Component II: Administrative

Module D: Medical Office Insurance

Topic 1: Billing and Coding

Statement of Purpose
To prepare the learner with basic knowledge and skills necessary to distinguish types of insurance and insurance claims used in the medical office setting.

Student Learning Outcomes
Upon completion of this topic, the learner will be able to:

1. Spell and define key terms.
2. Recognize legal ramifications of billing, filing claims and fraud.
3. Differentiate between methods of patient/insurance payments.
4. List and identify various insurance programs.
5. Demonstrate principles of coding by defining three coding systems used to describe diseases, injuries and procedures.
6. Examine the blocks on the CMS-1500 form.
7. Identify reimbursement time frames and special requirements.
8. Interpret an Explanation of Benefits.
9. Understand medical insurance billing follow-up.
10. Recognize main differences between ICD-9-CM and new ICD-10-CM

Terminology

1. Authorization
2. Benefits
3. California State Disability Insurance (SDI)
4. Carrier
5. Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA)
6. Claims
7. Coding
8. Co-Insurance/Share of cost
9. Co-payment
10. Current Procedure Term (CPT)
11. Deductible
12. Defense Enrollment Eligibility Report System (DEERS)
13. Explanation of benefits
14. Fraud
15. Health Insurance Portability and Accountability Act (HIPAA)
16. Health Maintenance Organization (HMO)
17. Healthcare Common Procedure Coding System (HCPCS)
18. ICD-9-CM/ICD-10-CM
19. Insured
20. Medi-Cal/Medicaid
21. Medicare Advantage
22. Point of Service (POS)
23. Preferred Provider Organization (PPO)
24. Premium
25. Primary Care Physician (PCP)
26. Protected Health Information (PHI)
27. Provider
28. Reimbursement
29. Remittance Advice (RA)
30. TRICARE

References

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Content Outline Theory Objectives	Suggested Learning Activities
Objective 1 **Spell and define key terms.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in proper context	A. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman and concentration. B. Administer vocabulary pre-test and post-test. C. Discuss learning gaps and plan for applying vocabulary.
Objective 2 **Recognize legal ramifications of billing, filing claims, and fraud.** A. The HIPAA privacy rule covers the use and disclosure of patient's protected health information 1. An authorization to release the information document must be signed by the patient or authorized representative. 2. For purposes of treatment, payment or health care operations, a signed authorization document is not required under HIPAA a. An authorization for release of the information document is generally considered being in force for one year. b. Exceptions to this general rule 1) Medi-Cal patients. 2) Workers' compensation patients. 3) Medicare patients. 4) HIV positive and AIDS patients may be selective in releasing information. c. Must be in plain language and include: 1) Identification of person authorized to request (patient name). 2) Description of the information to be used or disclosed. 3) Name or other specific identification of the person(s) authorized to use or disclose the information. • Name. • Address where the records are to be sent. • Phone number and/or fax. 4) Description of each purpose of the requested use or disclosure • Legal. • Changing physicians. • School. • Consultation and second opinion.	A. Lecture/Discussion B. Assigned Readings

• Insurance. • Continuing care. • Workers' compensation. • Other. 5) An expiration date. 6) Statement that is revocable by written request. 7) Signature of the individual or authorized representative and date. d. A patient must also give specific authorization to release medical information to other family members and even a spouse. e. Protected Health Information in a medical office include 1) Intake form. 2) Encounter sheets. 3) Physician's notes. 4) Physician patient conversations. 5) Physician dictation tapes. 6) Telephone conversations with patients. 7) Prescriptions. 8) Insurance claim forms. 9) X-rays. 10) Labs. 11) E-mail messages. f. To send information via fax machine, care must be taken to advise any recipient receiving the information in error, to return the information and that the information is personal, privileged and confidential and intended for the named recipient only. 3. To knowingly submit a claim for services that either have not been done or are not medically necessary constitutes fraud a. Fraud is an intentional deception, outright lie or misrepresentation that could result in unauthorized benefit to the fraudulent party and consists of: 1) Altering the patient's medical record to increase the amount reimbursed. 2) Upgrading or falsifying medical procedures to increase the amount reimbursed. 3) Over-billing primary and secondary insurance carriers while at the same time collecting payment from the patient. 4) Changing a date on a chart so that a service is covered by a health insurance plan. b. Fraud is a felony, punishable by fine,	

incarceration and possible loss of a physician's license. c. If the fraud involves deceiving the government, it becomes a federal offense and federal laws will then apply. 4. Abuse is an action that misuses the money that the government has allocated, inconsistent with accepted sound medical business or fiscal practices a. Excessive charges for services or supplies. b. Excessive diagnostic tests when only a few are required for services. c. Excessive and unnecessary follow-up visits. 5. Insurance billing and filing claims may require additional verification a. Verify any requests that may seem questionable. b. Verify information that does not seem to fit from a medical perspective. c. If in doubt, verify with physician. 6. Any insurance company has the right to audit any claim being considered for payment owed or amount that has been paid; no advanced warning is required.	
Objective 3 **Differentiate between methods of payment.** A. Co-payment is a set amount of money the health plan requires a beneficiary to pay at the point of arriving in the office before he or she sees the physician B. Co-insurance (cost-sharing) is the amount the beneficiary is responsible for after the deductible has been met and insurance has paid its share, usually a percentage C. Deductible is a specific amount of money that must be paid annually before the insurance takes over (excluding office visits) D. Out-of-pocket expense is the amount insured patient must pay for services rendered	A. Lecture/Discussion B. Assigned Readings C. Create a matching exercise
Objective 4 **List and identify various insurance programs.** A. Private plans 1. Numerous companies across the United States offer different types of insurance policies. 2. Indemnity (fee-for-service), patient paid the health care provider and then submitted a claim form to the insurance company. 3. Basic benefits a. Basic hospital (cost of hospital bills). b. Major medical (surgeon's fees, anesthesia services, health professional's visits in the hospital, office visits and office visit procedures).	A. Lecture/Discussion B. Assigned Readings C. Claim for Disability Insurance Benefits (Administrative D: 1.4a) D. Doctors report of Occupation Injury or Illness (Administrative D: 1.4b) E. Contact local insurance companies to have a representative come out to your class to explain the

4. Usually have a deductible and co-insurance. B. Managed care plans 1. Generic term used to describe a variety of health plans. 2. Involves financing and the delivery of appropriate cost-effective health care services offered by the numerous companies across the United States to its members. 3. Health care professionals and hospitals organize a network that coordinates and provides health care services and benefits for a group of individuals for managing the cost, quality and access to health care a. PPO offers insured individuals certain incentives if they choose health care providers from a list of those contracted with the PPO 1) Lower deductibles and co-payments. 2) Payment made directly to the health care provider. b. HMO provides a wide range of comprehensive health care services for a fixed periodic monthly payment 1) Must use the HMO's physicians and facilities to receive benefit of lower premiums and co-payments. 2) Participants have restriction on their choice of health care providers. 3) The health care provider may need an authorization or referral prior to setting up appointments or giving treatment. 4) The insurance company may need to see the medical record to make a determination of the amount of reimbursement it will authorize for a given service. 5) Patients select a Primary Care Physician (PCP) who offers preventive health care, monitors a patient's care and authorizes referrals to specialists. c. Group practice 1) Pre-paid group practice model (Kaiser Permanente) physicians are partners. 2) Staff model health plan hires physicians directly and pays them a salary instead of contracting	insurance processing system for their company. F. Access the State of California government web page for most current information on Worker's Compensation and State Disability Workers' Compensation http://www.dir.ca.gov/DWC/dwc_home_page.htm G. Access government web page for most current information on State Disability Insurance http://www.edd.ca.gov/direp/diind.htm

with a medical group.
3) Network HMO (IPA) contracts with two or more group practices to provide health services.
4) Physicians see both HMO and non-HMO patients and usually reimbursed by a capitation payment (flat monthly fee) per patient along with co-pay payment for patients assigned to the provider whether seen or not.
5) Direct health plan contracts directly with private practice physicians in the community.
6) Point of Service (POS) "open-ended" HMO option has more flexibility, permits member to choose providers "out of network" but with increased cost to the member.

C. MediCal (California only) or Medicaid
    1. A federal-aided state operated and administered assistance program that provides essential medical care and services to preserve health, alleviate sickness and mitigate handicapping conditions for individuals or families on public assistance or whose income is not sufficient to meet their individual needs.
    2. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity or impairment.
    3. These services are comprehensive and provide care in the major disciplines of health care.
D. Medicare is a federal health insurance program for people 65 or older, permanently disabled people or people with end stage renal disease
    1. Medicare Part A
        a. Helps pay for medically necessary inpatient hospital care, inpatient skilled nursing care following a covered hospital stay, some home health care and hospice care.
        b. Primarily funded by a portion of the Social Security tax.
    2. Medicare Part B
        a. Helps pay for medically necessary physician/ non-physician services, ambulance services, durable medical equipment and many other health services and supplies not covered by Medicare Part

A hospital Insurance. b. Pay a monthly premium for this portion of the program. c. Premium is normally deducted from their monthly Social Security checks. d. The federal government contracts with private companies called *Contractors* to administer benefits. 3. Medicare Part C a. Medicare Advantage Plans and other Medicare Health Plans are health plans that allow beneficiaries to choose to receive their health care through private health plans instead of the traditional Medicare program 1) HMOs. 2) PPOs. 3) Private Fee-for-Service. 4) Medicare Cost Plans. 4. Medicare Part D a. Prescription Drug Coverage. b. Provides prescription drug coverage to all beneficiaries electing to enroll beginning on January 1, 2006. c. There are varying plans with an extra premium each month. E. TRICARE/CHAMPVA 1. A three-option managed health care program offered to spouses and dependents of service personnel families from any of the seven armed services a. Army b. Air Force c. Navy d. Marine Corps e. Coast Guard f. Public Health Service g. National Oceanic & Atmospheric Administration 2. TRICARE eligibility issued through DEERS for: a. Active duty and retired service members. b. Spouses and unmarried children of active duty or retired service members 1) Eligibility ends at age 21 unless the child is a full-time student (validation of student status required). 2) Then eligibility ends at age 23 or when the full-time student status ends, whichever comes first. c. Reserve Component members on active	

duty for more than 30 days, under Federal orders. d. Retired reserve component service members and their family members. When the retired reserve component service member is eligible for retirement pay (usually at age 60) the member and his/her eligible family members become TRICARE eligible e. CHAMPVA for families of veterans who have a 100 percent permanent disability or of veterans, who died from a service-connected disability, may be covered by CHAMPVA as long as they are not eligible for TRICARE. f. CHAMPVA is administered by the Department of Veterans' Affairs. F. Worker's compensation, state or federal plan that covers medical and other benefits for employees who suffer accidental injury or become ill as a result of employment. G. State disability is a plan that reimburses the insured for lost income when the insured is unable to work due to off-the-job injury or sickness and is paid for by deductions from a person's paycheck 1. California State Disability Insurance (SDI) is a partial wage-replacement insurance plan for California workers. 2. The SDI program is State-mandated and funded through employee payroll deductions. 3. SDI provides affordable, short-term benefits to eligible workers who suffer a loss of wages when they are unable to work due to a non-work-related illness or injury or medically disabling conditions from pregnancy or childbirth. H. Disability Compensation Insurance provides the policyholder with reimbursement for lost income due to a disability that prevents the individual from working 1. Does not provide medical expense benefits. 2. Individual policy may be purchased by a private insurance company. 3. Employer-sponsored plans.	
Objective 5 **Demonstrate principles of coding.** A. Procedural Coding, Current Procedural Terminology, (CPT) 1. Updated on an annual basis. 2. New codes added and deleted shown by the use of symbols. 3. Should have a current CPT book on hand for reference.	A. Lecture/Discussion B. Assigned Readings C. Utilize Medical Assisting or Medical Insurance Billing Textbooks for practice exercises and textbooks computer exercises.

4. Transformation made of written descriptions of procedures and professional services into code numbers by use of a five-digit coding system with two digit modifiers.
5. Procedure codes are a standardized method used to precisely describe the services provided by physicians and allied health personnel to report medical, surgical and diagnostic services they provide.
6. Codes are used by payers for appropriate reimbursement for services.
7. Six primary sections, each beginning with guidelines that cover definitions and terms unique to that section
    a. Evaluation and Management
        1) New patient versus established patient.
        2) Referral versus consultation.
    b. Anesthesia.
    c. Surgery
        1) Global period.
        2) Surgical package.
        3) Laceration repair.
    d. Radiology.
    e. Pathology and laboratory.
    f. Medicine.
8. Index.
9. Main terms and sub-terms.
10. Code ranges.
11. Cross references and conventions
    a. See synonyms, eponyms and abbreviations.
    b. See also Common Procedure Coding System; Health Care Financing Administration (HCFA) Healthcare Common Procedure Coding System, (HCPCS).

B. Common Procedure Coding System; Health Care Financing Administration (HCFA) Healthcare Common Procedure Coding System, (HCPCS)
    1. Standardized coding system that is used primarily to identify products, supplies and services not included in the CPT codes, such as ambulance services, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) when used outside a physician's office.
    2. Because Medicare and other insurers cover a variety of services, supplies and equipment that are not identified by CPT codes, the level II HCPCS codes are established for submitting

claims for these items.
3. Updated on an annual basis.
4. Alpha numeric codes assigned and maintained by each local or regional Medicare fiscal agent or carrier
    a. Alpha numeric range from W0000 through Z9999.
    b. Special alpha modifiers are used to further explain a given service, ranging from WA through ZZ.
5. Procedural Coding Steps
    a. Become familiar with the CPT and HCPCS coding books.
    b. Determine procedures and services to report from the superbill, fee ticket or encounter form.
    c. Identify the correct code(s).
    d. Determine the need for appropriate modifiers.
    e. Record the procedure code in the computer software system or type on the claim form.

C. Diagnostic Coding; International Classification of diseases, 9th edition, Clinical Modification. These are known as the ICD-9-CM codes.
1. Data on the types and number of diseases in the United States provide important information to help us understand the overall condition of our nation's health.
2. The World Health Organization collaborates with the United States to strengthen their health services wherever possible.
3. The ICD-9-CM consists of
    a. Volume I is a tabular list containing a numerical list of the disease code numbers.
    b. Volume II is an alphabetical index to the disease entries, organized by condition not anatomical site
        1) Main terms bold type.
        2) Sub-terms indented two spaces to the right under main term.
        3) Sub-term to a sub-term.
        4) Non-essential modifiers.
        5) Conventions.
        6) Carryover lines.
        7) Cross-references.
        8) V codes.
        9) Neoplasm table.
        10) Hypertension table.

11) 5th digits. c. Volume III is a classification system for surgical, diagnostic and therapeutic procedures alphabetic index and tabular list). 4. Volumes I and II are utilized in physicians' offices. 5. Updated on an annual basis. 6. Transformation of a written diagnosis into a three to five digit code number. The more digits the higher the specificity. a. Primary diagnosis. b. Secondary diagnosis. 7. Diagnostic coding steps a. Determine the primary diagnosis, condition, or symptom(s). b. Locate the term in the alphabetical index. c. Use any supplementary terms in the diagnostic statement to help locate the main term. d. Read and follow any notes below the main term. e. Review the sub-terms to find the most specific match to the diagnosis. f. Read and follow any cross-references. g. Verify the code in the tabular list. h. Read include or exclude notes. i. Be alert for and observe fifth digit requirements. j. Follow any instructions requiring the selection of additional codes. k. List multiple codes in the correct order.	

Objective 6 **Examine the blocks on the CMS-1500 form.** A. Blocks 1 through 33 1. Instructions change on an annual basis and health insurance billing specialists must keep up with the current trends. 2. Request permission to copy or use a current template of the basic information requested or required by the various insurance types from a current edition of a publisher's textbook, contact insurance companies or visit their websites a. Patient information section blocks 1-13. b. Physician or supplier information blocks 14-33. 3. With paper claims, be sure to use OCR guidelines. 4. Electronic claims a. Online error-edit process. b. Audit trail. c. Postage not required. d. Improved cash flow. e. Clearinghouses. f. HIPAA transaction and code set regulations. B. The National Uniform Claim Committee (NUCC) 1. Created to develop a standardized data set for use by the non-institutional health care community to transmit claim and encounter information to and from all third-party payers. 2. It is chaired by the American Medical Association (AMA), with the Centers for Medicare and Medicaid Services (CMS), 1500 Reference Instruction Manual.	A. Lecture/Discussion B. Assigned Readings C. Download blank forms from various websites or contact insurance companies for templates. D. Utilize Medical Assisting or Medical Insurance Billing Textbooks for practice exercises and textbooks computer exercises. E. Revised Claim Form CMS-1500 (Administrative D: 1.6)
Objective 7 **Identify reimbursement time frames and special requirements.** A. Reimbursement time frames vary depending on the insurance payer involved and the method used to bill 1. Private insurance companies range from 15 to 60 days a. Electronically submitted, 15 days b. Submitted by mail, 60 days 2. Government programs like MediCal, Medicare, and TRICARE/CHAMPVA prefer electronically submitted claims and payment varies from 30 to 60 days. If submitting other than electronically, reimbursement can be considerably longer. B. Insurance payers have unique claims submission requirements and instructions; reimbursement times will also vary C. Understand the mechanics of submitting an insurance	A. Lecture/Discussion B. Assigned Readings C. Give students a fictitious problem and have the student the code the necessary information from the CPT, the ICD-9-CM, and the HCPCS on a CMS1500 claim form. D. Have the student type and fill in the appropriate information in the blocks 1-33. Submit the claim form for processing and grade according to the status PAID or DENIED. If the claim is denied,

claim	request the claim be resubmitted with the missing or incorrect information. E. Utilize Medical Assisting or Medical Insurance Billing Textbooks for practice exercises and textbooks computer exercises.
Objective 8 **Interpret an explanation of benefits.** A. All insurance companies use a type of Explanation of Benefits (EOB) form 1. Medicare terms it an EOMB, an explanation of Medicare benefits 2. Medi-Cal terms it an EOB, explanation of benefits, as do most other fiscal intermediaries B. Insurance companies have codes for the action taken on each claim C. The codes are generally explained on the front or back side of the EOB, or in the insurance billing manual for the particular carrier D. Be aware that an Electronic Remittance Advice (eRA) will be used with the Electronic Health Record (EHR)	A. Lecture/Discuss B. Assigned Readings C. Use EOBs and EOMBs to have students practice interpretation and bookkeeping of funds paid on claims submission. D. Remember Health Insurance Portability Accountability Act (HIPAA) requirements. Ask physicians in your area for copies of various EOBs with PHI blacked out. E. Go to www.hhs.gov/ocr/hipaa/ for education materials.
Objective 9 **Understand medical insurance billing follow-up.** A. Second-request billing. B. Letter to request insurance claim be traced. C. Each facility will have a procedure manual to follow to collect insurance claims. D. Most insurance types have several levels of appeal to satisfy claimant's demands.	A. Lecture/Discussion B. Assigned Readings C. Use a software program for students to practice data entry, insurance coding input and update. Grade students on a claims processing basis (allowed/approved for payment, denied and others.)
Objective 10 **Recognize main differences between ICD-9-CM and new ICD-10-CM.** A. Over 55,000 additional codes in ICD-10-CM. B. To include more diseases and conditions. C. Better grouping with more complete descriptions. D. Reduced need for attachments. E. Interoperability (US and most countries).	A. Lecture/Discussion B. Assigned Readings