WORKING WITH MEDICAL INSURANCE AND BILLING

1 INTRODUCTION TO THE MEDICAL BILLING CYCLE

KEY TERMS

accounts payable (AP)
accounts receivable (AR)
adjudication
benefits
capitation
cash flow
certification
coinsurance
compliance
consumer-driven health plan (CDHP)
copayment
covered services
deductible
diagnosis code
electronic health records (EHR)
ethics
etiquette
excluded services
fee-for-service
healthcare claim
health information technology (HIT)
health maintenance organization (HMO)
health plan
indemnity plan
managed care
managed care organization (MCO)
medical billing cycle
medical coder
medical insurance
medical insurance specialist
medical necessity
network
noncovered services
out-of-network
out-of-pocket
participation
patient ledger
Patient Protection and Affordable Care Act (ACA)
payer
per member per month (PMPM)
PM/EHR
policyholder
practice management program (PMP)
preauthorization

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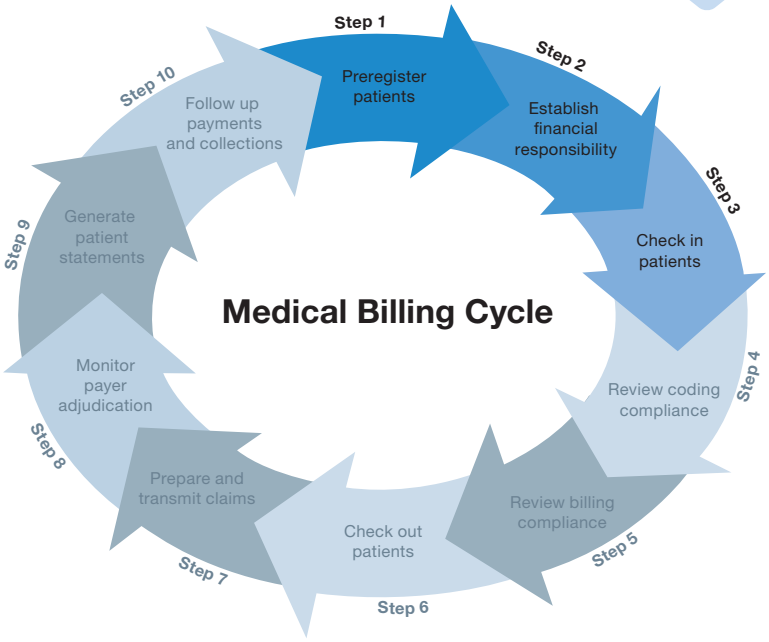


Learning Outcomes

After studying this chapter, you should be able to:

- **1.1** Identify three ways that medical insurance specialists help ensure the financial success of physician practices.
- **1.2** Differentiate between covered and noncovered services under medical insurance policies.
- **1.3** Compare indemnity and managed care approaches to health plan organization.
- **1.4** Discuss three examples of cost containment employed by health maintenance organizations.
- **1.5** Explain how a preferred provider organization works.
- **1.6** Describe the two elements that are combined in a consumer-driven health plan.
- **1.7** Define the three major types of medical insurance payers.
- **1.8** Explain the ten steps in the medical billing cycle.
- **1.9** Analyze how professionalism and etiquette contribute to career success.
- **1.10** Evaluate the importance of professional certification for career advancement.

KEY TERMS *(continued)*

preexisting condition
preferred provider organization (PPO)
premium
preventive medical services
primary care physician (PCP)
procedure code
professionalism
provider
referral
revenue cycle management (RCM)
schedule of benefits
self-funded (self-insured) health plan
third-party payer

Patients who come to physicians' practices for medical care are obligated to pay for the services they receive. Some patients pay these costs themselves, while others have medical insurance to help them cover medical expenses. Administrative staff members help collect the maximum appropriate payments by handling patients' financial arrangements, billing insurance companies, and processing payments to ensure both top-quality service and profitable operation.

1.1 Working in the Medical Insurance Field

The trillion-dollar healthcare industry—including pharmaceutical companies, hospitals, doctors, medical equipment makers, nursing homes, assisted-living centers, and insurance companies—is a fast-growing and dynamic sector of the American economy.

Rising Spending on Healthcare

Despite difficult economic times, spending on healthcare in the United States continues to rise. The most important reason for increased costs is the fact that the aging U.S. population requires more healthcare services. A higher percentage of the population is over age sixty-five, and older people need more healthcare services than do younger people. Two-thirds of Americans over 65 and three-quarters of those over 80 have multiple chronic diseases, such as diabetes, hypertension, osteoporosis, and arthritis.

Because medical costs are rising faster than the overall economy is growing, more of everyone's dollars are spent on healthcare. Federal and state government budgets increase to pay for medical services, employers pay more each year for medical services for their employees, and patients also pay higher costs. These rising costs increase the financial pressure on physicians' practices. To remain profitable, physicians must carefully manage the business side of their practices. Knowledgeable medical office employees are in demand to help. Figure 1.1 describes the rapidly growing employment possibilities in the healthcare administrative area.

Administrative Complexity Increases Career Opportunities

The healthcare industry offers many rewarding career paths for well-qualified employees. Providers must compete in a complex environment of various health plans, managed care contracts, and federal and state regulations. The average practice works with nearly twenty different health plans, and some with more than eighty of them. Employment in positions that help providers handle these demands is growing, as are opportunities for career development. According to *The Physician's Advisory*, a healthcare journal:

> " . . . good, experienced billing/coding specialists are in short supply; to retain good workers in these very important positions, going up in salary is a bargain compared to risking their going to another employer . . . the work of insurance specialists is an increasingly complex job."

U.S. Department of Labor
Bureau of Labor Statistics

Occupational Outlook Handbook

Health Information Technicians

- Health information technicians are projected to be one of the fastest-growing occupations.
- Job prospects for those with a certification in health information will be best. As electronic health record (EHR) systems continue to become more common, technicians with computer skills will be needed to use them. Employment of health information technicians is expected to grow faster than the average for all occupations through 2020, due to rapid growth in the number of medical tests, treatments, and procedures that will be increasingly scrutinized by third-party payers, regulators, courts, and consumers.
- Most technicians will be employed in hospitals, but job growth will be faster in offices and clinics of physicians, nursing homes, and home health agencies. Technicians who achieve additional qualifications through professional organizations, or who obtain a bachelor's or master's degree will be particularly successful.

Medical Assistants

- Employment of medical assistants is expected to grow much faster than the average for all occupations through 2020 as the health services industry expands due to technological advances in medicine and a growing and aging population. It is one of the fastest-growing occupations.
- Employment growth will be driven by the increase in the number of group practices, clinics, and other healthcare facilities that need a high proportion of support personnel, particularly the flexible medical assistant who can handle both administrative and clinical duties so that physicians can see more patients. Medical assistants work primarily in outpatient settings, where much faster than average growth is expected. As more and more physicians' practices switch to EHRs, medical assistants' job responsibilities will continue to change. They will need to become familiar with EHR computer software, including maintaining EHR security and analyzing electronic data, to improve healthcare information.
- Job prospects should be best for medical assistants with formal training or experience, particularly those with certification. The medical assistants who are expected to excel are those best fit to deal with the public through a courteous, pleasant manner and a professional demeanor.

Medical Administrative Support

- Growth in the health services industry will spur faster than average employment growth for medical support staff.
- Medical administrative support employees may transcribe dictation, prepare correspondence, and assist physicians or medical scientists with reports, speeches, articles, and conference proceedings. They also record simple medical histories, arrange for patients to be hospitalized, and order supplies. Most medical administrative support staff need to be familiar with insurance rules, billing practices, the use of EHRs and hospital or laboratory procedures.
- As with health information technicians and medical assistants, medical administrative support employees with advanced qualifications and degrees will excel.

FIGURE 1.1 Employment Opportunities

Helping to Ensure Financial Success

cash flow movement of monies into or out of a business

Medical insurance specialists' effective and efficient work is critical for the satisfaction of the patients—the physician's customers—and for the financial success of the practice. To maintain a regular **cash flow**—the movement of monies into or out of a business—specific tasks must be completed on a regular schedule before, during, and after a patient visit. Managing cash flow means making sure that sufficient monies flow

into the practice from patients and insurance companies paying for medical services, referred to as **accounts receivable (AR)**, to pay the practice's operating expenses, such as for rent, salaries, supplies, and insurance—called **accounts payable (AP)**.

accounts receivable (AR) monies owed to a medical practice

accounts payable (AP) a practice's operating expenses

Tracking AR and AP is an accounting job. *Accounting*, often referred to as "the language of business," is a financial information system that records, classifies, reports on, and interprets financial data. Its purpose is to analyze the financial condition of a business following generally accepted accounting principles (GAAP). The accountant of the practice sets up accounts such as AR, AP, and patient accounts for all aspects of running the practice and then prepares financial statements that show whether the cash flow is adequate. These statements are monitored regularly to see whether revenues are sufficient or need improving.

Having adequate cash flow is measured in terms of **revenue cycle management (RCM)**—the process of making sure that sufficient monies flow into the practice from patients and insurance companies paying for medical services to pay the practice's bills.

revenue cycle management (RCM) process of making sure sufficient monies flow into the practice to pay the practice's bills

Medical insurance specialists have an important role in revenue cycle management. They help to ensure financial success by (1) carefully following procedures, (2) communicating effectively, and (3) using health information technology—medical billing software and electronic health records—to improve efficiency and contribute to better health outcomes.

Following Procedures

Medical billing requires a set of procedures. Some procedures involve administrative duties, such as entering data and updating patients' records. Other procedures are done to comply with government regulations, such as keeping computer files secure from unauthorized viewing. In most offices, policy and procedure manuals that describe how to perform major duties are available.

For most procedures, medical insurance specialists work in teams with both licensed medical professionals and other administrative staff members. Providers include physicians and nurses as well as physician assistants (PAs), nurse-practitioners (NPs), clinical social workers, physical therapists, occupational therapists, audiologists, and clinical psychologists. Administrative staff may be headed by an office manager, practice manager, or practice administrator to whom medical assistants, patient services representatives or receptionists, and billing, insurance, and collections specialists report.

Communicating

Communication skills are as important as knowing about specific forms and regulations. A pleasant tone, a friendly attitude, and a helpful manner when gathering information increase patient satisfaction. Having interpersonal skills enhances the billing and reimbursement process by establishing professional, courteous relationships with people of different backgrounds and communication styles. Effective communicators have the skill of empathy; their actions convey that they understand the feelings of others.

Equally important are effective communications with physicians, other professional staff members, and all members of the administrative team. Conversations must be brief and to the point, showing that the speaker values the provider's time. People are more likely to listen when the speaker is smiling and has an interested expression, so speakers should be aware of their facial expressions and should maintain moderate eye contact. In addition, good listening skills are important.

Using Health Information Technology

Medical insurance specialists use **health information technology (HIT)**—computer hardware and software information systems that record, store, and manage patient information—in almost all physician practices.

health information technology (HIT) computer information systems that record, store, and manage patient information

practice management program (PMP) account software used for scheduling appointments, billing, and financial record keeping

Practice Management Programs **Practice management programs (PMPs)**, which are accounting software used in almost all medical offices for scheduling appointments, billing, and financial record keeping, are good examples of HIT.

They streamline the process of creating and following up on healthcare claims sent to payers and on bills sent to patients.

Expertise in the use of practice management programs is an important skill in the medical practice. Medical insurance specialists use them to:

- Schedule patients
- Organize patient and insurance information
- Collect data on patients' diagnoses and services
- Generate, transmit, and report on the status of healthcare claims
- Record payments from insurance companies
- Generate patients' statements, post payments, and update accounts
- Create financial and productivity reports

BILLING TIP

Medisoft and Medisoft Clinical

In this text, Medisoft Advanced Patient Accounting from McKesson Corporation is the PMP used to illustrate typical data entry screens and printed accounting reports. Medisoft Clinical, also from McKesson Corporation, illustrates typical electronic records and population-management reports.

Electronic Health Records

Another HIT application is rapidly becoming critical in physician practices: electronic health records, or EHRs. While patients' financial records have been electronic for more than a decade, clinical records—the information about a patient's health entered by doctors, nurses, and other healthcare professionals—until recently, have been stored in paper charts. An **electronic health record (EHR)** is a computerized lifelong healthcare record for an individual that incorporates data from all sources that provide treatment for the individual. Note that EHRs are not the same as *electronic medical records*, or *EMRs*, which are a single provider's records of patients.

electronic health record (EHR) computerized lifelong healthcare record for an individual that incorporates data from all sources

EHR systems are set up to gather patients' clinical information using the computer rather than paper. Most EHR systems are designed to exchange information with—to "talk" to—the PMP and to eliminate the need for many paper forms. Electronic health record systems are discussed further in the chapter on EHRs, HIPAA, and HITECH.

PM/EHRs Some software programs combine both a PMP and an EHR in a single product called an integrated **PM/EHR.** Data entered in either the PMP or the EHR can be used in all applications, such as scheduling, billing, and clinical care. For example, if a receptionist enters basic information about a patient in the electronic health record during the patient's first visit to the practice, those data are available for the medical insurance specialist to use in the billing program. Facts such as the patient's identifying information, type of health insurance, and previous healthcare records must be entered only once rather than in both programs. PM/EHRs greatly improve administrative efficiency.

PM/EHR software program that combines both a PMP and an EHR into a single product

A Note of Caution: What Health Information Technology Cannot Do

Although computers increase efficiency and reduce errors, they are not more accurate than the individual who is entering the data. If people make mistakes while entering data, the information the computer produces will be incorrect. Computers are very precise and also very unforgiving. While the human brain knows that *flu* is short for *influenza*, the computer regards them as two distinct conditions. If a computer user accidentally enters a name as *ORourke* instead of *O'Rourke*, a human might know what is meant; the computer does not. It might respond with the message "No such patient exists in the database."

THINKING IT THROUGH 1.1

1. In your opinion, will employment opportunities for medical insurance specialists in physician practices continue to grow?

1.2 Medical Insurance Basics

Understanding how to work with the medical billing cycle begins with medical insurance basics. **Medical insurance**, which is also known as *health insurance*, is a written policy that states the terms of an agreement between a **policyholder**—an individual—and a **health plan**—an insurance company. The policyholder (also called the insured, the member, or the subscriber) makes payments of a specified amount of money. In exchange, the health plan provides **benefits**—defined by the America's Health Insurance Plans (AHIP) as payments for medical services—for a specific period of time. Because they pay for medical expenses, then, health plans are often referred to as **payers**.

medical insurance financial plan that covers the cost of hospital and medical care

policyholder person who buys an insurance plan

health plan individual or group plan that provides or pays for medical care

benefits health plan payments for covered services

payer health plan or program

BILLING TIP

Third-Party Payers

There are actually three participants in the medical insurance relationship. The patient (policyholder) is the first party, and the physician is the second party. Legally, a patient–physician contract is created when a physician agrees to treat a patient who is seeking medical services. Through this unwritten contract, the patient is legally responsible for paying for services. The patient may have a policy with a health plan, the third party, which agrees to carry some of the risk of paying for those services and therefore is called a **third-party payer.**

third-party payer private or government organization that insures or pays for healthcare on behalf of beneficiaries

Health plans create a variety of insurance products that offer different levels of coverage for various prices. In each product, they must manage the risk that some individuals they insure will need very expensive medical services. They do that by spreading that risk among many policyholders.

Healthcare Benefits

The medical insurance policy contains a **schedule of benefits** that summarizes the payments that may be made for medically necessary medical services that policyholders receive. The payer's definition of **medical necessity** is the key to coverage and payment. A medically necessary service is reasonable and is consistent with generally accepted professional medical standards for the diagnosis or treatment of illness or injury.

Payers scrutinize the need for medical procedures, examining each bill to make sure it meets their medical necessity guidelines. The **provider** of the service must also meet the payer's professional standards. Providers include physicians, nurse-practitioners, physician assistants, therapists, hospitals, laboratories, long-term care facilities, and suppliers such as pharmacies and medical supply companies.

schedule of benefits list of medical expenses covered by a health plan

medical necessity payment criterion that requires medical treatments to be appropriate and provided in accordance with generally accepted standards

provider person or entity that supplies medical or health services and bills for, or is paid for, the services in the normal course of business

Covered Services

Covered services are listed on the schedule of benefits. These services may include primary care, emergency care, medical specialists' services, and surgery. Coverage of some services is mandated by state or federal law; others are optional. Some policies provide benefits only for loss resulting from illnesses or diseases, while others also cover accidents or injuries. Many health plans also cover **preventive medical services**, such as annual physical examinations, pediatric and adolescent immunizations, prenatal care, and routine screening procedures such as mammograms.

covered services medical procedures and treatments that are included as benefits in a health plan

preventive medical services care provided to keep patients healthy or prevent illness

Not all services that are covered have the same benefits. A policy may pay less of the charges for specialty care than for primary care, for example. Many services are also limited in frequency. A payer may cover just three physical therapy treatments for a condition or a certain screening test every five years, not every year.

Noncovered Services

noncovered services medical procedures that are not included in a plan's benefits

excluded services services not covered in a medical insurance contract

The medical insurance policy also describes **noncovered services**—those for which it does not pay. Such **excluded services** or exclusions may include any of the following:

- Most medical policies do not cover dental services, eye examinations or eyeglasses, employment-related injuries, cosmetic procedures, or experimental/investigational procedures.
- Policies may exclude specific items such as vocational rehabilitation or surgical treatment of obesity.
- Many policies do not have prescription drug benefits.
- If a new policyholder has a medical condition that was diagnosed before the policy took effect—known as a **preexisting condition**—medical services to treat it are often not covered under current laws. (Note that these rules are changing under healthcare reform legislation [see page 20].)

preexisting condition illness or disorder that existed before the insurance coverage became effective

Group or Individual Medical Insurance Policies

Either groups or individuals may be insured. In general, policies that are written for groups cost policyholders less than those written for individuals. Group plans are bought by employers or organizations. The employer or the organization agrees to the contract and then offers the coverage to its group members. People who are not eligible for group insurance from employers—for example, independent contractors, temporary or part-time employees, or unemployed people—may purchase individual policies directly from health plans. In either a group or an individual plan, the policyholder's dependents, customarily the spouse and children, may also be covered for an additional cost.

Disability/Automotive Insurance and Workers' Compensation

Other types of health-related insurance are available. A patient may have disability insurance that provides reimbursement for income lost because of the person's inability to work. Automotive insurance policies cover specific vehicle-related situations. Disability insurance is discussed in the chapter about workers' compensation.

Workers' compensation insurance is purchased by employers to pay benefits and provide medical care for employees who are injured in job-related accidents or develop illnesses from their jobs and to pay benefits to employees' dependents in the event of work-related death. State laws determine the coverage that is required.

THINKING IT THROUGH 1.2

1. Describe the type of medical insurance coverage you have. If you are not insured, describe the policy held by someone you know, or select a plan to research by accessing the website of America's Health Insurance Plans (AHIP) at www.ahip.org, clicking Health Insurance Plans Site Link, and selecting a plan to view. According to the plan's policy information (often printed in a pamphlet that accompanies the policy itself or available online at the plan's website), what benefits does the policy cover? Are some services excluded from coverage? Are any preventive medical services included?

1.3 Healthcare Plans

Although there are many variations, all insurance plans are based on one of the two essential types of plans, indemnity and managed care.

BILLING TIP

Filing Claims for Patients

The practice usually handles the process of billing the insurance company for patients; patients are generally more satisfied with their office visits when this is done for them, and the practice receives payment more quickly.

Indemnity

An indemnity is protection against loss. Under an **indemnity plan**, the payer indemnifies the policyholder against costs of medical services and procedures as listed on the benefits schedule. Patients choose the providers they wish to see. The physician usually sends the **healthcare claim**—a formal insurance claim in either electronic or hard copy format that reports data about the patient and the services provided by the physician—to the payer on behalf of the patient.

indemnity plan health plan that offers protection from loss

healthcare claim electronic transaction or a paper document filed to receive benefits

Conditions for Payment

For each claim, four conditions must be met before the insurance company makes a payment:

1. The medical charge must be for medically necessary services and covered by the insured's health plan.
2. The insured's payment of the **premium**—the periodic payment the insured is required to make to keep the policy in effect—must be up-to-date. Unless the premium is current, the insured is not eligible for benefits and the insurance company will not make any payment.
3. If part of the policy, a **deductible**—the amount that the insured pays on covered services before benefits begin—must have been met (paid) by the insured. Deductibles range widely, usually from $200 to thousands of dollars annually. Higher deductibles generally mean lower premiums.
4. Any **coinsurance**—the percentage of each claim that the insured pays—must be taken into account. The coinsurance rate states the health plan's percentage of the charge, followed by the insured's percentage, such as 80-20. This means that the payer pays 80 percent of the covered amount and the patient pays 20 percent after the premiums and deductibles are paid.

premium money the insured pays to a health plan for a policy

deductible amount the insured must pay for healthcare services before a health plan's payment begins

coinsurance portion of charges an insured person must pay for healthcare services after the deductible

The formula is as follows:

Charge − Deductible − Patient Coinsurance = Health Plan Payment.

Example

An indemnity policy states that the deductible is the first $200 in covered annual medical fees and that the coinsurance rate is 80-20. A patient whose first medical charge of the year was $2,000 would owe $560:

Charge	$2,000
Patient owes the deductible	$ 200
Balance	$1,800
Patient also owes coinsurance (20% of the balance)	$ 360
Total balance due from patient	$ 200 + $360 = $560

out-of-pocket expenses the insured must pay prior to benefits

In this case, the patient must pay an **out-of-pocket** expense of $560 this year before benefits begin. The health plan will pay $1,440, or 80 percent of the balance:

Charge	$2,000
Patient payment	−$560
Health plan payment	$1,440

If the patient has already met the annual deductible, the patient's benefits apply to the charge, as in this example:

Charge	$2,000
Patient coinsurance (20%)	$ 400
Health plan payment (80%)	$1,600 ◀

Fee for Service Payment Approach

fee-for-service payment method based on provider charges

Indemnity plans usually reimburse medical costs on a fee-for-service basis. The **fee-for-service** payment method is retroactive: The fee is paid after the patient receives services from the physician (see Figure 1.2 below).

Managed Care

managed care system combining the financing and delivery of healthcare services

managed care organization (MCO) organization offering a managed healthcare plan

Managed care offers a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and other charges than traditional indemnity insurance. This approach to insurance combines the financing and management of healthcare with the delivery of services. **Managed care organizations (MCOs)** establish links between provider, patient, and payer. Instead of only the patient having a policy with the health plan, both the patient and the provider have

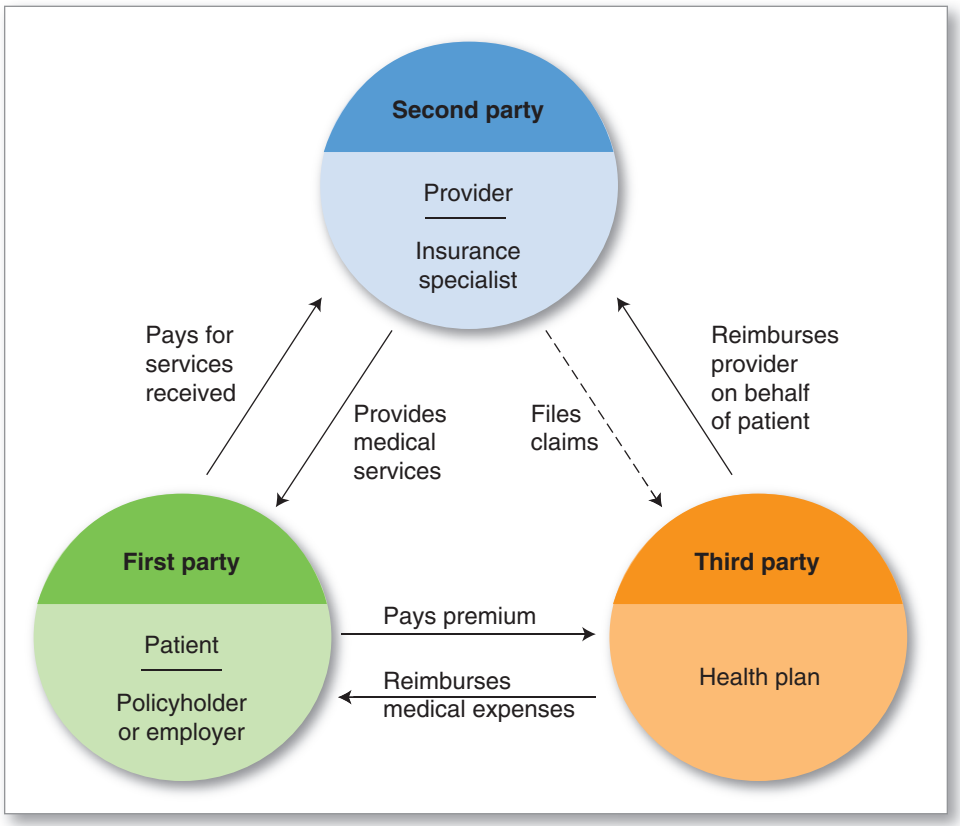


FIGURE 1.2 Payment Under Fee-for-Service

agreements with the MCO. This arrangement gives the MCO more control over what services the provider performs and the fees for the services.

Managed care plans, first introduced in California in 1929, are now the predominant type of insurance. More than 90 percent of all insured employees are enrolled in some type of managed care plan, and thousands of different plans are offered. The basic types are:

- Health maintenance organizations
- Point-of-service plans
- Preferred provider organizations
- Consumer-driven health plans

BILLING TIP

Participation as a Provider

Participation means that a provider has contracted with a health plan to provide services to the plan's beneficiaries. Participation brings advantages, such as more patients, as well as contractual duties and, usually, reduced fees.

participation contractual agreement to provide medical services to a payer's policyholders

THINKING IT THROUGH 1.3

1. Which types of health plans, indemnity or managed care, are likely to offer patients more selection in terms of which physicians patients can visit?

1.4 Health Maintenance Organizations

A **health maintenance organization (HMO)** combines coverage of medical costs and delivery of healthcare for a prepaid premium. The HMO creates a network of physicians, hospitals, and other providers by employing or negotiating contracts with them. The HMO then enrolls members in a health plan under which they use the services of those network providers. In most states, HMOs are licensed and are legally required to provide certain services to members and their dependents. Preventive care is often required as appropriate for each age group, such as immunizations and well-baby checkups for infants and screening mammograms for women.

health maintenance organization (HMO) managed healthcare system in which providers offer healthcare to members for fixed periodic payments

Capitation in HMOs

Capitation (from *capit*, Latin for *head*) is a fixed prepayment to a medical provider for all necessary contracted services provided to each patient who is a plan member (see Figure 1.3). The capitated rate is a prospective payment—it is paid *before* the patient visit. It covers a specific period of time. The health plan makes the payment whether the patient receives many or no medical services during that specified period.

capitation a fixed prepayment covering provider's services for a plan member for a specified period

In capitation, the physician agrees to share the risk that an insured person will use more services than the fee covers. The physician also shares in the prospect that an insured person will use fewer services. In fee-for-service, the more patients the provider sees, the more charges the health plan reimburses. In capitation, the payment per patient remains the same, and the provider risks receiving lower per-visit revenue.

Example

A family physician has a contract for a capitated payment of $30 a month for each of a hundred patients in a plan. This $3,000 monthly fee ($30 × 100 patients = $3,000) covers all office visits for all the patients. If half of the patients see the physician

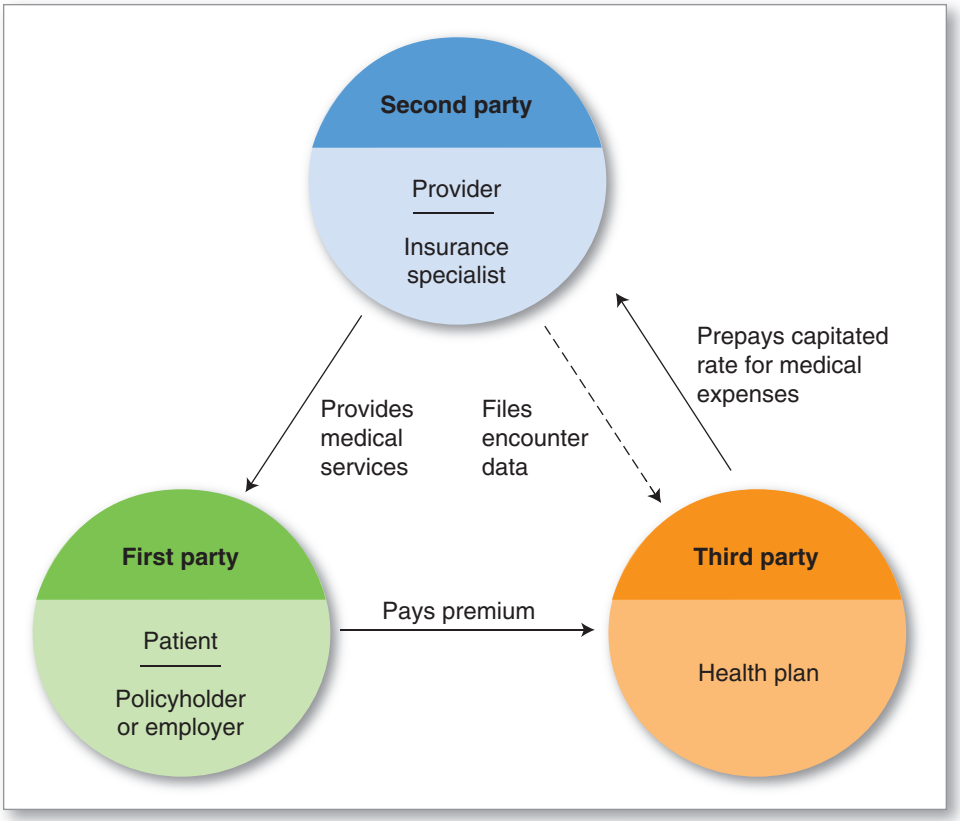


FIGURE 1.3 Payment Under Capitation

once during a given month, the provider in effect receives $60 for each visit ($3,000 divided by 50 visits). If, however, half of the patients see the physician four times in a month, the monthly fee is $3,000 divided by 200 visits, or $15 for each visit.

A patient is enrolled in a capitated health plan for a specific time period, such as a month, a quarter, or a year. The capitated rate, which is called **per member per month (PMPM)**, is usually based on the health-related characteristics of the enrollees, such as age and gender. The health plan analyzes these factors and sets a rate based on its prediction of the amount of healthcare each person will need. The capitated rate of prepayment covers only services listed on the schedule of benefits for the plan. The provider may bill the patient for any other services. ◄

per member per month (PMPM) periodic capitated prospective payment to a provider that covers only services listed on the schedule of benefits

Medical Management Practices in HMOs

Health maintenance organizations seek to control rising medical costs and at the same time improve healthcare.

Cost Containment An HMO uses the following cost-containment methods:

- *Restricting patients' choice of providers:* After enrolling in an HMO, members must receive services from the **network** of physicians, hospitals, and other providers who are employed by or under contract to the HMO. Visits to **out-of-network** providers are not covered, except for emergency care or urgent health problems that arise when the member is temporarily away from the geographical service area.
- *Requiring preauthorization for services:* HMOs often require **preauthorization** (also called *precertification* or *prior authorization*) before the patient receives many types of services. The HMO may require a second opinion—the judgment of another provider that a planned procedure is necessary—before authorizing service. Services that are not preauthorized are not covered. Preauthorization is almost always needed for nonemergency hospital admission, and it is usually required within a certain number of days after an emergency admission.

network a group of healthcare providers, including physicians and hospitals, who sign a contract with a health plan to provide services to plan members

out-of-network provider that does not have a participation agreement with a plan

preauthorization prior authorization from a payer for services to be provided

- *Controlling the use of services:* HMOs develop medical necessity guidelines for the use of medical services. The HMO holds the provider accountable for any questionable service and may deny a patient's or provider's request for preauthorization.

  For example, a patient who has a rotator cuff shoulder injury repair can receive a specific number of physical therapy sessions. More sessions will not be covered unless additional approval is obtained. Emergency care is particularly tightly controlled because it is generally the most costly way to deliver services. These guidelines are also applied to hospitals in the network, which, for instance, limit the number of days patients can remain in the hospital following particular surgeries.
- *Controlling drug costs:* Providers must prescribe drugs for patients only from the HMO's list of selected pharmaceuticals and approved dosages, called a *formulary*. Drugs that are not on the list require the patient to have preauthorization, which is often denied.
- *Cost-sharing:* At the time an HMO member sees a provider, he or she pays a specified charge called a **copayment** (or copay). A lower copayment may be charged for an office visit to the primary care physician, and a higher copayment may be required for a visit to the office of a specialist or for the use of emergency department services.

copayment amount a beneficiary must pay at the time of a healthcare encounter

One other cost-control method is now used less frequently but was a major feature of initial HMOs. This required a patient to select a **primary care physician (PCP)**—also called a *gatekeeper*—from the HMO's list of general or family practitioners, internists, and pediatricians. A PCP coordinates patients' overall care to ensure that all services are, in the PCP's judgment, necessary. In gatekeeper plans, an HMO member needs a medical **referral** from the PCP before seeing a specialist or a consultant and for hospital admission. Members who visit providers without a referral are directly responsible for the total cost of the service.

primary care physician (PCP) physician in a health maintenance organization who directs all aspects of a patient's care

referral transfer of patient care from one physician to another

Historically, the first HMOs used all of these cost-containment methods and reduced operating costs. However, both physicians and patients became dissatisfied with the policies. Physicians working under managed care contracts complained that they were not allowed to order needed treatments and tests. Patients often reported that needed referrals were denied. In response, the medical management practices of HMOs increasingly emphasize the quality of healthcare as well as the cost of its delivery. Just as providers must demonstrate that their services are both effective and efficient, HMOs must demonstrate that they can offer these services at competitive prices while improving the quality of healthcare.

BILLING TIP

Open-Access Plans

Many HMOs have switched from "gatekeeper" plans that require referrals to all specialists to open-access plans, in which members can visit any specialists in the network without referrals. Even if referrals are required for specialists, patients can usually see OB/GYN specialists without referrals.

Healthcare Quality Improvements The quality improvements made by HMOs are illustrated by these features, which most plans contain:

- *Disease/case management:* Some patients face difficult treatments, such as for high-risk pregnancies, and others need chronic care for conditions such as congestive heart failure, diabetes, and asthma. HMOs often assign case managers to work with these patients. Some conditions require case managers who are healthcare professionals. Others are assigned to people who are familiar with the healthcare system, such as social workers. The goal of case managers is to make sure that patients have access to all needed treatments. For example, physician case managers coordinate appropriate referrals to consultants, specialists, hospitals, and other services. Other types of case managers provide patient education, special equipment such as a blood glucose meter for a diabetic, and ongoing contact to monitor a patient's condition.

- *Preventive care:* Preventive care, which seeks to prevent the occurrence of conditions through early detection of disease, is emphasized through provisions for annual checkups, screening procedures, and inoculations.
- *Pay-for-performance (P4P):* HMOs collect and analyze large amounts of data about patients' clinical treatments and their responses to treatment. In this way, the HMOs can establish the most effective protocols—detailed, precise treatment regimens that work best. HMOs use financial incentives to encourage their providers to follow these protocols.

Point-of-Service Plans

Many patients dislike HMO rules that restrict their access to physicians. In order to better compete for membership, a *point-of-service (POS) plan*, also called an open HMO, reduces restrictions and allows members to choose providers who are not in the HMO's network.

Members must pay additional fees that are set by the plan when they use out-of-network providers. Typically, the patient must pay 20 to 30 percent of the charge for out-of-network service, and the deductible can be very high. The HMO pays out-of-network providers on a fee-for-service basis.

THINKING IT THROUGH 1.4

1. Managed care organizations often require different payments for different services. Table 1.1 shows the copayments for an HMO health plan. Study this schedule and answer these questions:
   - **A.** Does this health plan cover diabetic supplies? Dental exams? Emergency services?
   - **B.** Is the copayment amount for a PCP visit higher or lower than the charge for specialty care?

1.5 Preferred Provider Organizations

preferred provider organization (PPO) managed care organization in which a network of providers supplies discounted treatment for plan members

A **preferred provider organization (PPO)** is another healthcare delivery system that manages care. PPOs are the most popular type of insurance plan. They create a network of physicians, hospitals, and other providers with whom they have negotiated discounts from the usual fees. For example, a PPO might sign a contract with a practice stating that the fee for a brief appointment will be $60, although the practice's physicians usually charge $80. In exchange for accepting lower fees, providers—in theory, at least—see more patients, thus making up the revenue that is lost through the reduced fees.

A PPO requires payment of a premium and often of a copayment for visits. It does not require a primary care physician to oversee patients' care. Referrals to specialists are also not required. Premiums and copayments, however, are higher than in HMO or POS plans. Members choose from many in-network generalists and specialists. PPO members also can use out-of-network providers, usually for higher copayments, increased deductibles, or both.

Example

A PPO member using an in-network provider pays a $20 copayment at the time of service (the visit), and the PPO pays the full balance of the visit charge. A member who sees an out-of-network provider usually pays a deductible and a coinsurance that is a higher percentage than in-network visits.

Table 1.1 Example of Benefits Under an HMO

	Copayments
Primary Care Physician Visits	
Office Hours	$20 copay
After Hours/Home Visits	$20 copay
Specialty Care	
Office Visits	$30 copay
Diagnostic Outpatient Testing	$20 copay
Phys, Occ, Speech Therapy	$20 copay
SPU Surgery	$250 copay
Hospitalization	$250 copay
Emergency Room (copay waived if admitted)	$35 copay
Maternity	
First OB Visit	$30 copay
Hospital	$250 copay
Mental Health	
Inpatient	$250 copay, 60 days
Outpatient	$30 copay
Substance Abuse	
Detoxification	$250 copay
Inpatient Rehab (combined with mental health coverage)	$250 copay
Outpatient Rehabilitation	$30 copay
Preventive Care	
Routine Eye Exam	Not covered
Routine GYN Exam	$30 copay
Pediatric Preventive Dental Exam	Not covered
Chiropractic Care (20 visits/condition)	$20 copay
Prescriptions	$15/$20/$30 copay $150 deductible/calendar year
Contraceptives	Covered
Diabetic Supplies	Covered
31–90 Day Supply	$30/$40/$60 copay
Durable Medical Equipment	No copay

As managed care organizations, PPOs also control the cost of healthcare by:

- *Directing patients' choices of providers:* PPO members have financial incentives to receive services from the PPO's network of providers.
- *Controlling use of services:* PPOs have guidelines for appropriate and necessary medical care.
- *Requiring preauthorization for services:* PPOs may require preauthorization for nonemergency hospital admission and for some outpatient procedures.
- *Requiring cost-sharing:* PPO members are also required to pay copayments for general or specialist services. ◄

THINKING IT THROUGH 1.5

1. In your opinion, why are PPOs the most popular type of insurance plan?

Table 1.2 Comparison of Health Plan Options

Plan Type	Provider Options	Cost-Containment Methods	Features
Indemnity Plan	Any provider	• Little or none • Preauthorization required for some procedures	• Higher costs • Deductibles • Coinsurance • Preventive care not usually covered
Health Maintenance Organization (HMO)	Only HMO network providers	• Primary care physician manages care; referral required • No payment for out-of-network nonemergency services • Preauthorization required	• Low copayment • Limited provider network • Covers preventive care
Point-of-Service (POS)	Network providers or out-of-network providers	• Within network, primary care physician manages care	• Lower copayments for network providers • Higher costs for out-of-network providers • Covers preventive care
Preferred Provider Organization (PPO)	Network or out-of-network providers	• Referral not required for specialists • Fees are discounted • Preauthorization for some procedures	• Higher cost for out-of-network providers • Preventive care coverage varies
Consumer-Driven Health Plan	Usually similar to PPO	• Increases patient awareness of healthcare costs • Patient pays directly until high deductible is met	• High deductible/low premium • Savings account

1.6 Consumer-Driven Health Plans

consumer-driven health plan (CDHP) medical insurance that combines a high-deductible health plan with a medical savings plan

Consumer-driven health plans (CDHPs), also known as high-deductible health plans, combine two elements. The first element is a health plan, usually a PPO, that has a high deductible (such as $5,000) and low premiums. The second element is a special "savings account" that is used to pay medical bills before the deductible has been met. The savings account, similar to an individual retirement account (IRA), lets people put aside untaxed wages that they may use to cover their out-of-pocket medical expenses. Some employers contribute to employees' accounts as a benefit.

Cost containment in consumer-driven health plans begins with consumerism—the idea that patients who themselves pay for healthcare services become more careful consumers. Both insurance companies and employers believe that asking patients to pay a larger portion of medical expenses reduces costs. To this are added the other controls typical of a PPO, such as in-network savings and higher costs for out-of-network visits.

The major types of plans are summarized in Table 1.2.

THINKING IT THROUGH 1.6

1. What two elements are combined in a consumer-driven health plan?

1.7 Medical Insurance Payers

Nearly 250 million people in the United States have medical coverage through either private payers, self-funded health plans, or government programs. Nearly 50 million people—about 16 percent of the population—have no insurance. Many of the uninsured people work for employers that either do not offer health benefits or do not cover certain employees, such as temporary workers or part-time employees (see Figure 1.4).

Private Payers

A small number of large insurance companies dominate the national market and offer all types of health plans. The three largest are WellPoint, UnitedHealth Group, and Aetna. There are also a number of nonprofit organizations, such as Kaiser Permanente, which is the largest nonprofit HMO. Some organizations, such as the Blue Cross and Blue Shield Association, have both for-profit and nonprofit parts.

Private payers have contracts with businesses to provide benefits for their employees. These may be large-group or small-group healthcare plans. Payers may also offer individual insurance coverage.

Self-Funded Health Plans

Some 50 million employees have health insurance through employers that have established themselves as **self-funded (self-insured) health plans**. Rather than paying premiums to an insurance carrier, the organization "insures itself." It assumes the risk of paying directly for medical services and sets up a fund from which it pays for claims. The organization establishes the benefit levels and the plan types it will offer. Self-funded health plans may set up their own provider networks or, more often, buy the use of existing networks from managed care organizations.

Most self-funded health plans are set up as PPOs; fewer than 10 percent are set up as HMOs. As discussed in the chapter about private payers, being self-insured changes the regulations under which a plan works, giving the employer some financial advantages over paying for coverage through a typical insurance company.

self-funded (self-insured) health plan organization pays for health insurance directly and sets up a fund from which to pay

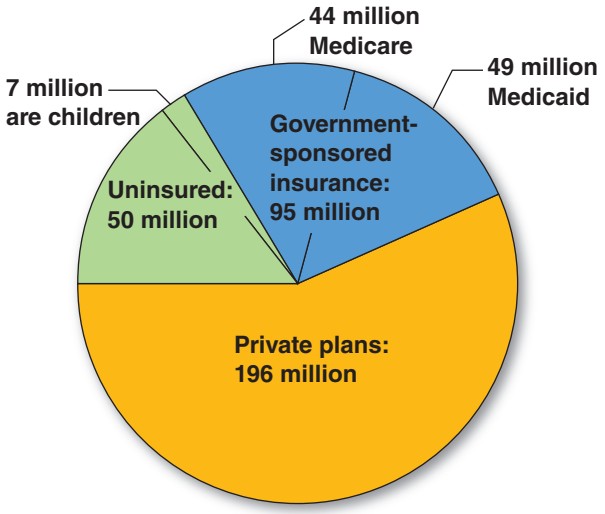


FIGURE 1.4 Types of Insurance Held

Source: U.S. Census Bureau, "Health Insurance Coverage: 2010," www.census.gov/hhes.

COMPLIANCE GUIDELINE

Unpaid Healthcare

Under the federal Emergency Medical Treatment and Active Labor Act, or EMTALA, hospital emergency departments must provide care for all patients in need of medical services, regardless of their ability to pay. More than $100 billion in unpaid healthcare is provided annually for uninsured and underinsured patients.

Government-Sponsored Healthcare Programs

The four major government-sponsored healthcare programs offer benefits for which various groups in the population are eligible:

1. Medicare is a 100 percent federally funded health plan that covers people who are sixty-five and over and also those who, regardless of age, are disabled or have permanent kidney failure (end-stage renal disease, or ESRD).
2. Medicaid, a federal program that is jointly funded by federal and state governments, covers low-income people who cannot afford medical care. Each state administers its own Medicaid program, determining the program's qualifications and benefits under broad federal guidelines.
3. TRICARE, a Department of Defense program, covers medical expenses for active-duty members of the uniformed services and their spouses, children, and other dependents; retired military personnel and their dependents; and family members of deceased active-duty personnel. (This program replaced CHAMPUS, the Civilian Health and Medical Program of the Uniformed Services, in 1998.)
4. CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, covers the spouses and dependents of veterans with permanent service-related disabilities. It also covers surviving spouses and dependent children of veterans who died from service-related disabilities.

These government programs are covered in the chapters about Medicare, Medicaid, TRICARE, and CHAMPVA.

THINKING IT THROUGH 1.7

1. As national health reform (see page 20) is implemented, what are probable effects on the number of uninsured patients who are seen in physician practices?

1.8 The Medical Billing Cycle

medical insurance specialist staff member who handles billing, checks insurance, and processes payments

In this text, the job title **medical insurance specialist** encompasses all the tasks that are completed by administrative staff members during the medical billing cycle. Typically, *front office* staff members handle duties such as reception (registration) and scheduling. *Back office* staff duties are related to billing, insurance, and collections. Job titles in common use are billing clerk, insurance specialist, reimbursement specialist, and claims specialist. The broad picture of the medical insurance specialist is presented in *Medical Insurance*, Sixth Edition, to provide the widest background for future employment.

The main job functions of medical insurance specialists are:

- To understand patients' responsibilities for paying for medical services
- To analyze charges and insurance coverage to prepare accurate, timely claims
- To collect payment for medical services from health plans and from patients

These functions entail:

- Verifying patient insurance information and eligibility before medical services are provided
- Collecting payments that are due, such as copayments, at the time of service
- Maintaining up-to-date information about health plans' billing guidelines
- Following federal, state, and local regulations on maintaining the confidentiality of information about patients
- Abstracting information from patients' records for accurate billing
- Billing health plans and patients, maintaining effective communication to avoid problems or delayed payments
- Assisting patients with insurance information and required documents
- Processing payments and requests for further information about claims and bills

BEFORE THE ENCOUNTER	Step 1	Preregister patients
DURING THE ENCOUNTER	Step 2	Establish financial responsibility
	Step 3	Check in patients
	Step 4	Review coding compliance
	Step 5	Review billing compliance
	Step 6	Check out patients
AFTER THE ENCOUNTER	Step 7	Prepare and transmit claims
	Step 8	Monitor payer adjudication
	Step 9	Generate patient statements
	Step 10	Follow up payments and collections

FIGURE 1.5 The Medical Billing Cycle

- Maintaining financial records
- Updating the forms and computer systems the practice uses for patient information and healthcare claims processing

To complete their duties and contribute to financial success, medical insurance specialists follow a **medical billing cycle**. This cycle is a series of steps that lead to maximum, appropriate, timely payment for patients' medical services (see Figure 1.5).

medical billing cycle steps that lead to maximum, appropriate, timely payment for patients' medical services

BILLING TIP

The Medical Billing Cycle

Study the medical billing cycle in Figure 1.5 as you read the steps. The cycle is also printed on the inside front cover of your text for your convenience. Refer to the cycle as you read the text's chapters; it serves as your path toward expertise in medical insurance.

Step 1 Preregister Patients

The first step in the medical billing cycle is to preregister patients. It involves two main tasks:

- Schedule and update appointments
- Collect preregistration demographic and insurance information

New patients who call for appointments provide basic personal and insurance information to the scheduler. Both new and returning patients are asked about the medical reason for the visit so appropriate visits can be scheduled for them.

Step 2 Establish Financial Responsibility

The second step is very important: determine financial responsibility for visits. For insured patients, these questions must be answered:

- What services are covered under the plan? What medical conditions establish medical necessity for these services?
- What services are not covered?
- What are the billing rules of the plan?
- What is the patient responsible for paying?

Healthcare Reform

The Patient Protection and Affordable Care Act (ACA)

Health system reform legislation signed into law by President Obama in 2010 introduced a number of significant benefits for patients. Some benefits took effect immediately, and others are being gradually phased in through 2014. Medical insurance specialists should stay updated on all aspects of the regulations as they emerge. Here is an overview.

Improvements that are now in effect for patients with private health insurance are:

- A payer can no longer drop a beneficiary from a plan because of a preexisting illness or a new condition, a practice known as rescission.
- Children ages 18 and younger cannot be denied private insurance coverage if they have a preexisting medical condition.
- For adults with preexisting medical conditions who cannot obtain private insurance coverage, a temporary national "high-risk pool" will be established to provide coverage, with financial subsidies to make premiums more affordable, until all insurers are required to cover people with preexisting conditions in 2014.
- Young adults up to age 26 can remain as dependents on their parents' private health insurance plan.
- Payers cannot impose lifetime financial limits on benefits.
- Insurance plan beneficiaries have expanded rights to appeal denials or cancellation of coverage.
- Insurance companies must spend at least 80 cents of every dollar they collect from customers on providing healthcare, limiting salaries and profits. If this is not the case, health plan subscribers will get a tax-free rebate.
- Preventive services for women such as mammograms and immunizations for children must be covered by insurers with no copayments or deductibles required.

Patient Protection and Affordable Care Act (ACA) health system reform legislation that introduced significant benefits for patients

Future patient benefits include:

- Preventive services for all patients in new health plans, such as annual physicals and dozens of screening tests, must be completely covered by payers as long as in-network providers are used.
- U.S. citizens and legal residents cannot be denied private health insurance coverage for any reason beginning in 2014, and they must obtain health insurance coverage or pay a minor tax penalty (although there are some exemptions).
- State-based health insurance exchanges will begin operating in 2014, enabling people who do not have access to employer-based insurance to compare the benefits and costs of private health insurance plans. These exchanges will create insurance pools that will allow people to choose among affordable coverage options. All insurance companies in the exchange must provide at least a minimum benefit package, as well as additional coverage options beyond a basic plan.
- Federal subsidies through tax credits or vouchers will be provided in 2014 to people who cannot afford the full cost to help them purchase coverage through the exchanges.

For patients enrolled in Medicare or Medicaid:

- Preventive services recommended by the U.S. Preventive Services Task Force (USPSTF), which uses a letter grading system to determine when a service is appropriate, are now provided without deductible or coinsurance requirements. Examples include bone mass measurement, colorectal cancer screening, influenza and pneumococcal vaccines, and ultrasound abdominal aortic aneurysm screening.
- The cost of Medicare drug coverage is reduced.
- A series of pilot programs will be implemented to help find new ways to improve quality and lower the cost of care.
- Medicaid coverage will be expanded in 2014 to all eligible children, pregnant women, and parents and childless adults under age 65 who have incomes at or below 138 percent of the federal poverty level.

Knowing the answers to these questions is essential to correctly bill payers for patients' covered services. This knowledge also helps medical insurance specialists ensure that patients will pay their bills when benefits do not apply.

To determine financial responsibility, these procedures are followed:

- Verify patients' eligibility for their health plan.
- Check the health plan's coverage.
- Determine the first payer if more than one health plan covers the patient (this is the payer to whom the first claim will be sent).
- Meet payers' conditions for payment, such as preauthorization, ensuring that the correct procedures are followed to meet them.

The practice's financial policy—when bills have to be paid—is explained so that patients understand the medical billing cycle. Patients are told that they are responsible for paying charges that are not covered under their health plans. Uninsured patients are informed of their responsibility for the entire charge. Payment options are presented if the bill will be substantial.

Step 3 Check in Patients

The third step is to check in individuals as patients of the practice. When new patients arrive for their appointments, detailed and complete demographic and medical information is collected at the front desk. Returning patients are asked to review the information that is on file for them, making sure that demographics and medical data are accurate and up-to-date. Their financial records are also checked to see whether balances are due from previous visits.

Both the front and back of insurance cards and other identification cards such as driver's licenses are scanned or photocopied and stored in the patient's record. If the health plan requires a copayment, the correct amount is noted for the patient. Copayments should always be collected at the time of service. Some practices collect copayments before the patient's encounter with the physician, others after the encounter.

A number of other important forms may need to be completed by patients. These forms are part of the process of recording administrative and clinical facts about patients. Often they involve authorizing planned procedures and payments to the practice from the health plan.

During the office visit, a physician evaluates, treats, and documents a patient's condition. These notes include the procedures performed and treatments provided, as well as the physician's determination of the patient's complaint or condition.

Steps 1–3 are covered in later chapters of this text.

COMPLIANCE TIP

ICD-9-CM versus ICD-10-CM

ICD-9-CM is required until Oct. 1, 2014, when ICD-10-CM must be used for medical coding. Chapter 18, available at the text's Online Learning Center, www.mhhe.com/valerius6e, covers ICD-9-CM coding basics.

Step 4 Review Coding Compliance

To bill for the visit, the medical diagnoses and procedures must be assigned medical codes. In some practices, physicians assign these codes; in others, a **medical coder** or a medical insurance specialist handles this task. The medical insurance specialist may verify the codes with data in the patient's medical record.

medical coder staff member with specialized training who handles diagnostic and procedural coding

The patient's primary illness is assigned a **diagnosis code** from the *International Classification of Diseases*, 10th Revision, *Clinical Modification* (ICD-10-CM) (see the chapter about diagnostic coding).

diagnosis code number assigned to a diagnosis

Example

The ICD-10-CM code for Alzheimer's disease is G30.9.

The ICD-10-CM code for frostbite with tissue necrosis of the left wrist is T34.512A. ◄

Similarly, each procedure the physician performs is assigned a **procedure code** that stands for the particular service, treatment, or test. This code is selected from the *Current Procedural Terminology* (CPT) (see the chapter about procedural

procedure code code that identifies medical treatment or diagnostic services

coding). A large group of codes cover the physician's evaluation and management of a patient's condition during office visits or visits at other locations, such as nursing homes. Other codes cover groups of specific procedures, such as surgery, pathology, and radiology. Another group of codes covers supplies and other services.

Example

99460 is the CPT code for the physician's examination of a newborn infant.

27130 is the CPT code for a total hip replacement operation.

patient ledger record of a patient's financial transactions

The physician identifies the patient's diagnoses and procedures. The medical insurance specialist uses this information after the encounter to update the patient's account in the PMP. The transactions for the visit, which include both the charges and any payment the patient has made, are entered in the **patient ledger** (the record of a patient's financial transactions; also called the patient account record stored in the PMP), and the patient's balance is updated. Following is an example of the account for one patient's recent series of visits:

Date/Procedure		Charge	Payment		Balance
7/2/16	OV	200.00		200.00	—
7/3/16	OV	150.00			
7/4/16	INS	—		—	150.00
7/13/16	PMT		Insurance	120.00	30.00
7/25/16	STM	—		—	30.00
7/30/16	PMT		Patient	30.00	0.00

This formula is followed to calculate the current balance:

Previous Balance + Charge − Payment = Current Balance.

In this example, on 7/2 the patient's office visit (OV) resulted in a $200 charge. The patient paid this bill, so there is no current balance. The patient's next office visit, 7/3, resulted in a charge of $150. The medical insurance specialist sent a healthcare claim to the health plan (INS for insurance) the next day, and the payer paid $120 (PMT) on 7/13. This payment is subtracted from the charge to equal the current balance of $30.

As noted on the account, then a statement (STM) (a bill) was sent to the patient on 7/25 showing the current balance now owed. The patient sent a payment of $30 (PMT) received on 7/30, which reduced the patient's current balance to zero. ◄

At the time of the visit, patients may owe a previous balance, coinsurance, deductibles, and/or fees for noncovered services. Payments may be made by cash, check, or credit/debit card. When a payment is made, a receipt is given to the patient. Patients' follow-up visits are also scheduled.

Coding Compliance

compliance actions that satisfy official requirements

Compliance means actions that satisfy official requirements. In the area of coding, compliance involves following official guidelines when codes are assigned. Also, after diagnosis and procedure codes are selected, they must be checked for errors. The diagnosis and the medical services that are documented in the patient's medical record should be logically connected (linked), so that the payer understands the medical necessity of the charges.

Step 5 Review Billing Compliance

Each charge, or fee, for a visit is related to a specific procedure code. The provider's fees for services are listed on the medical practice's fee schedule. Most medical practices have standard fee schedules listing their usual fees.

Although a separate fee is associated with each code, each code is not necessarily billable. Whether a code can be billed depends on the payer's rules. Following these rules when preparing claims results in billing compliance. Some payers combine certain physician work in the payment for another code. Medical insurance specialists apply their knowledge of payer guidelines to analyze what can be billed on healthcare claims.

Step 6 Check Out Patients

Checkout is the last step that occurs while the patient is still in the office. The medical codes have been assigned and checked, and the amounts to be billed have also been verified according to payers' rules. The charges for the visit are calculated and discussed with the patient. Payment for these types of charges is usually collected at time of service:

Previous balances

Copayments or coinsurance

Noncovered services

Charges of nonparticipating providers

Charges for self-pay patients

Deductibles

A receipt is prepared for the payments made by the patients, and follow-up work is scheduled as ordered by the physician.

Steps 4, 5, and 6 are covered in Chapters 4–6.

Step 7 Prepare and Transmit Claims

A major step in the medical billing cycle is the preparation of accurate, timely healthcare claims. Most practices use the PMP to prepare claims for their patients and send them to the payer electronically. A claim communicates information about the diagnosis, procedures, and charges to a payer. A claim may be for reimbursement for services rendered or to report an encounter to an HMO. The practice has a schedule for transmitting claims, such as daily or every other day, which is followed.

General information on claims found in the chapters about healthcare claim preparation and transmission, private payers, and workers' compensation explains how to prepare correct claims for each major payer group:

Private payers/Blue Cross and Blue Shield

Medicare

Medicaid

TRICARE and CHAMPVA

Workers' compensation and disability

A related topic, hospital coding and billing, is covered in Chapter 17.

Step 8 Monitor Payer Adjudication

Once healthcare claims have been sent to health plans, it is important to collect payments as soon as possible. The money due from the plans, as well as payments due from patients, adds up to the practice's accounts receivable (AR)—the money that is needed to run the practice.

Payers review claims by following a process known as **adjudication**. This term means that the payer puts the claim through a series of steps designed to judge whether it should be paid. What the payer decides about the claim—to pay it in full, to pay some of it, to *pend* it for further information to arrive, or to deny it—is explained on a report sent back to the provider with the payment. Common

adjudication health plan process of examining claims and determining benefits

reasons that claims are not paid in full include factual errors and failure to satisfy the payer's medical necessity guidelines. When patients are covered by more than one health plan, the additional plans are then sent claims based on the amounts still due.

The amount of the payment depends on the practice's contract with the payer. Seldom do the practice's fee and the payer's fee match exactly. Most payers have their own fee schedules for providers with whom they have contractual arrangements. The medical insurance specialist compares each payment with the claim to check that:

- All procedures that were listed on the claim also appear on the payment transaction.
- Any unpaid charges are explained.
- The codes on the payment transactions match those on the claim.
- The payment listed for each procedure is correct according to the contract with the payer.

If discrepancies are found, an appeal process may be started. In this process, the medical insurance specialist follows payers' or state rules to seek full appropriate reimbursement for a claim.

When a patient is covered by more than one health plan, the second and any other plans must be sent claims.

Step 8 is covered in Chapter 13.

Step 9 Generate Patient Statements

Payers' payments are applied to the appropriate patients' accounts. In most cases, these payments do not fully pay the bills, and patients will be billed for the rest. The amount paid by all payers (the primary insurance and any other insurance) plus the amount to be billed to the patient should equal the expected fee. Bills that are mailed to patients list the dates and services provided, any payments made by the patient and the payer, and the balances now due.

Step 10 Follow Up Payments and Collections

Patient payments are regularly analyzed for overdue bills. A collection process is often started when patient payments are later than permitted under the practice's financial policy.

Patient medical records and financial records are stored and retained according to the medical practice's policy. Federal and state regulations govern what documents are kept and for how long.

Steps 9 and 10 are covered in Chapter 14.

THINKING IT THROUGH 1.8

1. In your opinion, is each of the following procedures likely to be considered medically necessary by a payer's healthcare claims examiner? Why?

   A. Diagnosis: deviated septum

   _____ Procedure: nasal surgery

   B. Diagnosis: mole on a female patient's cheek, questionable nature

   _____ Procedure: surgical removal and biopsy

   C. Diagnosis: male syndrome hair loss

   _____ Procedure: implant hair plugs on scalp

   D. Diagnosis: probable broken wrist

   _____ Procedure: comprehensive full-body examination, with complete set of lab tests, chest X-ray, and ECG

1.9 Achieving Success

In addition to working in physicians' practices, medical insurance specialists work in clinics, for hospitals or nursing homes, and in other healthcare settings such as in insurance companies as claims examiners, provider relations representatives, or benefits analysts. The majority of these employees work for small to medium-sized practices that range from solo doctors to ten-physician practices. Positions are also available in government and public health agencies. Employment with companies that offer billing or consulting services to healthcare providers is an option, as is self-employment as a claims assistance professional who helps consumers with medical insurance problems or as a billing service for providers.

In small physician practices, medical insurance specialists handle a variety of billing and collections tasks. In larger medical practices, duties may be more specialized. Billing, insurance, and collections duties may be separated, or a medical insurance specialist may work exclusively with claims sent to just one of many payers, such as Medicare or workers' compensation. Practice size varies by specialty. Seventy-five percent of physicians provide care in small settings, usually in practices with one to three physicians. Specialties that require a lot of technology, such as radiology, tend to have large single-specialty medical groups.

Regardless of the size of the practice, the most important characteristic that medical insurance specialists should evidence is **professionalism**, always acting for the good of the public and the medical practice they serve. Professional staff members act with honor and integrity to ensure a high quality of service. They are internally motivated to do their best. They aim for a professional image in their appearance, their actions, and their oral communications.

professionalism acting for the good of the public and the medical practice

Requirements for Success

A number of skills and attributes are required for successful mastery of the tasks of a medical insurance specialist.

Skills

Knowledge of medical terminology, anatomy, physiology, and medical coding: Medical insurance specialists must analyze physicians' descriptions of patients' conditions and treatments and relate these descriptions to the systems of diagnosis and procedure codes used in the healthcare industry.

Communication skills: The job of a medical insurance specialist requires excellent oral and written communication skills. For example, patients often need explanations of insurance benefits or clarification of instructions such as referrals. Courteous, helpful answers to questions strongly influence patients' willingness to continue to use the practice's services. Memos, letters, telephone calls, and e-mail are used to research and follow up on changes in health plans' billing rules. Communication skills also are needed to create and send collection letters that are effective and claim attachments that explain special conditions or treatments so as to obtain maximum reimbursement.

Attention to detail: Many aspects of the job involve paying close attention to detail, such as correctly completing healthcare claims, filing patients' medical records, recording preauthorization numbers, calculating the correct payments, and posting payments for services.

Flexibility: Working in a changing environment requires the ability to adapt to new procedures, handle varying kinds of problems and interactions during a busy day, and work successfully with different types of people with various cultural backgrounds.

Health information technology (HIT) skills: Most medical practices use computers to handle billing and to process claims. Many also use or plan to use computers to

BILLING TIP

Keeping Up-to-Date: The Internet

The Internet is frequently used for research about government regulations, payer billing updates, and code updates. Ignorance of new instructions, rules, or codes is not an excuse for incorrect billing. Experienced medical insurance specialists make it a habit to regularly check the websites that are most important for their billing environment. Many are provided throughout this text and summarized in Appendix D.

keep patients' medical records. General computer literacy is essential, including working knowledge of the Microsoft Windows operating system, a word-processing program, a medical billing program, and Internet-based research. Data-entry skills are also necessary. Many human errors occur during data entry, such as pressing the wrong key on the keyboard. Other errors are a result of a lack of computer literacy—not knowing how to use a program to accomplish tasks. For this reason, proper training in data-entry techniques and in using computer programs are essential for medical insurance specialists.

Honesty and integrity: Medical insurance specialists work with patients' medical records and with finances. It is essential to maintain the confidentiality of patient information and communications as well as to act with integrity when handling these tasks.

Ability to work as a team member: Patient service is a team effort. To do their part, medical insurance specialists must be cooperative and must focus on the best interests of the patients and the practice.

Attributes

A number of attributes are also very important for success as a medical insurance specialist. Most have to do with the quality of professionalism, which is key to getting and keeping employment. These factors include the following:

Appearance: A neat, clean, professional appearance increases other people's confidence in your skills and abilities. When you are well groomed, with clean hair, nails, and clothing, patients and other staff members see your demeanor as businesslike. Many employers do not permit visible piercings or tattoos, and following their guidelines is critical for being hired and keeping the job.

Attendance: Being on time for work demonstrates that you are reliable and dependable.

Initiative: Being able to start a course of action and stay on task is an important quality to demonstrate.

Courtesy: Treating patients and fellow workers with dignity and respect helps build solid professional relationships at work.

Medical Ethics and Etiquette in the Practice

Licensed medical staff and other employees working in physicians' practices share responsibility for observing a code of ethics and for following correct etiquette.

Ethics

ethics standards of conduct based on moral principles

Medical **ethics** are standards of behavior requiring truthfulness, honesty, and integrity. Ethics guide the behavior of physicians, who have the training, the primary responsibility, and the legal right to diagnose and treat human illness and injury. All medical office employees and those working in health-related professions share responsibility for observing the ethical code.

Each professional organization has a code of ethics that is to be followed by its membership. In general, this code states that information about patients and other employees and confidential business matters should not be discussed with anyone not directly concerned with them. Behavior should be consistent with the values of the profession. For example, it is unethical for an employee to take money or gifts from a company in exchange for giving the company business.

Etiquette

etiquette standards of professional behavior

Professional **etiquette** is also important for medical insurance specialists. Correct behavior in a medical practice is generally covered in the practice's employee policy and procedure manual. For example, guidelines establish which types of incoming

calls must go immediately to a physician or to a nurse or assistant and which require a message to be taken. Of particular importance are guidelines about the respectful and courteous treatment of patients and all others who interact with the practice's staff.

THINKING IT THROUGH 1.9

1. A. Dorita McCallister, the office manager of Clark Clinic, ordered medical office supplies from her cousin, Gregory Hand. When the supplies arrived, Gregory came to the office to check on them and to take Dorita out to lunch. Is Dorita's purchase of supplies from her cousin ethical? Why?
2. George McGrew is a medical insurance specialist in the practice of Dr. Sylvia Grets. Over the past few weeks, Dr. Grets has consistently assigned procedure codes that stand for lengthy, complex appointments to visits that were actually for the administration of flu shots—a brief procedure. Is it ethical for George to report these codes on healthcare claims?

1.10 Moving Ahead

Completion of a medical insurance specialist program, coding specialist program, or medical assisting or health information technology program at a postsecondary institution provides an excellent background for many types of positions in the medical insurance field. Another possibility is to earn an associate degree or a certificate of proficiency by completing a program in a curriculum area such as healthcare business services. Further baccalaureate and graduate study enables advancement to managerial positions.

Moving ahead in a career is often aided by membership in professional organizations that offer certification in various areas. **Certification** by a professional organization provides evidence to prospective employers that the applicant has demonstrated a superior level of skill on a national test. Certification is the process of earning a credential through a combination of education and experience followed by successful performance on a national examination.

certification recognition of a superior level of skill by an official organization

Medical Assisting Certification

Two organizations offer tests in the professional area of medical assisting. After earning a diploma in medical assisting from an accredited school (or having five years' work experience (for the RMA only)), medical assistants may sit for the Certified Medical Assistant (CMA) titles from the American Association of Medical Assistants or the Registered Medical Assistant (RMA) designation from the American Medical Technologists.

CMA

American Association of Medical Assistants (AAMA)
20 N. Wacker Drive, Suite 1575
Chicago, IL 60606-2903
312-899-1500
www.aama-ntl.org

Health Information Certification

Students who are interested in the professional area of health information (also known as medical records) may complete an associate degree from an accredited college program and pass a credentialing test from the American Health Information Management Association (AHIMA) to be certified as a Registered Health Information Technician, or RHIT. An RHIT examines medical records for accuracy, reports patient data for reimbursement, and helps with information for medical research and statistical data.

Also offered is the Registered Health Information Administrator (RHIA), requiring a baccalaureate degree and national certification. RHIAs are skilled in the collection, interpretation, and analysis of patient data. Additionally, they receive the

RMA

American Medical Technologists (AMT)
10700 West Higgins Road,
Suite 150
Rosemont, IL 60018
847-823-5169
www.AmericanMedTech.org

RHIT, RHIA, CCS, CCS-P, CCA

American Health Information Management Association (AHIMA)
233 N. Michigan Ave., Suite 2150
Chicago, IL 60601-5809
800-335-5535
www.ahima.org

CPC, CPC-H, CPC-P, CPC-A

American Academy of Professional Coders (AAPC)
2480 South 3850 West, Suite B
Salt Lake City, Utah 84120
800-626-2633
www.aapc.com

training necessary to assume managerial positions related to these functions. RHIAs interact with all levels of an organization—clinical, financial, and administrative—that employ patient data in decision making and everyday operations.

RHITs and RHIAs enjoy job placements in a broad range of settings that span the continuum of healthcare, including office-based physician practices, nursing homes, home health agencies, mental health facilities, and public health agencies. The growth of managed care has created additional job opportunities in HMOs, PPOs, and insurance companies. Prospects are especially strong in these settings for RHIAs who possess advanced degrees in business or health administration and informatics.

Coding Certification

Medical coders are expert in classifying medical data. They assign codes to physicians' descriptions of patients' conditions and treatments. For employment as a medical coder, employers typically prefer—or may require—certification. AHIMA offers three coding certifications: the Certified Coding Associate (CCA), intended as a starting point for entering a new career as a coder; the Certified Coding Specialist (CCS); and the Certified Coding Specialist-Physician-based (CCS-P). The American Academy of Professional Coders (AAPC) grants the Certified Professional Coder (CPC) and the CPC-A, an apprentice level for those who do not yet have medical coding work experience.

BILLING TIP

Moving Ahead in Your Career

Professional certification, additional study, and work experience contribute to advancement to positions such as medical billing manager and medical office manager. Billers may also advance through specialization in a field, such as radiology billing management. Some become medical coders or coding managers.

Advanced Professional Certification

Professional organizations such as AHIMA and AAPC also have professional certification that can be earned following work experience and additional education. For example, AHIMA offers the Certified Documentation Improvement Practitioner (CDIP) recognition, and AAPC offers the Certified Professional Medical Auditor (CPMA) certification.

Continuing Education

Most professional organizations require certified members to keep up-to-date by taking annual training courses to refresh or extend their knowledge. Continuing education sessions are assigned course credits by the credentialing organizations, and satisfactory completion of a test on the material is often required for credit. Employers often approve attendance at seminars that apply to the practice's goals and ask the person who attends to update other staff members.

THINKING IT THROUGH 1.10

1. Why is it important for administrative medical office employees to become certified in their area of expertise? At this point, what are your personal goals relating to certification?

Chapter Summary

Learning Objective	Key Concepts/Examples
1.1 Identify three ways that medical insurance specialists help ensure the financial success of physician practices. Pages 3–7	• Following all procedures carefully. • Communicating effectively with patients and with those who work in the practice. • Using health information technology skills to work with practice management programs and electronic health records.
1.2 Differentiate between covered and noncovered services under medical insurance policies. Pages 7–8	Covered services: • May include primary care, emergency care, medical specialists' services, and surgery • Are eligible for members • Are listed under the schedule of benefits of an insurance policy Noncovered services: • Are identified by the insurance policy as services for which it will not pay
1.3 Compare indemnity and managed care approaches to health plan organization. Pages 9–11	• All insurance plans are based on one of the two essential types of plans, indemnity and managed care. • Under an indemnity plan, the payer protects the member against loss from the costs of medical services and procedures. • Managed care offers a more restricted choice of providers and treatments in exchange for lower premiums, deductibles, and other charges.
1.4 Discuss three examples of cost containment employed by health maintenance organizations. Pages 11–14	Health maintenance organizations (HMOs) control healthcare costs by: • Creating a restricted number of physicians for members • Requiring preauthorization services • Controlling the use of services • Controlling drug costs • Using cost-sharing methods
1.5 Explain how a preferred provider organization (PPO) works. Pages 14–15	• Create a network of hospitals and other providers for members to use at negotiated, reduced fees • Are the most popular type of healthcare • Generally require the payment of premiums and copayments from patients
1.6 Describe the two elements that are combined in a consumer-driven health plan. Page 16	• Consumer-driven health plans (CDHPs) combine a high-deductible, low-premium PPO with a pretax savings account to cover out-of-pocket medical expenses up to the amount of the deductible.
1.7 Define the three major types of medical insurance payers. Pages 17–18	• Private payers of health benefits are either insurance companies or self-insured employers. • Most private health insurance is employer sponsored. • Government-sponsored healthcare programs include Medicare, Medicaid, TRICARE, and CHAMPVA.

Learning Objective	Key Concepts/Examples
1.8 Explain the ten steps in the medical billing cycle. Pages 18–24	The ten steps in the medical billing cycle are: 1. Preregister patients 2. Establish financial responsibility 3. Check in patients 4. Review coding compliance 5. Review billing compliance 6. Check out patients 7. Prepare and transmit claims 8. Monitor payer adjudication 9. Generate patient statements 10. Follow up payments and collections
1.9 Analyze how professionalism and etiquette contribute to career success. Pages 25–27	• It is a vital quality for everyone involved in the medical office to possess. • Office members acquire the proper skills and develop the necessary attributes in order to perform their work successfully. • Pair these characteristics with a strong code of ethics and correct etiquette.
1.10 Evaluate the importance of professional certification for career advancement. Pages 27–28	• Medical staff personnel advance their careers through membership in a professional organization and by receiving a certification by that organization. • Certifications are earned through a combination of education, experience, and an exam.

Review Questions

Match the key terms with their definitions.

_____ 1. **LO 1.4** health maintenance organization (HMO)

_____ 2. **LO 1.9** etiquette

_____ 3. **LO 1.2** schedule of benefits

_____ 4. **LO 1.3** fee-for-service

_____ 5. **LO 1.3** coinsurance

_____ 6. **LO 1.10** certification

_____ 7. **LO 1.4** copayment

_____ 8. **LO 1.1** electronic health record (EHR)

_____ 9. **LO 1.5** preferred provider organization (PPO)

_____ 10. **LO 1.3** indemnity

A. A list of the medical services covered by an insurance policy

B. A computerized lifelong healthcare record for an individual that incorporates data from all sources that provide treatment for the individual

C. A managed care network of providers under contract to provide services at discounted fees

D. An amount that an insured person pays at the time of a visit to a provider

E. The percentage of each claim that an insured person must pay

F. Standards of professional behavior

G. Payment method based on provider's charges

H. An organization that contracts with a network of providers for the delivery of healthcare for a prepaid premium

I. Recognition of a superior level of skill by an official organization

J. Health plan that protects beneficiaries against losses

Select the letter that best completes the statement or answers the question.

_____ **1.** **LO 1.4** In an HMO with a gatekeeper system, a(n) ______ coordinates the patient's care and provides referrals.

A. PPO
B. EPO
C. PCP
D. NPP

_____ **2.** **LO 1.6** Which of the following combines a health plan that has a high deductible and low premiums with a special "savings account" that is used to pay medical bills before the deductible has been met?

A. CDHP
B. HMO
C. PPO
D. EHR

_____ **3.** **LO 1.2** Health plans pay for ______ services.

A. indemnity
B. covered
C. coded
D. out-of-network

_____ **4.** **LO 1.4** In an HMO, securing ______ may be required before services are provided.

A. preauthorization
B. utilization
C. gatekeeper
D. formulary

_____ **5.** **LO 1.7** A self-insured health plan may use its own

A. physician-employees
B. funds
C. gatekeepers
D. primary care physicians

_____ **6.** **LO 1.5** Unlike an HMO, a PPO permits its members to use ______ providers, but at a higher cost.

A. subcapitated
B. out-of-network
C. nonphysician practitioner
D. primary care

_____ **7.** **LO 1.7** The major government-sponsored health programs are

A. TRICARE, CHAMPVA, Medicare, and Medicaid
B. HEDIS, Medicare, Medicaid, and CHAMPUS
C. Medicare and Medicaid
D. Medicare and TRICARE

_____ **8.** **LO 1.3** Coinsurance is calculated based on

A. the number of policyholders in a plan
B. a fixed charge for each visit
C. a capitation rate
D. a percentage of a charge

_____ **9.** **LO 1.8** When a patient has insurance coverage for which the practice will create a claim, the patient bill is usually done

A. before the encounter
B. during the encounter
C. after the encounter when the healthcare claim is transmitted
D. after the encounter and after the payer's payment is posted

_____**10.** **LO 1.8** If a patient's payment is later than permitted under the financial policy of the practice, the ______ may be started.

A. copayment process
B. appeal process
C. coding process
D. collection process

Answer the following questions.

1. **LO 1.8** List the ten steps in the medical billing cycle.

Step 1 _____

Step 2 _____

Step 3 _____

Step 4 _____

Step 5 _____

Step 6 _____

Step 7 _____

Step 8 _____

Step 9 _____

Step 10 _____

2. **LO 1.8** List at least four important skills of medical insurance specialists.

A. _____

B. _____

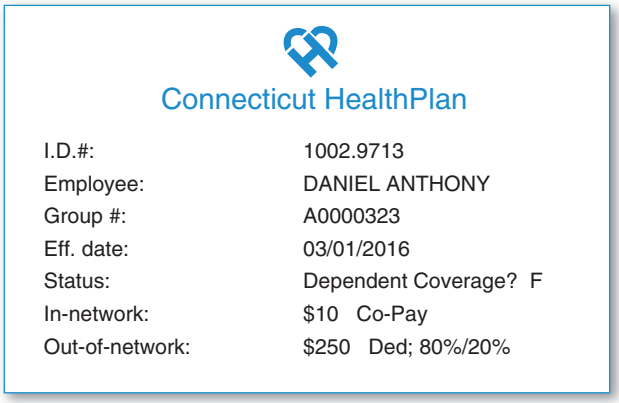
C. _____

D. _____

Applying Your Knowledge

Case 1.1 Abstracting Insurance Information

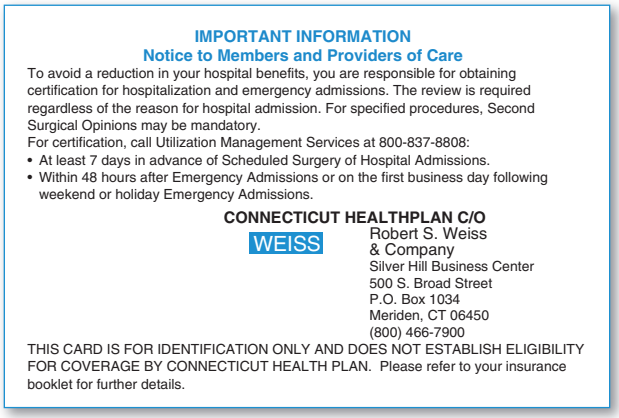
A patient shows the following insurance identification card to the medical insurance specialist:



Connecticut HealthPlan

I.D.#:	1002.9713
Employee:	DANIEL ANTHONY
Group #:	A0000323
Eff. date:	03/01/2016
Status:	Dependent Coverage? F
In-network:	$10 Co-Pay
Out-of-network:	$250 Ded; 80%/20%

Front of card



IMPORTANT INFORMATION
Notice to Members and Providers of Care

To avoid a reduction in your hospital benefits, you are responsible for obtaining certification for hospitalization and emergency admissions. The review is required regardless of the reason for hospital admission. For specified procedures, Second Surgical Opinions may be mandatory.
For certification, call Utilization Management Services at 800-837-8808:

- At least 7 days in advance of Scheduled Surgery of Hospital Admissions.
- Within 48 hours after Emergency Admissions or on the first business day following weekend or holiday Emergency Admissions.

CONNECTICUT HEALTHPLAN C/O
WEISS
Robert S. Weiss
& Company
Silver Hill Business Center
500 S. Broad Street
P.O. Box 1034
Meriden, CT 06450
(800) 466-7900

THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT ESTABLISH ELIGIBILITY FOR COVERAGE BY CONNECTICUT HEALTH PLAN. Please refer to your insurance booklet for further details.

Back of card

A. **LO 1.4, 1.5** What copayment is due when the patient sees an in-network physician?

B. **LO 1.4, 1.5** What payment rules apply when the patient sees an out-of-network physician?

C. **LO 1.4, 1.5** What rules apply when the patient needs to be admitted to the hospital?

Case 1.2 Calculating Insurance Math

Calculate the payment(s) billed in each of the following situations:

A. **LO 1.3** The patient's health plan has a $100 annual deductible. At the first visit of the year, the charges are $95. What does the patient owe?

B. **LO 1.3** The patient's coinsurance percentage is stated as 75-25 in the insurance policy. The deductible for the year has been met. If the visit charges are $1,000, what payment should the medical insurance specialist expect from the payer? What amount will the patient be billed?

C. **LO 1.3** The patient's coinsurance percentage is stated as 80-20 in the insurance policy. The deductible for the year has been met. If the visit charges are $420, what payment should the medical insurance specialist expect from the payer? What amount will the patient be billed?

D. **LO 1.4** The patient is enrolled in a capitated HMO with a $10 copayment for primary care physician visits and no coinsurance requirements. After collecting $10 from the patient, what amount can the medical insurance specialist bill the payer for an office visit?

E. **LO 1.3, 1.8** The patient has a policy that requires a $20 copayment for an in-network visit due at the time of service. The policy also requires 30 percent coinsurance from the patient. Today's visit charges total $785. After subtracting the copayment collected from the patient, the medical insurance specialist expects a payment of what amount from the payer? What amount will the patient be billed?

F. **LO 1.3** A patient's total surgery charges are $1,278. The patient must pay the annual deductible of $1,000, and the policy states a 80-20 coinsurance. What does the patient owe?

G. **LO 1.3, 1.6** A patient has a high-deductible consumer-driven health plan. The annual deductible is $2,500, of which $300 has been paid. After a surgical procedure costing $1,890, what does the patient owe? Can any amount be collected from a payer? Why?

H. **LO 1.3, 1.5, 1.6** A patient with a high-deductible consumer-driven health plan has met half of the $1,000 annual deductible before requiring surgery to repair a broken ankle while visiting a neighboring state. The out-of-network physician's bill is $4,500. The PPO that takes effect after the deductible has been met is an 80-20 in-network plan and a 60-40 out-of-network plan. How much does the patient owe? How much should the PPO be billed?

Case 1.3 Using Insurance Terms

Read the following information from a medical insurance policy.

Policy Number 054351278
Insured Jane Hellman Brandeis
Premium Due Quarterly $1,414.98

AMOUNT PAYABLE
Maximum Benefit Limit, per *covered person* $2,000,000
Stated Deductible per *covered person,* per *calendar year* $2,500
EMERGENCY ROOM DEDUCTIBLE (for each visit for illness to an emergency room when not directly admitted to the *hospital*) $50
Note: After satisfaction of the emergency room deductible, *covered expenses* are subject to any applicable *deductible amounts* and coinsurance provisions.
PREFERRED PROVIDER COINSURANCE PERCENTAGE, per *calendar year*
For *covered expenses* in excess of the applicable stated deductible, payer pays 100%

A. **LO 1.3, 1.4, 1.5** What type of health plan is described: HMO, PPO, or indemnity?

B. **LO 1.3, 1.4, 1.5** What is the *annual* premium? _____

C. **LO 1.3, 1.4, 1.5** What is the annual deductible? _____

D. **LO 1.3, 1.4, 1.5** What percentage of preferred provider charges does the patient owe after meeting the deductible each year? _____

E. **LO 1.3, 1.4, 1.5** If the insured incurs a $6,000 in-network medical bill after the annual deductible has been paid, how much will the health plan pay?