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 _____

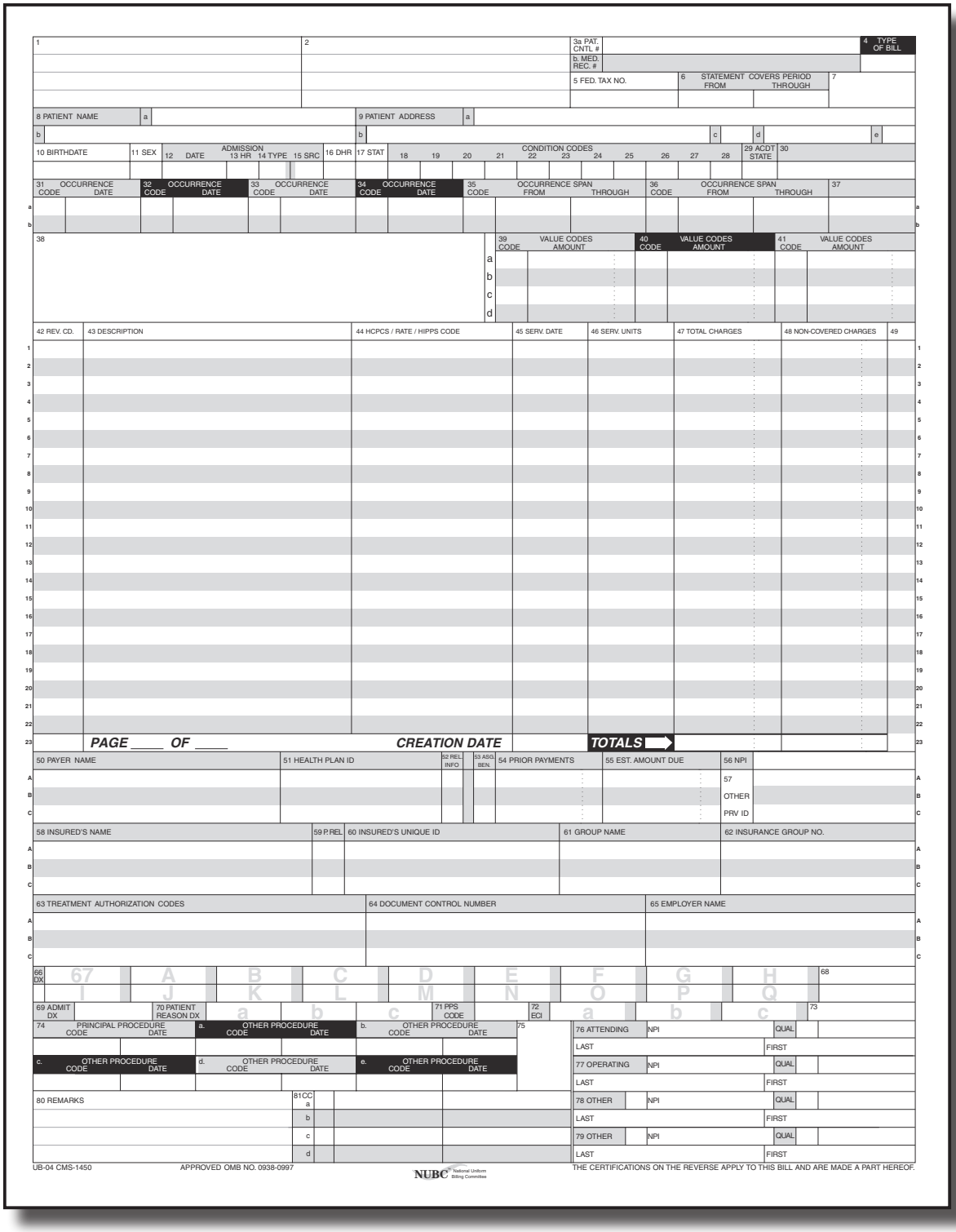
14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. 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.



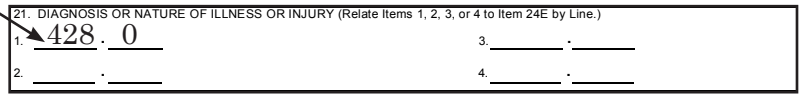
As a medical coding and billing specialist, you'll complete CMS-1500 and UB-04 forms and submit them to insurance companies for payment. You'll learn more about these forms soon.

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.

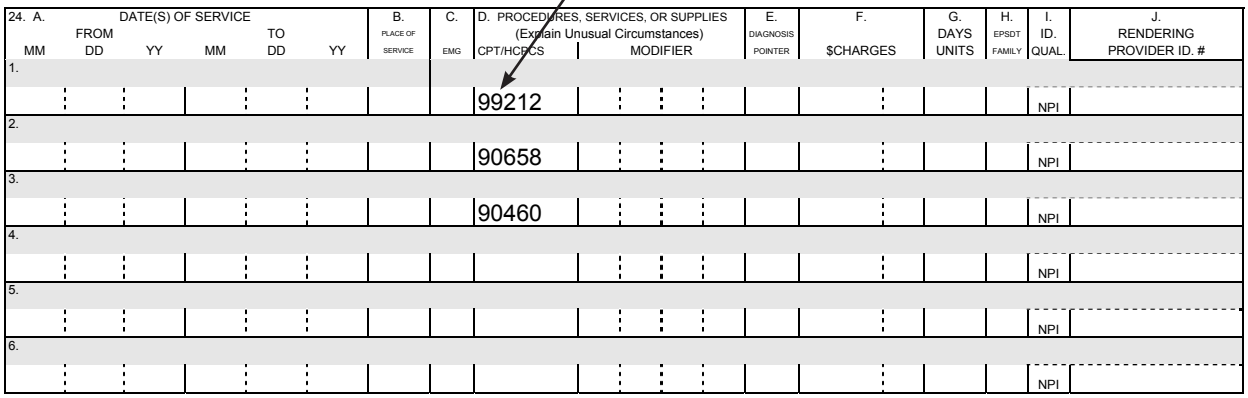
The codes and patient data then are transferred from the patient's chart to a claim form and sent to the insurance carrier for reimbursement to the provider based on the diagnoses and procedures involved. The types, frequency of treatments and diagnoses gathered from the patient information provide the 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

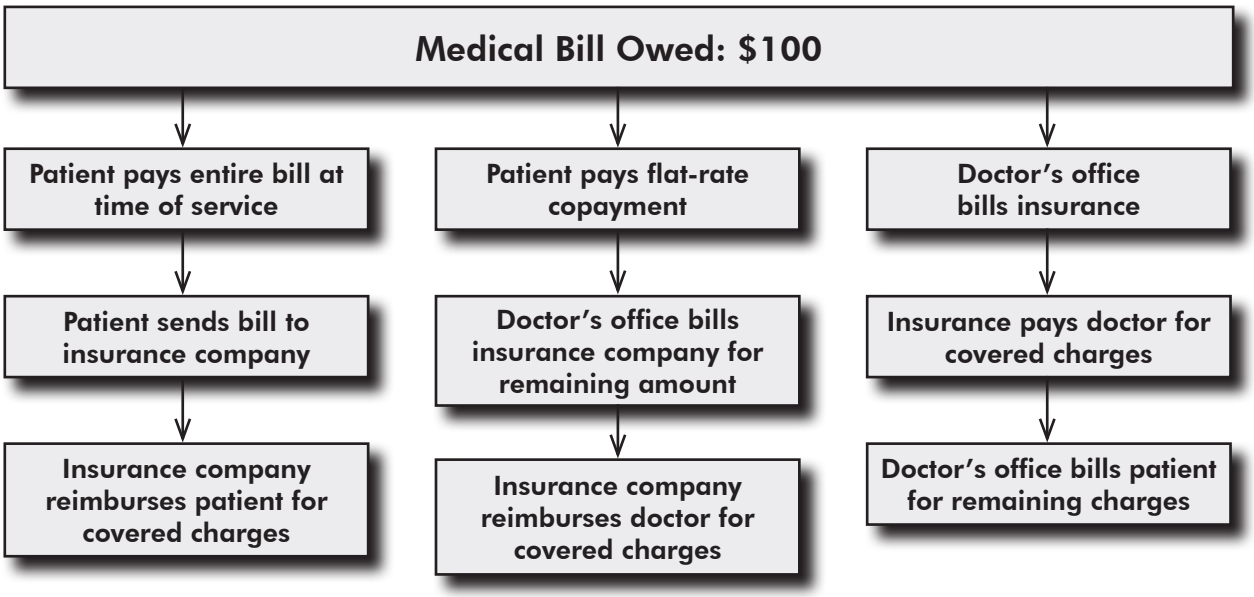
3. The patient might pay nothing at the time of the visit to the provider. Following the patient's visit, the provider submits a claim to the patient's insurance company for the bill. The provider is reimbursed by the insurance company for the charges the patient's insurance policy covers. The doctor's 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.