Instructor's Manual to Accompany

A Guide to Health Insurance Billing, Fourth Edition

Instructor's Manual to Accompany

A Guide to Health Insurance Billing, Fourth Edition

Marie A. Moisio, MA, RHIA

DELMAR
CENGAGE Learning®

Australia • Brazil • Japan • Korea • Mexico • Singapore • Spain • United Kingdom • United States

DELMAR
CENGAGE Learning®

Instructor's Manual to Accompany A Guide to Health Insurance Billing, Fourth Edition
Marie A. Moisio, MA, RHIA

Vice President, Careers & Computing: Dave Garza

Healthcare Publisher: Steve Helba

Executive Editor: Rhonda Dearborn

Director, Development-Career and Computing: Marah Bellegarde

Product Development Manager: Juliet Steiner

Product Manager: Amy Wetsel

Editorial Assistant: Courtney Cozzy

Brand Manager: Wendy Mapstone

Market Development Manager: Nancy Bradshaw

Senior Production Director: Wendy Troeger

Production Manager: Andrew Crouth

Senior Content Project Manager: Kathryn B. Kucharek

Senior Art Director: Jack Pendleton

Media Editor: Bill Overrocker

Cover image: www.Shutterstock.com

The 2013 versions of CPT, ICD-9-CM, ICD-10-CM, and ICD-10-PCS were used in preparation of this product.

Library of Congress Control Number: 2012949441

Book Only ISBN-13: 978-1-285-19360-1

Delmar
5 Maxwell Drive
Clifton Park, NY 12065-2919
USA

Cengage Learning is a leading provider of customized learning solutions with office locations around the globe, including Singapore, the United Kingdom, Australia, Mexico, Brazil, and Japan. Locate your local office at: **international.cengage.com/region**

Cengage Learning products are represented in Canada by Nelson Education, Ltd.

To learn more about Delmar, visit **www.cengage.com/delmar**

Purchase any of our products at your local college store or at our preferred online store **www.cengagebrain.com**

Printed in the United States of America
1 2 3 4 5 6 7 17 16 15 14 13

Contents

Section V: Answer Keys to Appendix A SimClaim Case Studies

Section VI: Blank Forms

SECTION I
Course Preparation

INTRODUCTION

Whether you are a new or an experienced instructor for insurance billing, the fourth edition of *A Guide to Health Insurance Billing* is an excellent introduction to health insurance billing. The Instructor's Manual is designed to assist you with lesson preparation and student performance assessment. The special features of this manual include **two sample syllabi**, **eleven quizzes**, and **two exams**.

A Guide to Health Insurance Billing is a student-focused approach to teaching and learning foundation insurance billing skills. Each chapter includes many examples that clarify insurance billing terminology, medical coding conventions and applications, and illustrate claims submission guidelines. The first three chapters introduce the roles of an insurance billing specialist, the various laws that affect insurance billing, and the "language" of the insurance billing industry.

Chapters 4, 5, and 6 cover the basics of medical coding, which includes the *International Classification of Diseases, Tenth Modification* (ICD-10-CM); the *International Classification of Diseases, Tenth Modification, Procedure Coding System* (ICD-10-PCS); the *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM); and *Current Procedural Terminology* (CPT). Students must have access to all coding references to complete all exercises in Chapters 4, 5, and 6. Beginning with Chapter 7, students are exposed to a variety of insurance billing situations. All chapters contain sample forms, procedures, step-by-step CMS-1500 completion activities, and reinforcement activities that provide students with practical applications. A few cartoons add a touch of humor in some of the chapters. All chapters and exercises were reviewed by educators and professional medical billing specialists.

CODING EXERCISES

The coding exercises in Chapter 4 through Chapter 6 include medical reports to give students an opportunity to "code from the record." The answers to all coding exercises are based on the 2013 editions of the coding references. Answer keys include both ICD-9 and ICD-10 codes, when applicable.

The Superiorland Clinic simulations and CD-ROM exercises expand students' exposure to realistic insurance billing situations. The clinic and CD-ROM exercises are based on interviews with professional insurance billing specialists as well as case studies and examples provided to the author by several medical office managers.

The insurance billing industry is constantly changing. Keeping that in mind, we have made every effort to include the most current information available at the time of publication. Websites for all government-sponsored health insurance programs—from TRICARE to workers' compensation—are excellent references. Commercial insurance company representatives were generous with their time and advice concerning insurance billing procedures. All resources—both professional and technical—add value to the text.

Thank you for choosing *A Guide to Health Insurance Billing* as your text.

DEVELOPING A COURSE SYLLABUS

The course syllabus is the overall guide for you and your students. In many cases, the syllabus is viewed as a contract with the students. Although the schedule for material covered may change based on student needs, grading policies, attendance, and makeup, work should be well-defined. The information you include in the syllabus must be applied equally to all students.

The semester (term) is divided into 10- or 15-week increments. Overall targets for covering a specific number of chapters within certain time frames can be identified. Both syllabi presume a three-credit course that meets three times per week. Because there is much material to cover, ask the students to read the chapters before coming to class.

GRADING POLICY

The grading policy in each syllabus is based on a 4.0 system that assigns plus and minus grades. You may want to amend the policy by implementing a different scale: weighting exams, allowing extra-credit or makeup assignments, selectively collecting end-of-chapter exercises, or allowing students to drop the lowest quiz grade. Using a point system simplifies the grading process. A 50-item test could be worth 50 points, and the 100-item final exam could be worth 100 points. Quizzes can be assigned a specific number of points, regardless of the number of items. Simple math allows the instructor (and the students) to track progress. A student who earns 25 of 50 points is able to calculate the percentage and compare it to the grading scale. The point system puts grade assignment on an objective plane.

10-WEEK COURSE SYLLABUS

COURSE TITLE: Health Insurance Billing
ROOM: **TIME:** **DAYS:** **CREDITS:** 3
INSTRUCTOR: (Include your name, office location, hours, and phone.)
COURSE DESCRIPTION: (Use the college bulletin description or write a new one.)
REQUIRED TEXTS: *A Guide to Health Insurance Billing*; ICD-9-CM, *Volumes 1*, *2*, and *3*; ICD-10-CM/PCS; and *Current Procedural Terminology* (CPT) code books. (List additional required texts and materials.)

COURSE OBJECTIVES

1. Introduce students to the health insurance industry.
2. Provide students with a foundation in medical coding.
3. Demonstrate commonly used insurance claims procedures.
4. Prepare students for entry-level insurance billing positions.
5. Present insurance claims processing instructions for several major health insurance programs.
6. Provide students with a variety of application exercises.

STUDENT OBJECTIVES

Upon successful completion of this course, the student should have the knowledge to:

1. Explain the career opportunities associated with health insurance billing.
2. Describe the development of the health insurance industry.
3. Discuss the legal aspects of health insurance billing.
4. Accurately complete insurance claims according to health insurance program guidelines.
5. Assign the correct medical codes to both diagnostic and treatment information.

COURSE DESIGN

Lectures, visual presentations, reviews of chapter exercises, and various application exercises are the primary instructional methods.

GRADING POLICY

Points are assigned to all evaluation activities. The number of points the student accumulates—expressed as a percentage of the total points available—determines the student's grade. Students are expected to monitor their own progress. If students are concerned about their grade, they should meet with the instructor early in the semester. In all written evaluations, spelling errors will result in a loss of points. Assignments, quizzes, and tests must be completed on the day scheduled unless prior arrangements are made with the instructor. Late assignments may receive no points. If makeup exams are given, they must be completed within one week of the date the exam was scheduled.

GRADING SCALE: (Varies according to school policy)

A	95–100%	B−	80–82%	D+	67–69%
A−	90–94%	C+	77–79%	D	63–66%
B+	87–89%	C	73–76%	D−	60–62%
B	83–86%	C−	70–72%	F	below 60%

10-WEEK COURSE SCHEDULE

Week 1	Chapter 1: The Insurance Billing Specialist Chapter 2: Legal Aspects of Insurance Billing Chapter 3: Introduction to Health Insurance
Week 2	Chapter 4: ICD-10-CM/PCS
Week 3	Chapter 5: ICD-9-CM
Week 4	Chapter 6: CPT and HCPCS
Week 5	Chapter 6 continued Chapter 7: Developing an Insurance Claim
Week 6	Chapter 8: CMS-1500 Completion Guidelines: Private/ Commercial Insurance Chapter 9: Common UB-04 (CMS-1450) Completion Guidelines
Week 7	Chapter 10: Electronic Claims Submission Chapter 11: Blue Cross/Blue Shield
Week 8	Chapter 12: Medicare Chapter 13: Medicaid
Week 9	Chapter 14: TRICARE and CHAMPVA Chapter 15: Workers' Compensation
Week 10	Superiorland Clinic Simulation Final Project/Exam/Evaluation

15-WEEK COURSE SYLLABUS

COURSE TITLE: Health Insurance Billing
ROOM: **TIME:** **DAYS:** **CREDITS:** 3
INSTRUCTOR: (Include your name, office location, hours, and phone.)
COURSE DESCRIPTION: (Use the college bulletin description or write a new one.)
REQUIRED TEXTS: *A Guide to Health Insurance Billing*; ICD-9-CM, *Volumes 1*, *2*, and *3*; ICD-10-CM/PCS; and *Current Procedural Terminology* (CPT) code books. (List additional required texts and materials.)

COURSE OBJECTIVES

1. Introduce students to the health insurance industry.
2. Provide students with a foundation in medical coding.
3. Demonstrate commonly used insurance claims procedures.
4. Prepare students for entry-level insurance billing positions.
5. Present insurance claims processing instructions for several major health insurance programs.
6. Provide students with a variety of application exercises.

STUDENT OBJECTIVES

Upon successful completion of this course, the student should have the knowledge to:

1. Explain the career opportunities associated with health insurance billing.
2. Describe the development of the health insurance industry.
3. Discuss the legal aspects of health insurance billing.
4. Accurately complete insurance claims according to health insurance program guidelines.
5. Assign the correct medical codes to both diagnostic and treatment information.

COURSE DESIGN

Lectures, visual presentations, reviews of chapter exercises, and various application exercises are the primary instructional methods.

GRADING POLICY

Points are assigned to all evaluation activities. The number of points the student accumulates—expressed as a percentage of the total points available—determines the student's grade. Students are expected to monitor their own progress. If students are concerned about their grade, they should meet with the instructor early in the semester. In all written evaluations, spelling errors result in a loss of points. Assignments, quizzes, and tests must be completed on the day scheduled unless prior arrangements are made with the instructor. Late assignments may receive no points. If makeup exams are given, they must be completed within one week of the date the exam was scheduled.

GRADING SCALE: (Varies according to school policy)

A	95–100%	B−	80–82%	D+	67–69%
A−	90–94%	C+	77–79%	D	63–66%
B+	87–89%	C	73–76%	D−	60–62%
B	83–86%	C−	70–72%	F	below 60%

15-WEEK COURSE SCHEDULE

Week 1	Introduction Chapter 1: The Insurance Billing Specialist Chapter 2: Legal Aspects of Insurance Billing
Week 2	Chapter 3: Introduction to Health Insurance
Week 3	Chapter 4: ICD-10-CM/PCS
Week 4	Chapter 5: ICD-9-CM
Week 5	Chapter 6: CPT and HCPCS
Week 6	Chapter 6 continued
Week 7	Chapter 7: Developing an Insurance Claim Chapter 8: CMS-1500 Completion Guidelines: Private/ Commercial Insurance
Week 8	Chapter 9: Common UB-04 (CMS-1450) Completion Guidelines Chapter 10: Electronic Claims Submission
Week 9	Chapter 11: Blue Cross/Blue Shield Chapter 12: Medicare
Week 10	Chapter 12 continued
Week 11	Chapter 13: Medicaid
Week 12	Chapter 14: TRICARE and CHAMPVA
Week 13	Chapter 15: Workers' Compensation
Week 14	Superiorland Clinic Simulation
Week 15	Final Project/Exam/Evaluation

SECTION II

Answer Keys to Textbook Exercises and Chapter Reviews

ANSWER KEYS TO TEXTBOOK EXERCISES AND CHAPTER REVIEWS

CHAPTER 1: THE INSURANCE BILLING SPECIALIST

REINFORCEMENT EXERCISES 1–1

1. reliable
2. maintains confidentiality, ethical
3. honest
4. assertive, confident, detail-oriented
5. self-motivated
6. detail-oriented

REINFORCEMENT EXERCISES 1–2

1. data entry (keyboarding)
2. written communication skills
3. documenting messages
4. ability to follow directions
5. math skills

REINFORCEMENT EXERCISES 1–3

1. medical biller, insurance claims processor, reimbursement specialist, billing clerk
2. claims assistance professional
3. patient account representative or insurance counselor
4. high school diploma or equivalent and additional experience or education; knowledge of medical terminology; keyboarding skills; word-processing skills
5. abstract information from patient records; communicate via fax, e-mail, telephone, letters, and memos; understand legal and ethical issues of insurance billing; follow office policies and procedures; operate word-processing equipment; participate in continuing education activities

REINFORCEMENT EXERCISES 1–4

1. medical terminology; anatomy and physiology; medical insurance processing; medical coding; word processing; English
2. certified medical billing specialist, MAB; certified medical billing specialist, MAB; certified medical billing specialist for hospital, MAB; certified medical reimbursement specialist, AMBA
3. certified coding assistant (CCA), entry level; certified coding specialist (CCS), experienced coders, hospital setting; certified coding specialist–physician-based (CCS-P), experienced coders, physician office setting
4. certified professional coder; certified professional coder–hospital; American Academy of Professional Coders (AAPC); CPC is appropriate for medical coders in physician-based settings, and CPC-H is appropriate for medical coders in hospital outpatient and ambulatory care facilities

REVIEW EXERCISES

Short Answer

1. Nursing, medicine, physical therapy, and other patient contact jobs represent clinical careers; medical record technician, medical coder, medical secretary, and insurance billing specialist represent the nonclinical workforce—also known as the support staff.
2. An insurance billing specialist is an individual who processes health insurance claims in accordance with legal, professional, and insurance company guidelines and regulations.
3. office manager, billing office staff, accounting department staff

Definition of Terms

1. certified coding specialist
2. insurance billing specialist
3. personal qualifications
4. medical coding
5. claims assistance professional
6. medical terminology
7. technical qualifications
8. insurance collection specialist
9. patient account representative or insurance counselor
10. certification
11. certified professional coder

Matching

1. h
2. f

3. b
4. a
5. c
6. e
7. d
8. g

Comprehension Exercises

1. It is the language of the industry; to understand medical reports; recognize discrepancies in medical documentation.
2. Answers will vary.

Critical Thinking Exercises

Answers will vary.

CHAPTER 2: LEGAL ASPECTS OF INSURANCE BILLING

REINFORCEMENT EXERCISES 2–1

1. embezzlement
2. guardian
3. guardianship
4. guardianship of the person
5. nonfeasance
6. subpoena duces tecum
7. emancipated minor
8. respondeat superior
9. employer liability
10. guardianship of estate
11. negligence
12. malpractice
13. power of attorney

REINFORCEMENT EXERCISES 2–2

1. medical, financial, educational
2. The HIPAA Privacy Rule is a federal regulation that defines and limits the circumstances in which an individual's protected health information may be used or disclosed; the Privacy Rule covers all protected health information, including past, present, and future physical or mental health conditions; health care provided to the individual; in general, requires express written consent of the individual.

3. Only that amount of information needed to accomplish the intended use, disclosure, or request may be released.
4. The HIPAA Privacy Rule covers all protected health information; the Security Rule applies only to protected health information that is electronically stored and transmitted.
5. release of information
6. HIV test results; AIDS, alcohol, and substance abuse information
7. Caller reads the line on the insurance claim form that needs verification; ask for claim number or other unique identifying information; offer to return the phone call.
8. The request must be in writing and accompanied by a valid release of information authorization form.
9. where the transmission is printed; who has access to fax messages; whether a confidentiality statement is sent with patient-related information
10. *encryption*, transforming information into a form that is unreadable by unauthorized users; *firewalls*, hardware and software applications that control incoming and outgoing Internet transactions and prevent unauthorized access to the office's computer files; *user authentication*, assigning a unique identifier to individuals who communicate via the Internet

REINFORCEMENT EXERCISES 2–3

Short Answer

1. Fraud is any intentional action designed to get something that a person has no legal right to have.
2. billing for services that were never provided; using medical codes that result in higher payments; ordering unnecessary tests
3. services provided; office visits, lab tests; diagnosis to ensure it is accurate; the record to ensure it supports the diagnosis; medical coding; medical codes to verify they accurately represent diagnoses and treatments

Abbreviations

1. Health Insurance Portability and Accountability Act
2. Office of Inspector General
3. Department of Health and Human Services
4. Federal Bureau of Investigation
5. Department of Justice
6. Centers for Medicare and Medicaid Services

REINFORCEMENT EXERCISES 2–4

1. Abuse is any medical, business, or fiscal activity that is inconsistent with accepted practice.
2. inadvertent billing and coding errors; excessive charges for services, equipment, or supplies; billing for services that are not medically necessary

3. educational sessions; recovery of insurance overpayments; withholding of further insurance payments
4. Fraud is intentional; abuse is not.

REVIEW EXERCISES

Definitions of Terms

1. self-supporting or married individual under 18 years of age
2. keeping money accessible to you that you have no legal claim to keep
3. legal request to appear as a witness
4. legal request to appear as a witness and to bring records with you
5. let the master respond; employer held responsible for actions of employees
6. bad practice
7. health plan, health care clearinghouse, and health care provider who transmits health information in electronic form
8. individually identifiable health information that relates to an individual's past, present, or future physical or mental condition; the treatment or health care provided related to the condition; information related to the payment for treatment or services
9. employees, volunteers, trainees, and other persons associated with and under the control of the agency
10. individually identifiable protected health information that is transmitted or stored in electronic form

Short Answer

1. to defend the physician's action in a lawsuit when the record is subpoenaed; child or elder abuse cases; Medicaid, workers' compensation cases; to provide treatment in a medical emergency and when delayed treatment would result in loss of function or death
2. Fraud is the intentional attempt to take money from health insurance programs; abuse is unintentional but still takes money from health insurance programs.
3. Determine whether lab tests or treatments fit with the diagnosis and whether the diagnosis fits with the lab tests or treatments (for example, a throat culture is necessary to identify strep throat); the description of the selected medical code must be consistent with the patient's diagnosis (for example, the code for migraine headache cannot be used for a sinus headache, even if both codes have the word "headache"). (Other examples as acceptable to the instructor)
4. information that relates to the individual's past, present, or future physical or mental condition; the treatment or health care provided related to the condition; information related to the payment for treatment or services
5. *physical safeguards:* policies/procedures to limit access to electronic health information systems; workstation safeguards; removing EPHI from electronic media; destruction, disposal, archiving procedures related to EPHI or the hardware/media used for storage; *technical safeguards:* unique identifiers for all users and

procedures to protect EPHI from improper destruction, alteration, and access; protection against unauthorized access during electronic transmission

6. consumer protection; improving quality and lowering costs; increasing access to affordable care

Abbreviations Review

1. Federal Bureau of Investigation
2. Centers for Medicare and Medicaid Services
3. Health Insurance Portability and Accountability Act
4. Office of Inspector General
5. release of information

Matching

1. b
2. e
3. d
4. a
5. c

Comprehension Exercises

1. Abuse
2. Fraud
3. Fraud
4. Abuse
5. Fraud
6. Abuse
7. Fraud
8. Fraud
9. Abuse

True or False

1. False
2. True
3. True
4. False
5. False
6. True
7. True
8. False