPVA and TRICARE provide a wide range of healthcare options. The program's guidelines determine how each service is covered. Services covered include hospitalization, maternity, 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.



Step 10 Filing TRICARE and CHAMPVA Claims

- ❑ Whether you are filing a TRICARE or CHAMPVA claim, you will need to follow the same basic steps. TRICARE or CHAMPVA must authorize all benefits under the programs in writing before patients receive services, supplies or equipment. Preauthorization gives the insurance provider a chance to look at a proposed treatment and determine if it is reasonable for the condition. The claim form needs an attached copy of the authorization.

After completing the preauthorization requirement, the next step is to check for the need for a nonavailability statement.

Nonavailability Statement

Remember that a nonavailability statement, or NAS, is a certification from a military hospital stating that it cannot provide the necessary medical care or services. An NAS is required for the patient who lives in certain ZIP code zones around a military hospital, usually a 40-mile radius, before receiving nonemergency inpatient care at a civilian hospital under TRICARE and CHAMPVA. If the patient lives in a ZIP code zone around a military hospital, the only time a nonavailability statement is not required is for a true medical emergency. Now, the NAS system is automated. This means that the uniformed service medical facility enters the NAS electronically into the DEERS computer files. An NAS is valid within 30 calendar days after it was issued.

Filing Claims

The TRICARE and CHAMPVA contractors receive thousands of claims every day. The claims are computer processed for speed in paying the healthcare provider. Any mistake, forgotten signature or other missing information can slow down the claim. The procedure for filing a TRICARE or CHAMPVA claim is similar to any other claim. Is the patient covered by other health insurance, maybe through a spouse, through a job, or under medical coverage for accidental injuries under automobile insurance? If so, the other insurance becomes the primary insurance company, and the provider must file a claim with the primary insurance company before filing with TRICARE or CHAMPVA. After the primary insurance company has decided what it's going to pay, a claim may be filed with TRICARE or CHAMPVA. A copy of the health plan's explanation of benefits and a copy of the bill must be included.

Claims for Physicians Who Have Accepted Assignment

A physician who agrees to accept assignment is known as a **participating provider**. Participating providers agree to accept the TRICARE or CHAMPVA allowable charge including the patient's cost-share and deductible, if any, as the full fee for the services provided. The physician agrees not to bill for the difference between his customary charge and the allowable charge established by TRICARE or CHAMPVA. The allowable charges for medical services are based on computations made under a method called the **Resource Based Relative Value System**, or **RBRVS**.

Beneficiaries pay a specified amount each year, called the catastrophic cap. The catastrophic cap applies only to the amount of money required to meet the patient's annual deductible and cost-shares based on the TRICARE Standard allowable charges for covered medical care received in any one fiscal year. When the beneficiary has paid the specified amount, TRICARE or CHAMPVA will then pay 100 percent of allowable charges for the remainder of the fiscal year.

For physicians who have accepted assignment, once the claim is completed and processed by the fiscal intermediary, payment is sent directly to the physician.

Claims for Physicians Who Have Not Accepted Assignment

Physicians who do not accept assignment (nonparticipating physicians) may bill TRICARE or CHAMPVA for their customary charges. By law, the bill may not be more than 15 percent above the TRICARE Standard allowable charge.

In the case of physicians who have not accepted assignment, the payment is sent directly to the patient.

Which Claim Form to Use?

A physician will usually submit a completed CMS-1500 claim form. Submit a completed DD Form 2527 with the CMS-1500 claim form if the claim is for care and supplies due to the result of an accidental injury or if the bill is \$500 or more. The **DD Form 2527** is a Personal Injury Statement about how the accident happened. The patient should complete the form.

When a hospital files the claim, it will use the CMS-1450 (also known as the UB-04) claim form. (We'll detail this form later in the course.) Always submit original claim forms and keep a copy of the claim form filed in the patient's file. After submitting the CMS-1450/UB04, the patient receives a **DD Form 2642**—Patient's Request for Medical Payment, which she must fill out and file along with an itemized superbill from the physician's office.

To learn specifics about TRICARE claims and to view the DD 2527 and DD 2642 forms, you can access the TRICARE Provider Manuals at the following Web sites: <http://manuals.tricare.osd.mil/Default.aspx> and <http://www.tricare.mil/>.

What Documentation to Include With the Claim?

One or more of the following may need to be included with the completed claim form:

- Nonavailability statement
- Explanation of benefits from other insurance plan
- DD Form 2527

Be sure to make copies of paper documents and keep the originals of these documents in the patient's file. If you don't provide the proper documents to the TRICARE/CHAMPVA contractor when needed, the claim could be denied or delayed. Send proper documentation with each claim, even if a claim was previously filed for similar services during the same course of treatment.



Make copies of original documents, and keep copies of paper documents with the patients' files.

Time Limits and Appeals

The TRICARE or CHAMPVA contractor must receive claims within one year of the date of service. Submit claims promptly to ensure full cost-share payment to the provider.

If you fail to file by the deadline, reimbursement will be denied. If a claim is denied or returned by the claims processor requesting additional information, or if you wish to appeal a decision, resubmit the claim within 90 days of the notice. If you should need more time to correctly resubmit or provide the additional requested information, you must contact the claims processor for your area that is noted on the document you received and request an extension of time.

TRICARE or CHAMPVA and Other Insurance

By law, TRICARE or CHAMPVA is the secondary insurance carrier when a beneficiary is enrolled in other health insurance plans. However, there are two exceptions. TRICARE or CHAMPVA becomes the primary insurance carrier when the beneficiary is a recipient of the Medicaid program or has MediGap supplemental health insurance.

If a TRICARE or CHAMPVA beneficiary is injured on the job or becomes ill because of his or her work, this becomes a workers' compensation case, and the claim must be filed with the compensation insurance carriers. Bill TRICARE or CHAMPVA once all workers' compensation benefits have been paid.

When a patient is injured in an automobile accident or receives an injury that may have third-party involvement, it is necessary to include DD Form 2527, Personal Injury Statement—Possible Third Party Liability. This form allows TRICARE or CHAMPVA to evaluate the circumstances of the accident and the possibility that the government may recover money for the medical care from the person who injured the patient.

Summary Payment Voucher

For each TRICARE and CHAMPVA claim submitted, the claims processor will issue a summary payment voucher. The **summary payment voucher** is the same as an explanation of benefits (EOB). The summary payment voucher includes information about the amount charged, allowable covered charges, deductible, cost-share and payment amount. Cost-share includes co-payment amounts. Following is an example of a summary payment voucher.

Medical Claims and Billing Specialist

TRICARE		EXPLANATION OF BENEFITS						
		PROVIDER NO 234567890183928000						
		PATIENT ACC # 00000000000000601						
PATIENT NAME NORA CARTER		SPONSOR NO 200-00-000			CLAIM NO 1904593847 2357			
SPONSOR NAME		RANDY CARTER						
PROVIDER	SERVICE DATES	PROCED	MOD	NO	TYP	BILLED	ALLOWED	CODE
FAY LESLIE MD	06/01/XX	99203	00	01	01	70.00	43.40	003
		99070	00	01	01	30.00	30.00	
		57100	00	01	02	225.00	92.90	003
		64435	00	01	02	65.00	41.20	003
TOTAL						390.00	207.50	
DEDUCT	COST SHARE	PAID BY PATIENT	TOTAL PAYABLE		NET PAYMENT			
** 0.00	0.00	0.00	207.50		207.50			
REMARKS								
CODE 003 SEE ITEM FIVE ON REVERSE OF PAGE 1. IF YOU ARE NOT SATISFIED WITH OUR DETERMINATION, YOU HAVE THE RIGHT TO REQUEST A REVIEW WITHIN 90 DAYS OF THE DATE OF THIS NOTICE. SEE ITEM ONE ON REVERSE OF PAGE 1.								
*****VOUCHER SUMMARY								
TOTAL PAYABLE						NET PAYMENT		
207.50						207.50		

Step 11 Practice Exercise 6-1

For questions 1 through 10, select the best answer from the choices provided.

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. TRICARE or CHAMPVA claims should be submitted within ____ of the date of service.
 - a. 90 days
 - b. 30 days
 - c. six months
 - d. one year

7. TRICARE or CHAMPVA is the ____ insurance carrier when a beneficiary is enrolled in other health insurance plans.
 - a. tertiary
 - b. primary
 - c. only
 - d. secondary

8. ____ 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

9. TRICARE Standard is the new name for ____.
- TRICARE Standard supplemental insurance
 - DEERS
 - CHAMPUS
 - CHAMPVA
10. ____ generally pays most or all of the balance due after TRICARE Standard has paid its benefits.
- TRICARE Standard supplemental insurance
 - TRICARE Extra
 - TRICARE Prime
 - CHAMPUS

Step 12 Answers to Practice Exercise 6-1

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

Step 13 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 provides coverage to employees and their dependents if the employees suffer a work-related 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.

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 two classifications of on-the-job injuries—traumatic injuries and occupational illnesses.

Facts About 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 plan, 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 provide 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 their employees.

Classification of On-The-Job Injuries

To qualify for workers' compensation benefits, the worker is required to have incurred an injury while doing the expected duties of the position or a disorder that can be linked to the employment of the worker, such as carpal tunnel syndrome. These are referred to as **on-the-job injuries**.

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 they recuperate from their injuries. Typically, coverage includes lost wages, and the cost associated with the health care. The employee is expected to return to work although they may not be able to hold their 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 their 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 sometimes referred to as double indemnity.



Step 14 Filing a Workers' Compensation Claim

- The first thing to remember is to check every bill that comes by you to see if it is for a work-related injury. All other insurance companies will refuse a claim that is covered by workers' compensation. You must file with workers' compensation (often referred to as *workers' comp*) first.

First Report of Injury

The **First Report of Injury** form gathers information regarding the injury, the patient's information, the employer's information, and the physician's initial assessment. Although it's the physician's responsibility to complete this form, you as a medical billing professional may be asked to assist with gathering the information. It's also important to contact the employer to obtain information regarding the compensation carrier.

File the form with the following entities:

- State Workers' Compensation Board/Commission
- Employer's Workers' Compensation carrier
- The employer of the injured worker
- The worker's medical record

Submit these forms within 24 hours to 14 days depending on the laws regulating your state. Regardless of the time period, it is important to have this form submitted as soon as possible as it could delay the benefits, or cause the claim to be denied. In some cases, the employer will dispute the on-the-job injury. If this happens, it will still be necessary to submit the First Report of Injury.

Progress Reports

As the injured worker receives treatment and progresses in his recovery, the physician will be required to submit progress reports to the compensation carrier. The progress report should include the patient's name, case number, treatment, progress, work status, and an estimation of the patient's ability to return to work. In some cases, the carrier may require copies of radiology, consultation, and laboratory reports. Again, the completion of the information falls on the shoulders of the physician. However, you will need to be prepared to assist in gathering the information required for this reporting.

FECA

Let's look at the process for FECA (Federal Employees Compensation Act). FECA requires a different form for each class of claim: either **Form CA-1** for a traumatic injury or **Form CA-2** for an occupational illness. *The patient must fill out these forms and file with the patient's employer.* It is important to make sure this step is completed; otherwise, benefits might be reduced.

After the employer receives either Form CA-1 or Form CA-2, the employer completes **Form CA-16**, which authorizes treatment for the first 60 days. This authorization applies only to the first treating physician. The **first treating physician** is the doctor who first diagnosed and treated the injury. You need to attach Form CA-16 to the insurance claim form you file.

In order to file a workers' compensation claim, you need to fill out the CMS-1500 form. We'll show you how to do this later in the course. As you can see, the CMS-1500 is a commonly used, important form. This form is filed with the Office of Workers' Compensation Programs (OWCP), a part of the United States Department of Labor.

In addition to the normal claim form and the CA-16 form, OWCP requires other documentation for a job-related injury. Here is a list of the information the employee must submit to file a claim.

Facts About Filing a Workers' Compensation Claim

The injured employee must submit this information to OWCP:

- ✓ Dates of examinations and treatment
- ✓ Patient's medical history
- ✓ Description of physician's findings
- ✓ Results of diagnostic tests, including x-rays
- ✓ Diagnosis
- ✓ Clinical treatment
- ✓ The physician's opinion regarding the connection between the injury and the job being performed

After receiving the necessary information, OWCP will assign a case file number. This number is important because it must be included on all documents you submit to the OWCP.

Many times, you will need to file progress reports stating the degree of recovery achieved by the patient. These progress reports usually go out when a person's situation changes and, therefore, the level of care changes. This report also includes the physician's opinion regarding the patient's availability for work, an estimate of future recovery and the extent of permanent loss or disability.

To ensure that you file state workers' compensation claims correctly, you should contact your state workers' compensation office, board or commission and ask these important questions:

- What forms and records do you need from the medical office, and where can you obtain them? The claim forms and medical records that physicians are required to provide vary from state to state.
- What organizations and agencies should receive the claim forms? You should verify that you have the correct addresses.
- What is the filing deadline? Failure to file within the required deadline may result in a denied claim or reduced payments.
- How is reimbursement determined? Does the state workers' compensation program use a system of allowable charges or a fee schedule with set fees for each medical service?
- Can the patient or employer be billed for the costs of medical services and treatments that the state workers' compensation does not cover? By law, some states prohibit physicians from billing patients for any unpaid balances on workers' compensation cases.

A Note About Patient Records

A regular patient might come to see the physician for a workers' compensation-covered injury. You must set up a separate file for all workers' compensation activity. Do not include any of the workers' compensation items in the patient's normal file. This helps keep records accurate and separate job-related injuries from injuries unrelated to the job.

Step 15 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 medical claims 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.

Facts About 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

You must have permission from the patient to release this information to anyone, including insurance companies. Be sure you have a signed release form.



Step 16 The Consolidated Omnibus Budget Reconciliation Act (COBRA)

- ❑ 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 their 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.

You as a medical billing professional, will bill COBRA as you would any other insurance program. They may be billed using a CMS-1500 form or electronically. 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.



Step 17 Practice Exercise 6-2

- ❑ For questions 1 through 9, match the term to the correct definition.
 1. ____ **Catastrophic cap** a. Physician approved to provide medical care
 2. ____ **Cost-share** b. Upper limit that will have to be paid by the patient
 3. ____ **Traumatic injury** c. Percentage paid by the patient
 4. ____ **Deductible** d. Computerized data bank that lists military members
 5. ____ **Occupational illness** e. Physician who provides care at contracted rates
 6. ____ **Authorized provider** f. Consolidated Omnibus Budget Reconciliation Act
 7. ____ **Network provider** g. Caused by a specific event
 8. ____ **DEERS** h. Caused by continued exposure to workplace
 9. ____ **COBRA** i. Amount patient must pay before cost-share begins



Step 18 Answers to Practice Exercise 6-2

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



Step 19 Lesson Summary

- This lesson introduced you to several special insurance programs that provide specific types of coverage. TRICARE is the Department of Defense's regional managed care program. It includes TRICARE Standard (the new name for CHAMPUS), TRICARE Extra and, the most restrictive of the three programs, TRICARE Prime. Family members, called *beneficiaries*, usually receive health care from a military physician in a military hospital or facility. If these are unavailable, private physicians or hospitals may provide health care, in which case the federal government pays for a portion of the cost. 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. DEERS (Defense Enrollment Eligibility Reporting System) is a worldwide database that lists people covered by TRICARE and CHAMPVA.

Workers' compensation provides coverage to employees and their dependents if the employees suffer a work-related injury, illness or death. One important thing to remember is 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.

You learned a ton of information about insurance in the past few lessons. In the next lesson, we'll shift gears a bit, so you can learn what all those medical terms mean. That's right, you'll be able to decipher what doctors say by learning about medical terminology. You've nearly completed Pack 1—only one more lesson to go! Let's complete a quiz and move on to the final lesson in Pack 1. Nice job!

Step 20 Mail-in Quiz 6

- Follow the steps to complete the quiz.
 - a. Be sure you've mastered the instruction and the Practice Exercises that this quiz covers.
 - b. Mark your answers on your quiz. Remember to check your answers with the lesson content.
 - c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.
 - d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your quiz online.
 - e. Submit your answers to the school via mail, e-mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 6

For questions 1 through 17, select the best answer from the choices provided. Each item in this quiz is worth 5 points.

1. ____ provides healthcare options for families of active-duty service members.
 - a. CHAMPVA
 - b. TRICARE
 - c. Blue Cross and Blue Shield
 - d. The Government Employees' Union
2. The family members of uniformed service members are called _____.
 - a. sponsors
 - b. beneficiaries
 - c. reciprocity recipients
 - d. fiscal agents
3. DEERS requires the ____ to register the beneficiaries.
 - a. family member
 - b. doctor
 - c. government
 - d. military sponsor

4. ____ was developed in 1966 to control the rising costs of healthcare coverage and to standardize healthcare benefits. It is now referred to as **TRICARE Standard**.
 - a. CHAMPVA
 - b. CHAMPUS
 - c. CHAMPGOV
 - d. Workers' comp

5. The **TRICARE** program that gets a discount on services and has a reduced cost-sharing fee is **TRICARE ____**.
 - a. Extra
 - b. Prime
 - c. Standard
 - d. Inclusive

6. **TRICARE ____** is the **TRICARE** program most like an HMO.
 - a. Extra
 - b. Standard
 - c. Inclusive
 - d. Prime

7. The program established to provide health care for the families of veterans with service-connected disabilities is _____.
 - a. CHAMPUS
 - b. CHAMPVA
 - c. TRICARE Prime
 - d. TRICARE Extra

8. **CHAMPVA** was established in _____.
 - a. 1973
 - b. 1994
 - c. 1947
 - d. 1924

9. ____ is the Department of Defense's regionally managed care program.
 - a. CHAMPVA
 - b. DEERS
 - c. TRICARE
 - d. S.A.F.E.

Medical Claims and Billing Specialist

10. **An organization that contracts with the government to handle TRICARE and CHAMPVA claims is called a ____.**
 - a. claims intermediary
 - b. fiscal intermediary
 - c. fiscal advisor
 - d. benefits advisor

11. **If a patient is seeking treatment at a nonmilitary facility, TRICARE and CHAMPVA may require a ____ from the military hospital.**
 - a. co-payment
 - b. nonavailability statement (NAS)
 - c. military waiver statement (MWS)
 - d. copy of the patient's records

12. **The Federal Coal Mine Health and Safety Act is often referred to as the ____.**
 - a. American Lung Association Act
 - b. Miner's Union Act
 - c. Black Lung Benefits Act
 - d. TRICARE Black Lung Act

13. **FECA provides benefits for ____ injuries and ____ illnesses.**
 - a. minor/terminal
 - b. similar/brief
 - c. related/occasional
 - d. traumatic/occupational

14. **Workers' compensation is a ____ carrier for job-related injuries.**
 - a. primary
 - b. tertiary
 - c. secondary
 - d. disability

15. **Employers are required to complete Form ____ to authorize the first 60 days of treatment for a FECA claim.**
 - a. CA-14
 - b. CA-16
 - c. CMS-1450
 - d. CMS-1500

16. For a person to receive disability benefits, the disability must be defined as a _____ disability.
- a. permanent
 - b. legal
 - c. medical
 - d. conditional
17. For the Social Security Disability program, a legal disability _____.
- a. is the same as a medical disability
 - b. is more than 51 percent disabling, causing the worker to experience minor difficulty in performing certain industrial jobs
 - c. does not prevent the worker from working
 - d. prevents the worker from doing any work

For questions 18 through 20, match the definition with the corresponding workers' compensation terms.

- | | |
|--|---------------------------|
| 18. _____ Provides the initial information regarding the on-the-job injury | a. First Report of Injury |
| 19. _____ Provides the compensation carrier with the progress of the patient | b. Indemnity |
| 20. _____ Compensation for a loss | c. Progress report |



Just for Fun

The Just for Fun page is for your enjoyment.

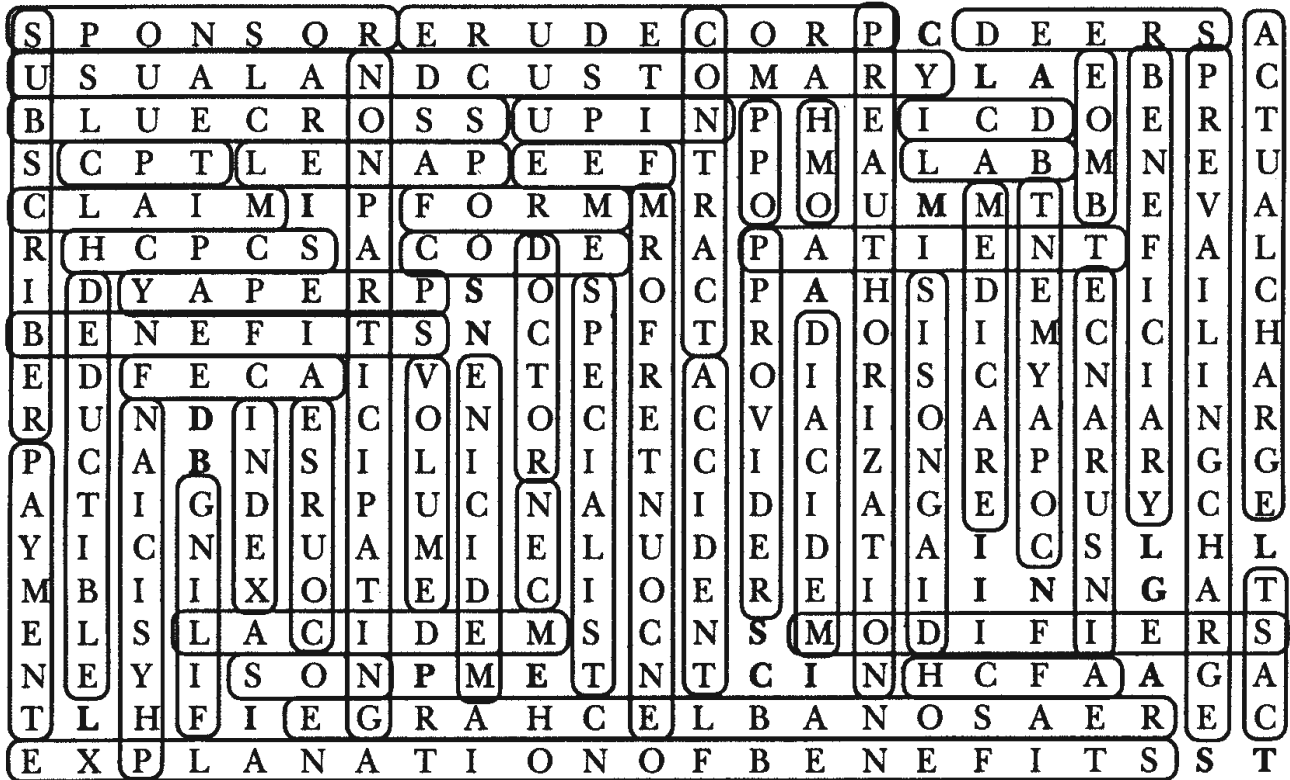
First, read the list of words and then look at the puzzle. The words can be found in vertical, horizontal and backwards directions. Circle each word found and strike it off the list. The letters are often used more than once. It is best to find the big words first. When you find all the words listed, you will have 26 letters left over that will spell out a phrase. Good luck!

- | | | | |
|---------------|-------------------------|------------------|---------------------|
| accident | diagnosis | insurance | PPO |
| actual charge | doctor | lab | preauthorization |
| beneficiary | encounter form | Medicaid | prepay |
| benefits | EOMB | medical | prevailing charge |
| Blue Cross | explanation of benefits | Medicare | procedure |
| cast | FECA | medicine | provider |
| claim | fee | modifiers | reasonable charge |
| code | filing | NEC | specialist |
| contract | form | nonparticipating | sponsor |
| copayment | HCFA | NOS | subscriber |
| course | HCPCS | panel | UPIN |
| CPT | HMO | patient | usual and customary |
| deductible | ICD | payment | volume |
| DEERS | index | physician | |

Lesson 6—Military Insurance, Workers' Compensation and COBRA

S P O N S O R E R U D E C O R P C D E E R S A
U S U A L A N D C U S T O M A R Y L A E B P C
B L U E C R O S S U P I N P H E I C D O E R T
S C P T L E N A P E E F T P M A L A B M N E U
C L A I M I P F O R M M R O O U M M T B E V A
R H C P C S A C O D E R A P A T I E N T F A L
I D Y A P E R P S O S O C P A H S D E E I I C
B E N E F I T S N C P F T R D O I I M C C L H
E D F E C A I V E T E R A O I R S C Y N I I A
R U N D I E C O N O C E C V A I O A A A A N R
P C A B N S I L I R I T C I C Z N R P R R G G
A T I G D R P U C N A N I D I A G E O U Y C E
Y I C N E U A M I E L U D E D T A I C S L H L
M B I I X O T E D C I O E R E I I I N N G A T
E L S L A C I D E M S C N S M O D I F I E R S
N E Y I S O N P M E T N T C I N H C F A A G A
T L H F I E G R A H C E L B A N O S A E R E C
E X P L A N A T I O N O F B E N E F I T S S T

PHRASE: - - - - -



ANSWER: CLAIMS AND BILLING SPECIALIST

Congratulations

You've completed Lesson 6.



Don't wait for your quiz results to continue with Lesson 7.

Lesson 7

Medical Terminology— Word Parts



Step 1 Learning Objectives for Lesson 7

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
 - Explain *word parts*.
 - Define *root word*, and describe how the term is used.
 - Demonstrate how *prefixes* and *suffixes* fit together with root words to form new terms.



Step 2 Lesson Preview

- ❑ Medicine is a rewarding field! You will experience its satisfactions and live up to its challenges every day when you work as a medical claims and billing specialist. And as you already know, skilled medical claims and billing specialists are in high demand. Doctors, hospitals and clinics all need qualified medical claims and billing specialists. In fact, many such positions remain unfilled due to a lack of qualified candidates. Most employers look for claims and billing specialists who have schooling and experience, and with the training you receive in this course, you can count on learning everything you need to know about this medical field. Finding the position you want should be a snap!



Medical terminology knowledge helps you decipher medical terms in conversations and on forms.

One very important part of medicine is its language. Doctors, nurses and other healthcare personnel, including medical claims and billing specialists, 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 claims specialist, you'll hear medical terminology in daily conversation. More importantly, you'll use this knowledge as you review medical records and process insurance claims. On occasion, you'll even research those terms in coding manuals to ensure that the correct medical code has been used. 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, though, learning medical terminology is much 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 learn how to 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, have your flashcards handy as you study the following material, complete Practice Exercises, and take the quiz. Let's get started!



Step 3 Word Parts

- ❑ Words are all around us. We use them every day to communicate. There are long words and short words, complex words and simple words. And, regardless of how much education you've had, there will be words that are new to you. As a medical claims and billing specialist, you will hear or see medical terms. These terms might seem complex at times, but you can simplify them. In every sentence we speak, every letter we write and every bill we process, the words are constructed of parts. These parts can give us clues to the words' meanings. Because you know this, you will be able to break words down and figure 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
television	=	tele	+	vision
telescope	=	tele	+	scope
microwave	=	micro	+	wave
microscope	=	micro	+	scope

You can also 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 part */scope*.

These smaller parts that words can be divided into are 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 and Word Parts

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

book	read	joy
cook	drive	

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. A **prefix** is a word part added to the beginning of a root word. 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. The new word means something slightly different. Below are some new words that were formed from the root words above. 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 can even be added to each other to form new words. Words that are 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 us understand new words—even long and complicated words.

You may never have heard the word *recalculate*. But if you know what *calculate* means, and you know what the prefix *re/* means, then you will 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 we've discussed. 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 and Word Parts

- ❑ Medical terms often appear to be long and complicated, but actually, even the longest medical term can be broken down into small parts that are easy to understand. Once you become familiar with the individual word parts, medical terminology becomes very easy. Try to look at medical terms like little puzzles. You're putting together different pieces (root words, prefixes, suffixes and combining vowels) to form complete words. And while it's important that you understand a bit about word parts, it is more important that as a medical claims and billing specialist you understand the meanings of the medical terms you learn here. You'll want to be familiar with common medical terminology as you hear or see it. As a claims specialist, your daily routine will revolve around the language of medicine!

Understanding some essential word parts will help you recognize medical terms. In your medical claims career, you'll use a medical dictionary to confirm correct spellings and meanings. You'll soon find that your medical dictionary will become as well-worn as a beloved teddy bear as you'll use it to confirm correct spellings and meanings. 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.

An Important Note About Medical Terms

- ✓ Many medical terms contain a fourth word part that we have not talked about yet—the combining vowel. The combining vowel is used to join 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 <i>skin</i>	o	/logy means <i>the study of</i>

➤ *Dermatology* means *the study of skin*.

Below are two more medical terms that show examples of word parts. These are compound words, since they contain more than one root word.

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

➤ *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/ means <i>around</i>	o	log/	/ist

➤ *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 medical claims and billing specialist!



Step 6 Practice Exercise 7-1

☐ Please complete the following sentences by filling in the blanks.

1. The foundation word part of a medical term is called a _____.
2. The word part that is attached to the end of a term is a _____.
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 _____.

5. The word part that is attached to the beginning of a term is a _____.
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 _____.
10. In the term *dermat/o/ology*, the word part */o/* is called a _____.

Step 7 Answers to Practice Exercise 7-1

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

Step 8 Root Words

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

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

You may have wondered why medical terms are so long and complicated. This is because these terms have very definite meanings. In medicine, one complicated word is used in place of four or five common words so that doctors can communicate exactly what they mean to other health workers. This is to prevent 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 to a doctor. Because of this, doctors use different words for the stomach and the abdomen. You will be learning the root words for these and other parts of the body in this lesson and in lessons to come.

Doctors and other healthcare workers use precise medical terms to communicate exact 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, the medical billing specialist, this patient information would not make it to the insurance companies in the correct format, meaning that your colleagues, other healthcare professionals, could not get properly reimbursed for their expertise and services. Thanks to claims and billing specialists like yourself, these doctors have professionals to handle their claims!

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 these examples of root words.

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

You can see these root words 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.

Medical Term	Meaning
neuritis	inflammation of nerves
gastritis	inflammation of the stomach
micro scope	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. They are called **compound words**. In the examples below, we will use the same root words we 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

Notice that the combining vowel /o/ was used to join the root words above.

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

Now that you know the basics about root words, we're going to move ahead and learn more about medical terms. First, you will practice pronouncing root words using the following easy exercise.



Step 9 Pronounce Root Words

- Follow these steps to familiarize yourself with root words.
 - a. Take your Quick-learn Tutor and Set 1 flashcards out of your Quick-learn Kit. Each flashcard contains many flashterms.
 - b. Find the first flashcard. It begins with Flashterm 1-1. Insert the card into the lower part of Side A of your Quick-learn Tutor. Push the card up until Flashterm 1-1 appears in the left window.
 - c. Take out the pronunciation CD and put it in your CD player.
 - d. Listen to a root word as it is pronounced on the CD. After you hear a root word, put the CD player on pause.
 - e. Look at the root word in the left window of your Quick-learn Tutor. Practice pronouncing it out loud several times to familiarize yourself with the term. Push the flashcard up until the meaning of the root word appears in the right window. Read the meaning of the root word.
 - f. Repeat steps d and e, continuing with all the flashterms on Flashcard 1.
 - g. When you have completed Flashcard 1, turn the card over for Flashcard 2. Proceed until you have pronounced all the root words for Set 1.
 - h. Next, begin again with Flashcard 1 and play the CD again. This time, pronounce each root word in order but do not stop the CD player after each term.
 - i. As you pronounce each root word, look at it on the flashcard.

Good job! You've already become familiar with some of the common medical terms you'll hear in your new claims career.

After you have finished pronouncing all the root words for this lesson, move on to the next exercise—learning to write root words.



Step 10 Write Root Words

- ❑ Follow these steps to learn to write root words.
 - a. Insert Flashcard 1 into Side A of your Quick-learn Tutor.
 - b. Look at each root word as it appears in the window and say it out loud. Write each root word on blank paper. Be sure to put a slash (/) between the root word and the combining vowel, just as you see it on the flashcard.
 - c. Push the card up until the meaning appears in the right window and read the meaning out loud. Write the meaning beside the root word. Writing these root words and meanings will help you learn them more easily. Here is an example of the first flashterm.

aden/o gland

- d. Do this for each flashterm for this set.

Finally, after you have pronounced and written each term, familiarize yourself with the meanings of these root words by performing the next exercise.



Step 11 Meanings of Root Words

- ❑ Follow these steps to learn the meanings of root words.
 - a. Again insert the flashcard for Set 1 into Side A of your Quick-learn Tutor. Beginning with Flashterm 1-1, pronounce each root word out loud. Before you look at the meaning, see if you can remember it. Check yourself by pushing the flashcard up until you can see the meaning in the right window. Do this for each flashterm for this set.
 - b. Now insert Flashcard 1 into Side B of your Quick-learn Tutor. Push the card up until you see the meaning of Flashterm 1-1 in the right window. Read each meaning out loud. Before you look, see if you can remember the word part that goes with that meaning. Check yourself by pushing the flashcard up until you can see the root word in the left window. Do this for each flashterm for this set.
 - 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 terms.** You will find that you become familiar with many medical terms as you use them throughout this course.

You may use your flashcards for all Practice Exercises and the Mail-in Quizzes. However, the time you spend reviewing the flashterms now will mean less time spent looking them up later.

Study Tip

- ✓ After you have finished your activities with a set of flashcards, return the flashcards, in order, to your Quick-learn Kit. You can easily refer to them later, as needed, throughout the course.

 **Step 12 Practice Exercise 7-2**

- Follow the instructions below to complete Parts I and II of the Practice Exercise.

Part I

For each root word listed below, 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.

Root Word	Meaning
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 below, write the correct root word. 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 had to look up on the flashcards.

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

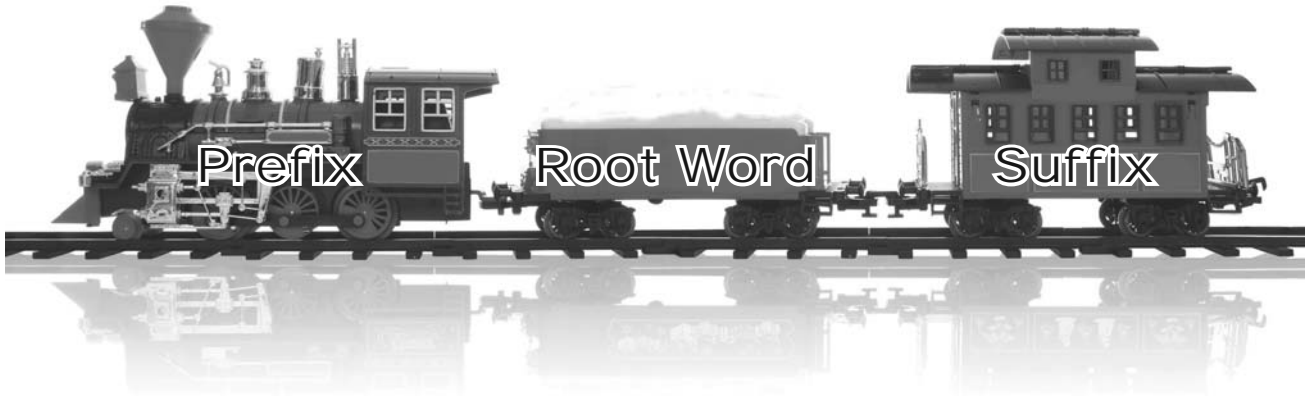
Step 13 Answers to Practice Exercise 7-2

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



Step 14 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. Prefixes are added in front of root words while suffixes are added at the end of root words.



As you have learned, a **prefix** is a word part that is attached to the beginning of a word. 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*.

- 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 not change the meaning of a root word—but a prefix *does* change the meaning of the whole medical term.

In the list below, you will see medical terms made from some of the root words you studied earlier. Notice that the prefix does not change the meaning of the root word.

Medical Term	Meaning
renal	relating to the kidney
peri /renal	relating to surrounding the kidney
cardia	heart
brady /cardia	slow heart
tachy /cardia	fast heart
glossia	tongue
macro /glossa	large tongue
gastric	relating to the stomach
hypo /gastric	relating to below the stomach
leukocytosis	condition of white cells
a /leukocytosis	condition of absence of white cells

Another 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.

peri/renal—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? 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 here means *heart*.

Medical Term	Meaning
cardia	heart
brady cardia	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 below. 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 you take away the root word *leuk/o*, the meaning of the term changes from *white cells* to just *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, we will make it easy for you. All the prefixes you will learn are followed by a slash. Look at these examples.

brady/ micro/ peri/

All the root words you will learn have a slash between the root and the combining vowel. Look at these examples.

cardi/o leuk/o cyt/o



Step 15 Pronounce Prefixes

- ❑ Follow these steps to familiarize yourself with prefixes.
 - a. Take your Quick-learn Tutor and your Set 2 flashcards out of your Quick-learn Kit.
 - b. Find the first flashcard for Set 2. Insert the card into Side A of your Quick-learn Tutor. Push the card up until the first prefix appears in the left window.
 - c. Put your pronunciation CD in your CD player. Advance the CD to Flashcard Set 2.
 - d. Listen to each prefix as it is pronounced on the CD. After you hear a prefix, put the CD player on pause.
 - e. Look at the prefix in the left window of your Quick-learn Tutor. Practice pronouncing it out loud several times to familiarize yourself with the term. Push the flashcard up until the meaning of the prefix appears in the right window. Read the meaning of the prefix.
 - f. Repeat steps d and e, continuing with all the flashterms on the flashcard.
 - g. When you have completed the flashcard, turn the card over. Proceed until you have pronounced all the prefixes for Set 2.
 - h. Next, begin again with the first flashcard and play the CD. This time, pronounce each prefix in order but do not stop the CD player after each term.
 - i. As you pronounce each prefix, look at it on the flashcard.

After you have finished pronouncing all the prefixes in this set, move on to the next exercise—learning to write the prefixes for this lesson.



Step 16 Write Prefixes

- ❑ Follow these steps to learn to write prefixes.
 - a. Insert the first flashcard for Set 2 into Side A of your Quick-learn Tutor.
 - b. Look at each prefix as it appears in the window and say it out loud. Write each prefix on blank paper. Remember to include the slash.
 - c. Push the card up until the meaning appears in the right window and read the meaning out loud. Write the meaning beside the prefix.
 - d. Do this for each prefix for this set.

Finally, after you have pronounced and written each term, learn the meanings of these prefixes by performing the next exercise.



Step 17 Meaning of Prefixes

- Follow these steps to learn the meanings of prefixes.
 - a. Again insert the flashcard into Side A of your Quick-learn Tutor. Pronounce each prefix out loud and then say the meaning. Check yourself by pushing the flashcard up until you can see the meaning in the right window.
 - b. Now insert the flashcard into Side B of your Quick-learn Tutor. Push the card up until you see the meaning of the first flashterm in the right window. Read each meaning out loud and then say the prefix. Check yourself by pushing the flashcard up until you can see the prefix in the left window. Do this for each flashterm for this set.
 - c. Practice with the flashcards several times until you are familiar with the prefixes and their meanings. Don't struggle to memorize them. The more times you review your flashcards, the more familiar they will be to you.

Study Tips

- ✓ Remember to keep your flashcards in order even after you're finished with an activity so they'll be easy to refer back to.
- ✓ A handy way to review flashcards from previous lessons is to read down the flashcard without inserting it into the Quick-learn Tutor.



Step 18 Practice Exercise 7-3

- Follow the instructions below to complete Parts I and II of the Practice Exercise.

Part I

For each prefix listed below, 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 looked up on the flashcards.

Prefix	Meaning
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 below, write the correct prefix. 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.

Meaning	Prefix
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 Answers to Practice Exercise 7-3

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

Medical Claims and Billing Specialist

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? The answer is that *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.

There are reasons that certain root words are joined to certain suffixes, and these reasons have to do with word origins. However, you needn't be concerned with this. Instead, simply learn which suffixes go with which root words. To help you with this, we have taken many root words and combined them with the correct suffix. This will help you remember which suffixes go with which roots.

In the next few lessons, you will not only 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,

$$\text{path/o} \quad + \quad /y \quad = \quad /pathy$$

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 Suffix	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)



Look closely, and you will be able to see the *root word* + *suffix* combination.

Facts About Suffixes and Root Words

- ✓ Most root words—but not all—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 can stand alone. They can also work as suffixes themselves.

- Listed below 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.

- Let's start off by learning how to pronounce suffixes.



Step 21 Pronounce Suffixes

- ❑ Follow these steps to familiarize yourself with suffixes.
 - Take your Quick-learn Tutor and your Set 3 flashcards out of your Quick-learn Kit.
 - Insert the first flashcard for Set 3 into Side A of your Quick-learn. Push the card up until the first flashterm appears in the left window.
 - Put your pronunciation CD in your CD player. Advance the to Flashcard Set 3.
 - Listen to a suffix as it is pronounced on the CD. After you hear a suffix, put the CD player on pause.
 - Look at the suffix in the left window of your Quick-learn Tutor. Practice pronouncing it out loud several times to familiarize yourself with the term. Push the flashcard up until the meaning of the suffix appears in the right window. Read the meaning of the suffix.
 - When you have completed the flashcard, turn it over for the next flashcard for this lesson. Proceed until you have pronounced all the suffixes for Set 3.
 - Next, begin again with the first flashcard and play the CD. This time, pronounce each suffix in order but do not stop the CD player after each term.
 - As you pronounce each suffix, look at it on the flashcard.



Step 22 Write Suffixes

- ❑ Follow these steps to learn to write suffixes.
 - a. Insert the first flashcard for Set 3 into Side A of your Quick-learn Tutor.
 - b. Look at each suffix as it appears in the window and say it out loud. Write each suffix on blank paper.
 - c. Push the card up until the meaning appears in the right window and read the meaning out loud. Write the meaning beside the suffix.
 - d. Do this for each suffix for this lesson.

Finally, after you have pronounced and written each term, learn the meanings of these suffixes by performing the next exercise.



Step 23 Meanings of Suffixes

- ❑ Follow these steps to learn the meanings of suffixes.
 - a. Again insert the first flashcard for Set 3 into Side A of your Quick-learn Tutor. Pronounce each suffix out loud. Before you look at the meaning, see if you can remember it. Check yourself by pushing the flashcard up until you can see the meaning in the right window.
 - b. Now insert the flashcard into Side B of your Quick-learn Tutor. Push the card up until you see the meaning of the first flashterm in the right window. Read each meaning out loud. Before looking, see if you can remember the suffix that goes with that meaning. Check yourself by pushing the flashcard up until you can see the suffix in left window.
 - c. Practice with the flashcards several times until you are familiar with suffixes and their meanings. You may use your flashcards for all Practice Exercises and the Quizzes.

Step 24 Practice Exercise 7-4

- Follow the instructions below to complete Parts I and II of the Practice Exercise.

Part I

For each suffix listed below, 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 looked up on the flashcards.

Suffix	Meaning
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 below, write the correct suffix. 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.

Meaning	Suffix
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 Answers to Practice Exercise 7-4

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



Step 26 Lesson Summary

- Understanding how to “decipher” medical terminology is a special link to becoming an effective medical claims specialist. Your ability to understand diagnosis and procedure terminology provides healthcare providers (and insurance companies) 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 medical claims 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.

Congratulations! You’re almost done with Pack 1! Let’s complete the following quiz and check Pack 1 off the list.

 **Step 27 Mail-in Quiz 7**

- ❑ Follow the steps to complete the quiz.
 - a. Be sure you've mastered the instruction and the Practice Exercises that this quiz covers.
 - b. Mark your answers on your quiz. Remember to check your answers with the lesson content.
 - c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.
 - d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your quiz online.
 - e. Submit your answers to the school via mail, e-mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 7

Select the best single answer for each of the following items. Remember, you may use your flashcards to answer these questions. Each item on this quiz is worth 5 points.

1. **Words are often made up of smaller _____.**
 - a. prefixes
 - b. word parts
 - c. medical terms
 - d. sentences

2. **The foundation of a word is called a _____.**
 - a. root word
 - b. word's base
 - c. suffix
 - d. prefix

3. **Word parts can be called the _____ of words.**
 - a. ladders
 - b. building blocks
 - c. root words
 - d. grammar

4. A word part that is attached to the end of a word is a _____.
- a. box car
 - b. prefix
 - c. combining vowel
 - d. suffix
5. A prefix is found at the _____ of a word.
- a. end
 - b. middle
 - c. beginning
 - d. none of the above
6. In many medical terms, the _____ joins a root word to a suffix.
- a. prefix
 - b. apostrophe
 - c. locomotive
 - d. combining vowel
7. If *driver* means *a person who drives*, what would *swimmer* mean? _____
- a. to swim again
 - b. to swim past
 - c. a person who swims
 - d. a person who drives and swims
8. Which of the following is a compound word? _____
- a. bookshelf
 - b. love
 - c. booklet
 - d. trust
9. A suffix is attached to the word part called the _____.
- a. end
 - b. root word
 - c. prefix
 - d. adjective

10. A word that is made up of two or more root words is called a _____.
- a. combining vowel
 - b. compound word
 - c. double root
 - d. none of the above
11. In the term *neo/nat/o/log/ist*, the word part *nat/* is a _____.
- a. suffix
 - b. prefix
 - c. combining vowel
 - d. root word
12. In the term *neo/nat/o/log/ist*, the word part *neo/* is a _____.
- a. prefix
 - b. root word
 - c. combining vowel
 - d. suffix
13. In the term *dermat/o/logy*, the word part */o/* is called a _____.
- a. suffix
 - b. prefix
 - c. combining vowel
 - d. root word
14. If *reread* means *to read again*, what does *review* mean? _____
- a. to view again
 - b. to view backwards
 - c. to view sometime in the past
 - d. to view and read together
15. _____ means to play sometime in the past.
- a. Replay
 - b. Player
 - c. Played
 - d. Will play

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For items 16 through 20, select the correct root word for each meaning.

16. skull

- a. criani/o
- b. crani/o
- c. neur/o
- d. cardi/o

17. liver

- a. lith/o
- b. hepat/o
- c. duct/o
- d. hist/o

18. kidney

- a. ren/o
- b. tens/o
- c. col/o
- d. enter/o

19. clot

- a. therm/o
- b. muc/o
- c. thromb/o
- d. myel/o

20. stomach

- a. enter/o
- b. hydr/o
- c. arthr/o
- d. gastr/o



Just for Fun

- ❑ The Just for Fun page is for your enjoyment. You will not be tested on the material, but you may find it interesting.

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. (Well, that's better than nothing.)
- It isn't fattening.
- It is free. (We're not talking about Disneyland here.)

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.

There are two words that nobody wants to hear. One word is *death* and the other is *taxes*.

In medical terminology, there are two words nobody wants to hear. One word is *Greek* and the other is *Latin*. These are two of the languages that medical terms come from. Most people use words that come from Greek and Latin everyday. 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.

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 and not just goofing off. 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 (wow)	blaze
job	profession	affair
happy	felicitous	joyous
behind	posterior	derriere

I know “behind” is longer than four letters, but the real Anglo-Saxon word is not one a professional would use.

Today, by choosing different words, English can still sound everyday, professional or elegant. Don't be afraid of long words. You will soon 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.

Congratulations—You're on your way to your new career as a medical claims and billing specialist! It won't be long before you're earning up to \$40,000 annually! You've put forth a lot of effort, so now is the time to treat yourself—take a bubble bath, go for a nature walk or make a special cup of coffee or tea.



While you're relaxing between lessons, take a few moments to visualize yourself in your new career. Will you be an integral part of a doctor's office or hospital staff, working alongside nurses and doctors? Or would you rather work surrounded by your children, pets or houseplants? Whatever your answer, the best part is that the choice is yours! The knowledge you gain will provide the foundation and confidence you'll need to begin your new career—whether at home or in a medical establishment.

You're already familiar with the claims and billing specialist's day-to-day activities and various career opportunities, and you understand how insurance works and how the process a claim goes through from beginning to end. You know how to communicate effectively with insurance companies and how to follow up on a claim. You've also learned quite a bit about medical terminology. Think of all the medical terms you can recognize—just because you understand how these terms are put together!

In Pack 2, you'll continue to explore medical terminology. You'll also learn about medical abbreviations and symbols. And you'll get to see some of these medical terms in use when you learn about human anatomy and the body systems. The best part is that as you learn the basics of the human body, you'll see how this knowledge applies to the claims specialist.

Ready for Pack 2? Jump right in and get ready to dazzle your friends and family with your anatomy knowledge!

Congratulations

You've completed Lesson 7.



Don't wait for your quiz results to continue with Lesson 8 in Pack 2.

Answer Key

Lesson 1

Practice Exercise 1-1

1. When an insurance company pays for medical services, it **d. reimburses** either the insured or the medical office.
2. The medical claims specialist is responsible for **b. filling out and submitting insurance claim forms**.
3. A **b. medical bill** usually begins its life as a questionnaire.
4. A preprinted form used by some doctors that contains the most common procedures performed by that doctor is called a(n) **c. patient encounter form**.
5. A patient may simply make a co-payment for a visit and then the **a. doctor's office bills the insurance company for the remainder of the bill**.
6. The front office professional in a medical facility typically has to **b. check in arriving patients**.
7. The insurance company that is billed first is called the **b. primary carrier**.
8. An outstanding claim is one that **d. hasn't been paid yet**.
9. An error on the claim form will **a. delay** reimbursement.
10. As a medical professional, you cannot release any information that doesn't normally appear on the insurance form unless you are given permission because **c. of confidentiality**.

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. Charges that exceed the reasonable and customary scale of a policy are **a. disallowed** by the carrier.
4. If the insurance company is paying nothing on a claim, you **b. still receive an explanation of benefits**.
5. How much does the insured owe (not including the co-payment, which has already been paid)? In this case, the patient is responsible for the disallowed charge. **a. \$14.00**
6. Since there is \$0.00 applied to the deductible, **a. the deductible has already been met**.
7. What is the amount that exceeds the reasonable and customary price scale? **c. \$14.00**
8. How much does the insured owe (not including the co-payment, which has already been paid)? In this case, the patient is not responsible for the disallowed charge. **c. \$67.00**
9. What is the maximum amount the insurance carrier will cover for this particular service? **c. \$121.00**
10. What is the amount that exceeds the reasonable and customary price scale? **a. \$26.00**

Lesson 3

Practice Exercise 3-1

1. The process of notifying an insurance company before hospitalization, surgery or tests is called **b. preauthorization**.
2. When you write a code on an insurance form, you are **b. coding** that entry.
3. The doctor confirmed that Jerry Smith has acute bronchitis. The diagnostic code is found in which field on the CMS-1500 claim form? 14
4. Georgia Whitham just had an appendectomy. The procedure code is found in which field on the following CMS-1500 claim form? 24A

Lesson 4

Practice Exercise 4-1

1. Operates for profit and can raise rates at will—**e. Private insurance carrier**
2. The amount a physician would charge the majority of patients and the amount determined to be appropriate for the service or procedure—**h. Usual, customary and reasonable**
3. Allows the physician to bill the subscriber for any amount not covered by the insurance company—**g. Indemnity benefit contract**
4. Describes the subscriber's benefits and coverage—**c. Policy**
5. The fee charged by most physicians in the community—**d. Customary maximum**
6. Advance payment for coverage of potential services—**b. Prepay**
7. Plan that has participating physicians—**f. Service benefit contract**
8. The maximum fee allowed for a specific medical service or procedure—**a. Fixed fee schedule**

Practice Exercise 4-2

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** health care costs.
3. **b. Managed care coverage** limits the patient's freedom to choose doctors.
4. HMO stands for **c. health maintenance organization**.
5. PPGs are **a. physician provider** groups.
6. HSA stands for **b. health savings account**.

Lesson 5

Practice Exercise 5-1

1. The Centers for Medicare & Medicaid Services acts a purchaser of health care services for **b. Medicaid** and **Medicare**.
2. There are **a. 10** CMS regional offices.
3. Medicaid was officially established in **d. 1965**.
4. Although **d. Medicaid** is financed by state and federal governments, it is run by each state.
5. **c. Medically needy** Medicaid recipients have too much income to qualify for the mandatory or optional categorically needy groups.
6. The levels of care required by federal law for Medicaid recipients are called **b. minimum standards**.
7. Medicaid recipients receive ID cards or coupons, which note **b. their classification of eligibility**.
8. Some health insurance programs require the insured to pay a percentage of the cost of covered charges, called **d. coinsurance**.
9. The difference between the fees normally charged for a service and the amount reimbursed by Medicaid is usually **a. written off as a loss by the physician**.

10. **c. Preauthorization** for specific services, or the review of proposed treatment for appropriateness by Medicaid, is required by some states.
11. From state to state, the time limits for submission of Medicaid claims vary between **d. two months and one year** from the date that the patient received medical services.
12. Depending on your state, you have between **b. 30 and 60** days to file an appeal of an action by Medicaid.
13. In most states, Medicaid claims should be submitted using the **a. CMS-1500** claim form.
14. If a person has other insurance coverage, Medicaid becomes the **c. secondary** carrier.
15. When filing a Medicaid claim for a person with a primary carrier, you must include a copy of the **b. EOB** from the primary carrier.

Practice Exercise 5-2

1. Medicare is a(n) **federally** funded health insurance program.
2. There are **two** kinds of Medicare coverage.
3. Medicare Part **A** covers medically necessary hospital care and services.
4. Medicare Part **B** covers medical services and supplies.
5. The procedure codes for Medicare claims can be Level I CPT codes and **Level II HCPCS codes**.
6. A(n) **NPI** is assigned by CMS for identification purposes.
7. Medicare claims should be submitted using the **CMS-1500** claim form.
8. Medicare claims should be filed within **one** year(s) from the date the patient received treatment.
9. You have **60** days to appeal a denied Medicare claim.
10. The **EOMB** explains what action Medicare took on a submitted claim.
11. **Medigap** policies pay for expenses not covered by Medicare Parts A and B.
12. Supplemental insurance policies **do not** duplicate Medicare coverage.
13. Supplemental insurance benefits are paid directly to the **physician**.

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14. Some patients **can** be covered by both Medicare and Medicaid.
15. Claims for Medi-Medi patients are submitted to **Medicare** first, as the primary carrier.
16. **Medicare part D** assists with the yearly out-of-pocket prescription expenses.
17. Medicare part D coverage is provided by **private insurance companies**.
18. Billing for services that were not provided is an example of **fraud**.
19. ABN stands for **Advanced Beneficiary Notice**.
20. Medicare **preventive** services are provided to detect the early onset of illnesses.

Lesson 6

Practice Exercise 6-1

1. The program that provides managed health care 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 health care 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. TRICARE or CHAMPVA claims should be submitted within **d. one year** of the date of service.
7. TRICARE or CHAMPVA is the **d. secondary** insurance carrier when a beneficiary is enrolled in other health insurance plans.
8. **b. TRICARE Prime** is an HMO-type option and is the least costly of the TRICARE options.
9. TRICARE Standard is the new name for **c. CHAMPUS**.
10. **a. TRICARE Standard supplemental insurance** generally pays most or all of the balance due after TRICARE Standard has paid its benefits.

Practice Exercise 6-2

1. Catastrophic cap—**b. Upper limit that will have to be paid by the patient**
2. Cost-share—**c. Percentage paid by the patient**
3. Traumatic injury—**g. Caused by a specific event**
4. Deductible—**i. Amount patient must pay before cost-share begins**
5. Occupational illness—**h. Caused by continued exposure to workplace**
6. Authorized provider—**a. Physician approved to provide medical care**
7. Network provider—**e. Physician who provides care at contracted rates**
8. DEERS—**d. Computerized data bank that lists military members**
9. COBRA—**f. Consolidated Omnibus Budget Reconciliation Act**

Lesson 7

Practice Exercise 7-1

1. The foundation word part of a medical term is called a **root word**.
2. The word part that is attached to the end of a term is a **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 **combining vowel**.

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5. The word part that is attached to the beginning of a term is a **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 **root word**.
10. In the term *dermat/o/logy*, the word part /o/ is called a **combining vowel**.

Practice Exercise 7-2

Part 1

Root Word	Meaning
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

Meaning	Root Word
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 7-3

Part I

Prefix	Meaning
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

Meaning	Prefix
11. under, inferior to	sub/ or infra/
12. half	hemi/
13. against, opposed	anti/
14. all, every	pan/

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- | | |
|-----------------------|---------------|
| 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 7-4

Part I

Suffix	Meaning
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

Meaning	Suffix
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 |

