Understanding Health Insurance 2024 19th edition Green Solutions Manual

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Solution and Answer Guide

MICHELLE A. GREEN, UNDERSTANDING HEALTH INSURANCE: A GUIDE TO BILLING AND REIMBURSEMENT: 2024, 19TH EDITION, 9780357932063; CHAPTER 1: HEALTH INSURANCE SPECIALIST CAREER

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REVIEW

1.1: MULTIPLE CHOICE

1. The document submitted to the payer requesting reimbursement is called a(n)
   a. explanation of benefits.
   b. health insurance claim.
   c. remittance advice.
   d. prior approval form.

   ANS: b

   Analysis:
   a. *Incorrect. The patient receives an explanation of benefits (EOB) from the third-party payer, which is a report detailing the results of processing a claim. A health insurance claim is the documentation submitted to a third-party payer or government program requesting reimbursement for the health care services provided.*
   b. ***Correct**. A health insurance claim is the documentation submitted to a third-party payer or government program requesting reimbursement for the health care services provided.*
   c. *Incorrect. The provider receives a remittance advice (or remit), a notice sent by the insurance company that contains payment information about a claim.*
      A health insurance claim is the documentation submitted to a third-party payer or government program requesting reimbursement for the health care services provided.
   d. *Incorrect. Many health insurance plans and programs require prior approval for treatment by specialists and documentation of post-treatment reports, and if the prior approval form is not submitted prior to treatment, payment of the claim is denied. A health insurance claim is the documentation submitted to a third-party payer or government program requesting reimbursement for the health care services provided.*

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2. The Centers for Medicare and Medicaid Services (CMS) is an administrative agency within the
   a. Administration for Children and Families.
   b. Department of Health and Human Services.
   c. Food and Drug Administration.
   d. Office of the Inspector General.

   ANS: b

   Analysis:
   a. *Incorrect. The Administration for Children and Families is an administrative agency of the Department of Health and Human Services. The Centers for Medicare and Medicaid Services is an administrative agency of the Department of Health and Human Services.*
   b. ***Correct**. The Centers for Medicare and Medicaid Services is an administrative agency of the Department of Health and Human Services.*
   c. *Incorrect. The Food and Drug Administration is an administrative agency of the Department of Health and Human Services. The Centers for Medicare and Medicaid Services is an administrative agency of the Department of Health and Human Services.*
   d. *Incorrect. The Office of the Inspector General for the Department of Health and Human Services reports to the Secretary of the Department of Health and Human Services and the United States Congress. The Centers for Medicare and Medicaid Services is an administrative agency of the Department of Health and Human Services.*

3. A health care practitioner is also called a health care
   a. dealer.
   b. provider.
   c. purveyor.
   d. supplier.

   ANS: b

   Analysis:
   a. *Incorrect. A health care dealer is an entity that purchases goods for wholesale or retail re-selling, such as durable medical equipment. A health care provider is a health care practitioner, such as a physician, physician's assistance, or nurse practitioner.*
   b. ***Correct**. A health care provider is a health care practitioner, such as a physician, physician's assistance, or nurse practitioner.*
   c. *Incorrect. A health care purveyor refers to an entity that sells or deals in a particular type of goods. A health care provider is a health care practitioner, such as a physician, physician's assistance, or nurse practitioner.*
   d. *Incorrect. A health care supplier is a person or organization that sells or supplies goods, such as durable medical equipment. A health care provider is a health care practitioner, such as a physician, physician's assistance, or nurse practitioner.*

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4. Which is the most appropriate response to a patient who calls the office and asks to speak with the physician?
   a. Politely state that the physician is busy and cannot be disturbed.
   b. Explain that the physician is unavailable and ask if the patient would like to leave a message.
   c. Transfer the call to the exam room where the physician is located.
   d. Offer to schedule an appointment for the patient to be seen by the physician.

   ANS: b

   Analysis:
   a. *Incorrect. Office personnel should not state that the physician is busy and cannot be disturbed. Office personnel should simply state that the physician is not available and offer to take a message that will be passed along to the physician when available.*
   b. ***Correct**. Office personnel should simply state that the physician is not available and offer to take a message that will be passed along to the physician when available.*
   c. *Incorrect. Unless the physician has specifically requested that a particular patient's call be forwarded to the exam room, the patient's call should be addressed by office personnel. Office personnel should simply state that the physician is not available and offer to take a message that will be passed along to the physician when available.*
   d. *Incorrect. The patient may only wish to speak to the physician; however, in many cases, the patient's issue may be addressed by the physician or other medical staff (e.g., nurse practitioner, physician assistant) without the need for a patient appointment. Office personnel should simply state that the physician is not available and offer to take a message that will be passed along to the physician when available.*

5. The process of assigning diagnoses, procedures, and services using numeric and alphanumeric characters is called
   a. coding.
   b. data processing.
   c. programming.
   d. reimbursement.

   ANS: a

   Analysis:
   a. ***Correct**. Coding involves the assignment of numeric or alphanumeric characters to diagnoses, procedures, and services.*
   b. *Incorrect. Data processing is the collection and manipulation of data to produce meaningful information. Coding involves the assignment of numeric or alphanumeric characters to diagnoses, procedures, and services.*
   c. *Incorrect. Programming is the process of creating executable computer software programs that instruct the computer to perform specific tasks. Coding involves the assignment of numeric or alphanumeric characters to diagnoses, procedures, and services.*
   d. *Incorrect. Reimbursement is the payment a provider receives for performing procedures and providing services or supplies. Coding involves the assignment of numeric or alphanumeric characters to diagnoses, procedures, and services.*

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6. If a health insurance plan's prior approval requirements are not met by providers and the claim is submitted for reimbursement,
   a. administrative costs are reduced.
   b. patients' coverage is cancelled.
   c. payment of the claim is denied.
   d. they pay a fine to the health plan.

   ANS: c

   Analysis:
   a. *Incorrect. Administrative cost actually increase as a result of billing the patient for services provided, submitting the bill to collections, and writing off the billed amount. If a health insurance plan's prior approval requirements are not met by providers and the claim is submitted for reimbursement, the third-party payer issues claims denials.*
   b. *Incorrect. The patient's coverage is not cancelled when prior approval requirements are not met. If a health insurance plan's prior approval requirements are not met by providers and the claim is submitted for reimbursement, the patient's coverage will not be cancelled or impacted but the payer will deny the claim.*
   c. ***Correct**. If a health insurance plan's prior approval requirements are not met by providers and the claim is submitted for reimbursement, the third-party payer issues claims denials.*
   d. *Incorrect. Providers and patients do not pay a fine to the health plan when prior approval requirements are not met. If a health insurance plan's prior approval requirements are not met by providers and the claim is submitted for reimbursement, the third-party payer issues claims denials.*

7. Which coding system is used to report diagnoses and conditions on claims?
   a. CPT
   b. HCPCS Level II
   c. ICD-10-CM
   d. ICD-10-PCS

   ANS: c

   Analysis:
   a. *Incorrect. CPT, or* Current Procedural Terminology*, is used to report procedures or services on outpatient and physician office claims. ICD-10-CM, or* International Classification of Diseases, 10th Revision, Clinical Modification*, is used to report diagnoses and conditions on all claims.*
   b. *Incorrect. HCPCS Level II, or* Healthcare Common Procedure Coding System Level II*, codes are used to report procedures or services on outpatient and physician office claims, especially for medical devices and supplies. ICD-10-CM, or* International Classification of Diseases, 10th Revision, Clinical Modification*, is used to report diagnoses and conditions on all claims.*
   c. ***Correct**. ICD-10-CM, or* International Classification of Diseases, 10th Revision, Clinical Modification*, is used to report diagnoses and conditions on all claims.*
   d. *Incorrect. ICD-10-PCS, or* International Classification of Diseases, 10th Revision, Procedure Coding System*, is used to report inpatient hospital procedures or services on UB-04 claims. ICD-10-CM, or* International Classification of Diseases, 10th Revision, Clinical Modification*, is used to report diagnoses and conditions on all claims.*

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8. Which organization publishes the CPT coding system?
   a. ADA
   b. AHIMA
   c. AMA
   d. CMS

   ANS: c

   Analysis:
   a. *Incorrect. The ADA, or American Dental Association, publishes CDT (Current Dental Terminology). The AMA, or American Medical Association, publishes CPT (Current Procedural Terminology).*
   b. *Incorrect. AHIMA, or American Health Information Management Association, is a professional organization that promotes the health information management and coding professions. The AMA, or American Medical Association, publishes CPT (Current Procedural Terminology).*
   c. ***Correct**. The AMA, or American Medical Association, publishes CPT (Current Procedural Terminology).*
   d. *Incorrect. CMS, or Centers for Medicare and Medicaid Services, along with the NCHS (National Center for Health Statistics) is responsible for developing and updating ICD-10-CM and ICD-10-PCS. The AMA, or American Medical Association, publishes CPT (Current Procedural Terminology).*

9. National codes are associated with
   a. CDT.
   b. CPT.
   c. HCPCS Level II.
   d. ICD.

   ANS: c

   Analysis:
   a. *Incorrect. CDT, or Current Dental Terminology, codes are assigned for dental services. HCPCS Level II codes, or National codes, are assigned for outpatient and physician office procedures and services.*
   b. *Incorrect. CPT, or Current Procedural Terminology, codes are assigned for outpatient and physician office procedures and services. HCPCS Level II codes, or National codes, are assigned for outpatient and physician office procedures and services.*
   c. ***Correct**. HCPCS Level II codes, or National codes, are assigned for outpatient and physician office procedures and services.*
   d. *Incorrect. ICD, or the International Classification of Diseases, is developed and updated by the World Health Organization. HCPCS Level II codes, or National codes, are assigned for outpatient and physician office procedures and services.*

10. The process of linking procedure/service and condition codes on a CMS-1500 claim justifies
    a. coding.
    b. hold harmless.
    c. medical necessity.
    d. scope of practice.

    ANS: c

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Analysis:

a. *Incorrect. Coding is the process of assigning ICD-10-CM, ICD-10-PCS, CPT, and HCPCS level II codes to diagnoses, procedures, and services; codes are reported on an insurance claim, and they play an important role in establishing medical necessity for an encounter. Medical necessity involves linking every procedure or service code reported on the claim to a condition code that justifies the need to perform that procedure or service.*
b. *Incorrect. Hold harmless is an insurance contract clause that states the patient is not responsible for paying what the insurance plan denies, and the health care provider cannot collect those fees from the patient. Medical necessity involves linking every procedure or service code reported on the claim to a condition code that justifies the need to perform that procedure or service.*
c. ***Correct**. Medical necessity involves linking every procedure or service code reported on the claim to a condition code that justifies the need to perform that procedure or service.*
d. *Incorrect. Scope of practice defines the profession, delineates qualifications and responsibilities, and clarifies supervision requirements. Medical necessity involves linking every procedure or service code reported on the claim to a condition code that justifies the need to perform that procedure or service.*

11. The medical practice that employs a health insurance specialist is legally responsible for their actions when performed within the context of their employment, which is called
    a. *per se*.
    b. *res gestae.*
    c. *respondeat superior*.
    d. *Subpoena duces tecum.*

    ANS: c

    Analysis:

    a. *Incorrect.* Per se *is Latin for "through itself," which means as such or what would be expected from a name, such as, "Your opinion about this process is interesting,* per se*, but it is not relevant to the current topic."* Respondeat superior *is Latin for "let the master answer," which means that the employer is liable for the actions and omissions of employees as performed and committed within the scope of their employment.*
    b. *Incorrect.* Res gestae *is Latin for "things done" or "things transacted," which refers to facts in evidence as part of a litigated issue and are admissible.* Respondeat superior *is Latin for "let the master answer," which means that the employer is liable for the actions and omissions of employees as performed and committed within the scope of their employment.*
    c. ***Correct**.* Respondeat superior *is Latin for "let the master answer," which means that the employer is liable for the actions and omissions of employees as performed and committed within the scope of their employment.*
    d. *Incorrect.* Subpoena duces tecum *is Latin for "you shall bring with you," and is a* subpoena *(written court order) that requires a witness to produce documents as part of a legal proceeding, such as patient records.* Respondeat superior *is Latin for "let the master answer," which means that the employer is liable for the actions and omissions of employees as performed and committed within the scope of their employment.*

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12. Which type of insurance guarantees repayment for financial losses resulting from an employee's act or failure to act?
    a. Bonding
    b. Liability
    c. Property
    d. Workers' compensation

    ANS: a

    Analysis:
    a. ***Correct**. Bonding insurance protects a medical practice from an employee's act or failure to act.*
    b. *Incorrect. Liability insurance protects a company against third-party lawsuits, such as medical malpractice lawsuits. Bonding insurance protects a medical practice from an employee's act or failure to act.*
    c. *Incorrect. Property insurance protects a company from lawsuits resulting from property owned (e.g., visitor or patient fall on a slippery floor). Bonding insurance protects a medical practice from an employee's act or failure to act.*
    d. *Incorrect. Workers' compensation insurance covers employees who are injured or become ill on the job. Bonding insurance protects a medical practice from an employee's act or failure to act.*

13. Physicians and other health care professionals purchase _____ insurance to protect them from liability relating to claims arising from patient treatment.
    a. bonding
    b. medical malpractice
    c. third-party payer
    d. workers' compensation

    ANS: b

    Analysis:
    a. *Incorrect. Bonding insurance protects a medical practice from an employee's act or failure to act. Medical malpractice insurance coverage is purchased to protect the medical practice from third-party lawsuits alleging medical malpractice or negligence.*
    b. ***Correct**. Medical malpractice insurance coverage is purchased to protect the medical practice from third-party lawsuits alleging medical malpractice or negligence.*
    c. *Incorrect. Third-party payer refers to a health plan, health program, or health insurance company entity that manages and reimburses health care expenses. Medical malpractice insurance coverage is purchased to protect the medical practice from third-party lawsuits alleging medical malpractice or negligence.*
    d. *Incorrect. Workers' compensation insurance covers employees who are injured or become ill on the job. Medical malpractice insurance coverage is purchased to protect the medical practice from third-party lawsuits alleging medical malpractice or negligence.*

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14. Which requires health insurance specialists to differentiate among the technical descriptions of similar procedures in the CPT coding manual?
    a. Critical thinking
    b. Data entry
    c. Pathophysiology
    d. Verbal and written communication

    ANS: a

    Analysis:
    a. ***Correct****. Critical thinking is the process of analyzing information, such as similar CPT code descriptions to determine the most appropriate code assignment.*
    b. *Incorrect. Data entry is the process of capturing and entering data into medical management software. Critical thinking is the process of analyzing information, such as similar CPT code descriptions to determine the most appropriate code assignment.*
    c. *Incorrect. Pathophysiology is the study of the mechanism responsible for a particular disease, along with etiology, treatments, and outcomes. Critical thinking is the process of analyzing information, such as similar CPT code descriptions to determine the most appropriate code assignment.*
    d. *Incorrect. Verbal and written communication is the first step in capturing or gathering information. Critical thinking is the process of analyzing information, such as similar CPT code descriptions to determine the most appropriate code assignment.*

15. The American Association of Medical Assistants offers which certification exam?
    a. CCS
    b. CMA
    c. CPC
    d. RHIT

    ANS: b

    Analysis:
    a. *Incorrect. The CCS, or Clinical Coding Specialist, certification exam is offered by the American Health Information Management Association (AHIMA). The CMA, or Certified Medical Assistant, certification exam is offered by the American Association of Medical Assistants (AAMA).*
    b. ***Correct****. The CMA, or Certified Medical Assistant, certification exam is offered by the American Association of Medical Assistants (AAMA).*
    c. *Incorrect. The CPC, or Certified Professional Coder, certification exam is offered by the AAPC. The CMA, or Certified Medical Assistant, certification exam is offered by the American Association of Medical Assistants (AAMA).*
    d. *Incorrect. The RHIT, or Registered Health Information Technician, certification exam is offered by AHIMA (American Health Information Management Association). The CMA, or Certified Medical Assistant, certification exam is offered by the American Association of Medical Assistants (AAMA).*

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1.2: Professionalism

1. Increased professional knowledge leads to increased _____ and performance improvement on the job.
   a. ethics
   b. leadership
   c. management
   d. productivity
   e. service

   ANS: d

   Analysis:
   a. *Incorrect. Rules that govern the conduct of members of a profession are called professional ethics. Increased professional knowledge leads to increased productivity and performance improvement on the job.*
   b. *Incorrect. An employee who motivates team members so that organizational goals are achieved demonstrates leadership. Increased professional knowledge leads to increased productivity and performance improvement on the job.*
   c. *Incorrect. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict management skills. Increased professional knowledge leads to increased productivity and performance improvement on the job.*
   d. ***Correct**. Increased professional knowledge leads to increased productivity and performance improvement on the job.*
   e. *Incorrect. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer service. Increased professional knowledge leads to increased productivity and performance improvement on the job.*

2. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict _____ skills.
   a. ethics
   b. leadership
   c. management
   d. productivity
   e. service

   ANS: c

   Analysis:
   a. *Incorrect. Rules that govern the conduct of members of a profession are called professional ethics. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict management skills.*
   b. *Incorrect. An employee who motivates team members so that organizational goals are achieved demonstrates leadership. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict management skills.*
   c. ***Correct**. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict management skills.*

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d. *Incorrect. Increased professional knowledge leads to increased productivity and performance improvement on the job. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict management skills.*
e. *Incorrect. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer service. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict management skills.*

3. An employee who motivates team members so that organizational goals are achieved demonstrates
   a. ethics.
   b. leadership.
   c. management.
   d. productivity.
   e. service.

   ANS: b

   Analysis:
   a. *Incorrect. Rules that govern the conduct of members of a profession are called professional ethics. An employee who motivates team members so that organizational goals are achieved demonstrates leadership.*
   b. ***Correct**. An employee who motivates team members so that organizational goals are achieved demonstrates leadership.*
   c. *Incorrect. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict management skills. An employee who motivates team members so that organizational goals are achieved demonstrates leadership.*
   d. *Incorrect. Increased professional knowledge leads to increased productivity and performance improvement on the job. An employee who motivates team members so that organizational goals are achieved demonstrates leadership.*
   e. *Incorrect. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer service. An employee who motivates team members so that organizational goals are achieved demonstrates leadership.*

4. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer
   a. ethics.
   b. leadership.
   c. management.
   d. productivity.
   e. service.

   ANS: e

   Analysis:
   a. *Incorrect. Rules that govern the conduct of members of a profession are called professional ethics. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer service.*

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b. *Incorrect. An employee who motivates team members so that organizational goals are achieved demonstrates leadership. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer service.*
c. *Incorrect. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict management skills. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer service.*
d. *Incorrect. Increased professional knowledge leads to increased productivity and performance improvement on the job. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer service.*
e. ***Correct**. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer service.*

5. Rules that govern the conduct of members of a profession are called professional
   a. ethics.
   b. leadership.
   c. management.
   d. productivity.
   e. service.

   ANS: a

   Analysis:
   a. ***Correct**. Rules that govern the conduct of members of a profession are called professional ethics.*
   b. *Incorrect. An employee who motivates team members so that organizational goals are achieved demonstrates leadership. Rules that govern the conduct of members of a profession are called professional ethics.*
   c. *Incorrect. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict management skills. Rules that govern the conduct of members of a profession are called professional ethics.*
   d. *Incorrect. Increased professional knowledge leads to increased productivity and performance improvement on the job. Rules that govern the conduct of members of a profession are called professional ethics.*
   e. *Incorrect. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer service. Rules that govern the conduct of members of a profession are called professional ethics.*

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ASSIGNMENTS

ASSIGNMENT 1.1: INTERVIEW A PROFESSIONAL

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

ASSIGNMENT 1.2: READY, SET, GET A JOB!

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

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Assignment 1.3: Journal Abstract

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

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

Assignment 1.4: Professional Discussion Forums (Listservs)

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

Assignment 1.5: Learning About Professional Credentials

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

Credential Abbreviation	Meaning of Credential	Education	Experience	Exam Fee	CEU Requirements
CPC	Certified Professional Coder	High-level knowledge of anatomy, medical terminology, pathophysiology, and medical coding	Not applicable	$399 for one attempt $499 for two attempts	36 CEUs every two years
COC	Certified Outpatient Coder	Associate degree in medical coding or health information management recommended	Two years of coding experience	$399 for one attempt $499 for two attempts	36 CEUs every two years
CPB	Certified Professional Biller	Associate degree in medical coding and reimbursement or health information management recommended	Not applicable	$399 for one attempt $499 for two attempts	36 CEUs every two years

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American Health Information Management Association
www.ahima.org

Credential Abbreviation	Meaning of Credential	Education	Experience	Exam Fee	CEU Requirements
CCS	Certified Coding Specialist	Medical coding certificate or Associate degree	Minimum two years coding experience	$299 (member) $399 (nonmember)	20 CEUs every two years, plus annual coding self reviews
CCS-P	Certified Coding Specialist – Physician-based	Medical coding certificate	Minimum two years coding experience	$299 (member) $399 (nonmember)	20 CEUs every two years, plus annual coding self reviews

Assignment 1.6: Professionalism

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

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Assignment 1.7: Telephone Messages

a. **Case 1**

DATE 9/8/YYYY TIME 12:15 P.M.
TO Dr. Al A. Sickmann, M.D.

WHILE YOU WERE OUT

MR./MRS. Faye Slift
FROM
PHONE (123) 934-6857

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

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

TAKEN BY (Student Name)

b. **Case 2**

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

WHILE YOU WERE OUT

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

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

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

TAKEN BY (Student Name)

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Assignment 1.8: Multiple Choice Review

1. The concept that every procedure or service reported to a third-party payer must be linked to a condition that justifies that procedure or service is called medical
   a. condition.
   b. necessity.
   c. procedure.
   d. requirement.

   ANS: b

2. The administrative agency responsible for establishing rules for Medicare claims processing is called the
   a. Centers for Medicare and Medicaid Services (CMS).
   b. Department of Education and Welfare (DEW).
   c. Department of Health and Human Services (DHHS).
   d. Office of Inspector General (OIG).

   ANS: a

3. When answering the telephone at a provider's office, you must
   a. place the patient on hold without asking.
   b. say the name of your office clearly.
   c. tell the patient to call back.
   d. use health care jargon.

   ANS: b

4. Which organization is responsible for administering the Certified Coding Specialist certification exam?
   a. AAPC
   b. AHIMA
   c. AMBA
   d. NHA

   ANS: b

5. Which clause is implemented if the requirements associated with prior approval of a claim prior to payment are not met?
   a. eligibility
   b. hold harmless
   c. no fault
   d. nonparticipation

   ANS: b

6. The ability to motivate team members to complete a common organizational goal display is called
   a. autonomy.
   b. collegiality.
   c. leadership.
   d. management.

   ANS: c

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7. Patients with health insurance may require _____ for treatment by specialists and documentation of post-treatment reports.
    a. billing
    b. coding
    c. electronic data interchange
    d. prior approval

    ANS: d

8. Which protects business contents (e.g., buildings and equipment) against fire, theft, and other risks?
    a. bonding insurance
    b. business liability insurance
    c. property insurance
    d. workers' compensation insurance

    ANS: c

9. Which is another title for a health insurance specialist?
    a. coder
    b. health information manager
    c. medical assistant
    d. reimbursement specialist

    ANS: d

10. If a patient is seen by a provider who orders a chest x-ray, which diagnosis should be linked with the procedure to prove medical necessity?
    a. abdominal distress
    b. heartburn
    c. shortness of breath
    d. sinus pain

    ANS: c

11. The principles of right or good conduct are known as
    a. bylaws.
    b. ethics.
    c. rights.
    d. standards.

    ANS: b

12. Which is submitted to a third-party payer to request reimbursement for procedures and services provided?
    a. health insurance claim
    b. electronic data interchange
    c. explanation of benefits
    d. remittance advice

    ANS: a

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13. When an individual chooses to perform services for another under an express or implied agreement and is not subject to the other's control, the individual is defined as a(n)
    a. casual employee.
    b. dependent contractor.
    c. independent contractor.
    d. statutory employee.

    ANS: c

14. Employers are generally considered liable for the actions and omissions of employees as performed and committed within the scope of their employment. This is known as
    a. the chain of command.
    b. errors and omissions.
    c. *respondeat superior*.
    d. the scope of practice.

    ANS: c

15. Third-party payer _____ review CMS-1500 claims to determine whether the charges are reasonable for payment.
    a. claims examiners
    b. coders
    c. providers
    d. remitters

    ANS: a

16. Which type of insurance should be purchased by health insurance specialist independent contractors?
    a. bonding
    b. errors and omissions
    c. medical malpractice
    d. workers' compensation

    ANS: b

17. ICD-10-CM codes are assigned to _____ on inpatient and outpatient claims.
    a. diagnoses
    b. procedures
    c. services
    d. treatments

    ANS: a

18. Which is used to report codes for inpatient hospital procedures?
    a. CPT
    b. HCPCS Level II
    c. ICD-10-CM
    d. ICD-10-PCS

    ANS: d

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19. High blood pressure is an example of a
    a. code.
    b. diagnosis.
    c. procedure.
    d. service.

    ANS: b

20. Which are usually considered self-employed?
    a. claims examiners
    b. health information technicians
    c. health insurance specialists
    d. independent contractors

    ANS: d

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Instructor Manual

Green, Understanding Health Insurance, 19ed., 2024, 9780357932063;
Chapter 1: Health Insurance Specialist Career

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Purpose and Perspective of the Chapter

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

Chapter Objectives

The following objectives are addressed in this chapter:

1. Define key terms related to the health insurance specialist career.
2. Briefly summarize health insurance claims processing and the parties involved.
3. Identify career opportunities available for health insurance specialists.
4. List the education and training requirements of a health insurance specialist.
5. Describe the job responsibilities of a health insurance specialist.
6. Differentiate among types of insurance purchased by contractors and employers.
7. Explain the role of workplace professionalism for a health insurance specialist.
8. Demonstrate telephone skills for the health care setting.
9. Identify coding and reimbursement professional associations and credentials offered.

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Key Terms

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

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

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

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

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

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

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

coder: Coders apply a working knowledge of coding systems, including coding conventions and guidelines, government regulations, and third-party payer requirements, to accurately assign ICD-10-CM/PCS and CPT/ HCPCS Level II codes to diagnoses and procedures/services documented in medical records.

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

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

errors and omissions insurance: See professional liability insurance.

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

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

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

health insurance claim: Documentation that is electronically or manually submitted to an insurance plan requesting reimbursement for health care procedures and services provided (e.g., CMS-1500 and UB-04 claims).

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

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

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

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

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

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

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

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

professionalism: Conduct or qualities that characterize a professional person.

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

reimbursement specialist: See health insurance specialist.

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

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

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

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What's New in This Chapter

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

- Content about essentials skills, medical devices, equipment, and supplies was added along with additional examples about training requirements for health insurance specialists. The health insurance overview and professional associations sections of the chapter were revised to clarify content.

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Chapter Outline

In the outline below, each element includes references (in parentheses) to chapter objectives.

I. Introduction

II. Health Insurance Overview (01.02)

III. Career Opportunities (01.03)

IV. Education and Training (01.04)
   a. Student Internship

V. Job Responsibilities (01.05)
   a. Health Insurance Specialist Job Description

VI. Independent Contractor and Employer Liability (01.06)

VII. Professionalism (01.07)
   a. Attitude, Self-Esteem, and Etiquette
   b. Communication
   c. Conflict Management
   d. Customer Service
   e. Diversity Awareness
   f. Leadership
   g. Managing Change
   h. Productivity
   i. Professional Ethics
   j. Team-Building
   k. Professional Appearance

VIII. Telephone Skills for the Health Care Setting (01.08)

IX. Professional Associations and Credentials (01.09)

X. Summary

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XI. Internet Links

XII. Review
   a. 1.1 – Multiple Choice
   b. 1.2 – Professionalism

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Discussion Questions

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

1. **Discussion: Certification**: Research the different coding and reimbursement certifications that are available and choose one you would like to have. Discuss the following:
   - What are the requirements for sitting for the exam?
   - What expectations do you have about taking the exam?
   - Why did you choose that coding certification over the others you researched?
   - What is one thing you learned about the coding exam you chose that surprised you?
   - Why is obtaining this coding certification a benefit when looking for employment?

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Additional Resources

Internet Resources

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

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Appendix

Generic Rubrics

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

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

Standard Writing Rubric

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

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Standard Discussion Rubric

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

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