

# Contents

## **UNIT I      BUILDING A FOUNDATION**

---

### **Chapter 1    The Origins of Health Insurance**

- What Is Insurance?, 1
- History, 3
- Metamorphosis of Medical Insurance, 4
- Key Health Insurance Issues, 7
  - How Can People Obtain Health Insurance?, 7
  - Access to Health Insurance, 7
  - What Affects the Cost of Healthcare?, 9
  - Cost Sharing, 10
- How Much is Enough?, 10
- Health Insurance Plans, 10

### **Chapter 2    Tools of the Trade: A Career as a Health (Medical) Insurance Professional**

- Your Future as a Health Insurance Professional, 13
  - Required Skills and Interests, 14
- Job Duties and Responsibilities, 17
- Career Prospects, 18
  - Occupational Trends and Future Outlook, 18
  - What to Expect as a Health Insurance Professional, 19
  - Rewards, 20
- Is a Career in Healthcare Right for You?, 20
- Certification Possibilities, 20
- Career Focus for the Health Insurance Professional, 21
  - Electronic Claims, 21
  - CMS-1500 (08/05) Paper Form, 21

### **Chapter 3    The Legal and Ethical Side of Medical Insurance**

- Medical Law and Liability, 26
  - Employer Liability, 27
  - Employee Liability, 27
- Insurance and Contract Law, 27
  - Elements of a Legal Contract, 27
  - Termination of Contracts, 28
- Medical Law and Ethics Applicable to Health Insurance, 28
- Important Legislation Affecting Health Insurance, 29
  - Federal Privacy Act of 1974, 29
  - Federal Omnibus Budget Reconciliation Act of 1980, 29
  - Tax Equity and Fiscal Responsibility Act of 1982, 29
  - Consolidated Omnibus Budget Reconciliation Act of 1986, 29
  - Federal False Claim Amendments Act of 1986, 30
  - Fraud and Abuse Act, 30
  - Federal Omnibus Budget Reconciliation Act of 1987, 30
  - The Patient Protection and Affordable Care Act, 30
- Medical Ethics and Medical Etiquette, 30

## Contents

- Medical Ethics, 30
- Medical Etiquette, 31
- Medical Record, 32**
  - Purposes of a Medical Record, 32
  - Complete Medical Record, 32
  - Who Owns Medical Records?, 32
  - Retention of Medical Records, 32
  - Access to Medical Records, 33
  - Releasing Medical Record Information, 33
- Documentation of Patient Medical Record, 33**
- Health Insurance Portability and Accountability Act and Compliance, 36**
  - Impact of Health Insurance Portability and Accountability Act, 37
  - Enforcement of Confidentiality Regulations of Health Insurance Portability and Accountability Act, 38
  - Developing a Compliance Plan, 38
- Confidentiality and Privacy, 39**
  - Confidentiality, 39
  - Privacy, 39
  - Security, 39
  - Exceptions to Confidentiality, 40
  - Authorization to Release Information, 40
  - Exceptions for Signed Released of Information for Insurance Claims Submission, 40
  - Breach of Confidentiality, 41
- Healthcare Fraud and Abuse, 41**
  - Defining Fraud and Abuse, 41
  - Preventing Fraud and Abuse, 42

## Chapter 4 Types and Sources of Health Insurance

- Types of Health Insurance, 46**
  - Indemnity (Fee-for-Service), 46
  - Managed Care, 47
- Sources of Health Insurance, 47**
  - Group Contract, 48
  - Individual Policies, 48
  - Medicare, 48
  - Medicaid, 48
- TRICARE/CHAMPVA, 48**
  - Standardized Benefits and Coverage Rule, 49
  - Disability Insurance, 49
- Miscellaneous Healthcare Coverage Options, 50**
  - Medical Savings Account, 50
  - Flexible Spending Account, 50
  - Health Reimbursement Arrangements, 51
  - Health Insurance Exchanges, 52
  - Accountable Care Organizations (ACOs), 52
  - Long-Term Care Insurance, 52
  - Dental Care, 53
  - Vision Care, 53
- Consolidated Omnibus Budget Reconciliation Act, 53**
- Health Insurance “Watchdogs”, 54**
- Other Terms Common to Third-Party Carriers, 54**
  - Birthday Rule, 54
  - Coordination of Benefits, 55
  - Medical Necessity, 55
  - Usual, Reasonable, and Customary, 55
  - Participating Versus Nonparticipating Providers, 58
  - Miscellaneous Terms, 58

## UNIT II HEALTH INSURANCE BASICS

---

### Chapter 5 Claim Submission Methods

- Overview of the Health Insurance Claims Process, 62
  - Two Basic Claims Submission Methods, 62
  - Proposed Revisions to the CMS-1500 (08-05) Form, 63
- Electronic Claims, 63
- Health Insurance Portability and Accountability Act, 63
  - Electronic Transactions and Code Set Requirements, 64
  - Privacy Requirements, 64
  - Security Requirements, 64
  - National Identifier Requirements, 64
- The New HIPAA 5010 Standards, 65
- The Electronic Insurance Claims Process, 66
  - Essential Information for Claims Processing, 66
  - Verifying Insurance with New Technology, 73
- Advantages of Electronic Claims, 75
- Two Ways to Submit Electronic Claims, 75
  - Claims Clearinghouses, 75
  - Direct Claims, 76
  - Clearinghouses Versus Direct, 76
- The Universal Claim Form (CMS-1500), 77
  - Format of the Form, 77
  - Optical Character Recognition, 77
  - Who Uses the Paper Form?, 78
  - Proofreading, 79
  - Claim Attachments, 79
  - Tracking Claims, 80

### Chapter 6 Traditional Fee-for-Service/Private Plans

- Traditional Fee-for-Service/Indemnity Insurance, 85
- How a Fee-for-Service Plan Works, 86
- Health Care Reform and Preexisting Conditions, 87
  - HIPAA and Credible Coverage, 88
- Commercial or Private Health Insurance, 88
  - Who Pays for Commercial Insurance?, 88
  - High-Risk Pool, 88
  - Coverage Mandate 2014, 89
  - Health Insurance Exchange, 89
  - What Is Self-Insurance?, 89
- Blue Cross and Blue Shield, 90
  - History of Blue Cross, 90
  - History of Blue Shield, 90
  - Blue Cross and Blue Shield Programs, 91
- Participating Versus Nonparticipating Providers, 95
- Submitting BCBS and Commercial Claims, 95
  - Timely Filing, 95
  - Filing Electronic Claims, 95
- Commercial Claims Involving Secondary Coverage, 96
  - Electronic Remittance Advice (ERA), 96

### Chapter 7 Unraveling the Mysteries of Managed Care

- What Is Managed Care?, 102
- Common Types of Managed Care Organizations, 103
  - Preferred Provider Organization, 104

## Contents

- Health Maintenance Organization, 105
- Other Types of MCOs, 106
- Advantages and Disadvantages of Managed Care, 106**
  - Advantages, 106
  - Disadvantages, 106
- Managed Care Certification and Regulation, 107**
  - National Committee on Quality Assurance, 107
  - National Committee on Quality Assurance; Health Insurance Portability and Accountability Act, 107
  - The Joint Commission, 107
  - URAC, 107
  - Utilization Review, 108
  - Complaint Management, 108
- Preauthorization, Precertification, Predetermination, and Referrals, 108**
  - Preauthorization, 109
  - Precertification, 109
  - Predetermination, 109
  - Referrals, 109
- Health Insurance Portability and Accountability Act and Managed Care, 112**
- Impact of Managed Care, 115**
  - Impact of Managed Care on the Physician-Patient Relationship, 115
  - Impact of Managed Care on Healthcare Providers, 115
- Healthcare Reform's Impact on MCOs, 116**
- Future of Managed Care, 116**

## Chapter 8 Understanding Medicaid

- What Is Medicaid?, 120**
- Evolution of Medicaid, 121**
  - Temporary Assistance for Needy Families, 121
  - Supplemental Security Income, 121
  - Medicaid and Healthcare Reform, 123
- Structure of Medicaid, 123**
  - Federal Government's Role, 123
  - Mandated Services, 123
  - States' Options, 124
  - Community First Choice Option, 125
  - State Children's Health Insurance Program, 125
  - Fiscal Intermediaries/Medicaid Contractors, 126
  - Medicaid Integrity Contractors, 126
- Other Medicaid Programs, 127**
  - Maternal and Child Health Services, 127
  - Early and Periodic Screening, Diagnosis, and Treatment Program, 127
  - Program of All-Inclusive Care for the Elderly, 127
  - Medicaid Home and Community-Based Services Waivers, 127
- Premiums and Cost Sharing, 128**
  - Nonemergency Use of the Emergency Department, 129
  - Emergency Medical Treatment & Labor Act, 129
- Payment for Medicaid Services, 129**
  - Medically Necessary, 129
  - Prescription Drug Coverage, 129
  - Dual Eligibles, 129
  - Accepting Medicaid Patients, 130
  - Participating Providers, 130
- Verifying Medicaid Eligibility, 130**
  - Medicaid Identification Card, 131

- Automated Voice Response System, 131
- Electronic Data Interchange, 132
- Point-of-Sale Device, 132
- Computer Software Program, 132
- Benefits of Eligibility Verification Systems, 132
- Medicare/Medicaid Relationship, 132**
  - Special Medicare/Medicaid Programs, 132
  - Medicare and Medicaid Differences Explained, 133
- Medicaid Managed Care, 133**
- Medicaid Claims, 134**
  - Completing the CMS-1500 Using Medicaid Guidelines, 134
  - Medicaid Secondary Claims, 134
  - Resubmission of Medicaid Claims, 134
  - Reciprocity, 134
- Medicaid and Third-Party Liability, 135**
- Common Medicaid Billing Errors, 135**
- Medicaid Remittance Advice, 136**
- Special Billing Notes, 136**
  - Time Limit for Filing Medicaid Claims, 136
  - Copayments, 136
  - Accepting Assignment, 138
  - Services Requiring Prior Approval, 138
  - Preauthorization, 138
  - Retention, Storage, and Disposal of Records, 138
- Fraud and Abuse in the Medicaid System, 139**
  - What Is Medicaid Fraud?, 139
  - Patient Abuse and Neglect, 139
- Medicaid Quality Practices, 140**

## Chapter 9 Conquering Medicare's Challenges

- Medicare Program, 144**
  - Medicare Program Structure, 145
  - Enrollment, 150
  - Premiums and Cost-Sharing Requirements, 150
  - Medicare Part C (Medicare Advantage Plans), 151
  - Other Medicare Health Plans, 151
  - Medicare Part D (Medicare Prescription Drug Benefit Plan), 152
  - Changing Medicare Health or Prescription Drug Coverage, 152
  - Programs of All-Inclusive Care for the Elderly (PACE), 152
- Medicare Combination Coverages, 153**
  - Medicare/Medicaid Dual Eligibility, 153
  - Medicare Supplement Policies, 153
- Medicare and Managed Care, 155**
  - Medicare HMOs, 155
  - Advantages and Disadvantages of Medicare HMOs, 158
  - Why This Information Is Important to the Health Insurance Professional, 160
- Preparing for the Medicare Patient, 160**
  - Medicare's Lifetime Release of Information Form, 160
  - Determining Medical Necessity, 160
  - Advanced Beneficiary Notice, 161
  - Local Coverage Determination (LCD), 162
  - Health Insurance Claim Number and Identification Card, 162
  - Replacing the Medicare Card, 162
- Medicare Billing, 164**
  - Physician Fee Schedule, 164

## Contents

- Medicare Participating and Nonparticipating Providers, 165
- Determining What Fee to Charge, 165
- Filing Medicare Claims, 165**
  - Electronic Claims, 165
  - Administrative Simplification Compliance Act (ASCA), 165
  - Transition to ASC X12 Version 5010, 167
  - Exceptions to Mandatory Electronic Claim Submission, 167
  - Small Providers and Full-Time Equivalent (FTE) Employee Assessments, 167
  - ASCA Enforcement of Paper Claim Submission, 167
  - Deadline for Filing Medicare Claims, 168
- Using the CMS-1500 Form for Medicare Claims, 168**
  - CMS-1500 Completion Guidelines, 168
  - Completing a Medigap Claim, 169
  - Medicare Secondary Payer, 169
  - Medigap Crossover Program, 171
  - Medicare/Medicaid Crossover Claims, 171
- Medicare Summary Notice, 172**
  - Information Contained on the MSN, 172
  - Medicare Remittance Advice, 172
  - Electronic Funds Transfer, 175
- Medicare Audits and Appeals, 175**
  - Audits, 175
  - Recovery Audit Contractor (RAC) Program, 176
  - Appeals (Fee-for-Service Claims), 176
  - Appeals Process (Medicare Managed Care Claims), 179
- Quality Review Studies, 180**
  - Quality Improvement Organizations, 181
  - Beneficiary Notices Initiative, 181
  - Beneficiary Complaint Response Program, 181
  - Hospital-Issued Notice of Noncoverage (HINN) and Notice of Discharge (NODMAR) and Medicare Appeal Rights Reviews, 181
  - The Center for Medicare and Medicaid Innovation (CMI), 182
  - Physician Review of Medical Records, 182
  - Physician Quality Reporting System (PQRS), 182
  - Medicare Billing Fraud, 182
  - Clinical Laboratory Improvement Amendments Program, 182

## Chapter 10 Military Carriers

- Military Health Programs, 187**
- TRICARE, 187**
  - Military Health System, 188
  - TRICARE Management Activity (TMA), 188
  - TRICARE Regional Contractors, 188
  - Who is Eligible for TRICARE?, 188
  - Who Is Not Eligible for TRICARE?, 189
  - Losing TRICARE Eligibility, 189
  - TRICARE Program Options, 189
  - TRICARE Overseas Program (TOP), 189
  - TRICARE Young Adult (TYA) Program, 189
  - What TRICARE Pays, 190
- TRICARE's Additional Programs, 190**
  - TRICARE Dental Programs, 190
  - Supplemental TRICARE Programs, 193
  - TRICARE and Other Health Insurance (OHI), 193
  - TRICARE Standard Supplemental Insurance, 193

- TRICARE For Life, 193
- Verifying TRICARE Eligibility, 194**
- TRICARE-Authorized Providers, 194**
  - TRICARE PARs and nonPARs, 196
- Cost Sharing, 196**
  - TRICARE Coding and Payment System, 196
- TRICARE Claims Processing, 197**
  - Who Submits Claims, 197
  - Submitting Paper Claims, 198
  - Deadline for Submitting Claims, 199
  - TRICARE Explanation of Benefits, 199
- CHAMPVA, 199**
  - Extending Eligibility, 202
  - Identifying CHAMPVA-Eligible Beneficiaries, 202
  - CHAMPVA Benefits, 203
  - CHAMPVA Cost Sharing, 203
  - Prescription Drug Benefit, 205
  - CHAMPVA In-house Treatment Initiative (CIT), 206
  - CHAMPVA-TRICARE Connection, 206
  - CHAMPVA-Medicare Connection, 206
  - CHAMPVA and HMO Coverage, 206
  - CHAMPVA Providers, 206
  - CHAMPVA For Life (CFL), 207
- Filing CHAMPVA Claims, 207**
  - CHAMPVA Preauthorization Requirements, 207
  - CHAMPVA Claims Filing Deadlines, 208
- Instructions for Completing TRICARE/CHAMPVA Paper Claim Forms, 208**
  - Claims Filing Summary, 209
  - CHAMPVA Explanation of Benefits, 209
  - Claims Appeals and Reconsiderations, 209
- HIPAA and Military Insurers, 209**

## **Chapter 11 Miscellaneous Carriers: Workers' Compensation and Disability Insurance**

- Workers' Compensation, 214**
  - History, 214
  - Federal Legislation and Workers' Compensation, 215
  - Eligibility, 215
  - Workers' Compensation Claims Process, 217
  - Special Billing Notes, 222
  - Workers' Compensation and Managed Care, 224
  - Health Insurance Portability and Accountability Act and Workers' Compensation, 224
  - Workers' Compensation Fraud, 224
  - Online Workers' Compensation Service Center, 224
- Private and Employer-Sponsored Disability Income Insurance, 224**
  - Defining Disability, 225
  - Disability Claims Process, 225
- Federal Disability Programs, 230**
  - Americans with Disabilities Act, 231
  - Social Security Disability Insurance, 231
  - Supplemental Security Income, 232
  - State Disability Programs, 232
  - Centers for Disease Control and Prevention Disability and Health Team, 232
  - Ticket to Work Program, 233
  - Filing Supplemental Security Income and Social Security Disability Insurance Claims, 233

**UNIT III      CRACKING THE CODES**

---

**Chapter 12 Diagnostic Coding**

**Introduction to International Classification of Diseases**

**Coding System, 239**

Three Major Coding Structures, 239

**History of International Classification of Diseases Coding, 240**

Uses of Coded Data, 240

**Two Diagnostic Coding Systems, 241**

Comparing the Two Systems, 241

Guidelines, 241

**ICD-9-CM Coding Manual, 242**

Volume 2, Alphabetic List (Index), 242

Three Sections of Volume 2, 243

National Coverage Determinations and Local Coverage Determinations, 246

**Process of Classifying Diseases, 246**

Volume 1, Tabular List, 248

Supplementary Sections of Volume 1, 248

Locating a Code in the Tabular List (Volume 1), 249

**Symbols and Conventions Used in Volume 1, 249**

Typefaces, 250

Instructional Notes, 250

**Essential Steps to Diagnostic Coding, 250**

**Special Coding Situations, 250**

Coding Signs and Symptoms, 250

Etiology and Manifestation Coding, 251

Combination Codes, 252

Coding Late Effects, 252

Coding Neoplasms, 252

Coding Hypertension, 253

**Overview of ICD-10 Coding System, 253**

ICD-10-CM Code Structure, 253

Format of ICD-10-CM Manual, 253

**Coding Steps for Alphabetic Index, 257**

**Tabular List, 258**

Format and Structure of Codes, 258

Tabular List Conventions, 259

Manifestation Codes, 263

Morphology Codes, 263

Default Codes, 264

**ICD-10-CM General Coding Guidelines and Chapter-Specific Guidelines, 264**

Codes from A00.0 through T88.9, Z00-Z99.89, 264

**Diagnostic Coding and Reporting Guidelines for Outpatient Services, 265**

Selection of First-Listed Condition, 266

Outpatient Surgery, 266

Observation Stay, 266

Codes That Describe Symptoms and Signs, 266

Encounters for Circumstances Other than a Disease or Injury, 266

Level of Detail in Coding, 266

Code for Diagnosis, Condition, Problem, or Other Reason for Encounter/Visit, 266

Code All Documented Conditions That Coexist, 266

**Health Insurance Portability and Accountability Act and Coding, 267**

Code Sets Adopted as Health Insurance Portability and Accountability

Act Standards, 268

Implementation of ICD-10, 268

**Importance of Learning Both Diagnostic Coding Systems, 268**



## Chapter 13 Procedural, Evaluation and Management, and HCPCS Coding

### Overview of Current Procedural Terminology (CPT) Coding, 273

Purpose of CPT, 274

Development of CPT, 274

### Three Levels of Procedural Coding, 274

#### CPT Manual Format, 275

Introduction and Main Sections, 275

Category II Codes, 275

Category III Codes, 276

Appendices A through N, 276

CPT Index, 277

Symbols Used in CPT, 277

Modifiers, 278

Unlisted Procedure or Service, 278

Special Reports, 278

### Conventions and Punctuation Used in CPT, 279

Importance of the Semicolon, 279

Section, Subsection, Subheading, and Category, 279

Cross-Referencing with *See*, 279

### Basic Steps of CPT Coding, 279

### Evaluation and Management (E & M) Coding, 281

Vocabulary Used in E & M Coding, 281

Documentation Requirements, 283

Three Factors to Consider, 283

Key Components, 284

Contributing Factors, 284

Prolonged Services, 286

### Subheadings of Main E & M Section, 286

Office or Other Outpatient Services, 286

Hospital Observation Services, 286

Hospital Inpatient Services, 287

Consultations, 287

Emergency Department Services, 288

Critical Care Services, 288

Nursing Facility Services, 288

### E & M Modifiers, 288

### Importance of Documentation, 289

E & M Documentation Guidelines: 1995 versus 1997, 289

Deciding Which Guidelines to Use, 289

### Overview of HCFA Common Procedure Coding System (HCPCS), 289

HCPCS Level II Manual, 290

Modifiers, 291

Appendices, 291

### National Correct Coding Initiative (NCCI), 291

### Health Insurance Portability and Accountability Act (HIPAA) and HCPCS Coding, 292

Crosswalk, 292

### *Current Procedural Terminology, 5th Edition (CPT-5), 292*

## UNIT IV THE CLAIMS PROCESS

---

### Chapter 14 The Patient

#### Patient Expectations, 296

Professional Office Setting, 297

Relevant Paperwork and Questions, 297

Honoring Appointment Times, 297

## Contents

- Patient Load, 298
- Getting Comfortable with the Healthcare Provider, 298
- Privacy and Confidentiality, 298
- Financial Issues, 298
- Future Trends, 299**
  - Aging Population, 299
  - Internet as a Healthcare Tool, 299
  - Patients as Consumers, 299
- Health Insurance Portability and Accountability Act (HIPAA) Requirements, 299**
  - Authorization to Release Information, 300
  - HIPAA and Covered Entities, 300
  - HIPAA Requirements for Covered Entities, 300
  - Patient's Right of Access and Correction, 301
  - Accessing Information through Patient Authorization, 301
  - Accessing Information through De-identification, 301
- Billing Policies and Practices, 303**
  - Assignment of Benefits, 303
  - Keeping Patients Informed, 304
  - Accounting Methods, 304
  - Electronic Medical Records, 306
- Billing and Collection, 308**
  - Billing Cycle, 308
  - Arranging Credit or Payment Plans, 308
  - Problem Patients, 310
- Laws Affecting Credit and Collection, 311**
  - Truth in Lending Act, 311
  - Fair Credit Billing Act, 311
  - Equal Credit Opportunity Act, 311
  - Fair Credit Reporting Act, 311
  - Fair Debt Collection Practices Act, 311
- Collection Methods, 312**
  - Collection by Telephone, 312
  - Collection by Letter, 313
- Billing Services, 314**
- Collection Agencies, 314**
- Small Claims Litigation, 314**
  - Who Can Use Small Claims, 315
  - How the Small Claims Process Works, 315

## Chapter 15 The Claim

- Introduction, 319**
- General Guidelines for Completing CMS-1500 Form, 319**
- Keys to Successful Claims, 319**
  - First Key: Collect and Verify Patient Information, 320
  - Second Key: Obtain Necessary Preauthorization and Precertification, 321
  - Third Key: Documentation, 322
  - Fourth Key: Follow Payer Guidelines, 322
  - Fifth Key: Proofread Claim to Avoid Errors, 322
  - Sixth Key: Submit a Clean Claim, 322
  - Rejected Claims versus Denied Claims, 323
- Health Insurance Portability and Accountability Act (HIPAA) and National Standard Employer Identifier Number, 323**
- Claim Process, 323**
  - Step One: Claim Is Received, 325
  - Step Two: Claims Adjudication, 325
  - Step Three: Tracking Claims, 325

- Step Four: Receiving Payment, 328
- Step Five: Interpreting Explanation of Benefits, 328
- Step Six: Posting Payments, 330
- Time Limits, 330
- Processing Secondary Claims, 333**
  - Real-Time Claims Adjudication, 334
- Appeals, 334**
  - Incorrect Payments, 334
  - Denied Claims, 334
  - Appealing a Medicare Claim, 335

## **UNIT V      ADVANCED APPLICATION**

---

### **Chapter 16 The Role of Computers in Health Insurance**

- Introduction, 338
- Impact of Computers on Health Insurance, 338
- Role of Health Insurance Portability and Accountability Act (HIPAA) in Electronic Transmissions, 338
- Electronic Data Interchange, 339**
  - History of Electronic Data Interchange, 339
  - Benefits of Electronic Data Interchange, 339
- Electronic Claims Process, 340**
  - Methods Available for Filing Claims Electronically, 340
  - Enrollment, 340
  - Electronic Claims Clearinghouse, 340
  - Direct Data Entry Claims, 341
  - Clearinghouse versus Direct, 341
  - Advantages of Filing Claims Electronically, 342
- Medicare and Electronic Claims Submission, 342**
- Additional Electronic Services Available, 343**
  - Electronic Funds Transfer, 343
  - Electronic Remittance Advice, 344
  - Role of Computers in Transitioning to ICD-10 Diagnostic Coding System, 344
- Electronic Medical Record, 344**
  - Combination Records, 347
  - Digital Imaging Hybrid, 347
  - Potential Issues, 347
  - Future of Electronic Medical Records, 348
  - Privacy Concerns of Electronic Medical Records, 348
  - Federal Funding for Electronic Medical Record Trials and “Meaningful Use”, 348

### **Chapter 17 Reimbursement Procedures: Getting Paid**

- Understanding Reimbursement Systems, 352**
  - Types of Reimbursement, 353
- Medicare and Reimbursement, 354**
  - Medicare Prospective Payment System, 354
  - How the Medicare Prospective Payment System Works, 355
- Other Systems for Determining Reimbursement, 356**
  - Relative Value Scale, 356
  - Resource-Based Relative Value Scale, 356
  - Diagnosis-Related Groups, 357
  - Ambulatory Payment Classifications, 358
  - Resource Utilization Groups, 358

## Contents

- Transition of Medicare to Resource-Based Relative Value Scale, 359**
  - Setting Medicare Payment Policy, 359
  - Medicare Inpatient Hospital Prospective Payment System, 359
  - Medicare Long-Term Care Hospital Prospective Payment System, 359
- Additional Prospective Payment Systems, 360**
  - Home Health Prospective Payment System, 360
  - Inpatient Rehabilitation Facility Prospective Payment System, 360
  - Significance of Reimbursement Systems to the Health Insurance Professional, 360
- Peer Review Organizations and Prospective Payment Systems, 361**
- Understanding Computerized Patient Accounting Systems, 361**
  - Selecting the Right Billing System, 361
  - Managing Transactions, 362
  - Generating Reports, 364
- Health Insurance Portability and Accountability Act and Practice Management software, 365**

## Chapter 18 Hospital Billing and the UB-04

- Hospital Versus Physician Office Billing and Coding, 374**
- Modern Hospital and Health Systems, 374**
  - Emerging Issues, 374
- Common Healthcare Facilities, 375**
  - Acute Care Facilities, 375
  - Critical Access Hospitals, 375
  - Ambulatory Surgery Centers, 376
  - Other Types of Healthcare Facilities, 376
- Legal and Regulatory Environment, 377**
  - Accreditation, 378
  - Professional Standards, 379
  - Governance, 379
  - Confidentiality and Privacy, 379
  - Fair Treatment of Patients, 380
- Common Hospital Payers and Their Claims Guidelines, 381**
  - Medicare, 381
  - Medicaid, 383
  - TRICARE, 383
  - CHAMPVA, 383
  - Blue Cross and Blue Shield, 384
  - Private Insurers, 384
- National Uniform Billing Committee and the UB-04, 384**
  - UB-04 Data Specifications, 385
  - 837I: Electronic Version of the UB-04 Form, 385
- Structure and Content of the Hospital Health Record, 387**
  - Standards in Hospital Electronic Medical Records, 388
  - Standard Codes and Terminology, 388
- Inpatient Hospital/Facility Coding, 388**
  - ICD-9-CM (Volume 3) Codes for Inpatient Hospital Procedures, 389
  - Code Sets Used for Inpatient Hospital/Facility Claims in ICD-10-PCS, 389
  - National Correct Coding Initiative, 392
  - Recent Rule Changes Affecting Hospital Billing, 393
- Outpatient Hospital Coding, 393**
  - Hospital Outpatient Prospective Payment System, 393
  - Ambulatory Payment Classification Coding, 394
- The Hospital Billing Process: Understanding the Basics, 394**
  - Informed Consent, 394
  - Present on Admission (POA), 396
  - Hospital Charges, 396

Electronic Claims Submission (ECS), 396  
Health Information Management (HIM) Systems, 397  
Payment Management, 397  
**HIPAA-Hospital Connection, 398**  
**Billing Compliance, 398**  
**Career Opportunities in Hospital Billing, 399**  
    Training, Other Qualifications, and Advancement, 399  
    Job Outlook, 400

**Appendix A Sample Blank CMS-1500 (08/05), 404**

**Appendix B CMS-1500 Claim Forms and Completion Instructions, 406**

**Appendix C UB-04 Claim Form and Completion Instructions, 425**

**Glossary, 430**