Understanding Health Insurance 16th edition Green Solutions Manual

SKU: 9780357515587-SOLUTIONS

Solution and Answer Guide

Green, Understanding Health Insurance, 2021, ISBN 9780357515587; Chapter 1: Health Insurance Specialist Career

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Solution and Answer Guide

Green, Understanding Health Insurance, 2021, ISBN 9780357515587; Chapter 2: Introduction to Health Insurance

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Solution and Answer Guide

Green, Workbook to Accompany Understanding Health Insurance, 2021, ISBN 9780357515594;
Chapter 1: Health Insurance Specialist Career

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Assignments

Assignment 1.1: Interview of a Professional

The student will submit a three-page, double-spaced, word-processed report on an interview of a professional; the paper should be in paragraph form (not written in a question/answer format). Each paragraph should include a minimum of three complete sentences, containing no typographical or grammatical errors. The last paragraph of the paper should summarize the student's reaction to the interview and whether the student would be interested in having this professional's position (along with why or why not). Also, the student should think about the future (in terms of family, employment, and so on).

Assignment 1.2: Ready, Set, Get a Job!

The student will submit a résumé and cover letter, using Figures 1-2 and 1-3 in the Workbook for guidance.

Assignment 1.3: Journal Abstract

The student will submit a one-page, word-processed journal abstract, which should be evaluated to make sure that it contains the following information:

- Name of article
- Name of author
- Name of journal
- Date of journal
- Journal article summary, in double-spaced paragraph format, that summarizes the article's content (and does not include the student's opinion about the content of the article)

Assignment 1.4: Professional Discussion Forums (Listservs)

The student will go to the list.nih.gov website, and click on "About NIH LISTSERV" to learn about online discussion forums (listservs). The student will also select a professional discussion forum from Table 1-2 in the Workbook and follow its membership instructions. If this assignment is completed by a student outside of class, the instructor can require students to submit a summary of the experience (or, if teaching online, to post a discussion).

Assignment 1.5: Learning About Professional Credentials

American Academy of Professional Coders (AAPC)
www.aapc.com

Credential Abbreviation	Meaning of Credential	Education	Experience	Exam Fee	CEU Requirements
CPC	Certified Professional Coder	Associate degree recommended	Two years of coding experience	$300 (member) $380 (nonmember)	36 continuing education units (CEUs) every two years
COC	Certified Outpatient Coder	Associate degree recommended	Two years of coding experience	$300 (member) $380 (nonmember)	36 CEUs every two years
CPC-P	Certified Professional Biller	Associate degree recommended	Not applicable	$300 (member) $380 (nonmember)	36 CEUs every two years

American Health Information Management Association
www.ahima.org

Credential Abbreviation	Meaning of Credential	Education	Experience	Exam Fee	CEU Requirements
CCA	Certified Coding Associate	High School Diploma or GED equivalent	Six months of coding experience directly applying codes	$199 (member) $299 (nonmember)	20 CEUs plus annual assessment, CEU cycle is two years
CCS	Certified Coding Specialist	AHIMA-approved coding program	Minimum two years coding experience	$299 (member) $399 (nonmember)	20 CEUs plus annual coding self-reviews, CEU cycle is two years
CCS-P	Certified Coding Specialist - Physician-based	AHIMA-approved coding program	Minimum two years coding experience	$299 (member) $399 (nonmember)	20 CEUs plus annual coding self-reviews, CEU cycle is two years

Assignment 1.6: Professionalism

1. c
2. a
3. i
4. d
5. e
6. g
7. j
8. f
9. b
10. h

Assignment 1.7: Telephone Messages

a. Case 1

DATE 9/8/YYYY TIME 12:15 P.M.

TO Dr. Al A. Sickmann, M.D.

WHILE YOU WERE OUT

MR./MRS. Faye Slift

FROM

PHONE (123) 934-6857

TELEPHONED	X	PLEASE CALL BACK	X
CALLED TO SEE YOU		WILL CALL AGAIN	
RETURNED YOUR CALL		URGENT	X

MESSAGE: Patient is almost out of her high blood pressure medication. She states that she has only enough to last her the rest of the week. She is requesting that a refill be called in to her pharmacy that is listed in her medical record. She would like someone to call her after.

TAKEN BY (Student Name)

b. Case 2

DATE 9/11/YYYY TIME 12:40 P.M.
TO Dr. Al A. Sickmann, M.D.

WHILE YOU WERE OUT

MR./MRS. Ed Overeels
FROM
PHONE (123) 212-6588

TELEPHONED	X	PLEASE CALL BACK	X
CALLED TO SEE YOU		WILL CALL AGAIN	
RETURNED YOUR CALL		URGENT	X

MESSAGE: New patient, would like to make an appointment for his chronic back pain. Just recently moved to area and is experiencing a flare up due to move. He works evenings so he would prefer a morning appointment as soon as possible.

TAKEN BY (Student Name)

c. Case 3

DATE 9/20/YYYY TIME 1:00 P.M.
TO Dr. Al A. Sickmann, M.D.

WHILE YOU WERE OUT

MR./MRS. Tristan N. Shout
FROM
PHONE (123) 319-6531

TELEPHONED	X	PLEASE CALL BACK	X
CALLED TO SEE YOU		WILL CALL AGAIN	
RETURNED YOUR CALL		URGENT	

MESSAGE: Patient is returning, has new insurance. Would like to schedule an appointment for an annual exam. He is requesting the latest appointment that is available on a Friday.

TAKEN BY (Student Name)

Assignment 1.8: Multiple Choice Review

1. b
2. a
3. b
4. b
5. b
6. c
7. d
8. c
9. d
10. c
11. b
12. d
13. c
14. c
15. a
16. b
17. a
18. c
19. b
20. c

Solution and Answer Guide

Green, Workbook to Accompany Understanding Health Insurance, 2021, ISBN 9780357515594;
Chapter 2: Introduction to Health Insurance

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Assignments

Assignment 2.1: Health Insurance Coverage Statistics

1a. Private insurance.

1b. There was an increase of 0.8 percent from Year 1 to Year 2.

(Note: 12.4% – 11.6% = 0.8%)

1c. Military health care, which includes TRICARE and CHAMPVA.

1d. The student may mention any two of the following:

- Increase in premium costs of employer-sponsored plans
- Increase in premium costs of private insurance plans
- Change in labor market; more individuals qualify for coverage
- Decrease in poverty rate; less individuals qualify for Medicaid

1e. The student may mention any three of the following:

- No early preventive screening; disease not detected in early, more treatable stage
- No early intervention for disease; outcome not as favorable
- Patient may suffer from early death as health care risk factor screening may not be performed
- Increase in infection rate due to lack of treatment of infectious disease, passing the disease on to others and little or no education on infection control
- Injuries that are treatable may cause long-term problems with lack of medical care

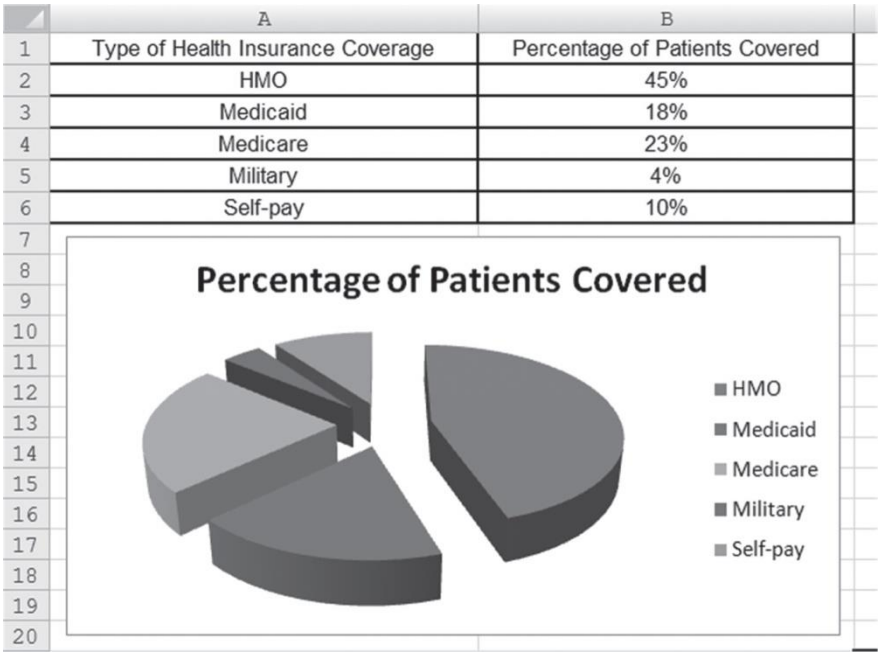
2a. The percentage of the general population who had no break in health insurance coverage between Year 1 and Year 4.

2b. Women were more likely to have continuous health care coverage than men.

2c. The Hispanic population had the smallest percentage of individuals with continuous health insurance coverage.

2d. Each group is experiencing a slow, incremental increase year to year in the number of individuals who have continuous health insurance coverage.

3. **Case Study:** The student will create a pie chart in Microsoft Excel using the detailed instructions provided in the Workbook, which will look like the following image:



Assignment 2.2: Major Developments in Health Insurance (Research Paper)

1. The student will prepare an annotated bibliography that incorporates at least four of the following items:

   - Description of the content or focus of the article
   - Consideration of whether the article content is useful
   - Limitations of the article (e.g., outdated)
   - Audience for which the article is intended
   - Evaluation of any research methods used in the article
   - Author's background
   - Any conclusions the author(s) made about the topic
   - Student's reaction to the article

2. The student will review, sign, and submit the plagiarism policy (refer to Figure 2-4 in the Workbook) to the instructor.

3. The student will submit a research paper (no more than five pages in length) that focuses on major developments in health insurance during a specific period of time. The paper will discuss the impact on health care quality, access, technology, reimbursement, and so on. The student will create a bibliography that cites a minimum of five references according to American Psychological Association (APA) or Modern Language Association (MLA) format, to be determined by the instructor.

Assignment 2.3: Calculating Reimbursement

1. a. $20	b. $28	c. $27
2. a. $18	b. $105	c. $117
3. a. $140	b. $560	c. $190
4. a. $30	b. $70	c. $50
5. a. $10	b. $60	c. $80

Assignment 2.4: Health Insurance Marketplace

Students will use the Health Insurance Marketplace website at www.healthcare.gov to obtain information about how to get coverage, change or update a health plan, learn more about government programs, and determine coverage eligibility. (Instructors might consider requiring students to write an essay about one or more topics described at the Marketplace.)

Assignment 2.5: Quality Payment Program—Merit-Based Incentive Payment System

1. a. Patient electronic access; health information exchange; patient electronic access; view, download, transmit; secure messaging; health information exchange; medication reconciliation

   b. Research information about each measure to determine what is required for reporting, and work with the practice's electronic health record vendor to ensure that required data is captured and reported.

2. a. Yes

   b. No

   c. The target percentile rank was 15, and the practice's rank was 17, which means that the practice's episode cost is higher than desired. However, the practice's rank of 17 is significantly lower than the highest national distribution of TPCC percentile rank of 32.

Assignment 2.6: Multiple Choice Review

1. b
2. d
3. b
4. b
5. b
6. b
7. c
8. b
9. a
10. b
11. d
12. a
13. c
14. b
15. a
16. b
17. a
18. a
19. a
20. c

Solution and Answer Guide

Green, Understanding Health Insurance, 2021, ISBN 9780357515617;
SimClaim™ Case Studies

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Note to Instructors

SimClaim™ is an educational tool designed to familiarize students with the basics of CMS-1500 claim form completion. Student practice software is available through the online MindTap program, accessed at **www.cengage.com**. Students should complete a claim for each case study based on the information provided in each case only. The SimClaim cases closely follow the claims processing instructions also found in the *Understanding Health Insurance* textbook.

- CMS-1500 claims answer keys to SimClaim Case Studies: Set One, and SimClaim Case Studies: Set Two are located in this Solution and Answer Guide.
- Students use the SimClaim blank form mode to enter CMS-1500 claims data or they make copies of the blank CMS-1500 claim located on the Student Resource Center. Sign up or sign in at **www.cengage.com** to access the resources for this product.
- SimClaim Case Studies: Set Two requires student assignment of ICD-10-CM, CPT, and HCPCS level II codes. Code answers are located in CMS-1500 claims answer keys in this Solution and Answer Guide.

SimClaim Case Studies: Set One

Case 1-1: Mary S. Hightower

AETNA
PO BOX 45

STILLWATER PA 12345-0045

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLKLUNG [ ] (ID#) OTHER [ ] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 272034109
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HIGHTOWER, MARY, S	3. PATIENT'S BIRTH DATE MM DD YY: 08 07 1951 SEX M [ ] F [X]		4. INSURED'S NAME (Last Name, First Name, Middle Initial): HIGHTOWER, WALTER, W
5. PATIENT'S ADDRESS (No., Street): 61 WATER TOWER STREET	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street):
CITY: ANYWHERE STATE: NY	8. RESERVED FOR NUCC USE		CITY: STATE:
ZIP CODE: 12345-1234 TELEPHONE (Include Area Code): ( )			ZIP CODE: TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER: NPW
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]		a. INSURED'S DATE OF BIRTH MM DD YY: 04 09 1951 SEX M [X] F [ ]
b. RESERVED FOR NUCC USE:	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):		b. OTHER CLAIM ID (Designated by NUCC):
c. RESERVED FOR NUCC USE:	c. OTHER ACCIDENT? YES [ ] NO [X]		c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. CLAIM CODES (Designated by NUCC):		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: SIGNATURE ON FILE DATE:			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: SIGNATURE ON FILE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 15 YYYY QUAL: 431	15. OTHER DATE QUAL: MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN IM GOODDOC MD	17a. 17b. NPI: 5678901234		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: 01 10 YYYY TO: 01 10 YYYY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES:
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.: 0 A. I25810 B. C. D. E. F. G. H. I. J. K. L.			22. RESUBMISSION CODE: ORIGINAL REF. NO.: 23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 10 YYYY		22		93458	26	A	2000 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
117654312 [ ] [X]	1-1	[X] YES [ ] NO	$ 2000 00	$	

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 #
IRMINA BRILL MD MMDDYYYY SIGNED DATE	GOODMEDICINE HOSPITAL 1 PROVIDER STREET ANYWHERE NY 12345-2345 a. 1123456789 b.	IRMINA BRILL MD 25 MEDICAL DRIVE INJURY NY 12347-2347 (101) 2013145 a. 2345678901 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov; claim data created by author.

Case 1-2: Ima Gayle

HEALTH INSURANCE CLAIM FORM

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

PICA

CONNECTICUT GENERAL
PO BOX 1234

HEALTH CA 01234-1234

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): **210010121**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **GAYLE, IMA**

3. PATIENT'S BIRTH DATE: **09 30 1945** SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): **GAYLE, IMA**

5. PATIENT'S ADDRESS (No., Street): **101 HAPPY DRIVE**

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

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

CITY: **ANYWHERE** STATE: **NY**

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: **12345-1234** TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: **101**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO

a. INSURED'S DATE OF BIRTH: **09 30 1945** SEX: M ☐ F ☒

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: **CONNECTICUT GENERAL**

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED **SIGNATURE ON FILE** DATE

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

SIGNED **SIGNATURE ON FILE**

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): **03 01 YYYY** QUAL. **431**

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. **0**

A. **R200** B. **M1712** C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 01 YYYY		11		99213	25	A	60 00	1		NPI	
2 03 01 YYYY		11		20552		A	75 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: **111397992** SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: **1-2**

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

28. TOTAL CHARGE: $ **135 00**

29. AMOUNT PAID: $ **50 00**

30. Rsvd for NUCC Use

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

SEJAL RAJA MD SIGNED **MMDDYYYY** DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (**101**) **2022923**

SEJAL RAJA MD
1 MEDICAL DRIVE
INJURY NY 12347-2347

a. **7890123456** b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov; claim data created by author.

Case 1-3: Sandy Spencer

AFLAC
PO BOX 33
ASHBURY TN 23456-0033

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLKLUNG [ ] (ID#) OTHER [X] (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): **5623569**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **SPENCER, SANDY**	3. PATIENT'S BIRTH DATE MM DD YY: **08 05 1985** SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): **SPENCER, SANDY**
5. PATIENT'S ADDRESS (No., Street): **101 HIGH STREET**	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street):
CITY: **ANYWHERE** STATE: **NY**	8. RESERVED FOR NUCC USE	CITY: STATE:
ZIP CODE: **12345-1234** TELEPHONE (Include Area Code): ( )		ZIP CODE: TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY: **08 05 1985** SEX M [ ] F [X]
b. RESERVED FOR NUCC USE:	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):	b. OTHER CLAIM ID (Designated by NUCC):
c. RESERVED FOR NUCC USE:	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: **AFLAC**
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. CLAIM CODES (Designated by NUCC):	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: **SIGNATURE ON FILE** DATE:		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: **SIGNATURE ON FILE**

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: **10 15 YYYY** QUAL.: **431**	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.: **0** A. **I10** B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	**10 15 YYYY**	**11**		**99214**		**A**	**100 00**	**1**		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: **117654312** SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: **1-3**	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ **100 00**	29. AMOUNT PAID: $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: **IRMINA BRILL MD** DATE: **MMDDYYYY**	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH #: **(101) 2013145** **IRMINA BRILL MD** **25 MEDICAL DRIVE** **INJURY NY 12347-2347** a. **2345678901** b.	

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE*

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov; claim data created by author.

Instructor Manual

Green, Understanding Health Insurance, 2021, ISBN 9780357515587; Chapter 1: Health Insurance Specialist Career

Table of Contents

Purpose and Perspective of the Chapter

This chapter presents an overview of the health insurance specialist career, background necessary for education and training, responsibilities the student can expect to perform on the job, and professional credentialing opportunities.

Cengage Supplements

The following product-level supplements provide additional information that may help you in preparing your course. They are available in the Instructor Resource Center.

- AHIMA Associate Degree Competency Mapping
- AHIMA Baccalaureate Degree Competency Mapping
- CAAHEP (MAERB) Curriculum Mapping
- ABHES Curriculum Mapping
- Educator's Guide
- Guide to Teaching Online
- Instructor Guide to Creating and Managing CNOW Assignments in MindTap
- Comprehensive Cognero Instructor Guide

Chapter Objectives

Upon successful completion of this chapter, you should be able to:

01.01 Define key terms related to the health insurance specialist career.

01.02 Briefly summarize health insurance claims processing and the parties involved.

01.03 Identify career opportunities available for health insurance specialists.

01.04 List the education and training requirements of a health insurance specialist.

01.05 Describe the job responsibilities of a health insurance specialist.

01.06 Differentiate among types of insurance purchased by contractors and employers.

01.07 Explain the role of workplace professionalism for a health insurance specialist.

01.08 Identify coding and reimbursement professional associations and credentials offered.

Complete List of Chapter Activities and Assessments

For additional guidance refer to the Teaching Online Guide.

Activity/Assessment
Chapter 1 Review
MindTap: Learning Lab: Health Insurance Specialist
MindTap: Writing Assignment: The Importance of Accuracy
MindTap: Quiz
Workbook: Assignment 1.1—Interview a Professional
Workbook: Assignment 1.2—Ready, Set, Get a Job!
Workbook: Assignment 1.3—Journal Abstract
Workbook: Assignment 1.4—Professional Discussion Forums (Listservs)
Workbook: Assignment 1.5—Learning About Professional Credentials
Workbook: Assignment 1.6—Professionalism
Workbook: Assignment 1.7—Telephone Messages
Workbook: Assignment 1.8—Multiple Choice Review
Instructor Manual: Discussion Question: Certification

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Key Terms

AAPC: professional association, previously known as the American Academy of Professional Coders, established to provide a national certification and credentialing process, to support the national and local membership by providing educational products and opportunities to networks, and to increase and promote national recognition and awareness of professional coding.

American Association of Medical Assistants (AAMA): enables medical assisting professionals to enhance and demonstrate the knowledge, skills, and professionalism required by employers and patients; as well as protect medical assistants' right to practice.

American Health Information Management Association (AHIMA): founded in 1928 to improve the quality of medical records, and currently advances the health information management (HIM) profession toward an electronic and global environment, including implementation of ICD-10-CM and ICD-10-PCS in 2013.

bonding insurance: an insurance agreement that guarantees repayment for financial losses resulting from the act or failure to act of an employee. It protects the financial operations of the employer.

business liability insurance: protects business assets and covers the cost of lawsuits resulting from bodily injury, personal injury, and false advertising.

Centers for Medicare and Medicaid Services (CMS): formerly known as the Health Care Financing Administration (HCFA); an administrative agency within the federal Department of Health and Human Services (DHHS).

claims examiner: employed by third-party payers to review health-related claims to determine whether the charges are reasonable and medically necessary based on the patient's diagnosis.

coding: process of reporting diagnoses, procedures, and services as numeric and alphanumeric characters (called codes) on the insurance claim.

Current Procedural Terminology **(CPT)**: published by the American Medical Association; includes five-digit numeric codes and descriptors for procedures and services performed by providers (e.g., 99203 identifies a detailed office visit for a new patient).

embezzle: the illegal transfer of money or property as a fraudulent action; to steal money from an employer.

errors and omissions insurance: *see* professional liability insurance.

ethics: principle of right or good conduct; rules that govern the conduct of members of a profession.

explanation of benefits (EOB): report that details the results of processing a claim (e.g., payer reimburses provider $80 on a submitted charge of $100).

HCPCS level II codes: national codes published by CMS, which include five-digit alphanumeric codes for procedures, services, and supplies not classified in CPT.

health care provider: physician or other health care practitioner (e.g., physician's assistant).

health information technician: professionals who manage patient health information and medical records, administer computer information systems, and code diagnoses and procedures for health care services provided to patients.

health insurance claim: documentation submitted to an insurance plan requesting reimbursement for health care services provided (e.g., CMS-1500 and UB-04 claims).

health insurance specialist: person who reviews health-related claims to match medical necessity to procedures or services performed before payment (reimbursement) is made to the provider; *see also* reimbursement specialist.

Healthcare Common Procedure Coding System (HCPCS): coding system that consists of CPT, national codes (level II), and local codes (level III); local codes were discontinued in 2003; previously known as HCFA Common Procedure Coding System.

hold harmless clause: policy that the patient is not responsible for paying what the insurance plan denies.

independent contractor: defined by the *'Lectric Law Library's Lexicon* as "a person who performs services for another under an express or implied agreement and who is not subject to the other's control, or right to control, of the manner and means of performing the services. The organization that hires an independent contractor is not liable for the acts or omissions of the independent contractor."

International Classification of Diseases, 10th Revision, Clinical Modification **(ICD-10-CM)**: coding system implemented on October 1, 2015, and used to report diseases, injuries, and other reasons for inpatient and outpatient encounters.

International Classification of Diseases, 10th Revision, Procedural Coding System **(ICD-10-PCS)**: coding system to be implemented on October 1, 2015, and used to report procedures and services on inpatient claims.

internship: nonpaid professional practice experience that benefits students and facilities that accept students for placement; students receive on-the-job experience prior to graduation, and the internship assists them in obtaining permanent employment.

medical assistant: employed by a provider to perform administrative and clinical tasks that keep the office or clinic running smoothly.

medical malpractice insurance: a type of liability insurance that covers physicians and other health care professionals for liability claims arising from patient treatment.

medical necessity: involves linking every procedure or service code reported on an insurance claim to a condition code (e.g., disease, injury, sign, symptom, other reason for encounter) that justifies the need to perform that procedure or service.

national codes: commonly referred to as HCPCS level II codes; include five-digit alphanumeric codes for procedures, services, and supplies that are not classified in CPT (e.g., J-codes are used to assign drugs administered).

professional liability insurance: provides protection from liability as a result of errors and omissions when performing their professional services; also called *errors and omissions insurance*.

professionalism: conduct or qualities that characterize a professional person.

property insurance: protects business contents (e.g., buildings and equipment) against fire, theft, and other risks.

reimbursement specialist: *see* health insurance specialist.

remittance advice (remit): electronic or paper-based report of payment sent by the payer to the provider; includes patient name, patient health insurance claim (HIC) number, facility

provider number/name, dates of service (from date/thru date), type of bill (TOB), charges, payment information, and reason and/or remark codes.

respondeat superior: Latin for "let the master answer"; legal doctrine holding that the employer is liable for the actions and omissions of employees performed and committed within the scope of their employment.

scope of practice: health care services, determined by the state, that an NP and PA can perform.

workers' compensation insurance: insurance program, mandated by federal and state governments, that requires employers to cover medical expenses and loss of wages for workers who are injured on the job or who have developed job-related disorders.

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What's New in This Chapter

The following elements are improvements in this chapter from the previous edition:

- Content about the National Healthcare Association (NHA) and its Certified Billing & Coding Specialist (CBCS) certification was added.

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Chapter Outline

I. Health Insurance Overview
II. Career Opportunities
III. Education and Training
IV. Job Responsibilities
V. Independent Contractor and Employer Liability
VI. Professionalism
VII. Professional Associations and Credentials

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Discussion Questions

You can assign these questions several ways: in a discussion forum in your LMS; as whole-class discussions in person; or as a partner or group activity in class.

1. **Discussion: Certification**: Research the different coding and reimbursement certifications that are available and choose one you would like to have. Discuss the following:
    - What are the requirements for sitting for the exam?
    - What expectations do you have about taking the exam?

- Why did you choose that coding certification over the others you researched?
- What is one thing you learned about the coding exam you chose that surprised you?
- Why is obtaining this coding certification a benefit when looking for employment?

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Additional Resources

Internet Resources

- **AAPC**: www.aapc.com
- **American Association of Medical Assistants (AAMA)**: www.aama-ntl.org
- **American Health Information Management Association (AHIMA)**: www.ahima.org
- **Ascend Learning's National Healthcareer Association (NHA)**: www.nhanow.com
- **Centers for Medicare and Medicaid Services (CMS)**: www.cms.gov
- **U.S. Department of Labor, Bureau of Labor Statistics (BLS)**: www.bls.gov

Cengage Audio Resources

- Chapter 1: Health Insurance Specialist Career Audio FAQ
  - What exactly is the hold harmless clause?
  - Do I really need to know anatomy and physiology and medical terminology just to process insurance claims?
  - How do I learn about new insurance rules and regulations?
  - Why is getting certified important?
  - How can I learn to code accurately?

List of Transcripts for Audio Assignments

- Chapter 1: Health Insurance Specialist Career Audio FAQ
  - Q: What exactly is the hold harmless clause?
    - A: The hold harmless clause is a legal phrase that you probably haven't heard before. It's included in the patient's insurance contract, but it really applies to the doctor. For example, some procedures have to be preauthorized by the insurance company so the doctor can be paid. If a procedure is not preauthorized and the doctor performs it anyway, the patient can't be charged. So, even though the insurance company won't reimburse the doctor, the patient doesn't have to pay either.

- Q: Do I really need to know anatomy and physiology and medical terminology just to process insurance claims?
  - A: To be really good at insurance claims processing, you're gonna need to know anatomy and physiology as well as medical terminology, but don't give up if you haven't taken these courses yet. I recommend that you get some good books on these topics. You can read along in these books as you learn claims processing. I suggest getting Delmar's *Medical Terminology for Health Professions*. I like this book because it teaches basic anatomy and physiology along with medical terminology.
- Q: How do I learn about new insurance rules and regulations?
  - A: Insurance companies and government programs publish rules and regulations about how insurance claims are to be processed and those rules and regulations are revised on a continuous basis. To stay up to date you'll need to subscribe to payer newsletters and bulletins. And it would also be a good idea to become familiar with websites that provide updates. Later in this course we'll visit those websites so you can see how easy it is to access them.
- Q: Why is getting certified important?
  - A: Passing a certification exam means that you can list a nationally recognized credential after your name. This has value for a number of reasons. For example, the credential indicates that you have mastered content in your field of specialization. It also demonstrates your commitment to professional growth and development because the sponsoring organization will require you to submit proof of continued education. You should also consider that a credential might be a condition of employment.
- Q: How can I learn to code accurately?
  - A: You have several options for coding education. One option is to take college courses, either on campus or through the Internet. Another option would be to attend workshops and seminars that teach basic, intermediate, and advanced coding. Or you could learn to code by taking an online course offered by a publisher. Regardless of how you learn, the way to improve your coding skills is to actually code and have someone check your work. That way, you will receive feedback about what you are doing right and where you need to improve.

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Appendix

Generic Rubrics

Providing students with rubrics helps them understand expectations and components of assignments. Rubrics help students become more aware of their learning process and progress, and they improve students' work through timely and detailed feedback.

Customize these rubric templates as you wish. The writing rubric indicates 40 points and the discussion rubric indicates 30 points.

Standard Writing Rubric

Criteria	Meets Requirements	Needs Improvement	Incomplete
Content	The assignment clearly and comprehensively addresses all questions in the assignment. 15 points	The assignment partially addresses some or all questions in the assignment. 8 points	The assignment does not address the questions in the assignment. 0 points
Organization and Clarity	The assignment presents ideas in a clear manner and with strong organizational structure. The assignment includes an appropriate introduction, content, and conclusion. Coverage of facts, arguments, and conclusions are logically related and consistent. 10 points	The assignment presents ideas in a mostly clear manner and with a mostly strong organizational structure. The assignment includes an appropriate introduction, content, and conclusion. Coverage of facts, arguments, and conclusions are mostly logically related and consistent. 7 points	The assignment does not present ideas in a clear manner and with strong organizational structure. The assignment includes an introduction, content, and conclusion, but coverage of facts, arguments, and conclusions are not logically related and consistent. 0 points
Research	The assignment is based upon appropriate and adequate academic literature, including peer reviewed journals and other scholarly work. 5 points	The assignment is based upon adequate academic literature but does not include peer reviewed journals and other scholarly work. 3 points	The assignment is not based upon appropriate and adequate academic literature and does not include peer reviewed journals and other scholarly work. 0 points
Research	The assignment follows the required citation guidelines. 5 points	The assignment follows some of the required citation guidelines. 3 points	The assignment does not follow the required citation guidelines. 0 points
Grammar and Spelling	The assignment has two or fewer grammatical and spelling errors. 5 points	The assignment has three to five grammatical and spelling errors. 3 points	The assignment is incomplete or unintelligible. 0 points

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Standard Discussion Rubric

Criteria	Meets Requirements	Needs Improvement	Incomplete
Participation	Submits or participates in discussion by the posted deadlines. Follows all assignment instructions for initial post and responses. 5 points	Does not participate or submit discussion by the posted deadlines. Does not follow instructions for initial post and responses. 3 points	Does not participate in discussion. 0 points
Contribution Quality	Comments stay on task. Comments add value to discussion topic. Comments motivate other students to respond. 20 points	Comments may not stay on task. Comments may not add value to discussion topic. Comments may not motivate other students to respond. 10 points	Does not participate in discussion. 0 points
Etiquette	Maintains appropriate language. Offers criticism in a constructive manner. Provides both positive and negative feedback. 5 points	Does not always maintain appropriate language. Offers criticism in an offensive manner. Provides only negative feedback. 3 points	Does not participate in discussion. 0 points

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Instructor Manual

Green, Understanding Health Insurance, 2021, ISBN 9780357515587; Chapter 2: Introduction to Health Insurance

Table of Contents

Purpose and Perspective of the Chapter

This chapter presents an overview of types of health insurance coverage. Insurance terms and concepts are also explained.

Cengage Supplements

The following product-level supplements provide additional information that may help you in preparing your course. They are available in the Instructor Resource Center.

- AHIMA Associate Degree Competency Mapping
- AHIMA Baccalaureate Degree Competency Mapping
- CAAHEP (MAERB) Curriculum Mapping
- ABHES Curriculum Mapping
- Educator's Guide
- Guide to Teaching Online
- Instructor Guide to Creating and Managing CNOW Assignments in MindTap
- Comprehensive Cognero Instructor Guide

List of Student Downloads

Students should download the following items from the Student Resource Center to complete the activities and assignments related to this chapter:

- Comprehensive History of Health Care Reimbursement

Chapter Objectives

Upon successful completion of this chapter, you should be able to:

02.01 Define key terms related to an introduction to health insurance.

02.02 Distinguish among introductory health insurance concepts.

02.03 Identify major developments in U.S. health insurance from 1850 to the present.

02.04 Describe health care documentation methods.

02.05 Discuss the impact of the electronic health record (EHR) on health care.

Complete List of Chapter Activities and Assessments

For additional guidance refer to the Teaching Online Guide.

Activity/Assessment
Chapter 2 Review
MindTap: MOSS 2.0 Training: Navigating Menu Systems
MindTap: MOSS 2.1 Training: Logging In, Changing Your Password, and Logging Out
MindTap: MOSS 2.2 Training: Using Meaningful Use Statistics
MindTap: Learning Lab: Introduction to Health Insurance
MindTap: Writing Assignment: Documentation and Reimbursement
MindTap: Quiz 2.1
MindTap: Quiz 2.2
MindTap: MOSS 2.1 Assessment: Logging In, Changing Your Password, and Logging Out
MindTap: MOSS 2.2 Assessment: Using Meaningful Use Statistics
Workbook: Assignment 2.1—Health Insurance Coverage Statistics
Workbook: Assignment 2.2—Major Developments in Health Insurance (Research Paper)
Workbook: Assignment 2.3—Calculating Reimbursement
Workbook: Assignment 2.4—Health Insurance Marketplace
Workbook: Assignment 2.5—Quality Payment Program—Merit-Based Incentive Payment System
Workbook: Assignment 2.6—Multiple Choice Review

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Key Terms

accountable care organization (ACO): groups of physicians, hospitals, and other health care providers, all of whom come together voluntarily to provide coordinated high-quality care to Medicare patients.

advanced alternative payment models (advanced APMs): include new ways for CMS to reimburse health care providers for care provided to Medicare beneficiaries; providers who participate in an Advanced APM through Medicare Part B may earn an incentive payment for participating in the innovative payment model.

alternative payment models (APMs): payment approach that includes incentive payments to provide high-quality and cost-efficient care; APMs can apply to a specific clinical condition, a care episode, or a population.

ambulatory payment classifications (APCs): prospective payment system used to calculate reimbursement for outpatient care according to similar clinical characteristics and in terms of resources required.

American Recovery and Reinvestment Act of 2009 (ARRA): authorized an expenditure of $1.5 billion for grants for construction, renovation, and equipment, and for the acquisition of health information technology systems.

Balanced Budget Act of 1997 (BBA): addresses health care fraud and abuse issues, and provides for Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) investigative and audit services in health care fraud cases.

benchmarking: practice that allows an entity to measure and compare its own data against that of other agencies and organizations for the purpose of continuous improvement (e.g., coding error rates).

CHAMPUS Reform Initiative (CRI): conducted in 1988; resulted in a new health program called TRICARE, which includes two options: TRICARE Prime and TRICARE Select (formerly called TRICARE Standard).

Children's Health Insurance Program (CHIP): provides health insurance coverage to uninsured children whose family income is up to 200 percent of the federal poverty level (monthly income limits for a family of four also apply).

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA): program that provides health benefits for dependents of veterans rated as 100 percent permanently and totally disabled as a result of service-connected conditions, veterans who died as a result of service-connected conditions, and veterans who died on duty with less than 30 days of active service.

Civilian Health and Medical Program—Uniformed Services (CHAMPUS): originally designed as a benefit for dependents of personnel serving in the armed forces and uniformed branches of the Public Health Service and the National Oceanic and Atmospheric Administration; now called TRICARE.

Clinical Laboratory Improvement Act (CLIA): established quality standards for all laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test was performed.

CMS-1500 claim: claim submitted for reimbursement of physician office procedures and services; electronic version is called ANSI ASC X12N 837P.

coinsurance: also called *coinsurance payment;* the percentage the patient pays for covered services after the deductible has been met and the copayment has been paid.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): allows employees to continue health care coverage beyond the benefit termination date.

consumer-driven health plans (CDHPs): health care plan that encourages individuals to locate the best health care at the lowest possible price, with the goal of holding down costs; also called *consumer-directed health plan*.

continuity of care: documenting patient care services so that others who treat the patient have a source of information on which to base additional care and treatment.

copayment (copay): provision in an insurance policy that requires the policyholder or patient to pay a specified dollar amount to a health care provider for each visit or medical service received.

deductible: amount for which the patient is financially responsible before an insurance policy provides coverage.

diagnosis-related groups (DRGs): prospective payment system that reimburses hospitals for inpatient stays.

eHealth exchange: health information exchange network for securely sharing clinical information over the Internet nationwide that spans all 50 states and is the largest health information exchange infrastructure in the United States; participants include large provider networks, hospitals, pharmacies, regional health information exchanges, and many federal agencies.

electronic clinical quality measures (eCQMs): processes, observations, treatments, and outcomes that quantify the quality of care provided by health care systems; measuring such data helps ensure that care is delivered safely, effectively, equitably, and timely.

electronic health record (EHR): global concept that includes the collection of patient information documented by a number of providers at different facilities regarding one patient.

electronic medical record (EMR): considered part of the electronic health record (EHR), the EMR is created using vendor software, which assists in provider decision making.

Electronic Submission of Medical Documentation System (esMD): implemented to reduce provider and reviewer costs and cycle time by minimizing and eventually eliminating paper processing and mailing of medical documentation.

Employee Retirement Income Security Act of 1974 (ERISA): mandated reporting and disclosure requirements for group life and health plans (including managed care plans), permitted large employers to self-insure employee health care benefits, and exempted large employers from taxes on health insurance premiums.

Evaluation and Management (E/M): services that describe patient encounters with providers for evaluation and management of general health status.

Federal Employees' Compensation Act (FECA): provides civilian employees of the federal government with medical care, survivors' benefits, and compensation for lost wages.

Federal Employers' Liability Act (FELA): legislation passed in 1908 by President Theodore Roosevelt that protects and compensates railroad workers who are injured on the job.

fee schedule: list of predetermined payments for health care services provided to patients (e.g., a fee is assigned to each CPT code).

Financial Services Modernization Act (FSMA): prohibits sharing of medical information among health insurers and other financial institutions for use in making credit decisions; also allows banks to merge with investment and insurance houses, which allows them to make a profit no matter what the status of the economy, because people usually house their money in one of the options; also called *Gramm-Leach-Bliley Act.*

Gramm-Leach-Bliley Act: *see* Financial Services Modernization Act.

group health insurance: traditional health care coverage subsidized by employers and other organizations (e.g., labor unions, rural and consumer health cooperatives) whereby part or all of premium costs are paid for and/or discounted group rates are offered to eligible individuals.

health care: expands the definition of medical care to include preventive services.

Health Care and Education Reconciliation Act (HCERA): includes health care reform initiatives that amend the Patient Protection and Affordable Care Act to increase tax credits to buy health care insurance, eliminate special deals provided to senators, close the Medicare "donut hole," delay taxing of "Cadillachealth care plans" until 2018, and so on.

Health Information Technology for Economic and Clinical Health Act (HITECH Act): included in the American Recovery and Reinvestment Act of 2009 and amended the Public Health Service Act to establish an Office of National Coordinator for Health Information Technology within HHS to improve health care quality, safety, and efficiency.

health insurance: contract between a policyholder and a third-party payer or government program to reimburse the policyholder for all or a portion of the cost of medically necessary treatment or preventive care by health care professionals.

health insurance exchange: *see* health insurance marketplace.

health insurance marketplace: method Americans use to purchase health coverage that fits their budget and meet their needs, effective October 1, 2013.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): mandates regulations that govern privacy, security, and electronic transactions standards for health care information.

Hill-Burton Act: provided federal grants for modernizing hospitals that had become obsolete because of a lack of capital investment during the Great Depression and WWII (1929–1945). In return for federal funds, facilities were required to provide services free, or at reduced rates, to patients unable to pay for care.

Home Health Prospective Payment System (HH PPS): reimbursement methodology for home health agencies that uses a classification system called home health patient-driven groupings model (PDGM), which establishes a predetermined rate for health care services provided to patients for each 60-day episode of home health care.

individual health insurance: private health insurance policy purchased by individuals or families who do not have access to group health insurance coverage; applicants can be denied coverage, and they can also be required to pay higher premiums due to age, gender, and/or pre-existing medical conditions.

Inpatient Psychiatric Facility Prospective Payment System (IPF PPS): system in which Medicare reimburses inpatient psychiatric facilities according to a patient classification system that reflects differences in patient resource use and costs; it replaces the cost-based payment system with a *per diem* IPF PPS.

Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS): implemented as a result of the BBA of 1997; utilizes information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs.

International Classification of Diseases (ICD): classification system used to collect data for statistical purposes.

Investing in Innovations (i2) Initiative: designed to spur innovations in health information technology (health IT) by promoting research and development to enhance competitiveness in the United States.

lifetime maximum amount: maximum benefit payable to a health plan participant.

major medical insurance: coverage for catastrophic or prolonged illnesses and injuries.

meaningful EHR user: providers who demonstrate that certified EHR technology is used for electronic prescribing, electronic exchange of health information in accordance with law and HIT standards, and submission of information on clinical quality measures; and hospitals that demonstrate that certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve quality of care and that the technology is used to submit information on clinical quality measures.

meaningful use: objectives and measures that achieved goals of improved patient care outcomes and delivery through data capture and sharing, advance clinical processes, and improved patient outcomes; replaced by *quality payment program (QPM)*.

Medicaid: cost-sharing program between the federal and state governments to provide health care services to low-income Americans; originally administered by the Social and Rehabilitation Service (SRS).

medical care: includes the identification of disease and the provision of care and treatment as provided by members of the health care team to persons who are sick, injured, or concerned about their health status.

medical record: *see* patient record.

Medicare: reimburses health care services to Americans over the age of 65.

Medicare Access and CHIP Reauthorization Act (MACRA): ended the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services, the *Merit-Based Incentive Payment System (MIPS)*, and *required* CMS to remove Social Security Numbers (SSNs) from all Medicare cards, replacing them with new randomly generated *Medicare beneficiary identifiers (MBIs)* that will be appear on new Medicare cards.

Medicare beneficiary identifier (MBI): replaces SSN as health insurance claim number on new Medicare cards for transactions such as billing, eligibility status, and claim status.

Medicare Catastrophic Coverage Act: mandated the reporting of ICD-9-CM diagnosis codes on Medicare claims; in subsequent years, private third-party payers adopted similar requirements for claims submission. Effective October 1, 2015, ICD-10-CM (diagnosis) codes are reported.

Medicare contracting reform (MCR) initiative: established to integrate the administration of Medicare Parts A and B fee-for-service benefits with new entities called Medicare administrative contractors (MACs); MACs replaced Medicare carriers, DMERCs, and fiscal intermediaries.

Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act of 2000 (BIPA): requires implementation of a $400 billion prescription drug benefit, improved Medicare Advantage (formerly called Medicare+Choice) benefits, faster Medicare appeals decisions, and more.

Medicare Outpatient Observation Notice (MOON): standardized notice provided to Medicare beneficiaries that they are outpatients receiving observation services and are not inpatients of a hospital or a critical access hospital (CAH).

Medicare Prescription Drug, Improvement, and Modernization Act (MMA): adds new prescription drug and preventive benefits and provides extra assistance to people with low incomes.

Merit-Based Incentive Payment System (MIPS): eliminated PQRS, value-based payment modifier, and the Medicare EHR incentive program, creating a single program based on quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology.

Minimum Data Set (MDS): data elements collected by long-term care facilities.

National Correct Coding Initiative (NCCI): developed by CMS to promote national correct coding methodologies and to eliminate improper coding practices.

Obamacare: nickname for the *Patient Protection and Affordable Care Act (PPACA)*, which was signed into federal law by President Obama on March 23, 2010, and created the Health Care Marketplace.

Omnibus Budget Reconciliation Act of 1981 (OBRA): federal law that requires providers to keep copies of any government insurance claims and copies of all attachments filed by the provider for a period of five years; also expanded Medicare and Medicaid programs.

Outcomes and Assessment Information Set (OASIS): group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.

Outpatient Prospective Payment System (OPPS): uses ambulatory payment classifications (APCs) to calculate reimbursement; was implemented for billing of hospital-based Medicare outpatient claims.

Patient Protection and Affordable Care Act (PPACA): focuses on private health insurance reform to provide better coverage for individuals with pre-existing conditions, improve prescription drug coverage under Medicare, extend the life of the Medicare Trust fund by at least 12 years, and create the health insurance marketplace.

patient record: documents health care services provided to a patient.

payer mix: different types of health insurance payments made to providers for patient services.

per diem: Latin term meaning "for each day," which is how retrospective cost-based rates were determined; payments were issued based on daily rates.

personal health record (PHR): web-based application that allows individuals to maintain and manage their health information (and that of others for whom they are authorized, such as family members) in a private, secure, and confidential environment.

policyholder: a person who signs a contract with a health insurance company and who, thus, owns the health insurance policy; the policyholder is the insured (or enrollee), and the policy might include coverage for dependents.

preventive services: designed to help individuals avoid problems with health and injuries.

problem-oriented record (POR): a systematic method of documentation that consists of four components: database, problem list, initial plan, and progress notes.

Promoting Interoperability (PI) Programs: focus on improving patient access to health information and reducing the time and cost required of providers to comply with the programs' requirements; previously called EHR incentive programs.

prospective payment system (PPS): issues predetermined payment for services, such as bundled payments, capitation, case rates, and global payments.

Protecting Access to Medicare Act (PAMA): implemented skilled nursing facility (SNF) value-based purchasing (VBP) program.

public health insurance: federal and state government health programs (e.g., Medicare, Medicaid, CHIP, TRICARE) available to eligible individuals.

quality improvement organization (QIO): performs utilization and quality control review of health care furnished, or to be furnished, to Medicare beneficiaries.

quality payment program (QPP): helps providers focus on quality of patient care and making patients healthier; includes advanced alternative payment models (Advanced APMs) and merit-based incentive payment system (MIPS); replaced the EHR Incentive Program (or Meaningful Use), Physician Quality Reporting System, and Value-Based Payment Modifier program.

record linkage: allows patient information to be created at different locations according to a unique patient identifier or identification number.

Resource-Based Relative Value Scale (RBRVS) system: payment system that reimburses physicians' practice expenses based on relative values for three components of each physician's services: physician work, practice expense, and malpractice insurance expense.

rural health information organization (RHIO): type of health information exchange organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

self-insured (or self-funded) employer-sponsored group health plans: allows a large employer to assume the financial risk for providing health care benefits to employees; employer does not pay a fixed premium to a health insurance payer, but establishes a trust fund (of employer and employee contributions) out of which claims are paid.

single-payer system: centralized health care plan adopted by some Western nations (e.g., Canada, Great Britain) and funded by taxes. The government pays for each resident's health care, which is considered a basic social service.

Skilled Nursing Facility Prospective Payment System (SNF PPS): implemented (as a result of the BBA of 1997) to cover all costs (routine, ancillary, and capital) related to services furnished to Medicare Part A beneficiaries.

socialized medicine: type of single-payer system in which the government owns and operates health care facilities and providers (e.g., physicians) receive salaries; the VA health care program is a form of socialized medicine.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA): created Medicare risk programs, which allowed federally qualified HMOs and competitive medical plans that met specified Medicare requirements to provide Medicare-covered services under a risk contract.

third-party administrators (TPAs): company that provides health benefits claims administration and other outsourcing services (e.g., employee benefits management) for self-insured companies; provides administrative services to health care plans; specializes in mental health case management; and processes claims, serving as a system of "checks and balances" for labor management.

third-party payer: a health insurance company that provides coverage, such as BlueCross BlueShield.

total practice management software (TPMS): used to generate the EMR, automating medical practice functions of registering patients, scheduling appointments, generating insurance claims and patient statements, processing payments from patient and third-party payers, and producing administrative and clinical reports.

universal health insurance: goal of providing every individual with access to health coverage, regardless of the system implemented to achieve that goal.

usual and reasonable payments: based on fees typically charged by providers in a particular region of the country.

World Health Organization (WHO): developed the International Classification of Diseases (ICD).

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What's New in This Chapter

The following elements are improvements in this chapter from the previous edition:

- Content about Clinical Quality Language (CQL) was added.

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Chapter Outline

I. Introduction to Health Insurance
II. Major Developments in Health Insurance
III. Health Care Documentation
IV. Electronic Health Record

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Additional Resources

Internet Resources

- **Consolidated Omnibus Budget Reconciliation Act (COBRA)**: www.cobrainsurance.com
- **eCQI Resource Center**: ecqi.healthit.gov
- **Healthcare Insurance Marketplace**: www.healthcare.gov
- **Rochester Regional Health Information Organization (RHIO)**: www.rochesterrhio.org

Cengage Audio Resources

- Chapter 2: Introduction to Health Insurance Audio FAQ
  - What exactly is the difference between coinsurance and a copay?
  - How do providers handle patients who have no health insurance or Medicare and Medicaid coverage?

List of Transcripts for Audio Assignments

- Chapter 2: Introduction to Health Insurance Audio FAQ
  - Q: What exactly is the difference between coinsurance and a copay?
    - A: Coinsurance is the percentage the patient pays on a claim. For example, most insurance companies require the patients to pay 20 percent of outpatient care. A copayment is the amount of money the patient pays for each service or procedure provided. For example, a patient may be required to pay the provider 10 dollars for each office visit. You might wonder if a patient would ever have to pay both the coinsurance and copay amounts at the same time. This is unlikely because once the copayment is met, or paid, the insurance company pays for the remaining charges. So, there is nothing on which to base the coinsurance.
  - Q: How do providers handle patients who have no health insurance or Medicare and Medicaid coverage?
    - A: Patients who are not covered by health care insurance or government health care programs are classified as “self-pay.” This means that the patient pays cash for office visits and health care provided. Some offices require these patients to pay at the time of an office visit. Others will just bill the patient.

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Appendix

Generic Rubrics

Providing students with rubrics helps them understand expectations and components of assignments. Rubrics help students become more aware of their learning process and progress, and they improve students' work through timely and detailed feedback.

Customize these rubric templates as you wish. The writing rubric indicates 40 points and the discussion rubric indicates 30 points.

Standard Writing Rubric

Criteria	Meets Requirements	Needs Improvement	Incomplete
Content	The assignment clearly and comprehensively addresses all questions in the assignment. 15 points	The assignment partially addresses some or all questions in the assignment. 8 points	The assignment does not address the questions in the assignment. 0 points
Organization and Clarity	The assignment presents ideas in a clear manner and with strong organizational structure. The assignment includes an appropriate introduction, content, and conclusion. Coverage of facts, arguments, and conclusions are logically related and consistent. 10 points	The assignment presents ideas in a mostly clear manner and with a mostly strong organizational structure. The assignment includes an appropriate introduction, content, and conclusion. Coverage of facts, arguments, and conclusions are mostly logically related and consistent. 7 points	The assignment does not present ideas in a clear manner and with strong organizational structure. The assignment includes an introduction, content, and conclusion, but coverage of facts, arguments, and conclusions are not logically related and consistent. 0 points
Research	The assignment is based upon appropriate and adequate academic literature, including peer reviewed journals and other scholarly work. 5 points	The assignment is based upon adequate academic literature but does not include peer reviewed journals and other scholarly work. 3 points	The assignment is not based upon appropriate and adequate academic literature and does not include peer reviewed journals and other scholarly work. 0 points
Research	The assignment follows the required citation guidelines. 5 points	The assignment follows some of the required citation guidelines. 3 points	The assignment does not follow the required citation guidelines. 0 points
Grammar and Spelling	The assignment has two or fewer grammatical and spelling errors. 5 points	The assignment has three to five grammatical and spelling errors. 3 points	The assignment is incomplete or unintelligible. 0 points

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Standard Discussion Rubric

Criteria	Meets Requirements	Needs Improvement	Incomplete
Participation	Submits or participates in discussion by the posted deadlines. Follows all assignment instructions for initial post and responses. 5 points	Does not participate or submit discussion by the posted deadlines. Does not follow instructions for initial post and responses. 3 points	Does not participate in discussion. 0 points
Contribution Quality	Comments stay on task. Comments add value to discussion topic. Comments motivate other students to respond. 20 points	Comments may not stay on task. Comments may not add value to discussion topic. Comments may not motivate other students to respond. 10 points	Does not participate in discussion. 0 points
Etiquette	Maintains appropriate language. Offers criticism in a constructive manner. Provides both positive and negative feedback. 5 points	Does not always maintain appropriate language. Offers criticism in an offensive manner. Provides only negative feedback. 3 points	Does not participate in discussion. 0 points

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