Lesson 1

The World of Health Care

Step 1 Learning Objectives for Lesson 1

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
  - ➤ Describe medical personnel and their role in quality health care.
  - ➤ Describe an average day of a medical coding and billing specialist.
  - ➤ Discuss the responsibilities of the medical coding and billing specialist.
  - ➤ Describe the job opportunities available in your new career.
  - ➤ Describe the personal qualities of this healthcare position.
  - ➤ Describe the desirable character traits of a medical coding and billing specialist.

Step 2 Lesson Preview

- ❑ Medical coding and billing is an exciting and expanding medical profession. You will work with people who save lives! Currently, employment opportunities in the medical coding and billing field are increasing throughout the country. This course will give you the knowledge you need to find the job you want. At U.S. Career Institute, we will continue to help you after you graduate. We offer graduate assistance to every student who completes our courses. We will counsel you on marketing yourself, as well as preparing yourself for your new career.

  We know you are ready to learn, and be assured that we are ready to teach you. From the very first page until you have completed the course and are working in the field, U.S. Career Institute is dedicated to your success. Your course is divided into lessons. Each lesson contains skills that you will master on your way to graduation. The lessons are easy-to-follow and offer step-by-step instruction to make learning simple—even fun!

We know you are ready to learn, and we are ready to teach you.

You will always begin with Learning Objectives and a Lesson Preview. From there, you will read new material and then take a Practice Exercise, which is a self-graded review with answers at the back of each course. This combination of new material followed by a review may repeat two or more times per lesson. This format helps you apply what you learn and retain the information.

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

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

In this first lesson, you'll study the key players in the healthcare field. You'll look at a typical day in the life of a coding and billing specialist, and will learn the responsibilities of this position. Then, you'll explore the types of job opportunities in your new career. Finally, you will look at the personal qualities and character traits of a successful coding and billing specialist.

Step 3 Teamwork in the Healthcare Profession

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

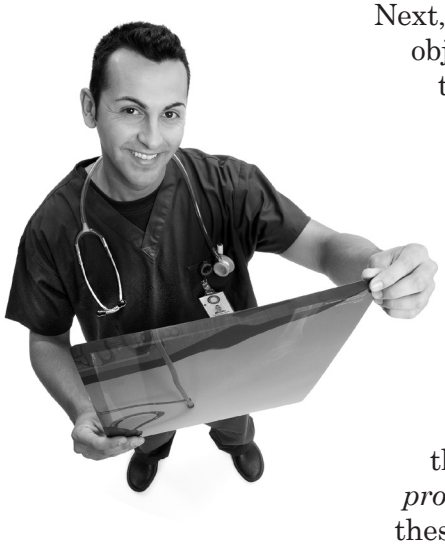
Success comes from a team of people working together to accomplish goals.

Physicians

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

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

Dr. Green is a physician that works at Weston Medical Clinic. He sees his first patient, Hannah, at 8:00 a.m. He examines Hannah, a woman in her mid-30s, complaining of pain to her right arm. A concise statement that describes why a patient is seeking treatment is called the **chief complaint**. Dr. Green documents the patient's description of the development of the condition. Then, Dr. Green asks a series of questions to identify signs and symptoms that Hannah may be experiencing.



The physician's opinion about what is wrong with the patient or what is causing the patient's complaint is the diagnosis.

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

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

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

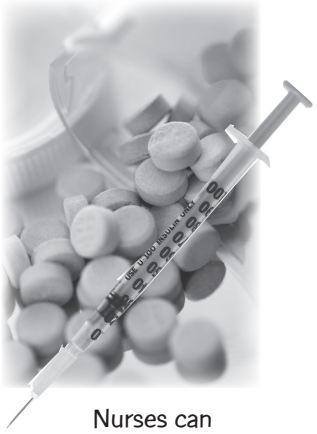
After Dr. Green dismisses the patient, he records some notes about the encounter. The office's *medical transcriptionist* will use this dictation to transcribe the encounter into a formatted medical report. Dr. Green also makes some notes on the patient's history or chart. Now he is ready to see his second patient.

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

Nurses

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

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



Nurses can give injections.

Nurse's and Physician Assistants

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

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

Emergency Personnel

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

When someone is hurt and needs an ambulance, emergency personnel will respond.

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

Support Staff

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

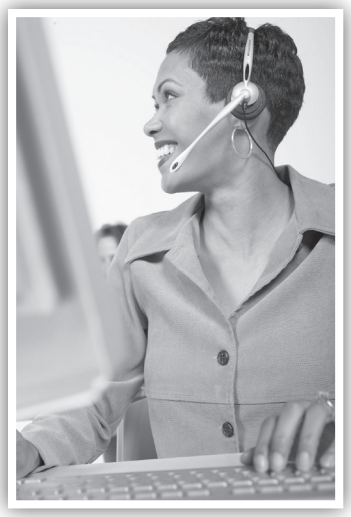
Office Professionals

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

Medical Transcriptionists

Do you remember when the doctor in our previous example recorded some notes about a patient encounter? Well, that dictation went to a **medical transcriptionist** who listened to the doctor's dictation and typed what she heard. This then was added to the patient's medical record. By using transcriptionists, doctors save time by speaking their notes.

While you don't need to know every aspect of medical transcription, you should be aware as to what transcribed reports look like. You often will work from these transcribed reports to determine the accurate code for a service. Two examples of transcribed reports follow: one for Laura Brown and one for Johnny Cruz. Study these reports so that you have a better understanding of a transcriptionist's role in the medical records process.



A medical transcriptionist listens to the doctor's dictation and types what she hears.

Transcribed Report Example One

Name: Laura Brown
#030311

PROBLEM
Upset stomach with vomiting and fever.

SUBJECTIVE
The patient is a 22-year-old female. She went to breakfast with her friends earlier this morning. She ordered a cream-filled pastry with her coffee. She stated that no one else had a pastry. About 4 hours later, she started having an abrupt onset of nausea, vomiting, abdominal cramps, diarrhea, headache and a slightly elevated fever. Since she had the symptoms for over 3 hours, she called her family physician and was able to see him this afternoon.

OBJECTIVE
Physical examination reveals a well-developed, well-nourished female in acute distress. Blood pressure: 125/85. Temperature: 99.6 ºF. Pulse: 88. Respirations: 24. Chest is clear. Cardiovascular examination: Regular rate and rhythm. Abdomen: Positive bowel sounds. Diffuse tenderness with slight pain. Laboratory results indicated a slightly elevated white blood cell count. Abdominal x-ray: Normal.

ASSESSMENT
Staphylococcus toxin gastroenteritis.

PLAN
The patient was sent home and told to get plenty of bed rest and begin clear fluids when nausea and vomiting cease. If the symptoms continue for more than 3 more hours, she should contact the office.

_____
Robert Snow, MD

D: 02-08-20XX
T: 02-08-20XX
RS:CJL

Transcribed Report Example Two

Name: Johnny Cruz
#249315

PROBLEM
Sore throat with fever.

SUBJECTIVE
Johnny, a 5 year old, presents to his pediatrician with a sore throat, fever, loss of appetite and a headache. His mother said that he has been on the couch all morning and refuses to eat or play.

OBJECTIVE
After examining the patient, the doctor reports enlargement of the lymphatic glands and a temperature of 103 ºF. The oral exam reveals a swollen, bright-red throat. A throat culture is positive for strep throat.

ASSESSMENT
Acute follicular pharyngitis (streptococcal sore throat).

PLAN
Take erythromycin as directed. Temperature to be taken frequently. Children's Tylenol every 4-6 hours as needed for fever. Encourage bed rest, modify activities, and increase fluid intake. All citrus juices should be avoided until symptoms subside. Call office if symptoms persist.

_____
Marikit Makabuhay, MD

D: 09-15-20XX
T: 09-15-20XX
MM:BDD

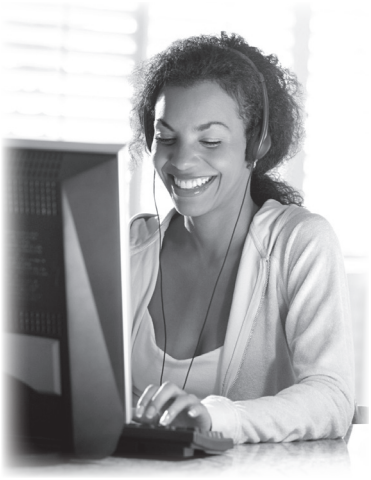
Medical Coding and Billing Specialists

Medical coding is the "translation" of narrative descriptions of diseases, injuries, procedures and services into numeric and/or alphanumeric terms. Codes are determined by the information obtained from a patient's visit to a medical facility. The medical record is reviewed for the diagnosis and treatment, and then coded. To code, you will look up the information in a reference book and find the right set of numeric and alphanumeric codes that describes exactly what happened. Once the accurate codes have been determined, the codes are transferred to forms that are submitted to insurance companies for reimbursement to the provider for his services. The doctor doesn't get paid unless the form is completed and filed correctly. **Medical billing** involves working with medical bills to help doctors and other healthcare providers get paid for their services. If the patient's insurance forms aren't completed correctly, then the healthcare providers cannot collect payments from insurance companies.

Now that you know the job duties of many of those in the healthcare world, let's talk about the role that you, the medical coding and billing specialist, will play in the healthcare profession.

Step 4 Daily Routine

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



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

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

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

Finally, Joann is ready to work on coding the services received during yesterday's clinic activity. At Weston Medical, the coding and billing specialist is one day behind the reception area. For instance, the medical coding and billing specialist works on Tuesday's bills on Wednesday, Wednesday's bills on Thursday and so on.

Joann spends most of the remainder of the day reading the dictation to assign the correct diagnoses and treatments. You will learn how to determine the correct diagnosis and procedure codes later in this course.

Joann also checks the patient information to make sure that the patient included all necessary information, including the name, address, insurance company and policy number. After making sure all the information is correct, she transfers the information to an insurance claim form, most commonly a CMS-1500. You will learn how to fill out this form later in the course.

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

You have an idea of what a medical coding and billing specialist does every day. Now let's review some general responsibilities.

 Step 5 Responsibilities

- As a medical coding and billing specialist, you have four basic responsibilities:

1. **Gather Information.**

   As a medical coding and billing specialist, you will gather all pertinent information. Usually, this means reading the dictation to determine the diagnoses and procedures. Then, you'll use reference manuals to translate this information into codes.

2. **Complete and Submit the Insurance Claim Form.**

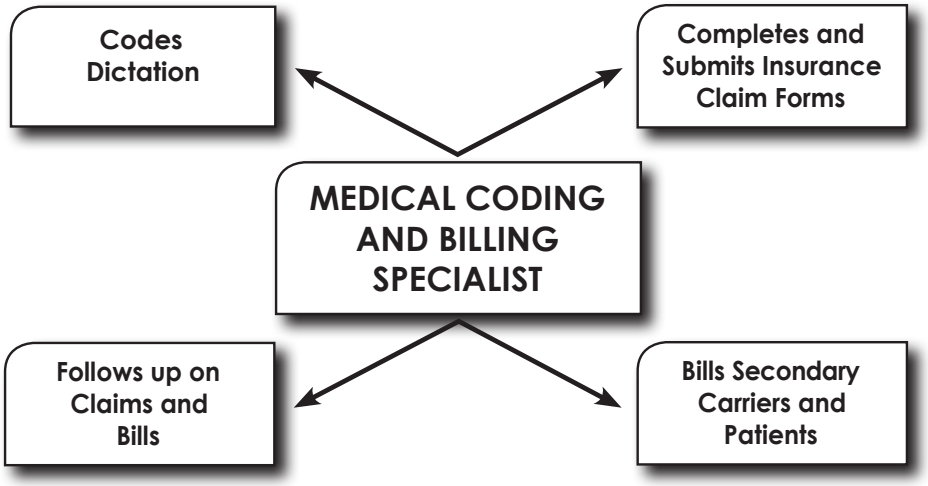
   Using the codes obtained from the manual, as well as patient and physician information, you will complete and submit the appropriate insurance claim form.

3. **Follow Up With Insurance Companies and Patients.**

   After you submit the insurance form, you might need to contact the company regarding the claim. You might also have to follow up with patients to secure payments.

4. **Secondary Insurance Claims and Patient Billing.**

   After the primary carrier has paid its share of the bill, if the patient has secondary insurance, you need to bill that secondary carrier. If the patient does not have secondary insurance, then the patient may be responsible for paying whatever remains after the primary carrier has paid.



Let's pause and complete a quick Practice Exercise.

✍ Step 6 Practice Exercise 1-1

❑ Select the best answer from the choices provided.

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

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

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

Answer the following question.

4. **Describe the four basic responsibilities of a medical coding and billing specialist.**

Step 7 Review Practice Exercise 1-1

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

Step 8 Medical Coding and Billing Career

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

  Employment in health care is growing rapidly for two reasons. First, the number of people in older age groups will grow faster than the total population. This increase is due to rising life expectancies and continual advances in medical technology. Second, healthcare costs continue to climb, which means more physicians want to get paid. As a result, you have more job opportunities—medical coding and billing specialists are in demand! You can see this by looking at the number of patients doctors see every day. Every appointment needs a code attached and a claim submitted!

  In your new career, you may work at home, in a doctor's office or outpatient facility, and some doctors even use independent coding and billing specialists. In fact, there are companies that hire coding and billing specialists across the country. These remote professionals work online in distant locations, and the company finds work for them to code and bill. So much depends on where and when you want to work. What's exciting is that you're in control—just as you are in this course, working toward your new career!

Where to Work

Someone with the knowledge you're gaining in this course will not be limited to simply filling out forms. No, the world of medical coding and billing is very diverse. As you already know, it offers full- or part-time job opportunities, at home or in offices.

Mercy Medical Center is looking for a part-time Medical Coding and Billing Specialist to accurately assign codes to records and assist in the claims process. One year of coding and billing experience is preferred, but those who can show they have real-world training in medical coding and billing also will be considered. Mercy Medical Center is an equal opportunity employer.

Please send cover letter, resume and references to:
Mercy Medical Center
111 Main Street Suite 1
Avery, Ohio 44444

Hart Family Practice is looking for a full-time medical coder/biller to code medical records, as well as submit claims to insurance for payment. Applicant must have knowledge of medical terminology, anatomy, medical coding and medical billing. The position offers a generous benefit package, and salary is based upon experience. EOE

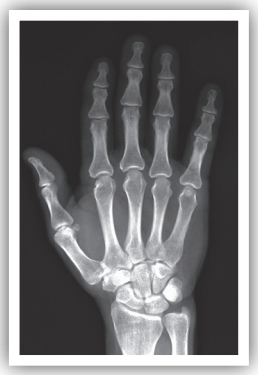
If interested in applying, please send a cover letter and resume to:
Hart Family Practice
222 Skinner Road
Pittman, Louisiana 23232

Medical coding and billing specialists no longer are restricted to the doctor's office but now work in hospitals, pharmacies, nursing homes, mental healthcare facilities, rehabilitation centers, insurance companies, consulting firms, health data organizations and their homes. And remember, if you decide you want to work at home, you set your own work schedule and save on items such as child daycare and transportation. How is it possible for one career to offer so many choices? Let's take a closer look at two different jobs available to you in this career.

Verify or Assign Codes

In some cases, the physician assigns the code, and you will simply verify that these codes are consistent with what the physician has documented. In other cases, the doctor does not assign codes. Instead, you'll translate the doctor's written diagnosis and treatment into codes. Once the codes are determined, you'll complete the claim form and send it to the insurance company for reimbursement.

For example, you might work for a radiologist that provided services to a patient for a broken finger. You review the dictation documenting how the x-ray was performed and the radiologist's reading of the x-ray. You would apply the correct codes for the diagnosis and the procedure, and create the claim to send these codes to the insurance company.



You'll review the dictation documenting how the x-ray was performed.

Coding and Billing Service

A medical coding and billing service is the most common at-home employment opportunity for this profession. Typically, the self-employed medical coding and billing specialist charges by the medical record and has more than one provider as a client.

The work of an independent medical coder and biller doesn't vary much from that of those who work in offices and hospitals. The biggest difference involves how the work gets to and leaves the medical coding and billing specialist. If the service does work for local providers, the work could be picked up and dropped off every 24 to 48 hours. The medical coding and billing specialist simply takes the information home, codes it, completes and submits claims and then returns it to the physician's office. If the physician is having his transcription done online, he is set up for online communication of all work. The coding and billing work can be exchanged online. The great thing about this route is the medical coding and billing specialist isn't limited to clients in his town or even state! Let's talk a bit about the personal qualities that medical coding and billing specialists should possess.

Step 9 Personal Qualities

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

Medical coders and billers do much of their work alone; however, they are still a vital part of the healthcare team. The main thing to remember when you approach a potential client or employer is that you are the best medical coding and billing specialist for the job. Your competence means money to your employers! You should remember and practice three qualities: *professionalism*, *presentation* and *adaptability*.

Professionalism

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

The image you project is important.

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

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

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

Has this ever happened to you? Perhaps if Jane wanted advice on which CD to buy for her son, the other clerk would have appeared more competent. Either way, Jane made a judgment based on how each employee looked. Of course, no two people look alike, but there are certain factors of appearance that are important in the work setting. This is especially true for a professional healthcare worker.

Another facet of professionalism is delivering what you promise. You've probably heard the saying, "Five minutes early is 10 minutes late." Basically, this means if you have a meeting at 10 a.m., be 15 minutes early. Never be late, especially for a first-time interview. Such promptness shows you are responsible and considerate.

If your client is a little late, be understanding. Just make sure you aren't the tardy one. When you are asked for work samples, be prepared. Explain what you know and how you gained your knowledge. If you ever are asked to complete a test task, do so promptly.

Presentation

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

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

Be sure to present a confident image.

Adaptability

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

Step 10 Character Traits

- ❑ What makes a top-notch medical coding and billing specialist? Let's examine some of the most important character traits of a successful coder and biller. You'll be able to boast about these traits by the end of your course!

Curiosity and Drive

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

Warmth and Confidence

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

You can put a patient at ease by showing warmth and compassion.

Organizational and Professional Skills

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

As you progress through this course, you'll learn the skills it takes to keep organized and to prioritize. Let's keep moving!

✍ Step 11 Practice Exercise 1-2

❑ Select the best answer from the choices provided.

1. **Some medical coders and billers work _____ in distant locations.**
   a. with medical transcriptionists
   b. online
   c. long hours
   d. by phone

2. **The most common at-home employment opportunity for the medical coding and billing specialist is the _____.**
   a. medical coding and billing service
   b. coding processor
   c. medical coding and billing software system
   d. insurance adjuster

3. **When a physician assigns the code, the coding and billing specialist simply _____.**
   a. ignores the codes and reassigns new ones
   b. verifies that these codes are consistent with what the physician has documented
   c. disputes whatever the doctor did
   d. calls the patient and asks what happened during the appointment

4. **An independent medical coding and billing specialist typically works _____.**
   a. in a doctor's office
   b. in a hospital
   c. in an insurance company office
   d. at home

Answer the following question as directed.

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

_____

_____

_____

_____

_____

Step 12 Review Practice Exercise 1-2

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

Step 13 Lesson Summary

- ❑ Medical coding and billing specialists are an important part of any medical setting. This lesson gave you a firm understanding as to what each member of the healthcare team does. You'll work with physicians, nurses, office managers and others to contribute to the best possible patient care. You learned that this care occurs in a three-part sequence: complaint, diagnosis and treatment. The diagnosis and treatment eventually are coded and billed by you, the medical coding and billing specialist!

  We also discussed a few important points for you to remember as you move toward your new career. You explored possible employment opportunities and settings. You also learned the importance of professionalism, presentation and adaptability in your new career. Lastly, this lesson discussed the character traits of a successful medical coding and billing specialist.

  The medical coding and billing specialist is important in the healthcare field.

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

  You are now ready to complete your first Mail-in Quiz!

✉ Step 14 Mail-in Quiz 1

❑ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Submit your answers to the school via mail, e-mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 1

Choose the best answer from the choices provided. Each question is worth 5 points.

1. **During residency, physicians might be asked to work _____ hours per week.**
   a. 200-250
   b. 100-150
   c. 85-100
   d. 1000

2. **The _____ assists the doctor by carrying out instructions under the doctor's supervision.**
   a. nurse's assistant
   b. EMT
   c. paramedic
   d. physician assistant

3. **_____ code and complete insurance forms to ensure proper reimbursement for patient encounters.**
   a. Accounts receivable specialists
   b. Medical coding and billing specialists
   c. Radiologic technologists
   d. Medical record technologists

4. Which of these lists correctly illustrates the order of training, from lowest to highest, of medical personnel? _____

a. EMT, paramedic, physician
b. Paramedic, EMT, physician
c. Physician, EMT, paramedic
d. EMT, physician, paramedic

5. EMT personnel _____ patients, while paramedics might begin to cure them.

a. perform surgery on
b. treat
c. stabilize
d. none of the above

6. The _____ organizes schedules and keeps appointments straight.

a. office manager
b. laboratory technician
c. physician
d. nurse

7. To give yourself the best chance of gaining a new client, you must remember and practice professionalism, adaptability and _____.

a. preoccupation
b. insurance billing
c. presentation
d. altruism

8. Medical coding is the process of _____.

a. identifying patient complaints
b. translating narrative into numeric and/or alphanumeric codes
c. identifying types of specialists
d. e-mailing messages to insurance companies

9. PA stands for _____.

a. protein allergy
b. podiatrist's assistant
c. payment allowed
d. physician assistant

10. Chief complaint means _____.

a. what is wrong
b. the complaint with the most letters in it
c. how long the patient waited to be seen
d. what the nurse thinks is the worst symptom

11. A medical coding and billing specialist's work attire should be _____.

a. coveralls
b. lab coat
c. clean, wrinkle-free, proper size, professional
d. whatever style you like best

12. As a medical coding and billing specialist, it is your responsibility to _____.

a. schedule appointments
b. examine patients
c. code and submit insurance claims
d. take patient vitals

13. Employment in health care is growing rapidly due to _____.

a. rising life expectancies
b. government mandates
c. early retirement of physicians
d. decline in technology

14. Two essential characteristics of a successful medical coding and billing specialist are _____.

a. tenacity and toughness
b. warmth and confidence
c. curiosity and free-spiritedness
d. being argumentative and organizational

15. A medical bill might be outstanding because the _____.

a. clinic isn't waiting for the insurance payment
b. patient paid the balance because he does not have insurance
c. insurance company has paid
d. insurance company has paid, but there is still a balance due for the patient to pay

16. The medical coding and billing specialist uses _____ to gather patient information.

a. an informal survey
b. an insurance salesperson
c. the dictation
d. the doctor

17. Making lists to not forget tasks for the day is an example of _____.

a. organization
b. warmth
c. drive
d. confidence

18. Professionalism includes how you _____.

a. talk
b. dress
c. interact
d. all of the above

19. Which is not a responsibility of the medical coding and billing specialist? _____

a. Follow up with insurance companies
b. Complete and submit insurance claim forms
c. Schedule appointments
d. Patient billing

20. Which is not a responsibility of a nurse or nurse's assistant? _____

a. Cleaning up exam rooms
b. Stitching up a cut
c. Taking a patient's temperature
d. Talking to patients to ensure they are comfortable

Congratulations!

You have completed Lesson 1.

Nice!

Triumph

Determination!

Progress

Winning

Do not wait to receive the results of your Quiz before you move on.

Lesson 2

Medical Insurance 101

Step 1 Learning Objectives for Lesson 2

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Define medical billing terms common to the healthcare profession.
  - Discuss the importance of preauthorization.
  - Describe the resources used by a medical coding and billing specialist.
  - Explain what a medical bill is and how it is used for reimbursement.
  - Discuss the importance of being accurate and thorough.

Step 2 Lesson Preview

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

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

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

Medical coding and billing specialists may verify codes from a patient's medical record.

Step 3 Insurance Terminology

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

Insurance is a contract between an insurance company and the insured.

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

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

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

A guarantor is responsible for the account because the patient is a minor.

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

Before moving on, let's review some common, related terms used in medical insurance.

Claim Form

The **claim form** is the document that is completed and submitted to an insurance carrier to request reimbursement for services rendered. The most common insurance forms are the CMS-1500 and the UB-04. We'll look at the history and format of these forms later in this lesson.

Allowable Charge

The **allowable charge** is the maximum amount an insurance carrier will pay for a specific service.

Deductible

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

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

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

Copayment

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

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

Explanation of Benefits

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

The physician bills the patient for amounts applied to the patient's deductible, any copayment amounts and noncovered procedures, depending on the contract. Often, a service benefit contract stipulates a maximum charge per service. The insurance company will disallow the difference if a doctor submits a claim for an amount that exceeds that maximum charge.

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

BLUE CROSS OF COLORADO

Date: 04/10/XX

Policy: STEEL RECYCLING

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

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

STEVE MAC
1823 KERRY COURT
YOURTOWN, CO 80000

Patient: FRAN MAC
Number: 605000508

Explanation of Payments:

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

Payment has been made to: Amount

Front Range Family Care **47.52**

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

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

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

Step 4 Preauthorization

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

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

The preauthorization allows the insurance company to review a patient's case history before major costs occur.

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

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

Visitation Limits

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

Now that you're aware of the lingo of the medical coding and billing field, let's apply what you've learned in the following Practice Exercise.

✍ Step 5 Practice Exercise 2-1

❑ Select the best answer from the choices provided.

1. _____ is a contract between an individual or group and an insurance company.

a. Insurance
b. Coverage
c. Deductible
d. A premium

2. The payments from the insured person or group that are collected by the carrier are known as _____.

a. deductibles
b. schedules of benefits
c. premiums
d. benefits

3. The second-party payer is the _____.

a. patient
b. guarantor
c. physician
d. insurance

4. The amount of money an individual must pay before insurance benefits begin is called the _____.

a. deductible
b. copayment
c. premium
d. benefits

5. The process of notifying an insurance company before hospitalization, surgery or tests is called _____.

a. preadmission screening
b. preauthorization
c. postoperative notification
d. preoperative testing notice

Step 6 Review Practice Exercise 2-1

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

Step 7 Tools of the Trade

- ❑ There are many resources available to help you succeed as a medical coding and billing specialist. Now, discuss the forms you'll use in billing and the manuals you'll use to obtain the accurate codes.

CMS-1500

The **CMS-1500** is the standard claim form used to request payment for services rendered by the healthcare provider, usually used by physician offices and government programs. The National Uniform Claim Committee (NUCC) is responsible for the design and maintenance of the CMS-1500 form.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid#)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX M F			4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other				7. INSURED'S ADDRESS (No., Street)
CITY	STATE		8. PATIENT STATUS Single Married Other				CITY STATE
ZIP CODE	TELEPHONE (Include Area Code)		Employed Full-Time Student Part-Time Student				ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) YES NO				a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F			b. AUTO ACCIDENT? YES NO Place (State)				b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? YES NO				c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

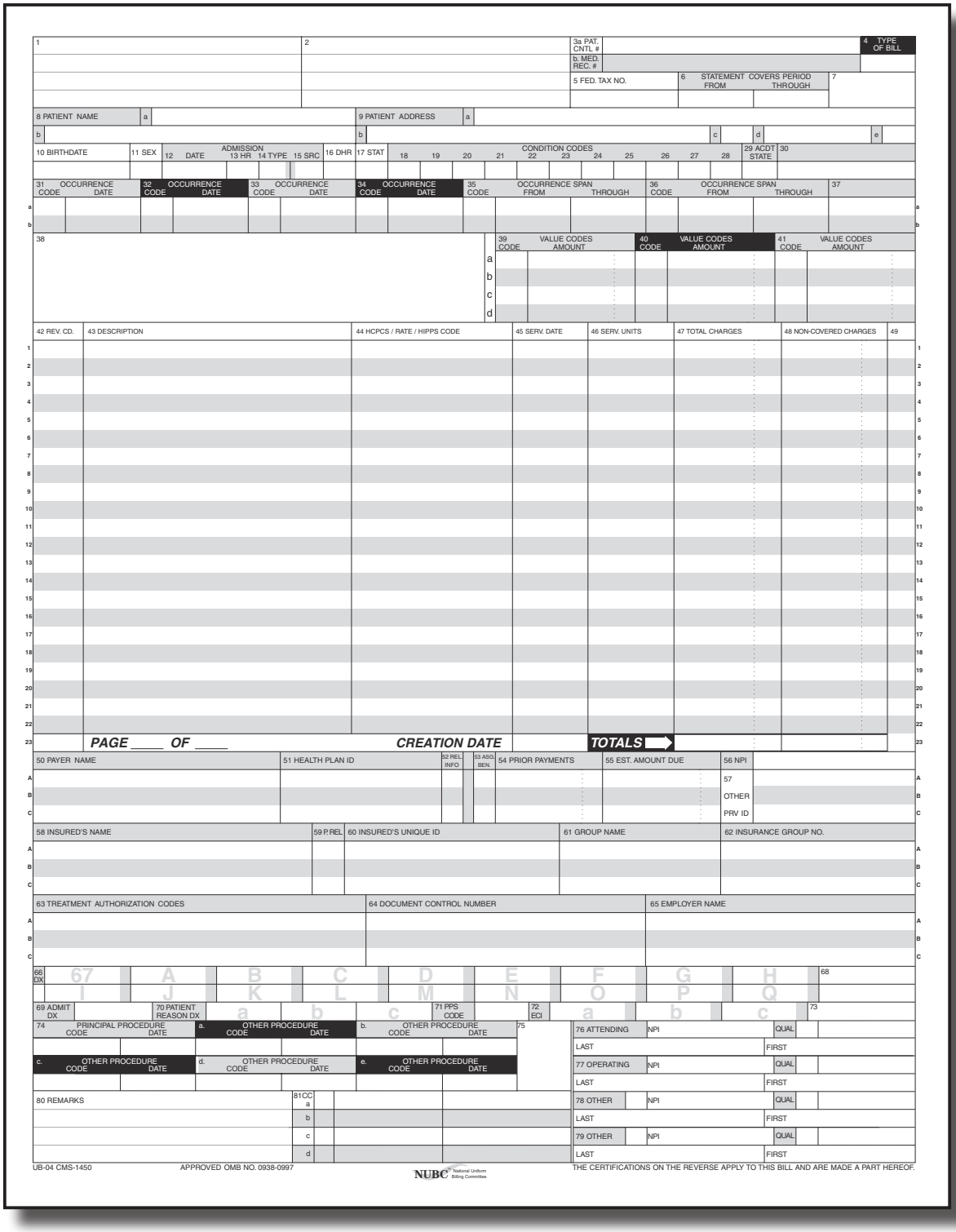
14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. _____ 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	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	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
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? YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # a. b.		

UB-04

The **UB-04**, also known as the CMS-1450, is the uniform claim form used in hospitals and other inpatient settings. The National Uniform Billing Committee (NUBC) is responsible for the design and printing of the UB-04 form.



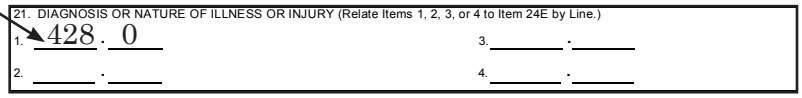
As a medical coding and billing specialist, you'll complete CMS-1500 and UB-04 forms and submit them to insurance companies for payment. You'll learn more about these forms soon.

Diagnostic Codes

Now that you were introduced to the different types of claim forms, let's take a moment to discuss medical codes and how they apply to insurance. After a patient's office visit, tests and other procedures, a claim form is completed. These forms require special codes—*diagnostic codes* and *procedure codes*. When you write a code on an insurance form, a bill or a patient's chart, you are "coding that entry."

When you look at the CMS-1500, you can see that there are many fields to be filled. One of the most important fields is *Field 21 Diagnosis or Nature of Illness or Injury*. In this field, you must enter some crucial information—the diagnostic code.

Field 21 is filled in with crucial information—the doctor's diagnosis. Here, the code listed represents the diagnosis of congestive heart failure.



Diagnostic codes are numbers that identify the physician's opinion about what is wrong with the patient. This is the physician's diagnosis. These codes are not random numbers; they are based on a system called the *International Classification of Diseases* or *ICD*. These diagnostic codes are listed in the *ICD-9-CM* manual. It is your accurate and complete coding that ensures maximum reimbursement to the provider and provides meaningful statistics to assist our nation with its health needs.

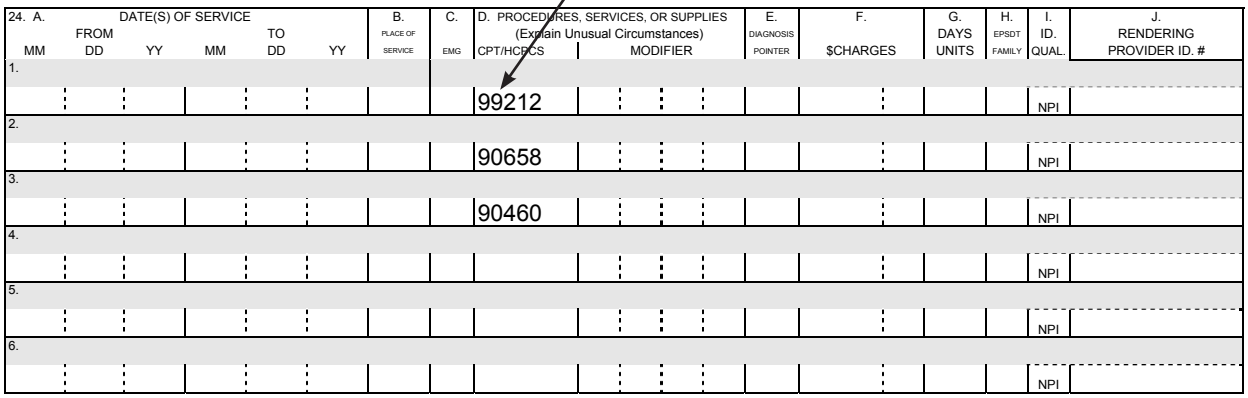
The codes and patient data then are transferred from the patient's chart to a claim form and sent to the insurance carrier for reimbursement to the provider based on the diagnoses and procedures involved. The types, frequency of treatments and diagnoses gathered from the patient information provide the statistics necessary to depict health care in this country. The government and insurance companies use these statistics to establish guidelines to develop the rates of reimbursement paid to medical practices in the future.

As you can see, it's the analysis of diagnostic codes that determines whether insurance carriers will provide coverage for a particular procedure or service. Now you have a bit of an idea as to how your new role affects insurance reimbursement. Without your coding skills, providers would not get reimbursed for their services. This is one reason why the medical coding and billing specialist's role is important! We will cover diagnostic coding concepts later in the course. Now, let's look at procedure coding.

Procedure Codes

Like diagnoses, procedures have a numerical language as well. The language of procedure codes is found in either the *Current Procedural Terminology* (*CPT*) or the *Healthcare Common Procedure Coding System* (*HCPCS*)—pronounced "Hick-Picks." If you look at the portion of the CMS-1500 that follows, you will see *Field 24D Procedures, Services or Supplies*. You will record CPT and/or HCPCS codes, along with appropriate modifiers in this field.

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



24. A. DATE(S) OF SERVICE 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 UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.								99212						NPI	
2.								90658						NPI	
3.								90460						NPI	
4.														NPI	
5.														NPI	
6.														NPI	

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

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

Now, let's look at how you'll use these tools to create a medical bill.

Step 8 Life Cycle of a Medical Bill

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

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

Processing the Bill

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

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

OR

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

OR

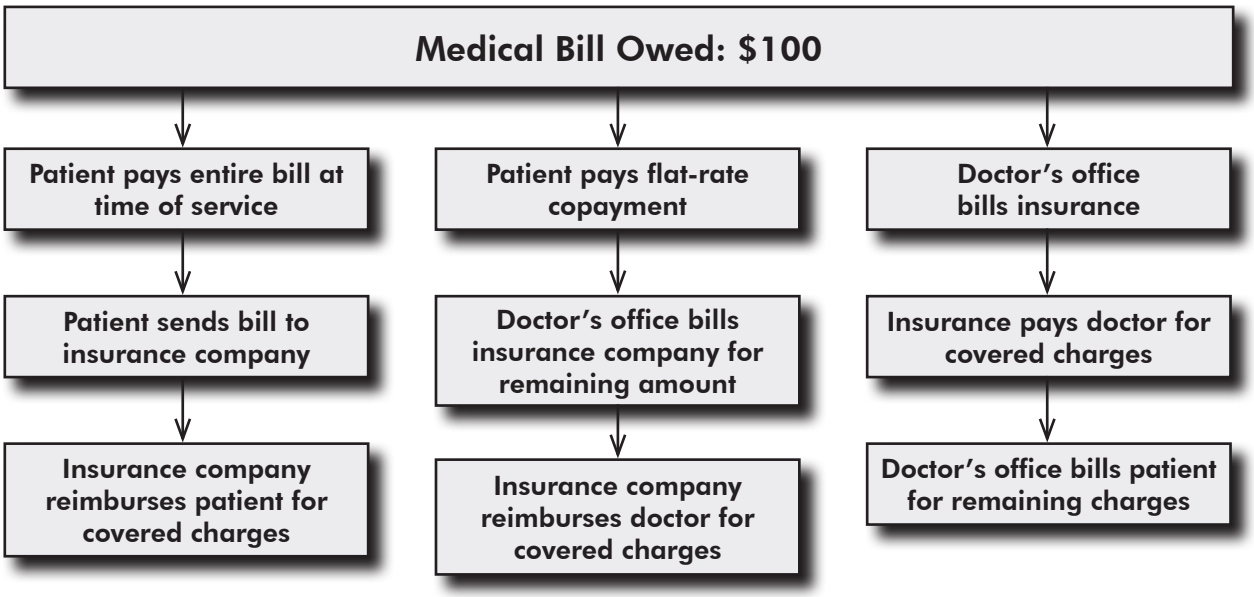
3. The patient might pay nothing at the time of the visit to the provider. Following the patient's visit, the provider submits a claim to the patient's insurance company for the bill. The provider is reimbursed by the insurance company for the charges the patient's insurance policy covers. The doctor's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

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

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

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

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



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

Step 9 Accurate and Thorough

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

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

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

✍ Step 10 Practice Exercise 2-2

❑ Select the best answer from the choices provided.

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

2. **The medical coding and billing specialist is responsible for _____.**
   a. transcribing the doctor's notes
   b. coding and submitting insurance claim forms
   c. examining patients
   d. scheduling patients

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

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

5. An error on the claim form may _____ reimbursement.

a. delay
b. not impact
c. speed up
d. improve

6. When you write a code on an insurance form, you are _____ that entry.

a. deleting
b. coding
c. highlighting
d. eliminating

7. Diagnosis codes are contained in the _____ manual.

a. CPT
b. Diagnostic Code Listing (DCL)
c. ICD-9-CM
d. HCPCS

Step 11 Review Practice Exercise 2-2

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

🕮 Step 12 Lesson Summary

- ❑ You now have a foundation to stand on in the world of insurance and coding. Insurance is very important in the medical field. Insurance companies have many regulations, including preauthorization requirements. It's essential that you keep up to date with these procedures and requirements. Lesson 2 introduced you to some insurance terminology, such as copayment and deductibles. You also got an overview of the billing process, and caught a glimpse of two common claim forms, the CMS-1500 and UB-04. You also learned about diagnostic and procedure codes, which learn about further in later lessons. Keep in mind that this lesson was a brief overview of how insurance and the coding and billing process work. As we move through this course, you will see the important role you'll play as the medical coding and billing specialist.

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

✉ Step 13 Mail-in Quiz 2

- ❑ Follow the steps to complete the Quiz.

  a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

  b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

  c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

  d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

  e. Submit your answers to the school via mail, e-mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 2

Each item is worth 5 points.

Match the term with its definition.

1. _____ Provider	a. An amount of money an individual must pay before insurance benefits kick in
2. _____ Deductible	b. The compensation or repayment for healthcare services
3. _____ Copayment	c. A flat amount of money paid by the patient every time a medical service is performed
4. _____ Reimbursement	d. A person or organization that provides medical services

Select the best answer from the choices provided.

5. When an insurance carrier pays for medical treatment based on a policy, it is paying _____.

a. premiums
b. a copayment
c. benefits
d. deductibles

6. Typically, the explanation of benefits contains _____.

a. nothing of interest to a coding and billing specialist
b. the doctor's contact numbers
c. payment for one or more patients
d. a privacy policy

7. Some providers use a(n) _____, which is a form that contains the most common procedures performed by that provider.

a. account-easing document
b. easy-accounting bill
c. encounter form
d. claim form

8. When an insurance company pays for medical services, it _____ the appropriate party (either the insured or the provider).

a. gerrymanders
b. processes
c. collects from
d. reimburses

9. If an insurance company pays 80 percent of a claim of $100, the patient is responsible for _____ percent of the bill.

a. 20
b. 10
c. 80
d. 100

10. The most commonly used insurance form is called the _____.

a. CMS-1500
b. CMS-1000
c. Common Carrier Insurance Form (CCIF)
d. Primary Carrier Claim Form (PCCF)

11. Paying someone for services already performed is _____.

a. claims processing
b. completing an encounter
c. reimbursement
d. always an insurance company's responsibility

12. If preauthorization is required, but the insurance company is not notified, the insurance company _____.

a. bills the doctor for the cost of the extra paperwork involved
b. might reduce reimbursement
c. pays more
d. any of the above

13. If an insurance company authorizes a hospital stay of five days and the patient stays seven days (not due to any medical necessity), then the _____.

a. patient must pay for the extra two days
b. hospital allows the patient to stay for free for the extra two days
c. insurance carrier pays for the extra two days
d. insurance agent must pay a penalty

14. _____ are numbers based on the diagnoses made and procedures performed.

a. Codes
b. Checks
c. HMOs
d. Terms

15. The diagnosis code is entered in field _____ of the CMS-1500.

a. 24D
b. 1
c. 21
d. It is not entered on the CMS form.

16. Codes that identify the physician's opinion about what's wrong with a patient are called _____ codes.

a. procedure
b. diagnosis
c. HCPCS
d. Medicare

17. The procedure code is entered in field _____ of the CMS-1500.

a. 24D
b. 1
c. 21
d. It is not entered on the CMS form.

18. ICD stands for _____.

a. International Coding Decimals
b. International Coding Disorders
c. International Classification of Diseases
d. Internal Classification of Disorders

19. HCPCS stands for _____.

a. Honorary Coding Procedures Common System
b. Healthcare Common Procedure Coding System
c. Health Care Primary Coding System
d. Hired Care Primary Coding System

20. CPT stands for _____.

a. Colorado Procedure Tests
b. Corporate Procedure Terminology
c. Current Primary Tests
d. Current Procedural Terminology

Congratulations!

You have completed Lesson 2.

Nice!

Progress

Winning

Triumph

Determination!

Do not wait to receive the results of your Quiz before you move on.