

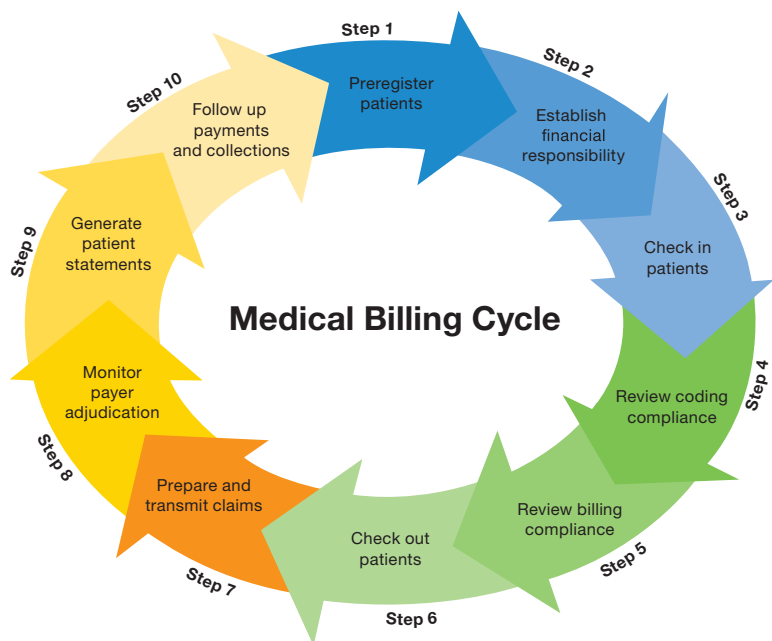
## Follow the Money!

Medical insurance plays an important role in the financial well-being of every healthcare business. The regulatory environment of medical insurance is now evolving faster than ever. Changes due to healthcare reform require medical office professionals to acquire and maintain an in-depth understanding of compliance, electronic health records, medical coding, and more.

The sixth edition of *Medical Insurance: An Integrated Claims Process Approach* emphasizes the **medical billing cycle**—ten steps that clearly identify all the components needed to successfully manage the medical insurance claims process. The cycle shows how administrative medical professionals “follow the money.”

Medical insurance specialists must be familiar with the rules and guidelines of each health plan in order to submit proper documentation. This ensures that offices receive maximum, appropriate reimbursement for services provided. Without an effective administrative staff, a medical office would have no cash flow!

The following are some of the key skills covered for you and your students in *Medical Insurance, 6e*:



Skills	Coverage
Procedural	<b>Learning</b> administrative duties important in medical practices as well as how to bill both payers and patients
Communication	<b>Working</b> with physicians, patients, payers, and others using both written and oral communication
Health information management	<b>Using</b> practice management programs and electronic health records technology to manage both patient records and the billing/collections process, to electronically transmit claims, and to conduct research
Medical coding	<b>Understanding</b> the ICD-10, CPT, and HCPCS codes and their importance to correctly report patients' conditions on health insurance claims and encounter forms as well as the role medical coding plays in the claims submission process
HIPAA/HITECH	<b>Applying</b> the rules of HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health act) to ensure compliance, maximum reimbursement, and the electronic exchange of health information

# Organization of *Medical Insurance, 6e*

An overview of the book's parts, including how they relate to the steps of the medical billing cycle, follows:

Part	Coverage
<b>1: Working with Medical Insurance and Billing</b>	Covers Steps 1 through 3 of the medical billing cycle by introducing the major types of medical insurance, payers, and regulators, as well as the medical billing cycle. Also covers HIPAA/HITECH Privacy, Security, and Electronic Health Care Transactions/Code Sets/Breach Notification rules.
<b>2: Claim Coding</b>	Covers Steps 4 through 6 of the medical billing cycle while building skills in correct coding procedures, using coding references, and complying with proper linkage guidelines.
<b>3: Claims</b>	Covers Step 7 of the medical billing cycle by discussing the general procedures for calculating reimbursement, how to bill compliantly, and preparing and transmitting claims.
<b>4: Claim Follow-Up and Payment Processing</b>	Covers Steps 8 through 10 of the medical billing cycle by describing the major third-party private and government-sponsored payers' procedures and regulations along with specific filing guidelines. Also explains how to handle payments from payers, follow up and appeal claims, and correctly bill and collect from patients. This part includes two case studies that provide exercises to reinforce knowledge of completing primary/secondary claims, processing payments from payers, and handling patients' accounts. The case studies in Chapter 15 can be completed using Connect Plus for simulated exercises created from Medisoft Advanced Version 17. The case studies in Chapter 16 can be completed using the CMS-1500 form.
<b>5: Hospital Services</b>	Provides necessary background in hospital billing, coding, and payment methods.

## New to the Sixth Edition

*Medical Insurance* is designed around the medical billing cycle with each part of the book dedicated to a section of the cycle followed by case studies to apply the skills discussed in each section. The medical billing cycle now follows the overall medical billing and documentation cycle used in practice management/electronic health records environments and applications.

Because of the mandate to the healthcare industry to adopt ICD-10-CM/PCS on October 1, 2014, students must work to gain expertise using this coding system. For this reason, ICD-10 is the primary diagnostic coding system taught and exemplified in the sixth edition of *Medical Insurance*. An alternate to Chapter 4 on ICD-9-CM (Chapter 18) is provided online for additional study if the instructor elects to cover it in more depth.

*Medical Insurance* offers several options for completing the case studies at the end of Chapters 8–12 and throughout Chapter 15:

- **Paper Claim Form** If you are gaining experience by completing a paper CMS-1500 claim form, use the blank form supplied to you (from the back of *Medical Insurance* or printed from a PDF file on the book's Online Learning Center, [www.mhhe.com/valerius6e](http://www.mhhe.com/valerius6e)), and follow the instructions in the text chapter that is appropriate for the particular payer to fill in the form by hand.
- **Electronic CMS-1500 Form** If you are assigned to use the electronic CMS-1500 form, access either the HTML or Adobe Form Filler form at the book's Online Learning Center, [www.mhhe.com/valerius6e](http://www.mhhe.com/valerius6e). See Appendix B, The Interactive Simulated CMS-1500 Form, for further instructions.
- **Connect Plus** Connect Plus provides simulated Medisoft® exercises in four modes: Demo, Practice, Test, and Assessment. The exercises simulate the use of

Medisoft Advanced Version 17 to complete the claims. If you are assigned this option, you should read Appendix A, Guide to Medisoft, as the first step, and then follow the instructions that are printed in each chapter's case studies. In this version, some data may be prepopulated to allow the students to focus on the key tasks of each exercise. These simulations are autograded.

**Key content changes include the following.**

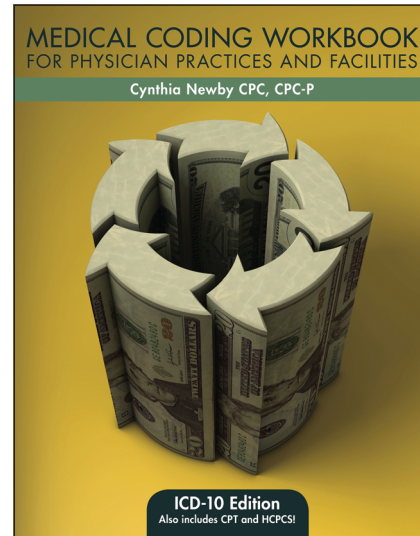
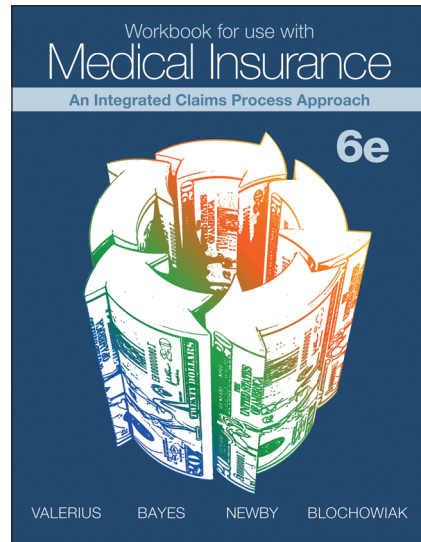
- **Pedagogy**
  - Learning Outcomes are restated to reflect the range of difficulty levels to teach and assess critical thinking about medical insurance and coding concepts and continue to reflect the revised version of Bloom's Taxonomy.
- **HIPAA-Related Updates**
  - 2013 ICD-10-CM and CPT/HCPCS codes are included.
  - The new Notice of Privacy Practices (NPP) that addresses disclosures in compliance with HITECH is illustrated.
- **Chapter-by-Chapter**
  - **Chapter 1:** New key terms: electronic health records (EHR), health information technology (HIT), revenue cycle management, medical billing cycle, PM/EHR, cash flow, and accounts payable (AP). New Learning Outcome 1.1 emphasizes revenue cycle management and the role played by the medical insurance specialist in this process. The medical billing cycle introduced here has been revised to conform to the EHR-based workflow presented in the medical documentation and billing cycle used in the PM/EHR.
  - **Chapter 2:** New key terms: accountable care organization (ACO), accounting of disclosure, Health Information Exchange (HIE), meaningful use incentives, medical documentation and billing cycle, Office of E-Health Standards and Services (OEHS), and operating rules. New Learning Outcomes 2.1 and 2.2 emphasize EHRs and their meaningful use as part of the discussion of documentation. Increased illustrations that show completed EHR screens rather than paper documents are included. A new OCR breach case and a new OCR physician practice case are provided. The new Notice of Privacy Practices (NPP) that addresses disclosures in compliance with HITECH is presented.
  - **Chapter 3:** New to this chapter are an updated flow chart on EP vs. NP based on CPT 2012; a new patient information form to collect race, ethnicity, and language for meaningful use incentives and compliance with 5010; explanation of how to determine primary coverage when the patient has a group and an individual plan; and ICD-10-CM codes placed on the encounter form illustration. Former learning outcome 3.10 has been moved to Chapter 6 as Learning Outcome 6.11 to follow revised medical billing cycle.
  - **Chapter 4:** This chapter has been completely rewritten to provide instruction on correct coding with ICD-10-CM and includes a brief comparison between ICD-10-CM and ICD-9-CM and notes on how to research ICD-9 codes when required.
  - **Chapter 5:** CPT and HCPCS have been combined into one chapter for consistency and appropriate level of coverage for these code sets (represents Chapters 5 and 6 from the previous edition, and as such, all subsequent chapters have been renumbered). The chapter also defines new modifier 33, provides a new definition of *moderate sedation* (no longer conscious) for E/M code range 99143–99150, and standardizes the use of the term *descriptor*.
  - **Chapter 6:** New key terms: adjustment, bundled payment, and walkout receipt. This chapter provides an explanation of the major global period indicators and a new exercise on accessing the period data by CPT code. The check of outpatient procedures from Chapter 3 has been added to follow the medical billing cycle more precisely. A new Billing Tip explains that some practices use the term *contractual adjustment* rather than *write-off*. A Health Reform

feature box explains the concept of bundled payments: a single payment for an entire episode of care to all providers

- **Chapter 7:** The CMS-1500 claim completion information for the current Reference Instruction Manual at NUCC.org has been updated. NUCC guidance on reconciling the CMS-1500 with the 5010 format for the 837P is included. According to the NUCC, some item numbers report data that are not reported on the 837P, and the organization recommends not reporting them on the CMS-1500. Following these guidelines requires a number of modifications to instructions, including *not* reporting the patient's telephone number, patient status, other insured's DOB and employer/school, insured's employer or school name, same/similar illness, balance due, and signature indication. The reference has been changed from 837 to 837P for clarity; the 837I is defined in Chapter 17. Appendix C, Medical Specialties and Taxonomy Codes, that was referenced here has been deleted; the website is more current and should be used. The discussion includes completing the 837P updated for 5010 claim completion requirements, such as no P.O. box or lock box addresses for the billing provider and new information needed for unlisted CPT/HCPCS codes and presents new 5010 definitions for billing provider, pay-to provider, rendering provider, and referring provider.
- **Chapter 8:** New key term: FAIR Health. Claim completion instructions have been updated to comply with NUCC CMS-1500 guidelines and ICD-10-CM codes.
- **Chapter 9:** New key terms: annual wellness visit (AWV), cost sharing, Internet-Only Manuals (IOM), Medicare Learning Network (MLN), and United States Preventive Services Task Force (USPSTF). The term *Physician Quality Reporting System (PQRS)* has been updated, as have the recovery auditor program and Zone Program Integrity Contractor (ZPIC). There is a new form and new learning objective on completing the new ABN; 2012 Part A and Part B premium/deductibles/coinsurance; and the section on ACA/USPSTF updates for preventive services coverage have been expanded. New material pulls together the various incentive programs; physician enrollment website information (PECOS) is included; and claim completion instructions have been updated to comply with NUCC CMS-1500 guidelines and ICD-10-CM codes.
- **Chapter 10:** The material includes coverage of the ACA effect on Medicaid enrollment in 2014 and updates of CHIP terminology and statistics, Medicaid managed care enrollment percentage, and claim completion instructions to comply with NUCC CMS-1500 guidelines and ICD-10-CM codes.
- **Chapter 11:** Cost sharing for Figure 11.2 and claim completion instructions to comply with NUCC CMS-1500 guidelines and ICD-10-CM codes have been updated.
- **Chapter 12:** New key terms: automotive insurance policy, personal injury protection, liens, and subrogation. The topic of automotive insurance has been added. ICD-10-CM codes are used.
- **Chapter 13:** The material uses ICD-10-CM codes and redefines RA/EOB into two parts: the RA for the provider and the EOB for the beneficiary per current industry practice.
- **Chapter 14:** New key terms: nonsufficient funds (NSF) check, collection ratio. The chapter includes the use of ICD-10-CM. Instructions on processing an NSF and an example of calculating the elements for a payment plan (items from a Truth in Lending form) are presented.
- **Chapters 15 and 16:** Case studies for ICD-10-CM and for NUCC CMS-1500 guidelines have been updated.
- **Chapter 17:** New key terms: inpatient-only list, three-day payment window, and ICD-10-PCS. There is a new section on coding with ICD-10-PCS and the use of ICD-10-CM.

For a detailed transition guide between the fifth and sixth editions, visit [www.mhhe.com/valerius6e](http://www.mhhe.com/valerius6e).

## Beyond *Medical Insurance*: Opportunities for Your Students to Apply Their Skills



### Workbook for use with *Medical Insurance: An Integrated Claims Process Approach, Sixth Edition* (0077520513, 9780077520519)

The *Workbook for use with Medical Insurance* has excellent material for reinforcing the text content, applying concepts, and extending understanding. It combines the best features of a workbook and a study guide. Each workbook chapter enhances the text's strong pedagogy through:

- Assisted outlining—reinforces the chapter's key points
- Key terms—objective questions
- Critical thinking—questions that stimulate process understanding
- Guided web activities—build skill in locating and then evaluating information on the Internet
- Applying concepts—reinforce and extend abstracting insurance information, calculating insurance math, and using insurance terms

The workbook matches the text chapter by chapter. It reinforces, applies, and extends the text to enhance the learning process.

### Medical Coding Workbook for Physician Practices and Facilities, ICD-10 Edition (0073511048, 9780073513713)

The *Medical Coding Workbook* provides practice and instruction in coding and using compliance skills. Because medical insurance specialists verify diagnosis and procedure codes and use them to report physicians' services, a fundamental understanding of coding principles and guidelines is the basis for correct claims. The coding workbook reinforces and enhances skill development by applying the coding principles introduced in *Medical Insurance, 6e* and extending knowledge through additional coding guidelines, examples, and compliance tips. It offers more than 75 case studies that simulate real-world application. Also included are inpatient scenarios for coding that require compliance with *ICD-10-CM Official Guidelines for Coding and Reporting* sequencing rule, as explained in Chapter 17 of the text.



# Medical Insurance in the Digital World—Supplementary Materials for the Instructor and Student

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## A one-stop spot to present, deliver, and assess digital assets available from McGraw-Hill: *McGraw-Hill Connect® Medical Insurance*

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## INSTRUCTORS' RESOURCES

You can rely on the following materials to help you and your students work through the material in the book; all are available on the book's website, [www.mhhe.com/valerius6](http://www.mhhe.com/valerius6) (instructors can request a password through their sales representative):

Supplement	Features
Instructor's Manual (organized by Learning Outcomes)	<ul style="list-style-type: none"> <li>• Lesson Plans</li> <li>• Answer Keys for all exercises</li> <li>• Documentation of Steps and Screenshots for Simulated Medisoft Exercises</li> </ul>
PowerPoint Presentations (organized by Learning Outcomes)	<ul style="list-style-type: none"> <li>• Key Terms</li> <li>• Key Concepts</li> <li>• Teaching Notes</li> </ul>
Electronic Testbank	<ul style="list-style-type: none"> <li>• EZ Test Online (Computerized)</li> <li>• Word Version</li> <li>• Questions tagged for Learning Outcomes, Level of Difficulty, Level of Bloom's Taxonomy, Feedback, ABHES, CAAHEP, CAHIM, and Estimated Time of Completion.</li> </ul>
Tools to Plan Course	<ul style="list-style-type: none"> <li>• Correlations of the Learning Outcomes to Accrediting Bodies such as ABHES, CAAHEP, and CAHIM</li> <li>• Sample Syllabi</li> <li>• Conversion Guide between fifth and sixth editions</li> <li>• Asset Map—recap of the key instructor resources as well as information on the content available through Connect Plus</li> </ul>
Medisoft Exercises Resources	<ul style="list-style-type: none"> <li>• <i>McGraw-Hill Guide to Success for Medical Insurance</i></li> <li>• Technical Support Information</li> <li>• Steps for students completing the simulated exercises in Connect Plus</li> </ul>
CMS-1500 and UB-04 Forms	<ul style="list-style-type: none"> <li>• Electronic versions of both forms</li> </ul>

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