Competent staff trained to handle physician billing is necessary to ensure that physicians receive financial remuneration for the services they provide. At the same time the need for competent staff is increasing, the role of insurance staff members has been enlarged and the demands on these individuals intensified.

The days of filing an insurance claim with the reasonable expectation that the claim will be paid are gone. The American Medical Association has publicized that one in five insurance claims is paid incorrectly.¹ This astounding fact will not surprise those who understand the healthcare insurance processes. Billing for physician services is a highly complex, yet ambiguous, activity.

The 21st-century environment of rising cost and decreased payments in healthcare is a reality. Physicians in strong medical groups face the dilemma of practice costs rising each year and the uncertainty of decreased payment. Independent physician groups depend on competent insurance staff to bring in the revenue for the services the physicians provide. Without the efforts of an expert insurance staff, physicians may face financial jeopardy. In addition, healthcare reform has encouraged integrated delivery systems as a desirable model for care delivery. Many physicians, even those in strong groups, feel threatened, and those in less stable groups are likely to seek employment with hospital systems.

Historically, members of the medical office insurance staff have been trained on the job. This training can be excellent; however, the quality of learning is dependent on the trainer. Occasionally, a knowledge gap exists between what a medical office insurance staff person thinks he or she “knows” to be correct and what is correct. In addition, there is often a broad disparity between the knowledge base of staff members in a single insurance department. Sometimes terms may be defined incorrectly, or terms within a single insurance department are coined and used as if they are industry-wide terms. Those situations are very uncomfortable for even an experienced person as a new employee in an insurance department. The training course in this book ensures that every insurance department member has consistent and accurate training in healthcare insurance basics and a working vocabulary of industry terms.

Managers of medical office insurance departments have placed and will continue to place great emphasis on experience. Equal training provides a starting point of fairness and equal opportunity for success.

This workbook explains the fundamentals of how to work effectively as a medical office insurance staff member. It introduces individuals to the various steps of filing a claim and the role that insurance staff members play in claims processing and thus in the organization’s financial health. Most people are surprised and shocked when they learn that many health insurance claims are not paid correctly and, of the large number of claims that are initially denied, many are not followed up on and re-filed.

Reading and working through this book, you will understand why an insurance claim is filed, gain a framework for thinking about the major types of health insurance, and learn about the various elements of health insurance. You will also learn about what constitutes fraud and abuse and how to avoid each. In addition you will come to understand the elements of coding and how to read an Explanation of Benefits. You will learn how to deal effectively with account follow-up, known as working insurance, and why it is a critical component of your success as a member of the medical office insurance staff.

**WHY TRAINING?**

Hiring a new employee is a huge investment, so medical practices should want to invest in well-trained staff. Knowledgeable staff members have the best opportunity to be successful in their position and give the organization the best chance of a positive return on its investment.

When organizations advertise for and hire staff, they may not have sufficient assurance that the person they select has good knowledge and experience, even when the insurance person says he or she has 20 years of experience. How successful was the individual in bringing in revenue to the organizations for which he or she worked?

**TRAINING IS FOR MORE THAN JUST NEW EMPLOYEES**

Certainly, new employees must be trained, but it is important to remember that training should not just be focused on new employees. Once a new employee has been trained and integrated into the organization, an opportunity exists to expand training for employees across the organization to ensure that all staff members share the same chance to acquire knowledge.

Cross-training provides a good occasion for expanding knowledge and for making staff more inclined to work as a team. For example, I heard an insurance staff member who had been covering at the front desk express in response to a complaint from another insurance staff person, “If she had any idea what the people at the front desk do, she wouldn’t be so critical. I have covered up there when I thought I was just going to cry.”

Cross-training benefits both the organization and the employee, allowing employees to learn new tasks and better understand how all the jobs in the practice fit together. Cross-training also gives managers more flexibility in moving employees around to get the work done. For insurance staff in particular, cross-training gives complete knowledge of the interlocking roles in the medical practice that affect their work.
THE ROLE OF THIS TRAINING MANUAL

This book provides a comprehensive introduction to the role of medical office billing staff. It presents a basis for understanding the fundamentals of the insurance claim process (Lesson 1), the different types of commercial and government insurance (Lessons 2–5), the revenue cycle (Lessons 6–9), how to read an Explanation of Benefits (Lesson 10), coding (Lessons 11–12), and insurance regulations (Lesson 13). Exercises and scenarios are presented at the end of each lesson, so that readers can test their knowledge and solidify their understanding. It is hoped that this manual will both provide an introduction to new medical office insurance staff and serve as a reference for existing insurance staff members and practice managers.

HOW TO USE THE CD

As an extra bonus, a CD comes with this book. It contains pre-tests and post-tests for training purposes.

The pre-tests are on the CD only and should be used by the billing staff employee and/or his or her manager to test knowledge about medical office billing before working through each lesson. Once the individual has completed the lesson, he or she should take the post-tests to gauge billing knowledge acquired. The post-tests on the CD are the same as those that follow each lesson.

In addition, the CD contains a master list of “Key Terms and Definitions,” which combines into one list the glossaries that appear at the end of each lesson.

The tests and reference material on the CD are extremely useful tools for managers — not only to help the billing staff member train himself or herself about the intricacies of medical office billing, but to strengthen their own knowledge of this complicated skill set.
LESSON 1

Overview of Medical Office
Insurance Staff Work .................................

OBJECTIVES

➤ Describe what constitutes an encounter.
➤ Summarize the steps through which claims are filed and processed.
➤ Identify factors that may affect the processing of a claim.
➤ Define the three major types of insurance in the United States.

WHAT IS AN ENCOUNTER?

When a patient seeks medical care from a healthcare provider, commonly in a face-to-face visit, this is an encounter. The provider may be a physician or a midlevel provider providing services on behalf of the physician. The midlevel provider may be a nurse practitioner or a physician assistant; regardless, the provider must be licensed in the state where service is provided.

WHAT ARE THE STEPS OF FILING AND PROCESSING A CLAIM?

Primarily physicians get paid for the services they provided to patients from insurance carriers. Filing the insurance claim is an essential step in resolving payment. This training manual starts with the claim, the fundamental work of insurance staff. An insurance claim is filed to get payment for services because services were provided, usually through an encounter.

After service is provided, the process of documentation and coding must be completed. The provider must document in detail the services that were provided. This documentation gets translated into a code called a *Current Procedural Terminology (CPT®)* code, which clearly describes the service that was provided. In addition to the CPT code, a corresponding diagnosis code(s), called an *International Classification of Diseases (ICD-9-CM)* code, that describes the medical condition(s) and why the patient sought treatment are attached. After that information is recorded in the practice management (PM) system the claim is ready to be filed, or in other words, sent to the insurance carrier for payment. The claim may be sent either electronically or on paper. But before the claim can be filed, work has already occurred behind the scenes. The PM system must be set up in the proper format with the correct

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information about the provider, the patient, and the insurance carrier to ensure that the claim gets to the carrier for payment consideration.

The claim will be sent to the insurance carrier or to its agent, such as a third-party administrator (TPA), for adjudication. *Adjudication* is the process of determining if the claim will be paid. When the claim arrives, the decision is made whether the claim is able to be processed. A claim that can be processed or is *processable* is called a *clean claim*. A claim that is not able to be processed is *unprocessable*. If the claim can be processed, it will be put through several edits to see how much will be paid. For example, the edits will determine if the provider is a *participating provider* and take assignment, meaning that the payment amount is predictable for the carrier, and the money will be sent directly to the provider. If the provider is *non-participating*, the claim is non-assigned — the provider has not made an agreement with the insurance carrier for payment — and the check for payment is sent to the insured instead of the provider.

**IMPACTS ON PAYMENTS**

Payment of a claim may be affected for many reasons. Those include:

- If the patient was not *eligible* for coverage on the date of service,
- If the insured patient had other coverage that could be a source of payment — the determination must be made if the carrier pays as the *primary payer* or the *secondary payer*,
- If the service provided is a *covered service* or an *excluded service* — the carrier will not pay for services that are excluded from coverage,
- If the claim is for treatment of a *pre-existing* condition,
- If the provider was in-network or out-of-network,
- If the service met precertification requirements,
- If the patient has met deductible requirements as outlined in the benefits package, or
- If the patient has met the out-of-pocket maximum.

Other payment considerations relating to the CPT and diagnosis code billed are based on modifiers and place of service. The considerations outlined above are not an exhaustive list but provide information about the complexity of the insurance filing and payment process.

After the insurance carrier has applied all edits, a payment determination is made and a check is sent out. Let’s assume that the check has been received in the physician’s office. The check will be accompanied by an Explanation of Benefits (EOB) that explains the payment amount. Then it is up to the medical office insurance staff members to decide if they agree with the payment determination. If payment has been denied or if staff members do not agree with the amount, the payment determination must be appealed. If the payment amount is correct, then an adjustment must be made to reconcile the difference between the amount charged and the amount paid. The practice management system may be set to automatically take the adjustment between the charged amount and the contracted amount. If not, medical office insurance staff must manually make the adjustment between the charge and the payment. Any remaining balance on the account is probably the
coinsurance that is the patient’s responsibility to pay. A statement is sent to the patient for the coinsurance, if it has not already been collected. It is the medical practice’s responsibility to follow up on the balance until it is resolved.

Complexity is a reality relating to healthcare insurance, and the body of knowledge is so large that no one individual can master it totally. “But gaining a working knowledge and building on that through experience is the best way to become proficient. The difficulty in learning how to work in a medical office insurance department reminds me of the saying, “How do you eat an elephant? One bite at a time.” We can apply that philosophy to the study of healthcare insurance by creating a framework to use in thinking about the fundamentals of healthcare insurance and then learning how to find the resources to use when questions arise.

WHAT TYPES OF INSURANCE ARE USED IN THE UNITED STATES?

A good rule of thumb when thinking about healthcare insurance is to break it down into major types. The three major types for consideration here are government insurance, commercial for-profit insurance, and non-governmental not-for-profit insurance. Use Exhibit 1.1 on the next page to help sort out the major types of insurance and their elements.

This training manual deals specifically with government insurance and commercial insurance. A good understanding of these two types of insurance allows individuals working in a medical office insurance department to have a broad base of knowledge from which they can draw in dealing with the situations that they will face during the course of their work.

KEY TERMS AND DEFINITIONS

**Adjudication** — The process of determining whether a claim will be paid.

**Adjustment** — The amount of a charge that is written off based on the difference between the fee-for-service charge amount and the contracted amount.

**Appeal** — A written request asking the insurance carrier to review or critically examine the initial determination of payment for services provided. Claims that were paid incorrectly are appealed by the medical practice to ask the payer for reconsideration on payment. Every claim that pays incorrectly should be appealed.

**Assignment** — An agreement to accept as payment in full the allowed amount established by Medicare for services provided. Assignment also refers to the situation when a patient agrees to have payment sent directly to the provider for services provided.

**Benefits Package** — The collection of services an insurance carrier has agreed to pay for under the insurance contract.

**Clean Claim** — A claim containing all relevant and correct information needed for processing.

**Coding** — Transforms a verbal description of treatment by assigning alpha or numeric identifiers from a recognized classification system to diagnostic and procedural clinical documentation.
EXHIBIT 1.1 ■ Major Types of Insurance and Their Elements

Healthcare insurance

Government insurance
- Medicare
- Medicaid
- TRICARE

Commercial for-profit insurance
- Fee-for-service (FFS)
- Discounted fee-for-service (DFFS)
- Managed care health maintenance organization (HMO)
- Managed care preferred provider organization (PPO)
- Managed care point-of-service (POS) plan

Non-governmental not-for-profit insurance
- Original Blue Cross/Blue Shield
- Private not-for-profit

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**Covered Service** — An approved medical service that will be paid by insurance.

**Current Procedural Terminology (CPT) Codes** — The official standard system of codes maintained annually by the American Medical Association of the medical industry. Descriptive terms are coupled with numeric codes and paired with diagnosis codes to bill for services provided.

**Date of Service** — The date a healthcare service was provided.

**Deductible** — The amount an insured individual must pay before insurance begins to pay for covered services. Deductibles are met at the beginning of each plan year and are defined by the insurance contract.

**Documentation** — The record of medical services provided to satisfy documentation guidelines as defined by either the 1995 or 1997 Medicare Documentation Guidelines for Evaluation and Management Services.

**Eligible** — A person who has met all the criteria to receive healthcare coverage for services.

**Encounter** — A face-to-face contact between a patient and a provider during which medical services are provided and the provider documents those services.

**Excluded Service** — Services not covered by insurance.

**Explanation of Benefits (EOB)** — A written description of payment made by a health plan that is sent to both provider and patient.

**In-Network** — A provider among a group of providers that have contracted with a health plan so that its insured can access healthcare services at discounted rates.

**International Classification of Diseases, Ninth Revision (ICD-9) Codes** — An international coding system for diagnosis codes used for billing and tracking purposes. They are paired with CPT codes and used to bill for services provided.

**Midlevel provider** — A nonphysician medical provider licensed to treat and diagnose patients under the supervision of a licensed physician.

**Modifiers** — Numeric codes that increase or decrease the relative value unit (RVU) of a Current Procedural Terminology (CPT) code. A complete list of modifiers with definitions is found in the CPT codebook.

**Non-participating Provider** — A provider who has not agreed to accept assignment on all Medicare claims.

**Nurse Practitioner (NP)** — A registered nurse who has completed additional educational training and is licensed to work as a midlevel provider under the supervision of a licensed physician.

**Out-of-Network** — A provider who has not contracted with an insurance company at a negotiated rate for reimbursement on services provided.

**Out-of-Pocket Maximum** — The maximum amount the insured will have to pay personally. The out-of-pocket amount is dictated by the health plan’s benefits package. Once healthcare services expenses have reached this amount, insurance pays 100 percent of future expenses during the current healthcare contract.

**Participating Provider** — A medical services provider who has voluntarily agreed to accept assignment on all claims benefits considered a covered service for Medicare beneficiaries.

**Payment Determination** — The decision of how much will be paid on a claim based on criteria to fulfill the responsibility of the insurance carrier in accordance with the benefits package of the insured.
Physician Assistant (PA) — A person prepared in an accredited academic and clinical program and certified to practice medicine under the supervision of a licensed physician.

Place-of-Service Codes — Codes used on providers’ claims to identify where a service to the patient was provided.

Pre-existing Condition — A medical condition acquired before the individual was enrolled in a health plan to receive insurance benefits.

Primary Payer — A carrier whose benefit plan pays first on medical care for an insured individual.

Processable — A claim that is considered a clean claim and can be processed for payment.

Secondary Payer — The carrier that will pay after the primary insurance on a claim for services when a beneficiary has two or more payers.

Third-Party Administrator (TPA) — An entity contracted to make payment or perform claims administration for a plan or an entity.

Unprocessable — A claim that contains incomplete or invalid information.

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**REVIEW OF OBJECTIVES**

- **Describe what constitutes an encounter.**
  - A patient receives services, usually face-to-face, from a physician or midlevel provider.

- **Summarize the steps through which claims are filed and processed.**
  - An encounter occurs with supporting documentation and coding.
  - Charges for the encounter are entered then batched for filing.
  - After edits, claims are filed and sent to a clearinghouse, which sends the claim on to the carrier.
  - Once received by the carrier, payment determination is made.
  - The claim is paid, accompanied by an EOB provided to both provider and patient.
  - Then the major work of the insurance department starts. Payment is posted, and the insurance department assesses the appropriateness of payment. It may be necessary to move the charges to the patient’s account or appeal the claim. In any case, follow-up is required.

- **Identify factors that may affect the processing of a claim.**
  - Benefit conditions such as eligibility, covered services, deductibles met, in-network or out-of-network provision of services.
  - Factors affecting payment such as documentation, coding requirements, modifiers, place of service.

- **Define the three major types of insurance in the United States.**
  - Government
  - Commercial (for-profit)
  - Not-for-profit commercial