

Lesson 2

Medical Insurance 101

Step 1: Learning Objectives

When you have completed the instruction in this lesson, you will be trained to:

- Define medical billing terms common to the healthcare profession.
- Describe the resources used by a healthcare professional.
- Explain what a medical bill is and how it is used for reimbursement.
- Discuss the importance of being accurate and thorough.
- Describe the basics of insurance programs available today.

Step 2: Lesson Preview

Liz is a receptionist for Dr. Grant. She is great at making appointments and keeping track of patients. Yesterday, Dr. Grant's support staff was at a training session and the doctor asked Liz to check on some information for him. He asked her to verify the diagnosis and procedure codes in a patient's medical record. Then he asked if any of the patients had paid their copayments and if their deductibles had been met yet.

While the doctor was speaking English, this all sounded like another language. Luckily, Liz knew exactly what Dr. Grant needed and could step in to help.



Thankfully, Liz knows her medical insurance information well enough to help Dr. Grant.

Medical Coding and Billing

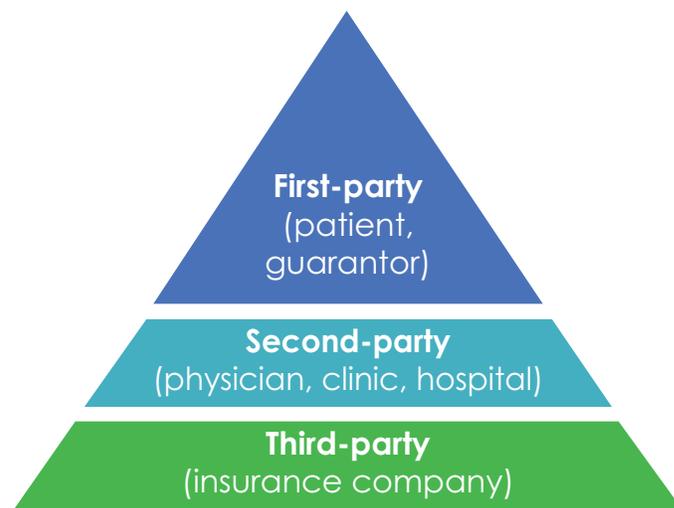
In this lesson, you'll study the language of the insurance world. You will find out about the reimbursement process and different types of reimbursement methods. Then we'll briefly discuss preauthorization. Next, we'll examine some of the resources used by the healthcare professional. After explaining the basics of diagnostic and procedural coding, we'll discuss the life cycle of a medical bill and the importance of accuracy. Finally, we'll discuss the basics of some of the insurance programs available today. So let's get started!

Step 3: Insurance Terminology

Insurance refers to a contract between an insurance company, also called the carrier or insurer, and an individual or a group, which is also called the **insured**. Meanwhile, **medical insurance**, also called health insurance or healthcare coverage, is a contract between an insurance company and the insured for medical benefits. This contract, or **policy**, states that in the case of certain injuries or illnesses, the insurance carrier will pay some or all of the medical bills of the insured. In exchange for this coverage, the insurance carrier collects payments from the insured. These payments are called **premiums**. Premiums are paid in advance, either monthly, quarterly, semi-annually or annually, depending on the contract between the carrier and the insured. When an insurance carrier pays for medical treatment based on a policy, it is paying **benefits**.

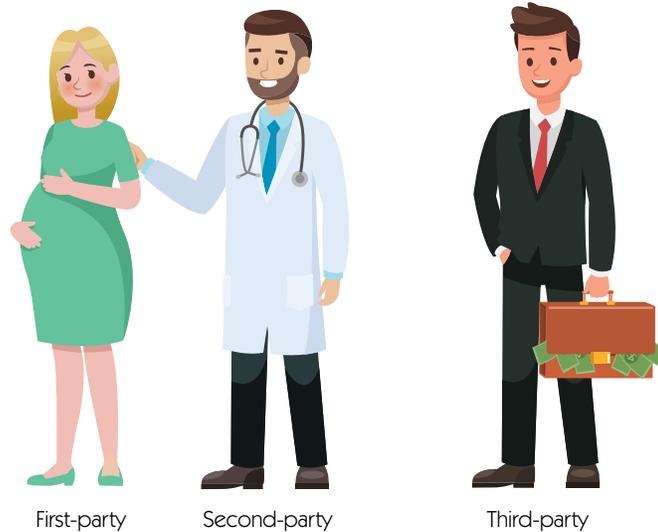
The insurance carrier collects premiums from many people and only has to pay benefits to relatively few. That is how insurance companies make money and are able to provide services. Every insurance company requires an itemized list of diagnoses, procedures, pharmaceuticals and other materials before it pays benefits. Every procedure has its own code, and insurance companies use these codes to help determine benefits.

Medical providers offer their services in return for payment. **Reimbursement**, in health care, refers to the compensation or repayment for healthcare services. Reimbursement is the process of paying a provider back for services already performed or provided. In health care, patients may walk out of a clinic without paying a large portion of the medical bill. Providers must seek to be paid back for the services that they have already provided, which is the reimbursement process. There is a hierarchy to this process.



The **first-party** is the patient, or the person responsible for the patient's health bill. In some cases, this may be a guarantor. A **guarantor** is someone who is responsible for an account. This may be because the patient is a minor. The guarantor is liable for any amounts that have not been paid to the provider, whether the insurance company makes partial payment or declines to pay.

The **second-party** is the physician, clinic or hospital. This group is often known as the **provider** because it provides the health care. An organization other than the patient (first-party) or healthcare provider (second-party) involved in the financing of personal health services is known as the **third-party payer**. Therefore, when you submit a claim to an insurance company for payment on a service, you are billing a third-party payer.



Before moving on, let's review some common, related terms used in medical insurance. Please note that, as with all terminology in this course, you are not expected to memorize the terms. Use your course materials as a reference and refer back to the term when needed. You will find that the more you use the terms, the less you'll need to use your materials as a reference. Soon, you will know and understand the terms from memory.

Allowable Charge

Physicians often sign contracts with certain insurance companies. When physicians enter into contracts with specific companies, they are called **participating providers**.

Participating providers agree to accept a level of payment determined by the insurance company. The **allowable charge** is the maximum amount an insurance carrier will pay for a specific service. When a subscriber sees a nonparticipating provider, sometimes insurance companies will pay minimal benefits.

Deductible

The amount of money an individual must pay before insurance benefits begin is called the **deductible**. Usually a policy will not pay the first \$250, \$500 or \$1,000 of medical charges and then will pay a percentage of everything above that amount every year.

Any amount that is “applied to deductible” is an allowable charge that is subtracted from the total deductible amount. The insurance carrier does not pay any money on “applied to deductible” charges.

Medical Coding and Billing

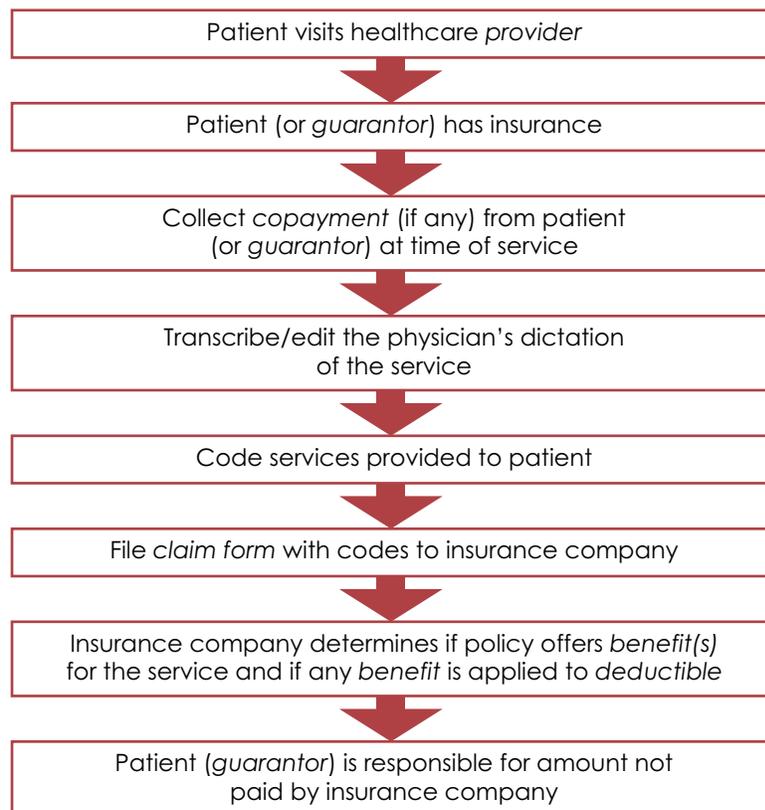
Imagine that Toby has a medical policy that has a \$250 deductible and, after the deductible is paid, 80 percent coverage. So far this year, Toby has spent \$200 of his own money on medical care, and that medical care has been defined as covered under his insurance policy. For the insurance company to begin to pay 80 percent of Toby's covered medical care costs, he must still pay out \$50 more for covered charges. After he has met the \$250 deductible, Toby's medical insurance benefits will begin, and the carrier will pay 80 percent of each claim submitted for covered charges.

Copayment

A **copayment** is a flat amount of money paid by the patient. Many policies have a copayment for prescription drugs or office visits to a doctor. That means every time a person has a prescription filled or visits the doctor, it costs her no more than her copayment; however, she must pay that copayment every time she has a prescription filled or goes to the doctor. Some policies require copayments even after the deductible has been met. Other policies have no deductible, but a copayment is required every time any type of medical care is received. Copayments are usually paid immediately at the time of service.

Let's review a reimbursement scenario so you can see how your new vocabulary words are used in the billing process (note this is just one of several types of reimbursement scenarios).

Reimbursement Scenario



Explanation of Benefits

After you have submitted a claim to an insurance carrier and it is processed, the physician will receive an explanation of benefits. The **explanation of benefits (EOB)** is a document that explains how much the insurance company paid and how much is disallowed. The EOB may include payment for one patient or several patients. Always check each patient’s name, dates of service, procedures billed for, the amounts billed, the amounts allowed, deductibles, copayment amounts and the amount paid on each individual claim.

The physician bills the patient for amounts applied to the patient’s deductible, any copayment amounts and noncovered procedures, depending on the contract. Often, a service benefit contract stipulates a maximum charge per service. The insurance company will disallow the difference if a doctor submits a claim for an amount that exceeds that maximum charge. Depending on the insurance coverage, either the patient is responsible for the disallowed amount, or the provider will write-off the amount.

ONLINE LEARNING

Build on what you are learning. Go to <http://westonvideos.screencasthost.com> and select Health Care. Locate *Explanation of Benefits* to watch the video.

EXPLANATION OF BENEFITS								
THIS IS NOT A BILL								
BLUE CROSS OF COLORADO								
Date:	04/10/XX	If you have any questions regarding this notice, please write or call our Customer Service Department at:						
Policy:	STEEL RECYCLING	MEMBER SERVICE P.O. BOX 8000 AVON, CO 80000 (612) 936-1234 OR 1-800-936-1234 TDD (612) 936-1234 OR 1-800-936-1234						
		STEVEN H. MAC 1823 KERRY COURT BROWN, CO 80001						
Patient:	FRANCES M MAC							
Number:	60508							
Explanation of Payments:								
Claim Number	Provider/Type of Service	Date of Service From – Through	Billed Charges	Disallowed Amount	Deductible	Copay/Coins	Total Reimbursement Amount	
66355912	Roger Small MD* 99212	0317XX-0317XX	50.00	6.48	9	20.00	23.52	
66355912	84550	0317XX-0317XX	33.00	9.00	9		24.00	
Totals			83.00	15.48		20.00	47.52	
Payment has been made to:			Amount	Deductible and out of pocket expenses for 03/17/XX-03/17/XX Copayment \$20.00				
Family Care			47.52	Non-covered amount \$15.48 Total Patient Responsibility \$20.00				
* Message 9: This amount is above the maximum allowable reimbursement for this procedure.								

Sample EOB for Frances Mac. Notice that the insurance company disallowed \$15.48.

Preauthorization

John has to go into the hospital. He knows it. His doctor knows it. According to his insurance policy, John must make sure his insurance company knows it as well. If he doesn't notify his insurance company *before* he enters the hospital, the company will reduce or deny his benefits. In addition to hospitalization, many insurance companies require notification before surgery or certain tests are performed. This process of notifying an insurance company before hospitalization, surgery or tests is called **preauthorization**. The insured must call the insurance company (or the company's designated agent, which is sometimes a third-party oversight company) and explain what is planned and why. A third-party oversight company might be contracted with the insurance company to review all hospitalizations, surgeries and certain other tests and procedures to make sure these procedures are medically necessary.

The preauthorization requirement helps reduce fraud by enabling the insurance company to review a patient's case history before major costs occur. Usually the insurance company approves the procedures, but the company might call the doctor handling the case to discuss the necessity.

The insurance company might extend or reduce the proposed hospital stay. For example, if John's doctor wanted him to stay in the hospital for four days after knee surgery, the insurance company might only authorize three days. This authorization is based on an average stay for that particular procedure. If no complications from the surgery arise and John stays four days, the insurance company would pay for only three days. John becomes responsible for the fourth.

In many cases, preauthorization is required even in the event of an emergency. When a patient is admitted to a hospital because of an accident or other emergency, the insurance company requires someone to notify the insurance company within 24 hours of hospitalization. Although the insurance company may deny a claim because preauthorization was not received, usually the company simply reduces the amount it will pay for that claim.

Visitation Limits

In this case, visitation limits doesn't refer to how many visitors a patient can have. It refers to the visits to a specialist. **Visitation limits** set the number of visits to specialists that a patient may make, or the number of special treatments a patient may have, such as five physical therapy sessions. Insurance companies set visitation limits.

Step 4: Practice Exercise 2-1

Select the best answer from the choices provided.

1. _____ is a contract between an individual or group and an insurance company.
 - a. Insurance
 - b. Coverage
 - c. Deductible
 - d. A premium

2. The payments from the insured person or group that are collected by the carrier are known as _____.
 - a. deductibles
 - b. schedules of benefits
 - c. premiums
 - d. benefits

3. The second-party is the _____.
 - a. patient
 - b. guarantor
 - c. physician
 - d. insurance

4. The amount of money an individual must pay before insurance benefits begin is called the _____.
 - a. deductible
 - b. copayment
 - c. premium
 - d. benefits

5. The process of notifying an insurance company before hospitalization, surgery or tests is called _____.
 - a. preadmission screening
 - b. preauthorization
 - c. postoperative notification
 - d. preoperative testing notice

Step 5: Review Practice Exercise 2-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6: Tools of the Trade

There are many resources available to help you succeed in your field of study. Now, you will learn the basics of the forms used in billing, and the manuals used to obtain the accurate codes.

Coding Resources

Now, let's take a moment to discuss medical codes and how they apply to insurance. After a patient's office visit, tests and other procedures, a claim form is completed. Claim forms require special codes—to identify the diagnosis and procedure. The **diagnosis** is the physician's opinion about what's wrong with the patient, while a **procedure** is anything the physician does to determine a diagnosis and treat a patient.

Medical coding is the translation of medical record documentation of illnesses, diseases, injuries, treatments and procedures into numeric and alphanumeric characters. These characters are then submitted for reimbursement purposes and statistical analysis. The tools the medical coding specialist utilizes to translate documentation include the *CPT*, *HCPCS*, *ICD-10-CM* and *ICD-10-PCS* manuals.

Accurate and complete coding ensures maximum reimbursement, and provides meaningful statistics to assist the nation with its healthcare needs. Let's look at the basics of each manual now.

CPT

The *Current Procedural Terminology (CPT)* manual, developed and maintained by the American Medical Association (AMA), contains codes that describe the procedures and services performed by the provider for outpatient services. CPT codes are then used by insurers to determine the amount of reimbursement for the provider. Within the *CPT* manual, there are *Category I*, *II* and *III* codes.

Category I codes include all of the “regular” CPT codes in the six main sections of the manual. These are all five-digit numeric codes.

Category II codes are a special collection of CPT codes that providers use to track and measure performance internally. Insurance companies do not use these codes to determine reimbursement. Instead, physicians use them to see just how much work they do in certain situations. Category II codes are optional.

Category III codes are temporary codes. These codes, unlike Category I codes, are listed in numeric order, not by anatomic location. After five years, if an emerging technology code is not accepted for placement in the Category I section of the *CPT* manual, it may be renewed for another five years by the actions of the CPT Editorial Panel. Otherwise, it will automatically be removed from the *CPT* manual.

HCPCS Level II

The Centers for Medicare and Medicaid Services (CMS) developed the *Healthcare Common Procedure Coding System, Level II (HCPCS)* to carry out the operational needs of the Medicare reimbursement system. **HCPCS Level II codes** consist of five-digit, alphanumeric codes. The CMS developed these codes (and releases updates on January 1st of each year) for physician and nonphysician services that the *CPT* manual does not cover. These codes include drugs, durable medical equipment, ambulance services and prosthetic procedures.

ICD-10-CM

The *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* manual is the system to determine diagnostic codes for both inpatient and outpatient services. The *ICD-10-CM* is an alphanumeric classification system. A valid code may be between three and seven characters, with a decimal after the third character.

ICD-10-PCS

The *International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS)* manual is the system for inpatient procedures. It is a seven-character, alphanumeric code system using digits 0 through 9 and letters A through H, J through N and P through Z, with no decimal.

Using Medical Codes

Once the medical documentation has been translated into codes, the codes and patient data are then transferred to a claim form and sent to the insurance carrier for reimbursement. The types and frequency of treatments and the diagnoses gathered from the patient information provide the statistics necessary to depict health care in this country overall. The government and insurance companies use these statistics to establish guidelines to develop rates of reimbursement to be paid to medical practices in the future.

A medical coding specialist might be called upon to double-check records. Usually, double-checking means confirming to be sure the diagnosis matches the procedures. Insurance companies check the procedures to make sure they are consistent with the diagnosis. If they aren't consistent, reimbursement from the insurance company may be delayed, denied or reduced.

Most procedures the doctor performs will have a code. The correct code is entered in the correct area of the claim form. Now, let's look at how these tools are used to create a medical bill.

Step 7: Life Cycle of a Medical Bill

Imagine you are a patient at a doctor's office. This is the first time you've been to this particular doctor. When you check in with the front desk, the office manager hands you a questionnaire to complete. This form asks for your name, address, telephone number, medical history and insurance information. After you complete the form, you give it back to the receptionist. With this process, you've just started the medical bill's life cycle.

When your examination is complete, the doctor may use an encounter form to document your visit. An **encounter form**, also known as a superbill, is a template of commonly used codes that may be used in a specific practice that serves as a communication device between the physician and the medical billing specialist. In addition, the physician dictates the details of each visit to substantiate the charges. A medical bill is created once the diagnosis and procedure codes are applied to the service. Let's look at the details involved in the billing process.

Processing the Bill

Once the medical bill exists, it goes through several steps on its way to being paid. A patient and provider handle bills for medical care in one of three common ways:

1	2	3
<p>The insurance company might require the patient to pay the entire bill at the time of service, before the patient leaves the provider's facility. Then the patient submits a claim to the insurance company for reimbursement.</p>	<p>The patient might pay a copayment before leaving. Then the provider submits a claim to the patient's insurance company for the remainder of the bill.</p>	<p>The patient might pay nothing at the time of the visit to the provider. Following the patient's visit, the provider submits a claim to the patient's insurance company for the bill. The provider is reimbursed by the insurance company for the charges the patient's insurance policy covers. The doctor's office then sends a bill to the patient for the remaining costs that the insurance doesn't cover.</p>

Medical Coding and Billing

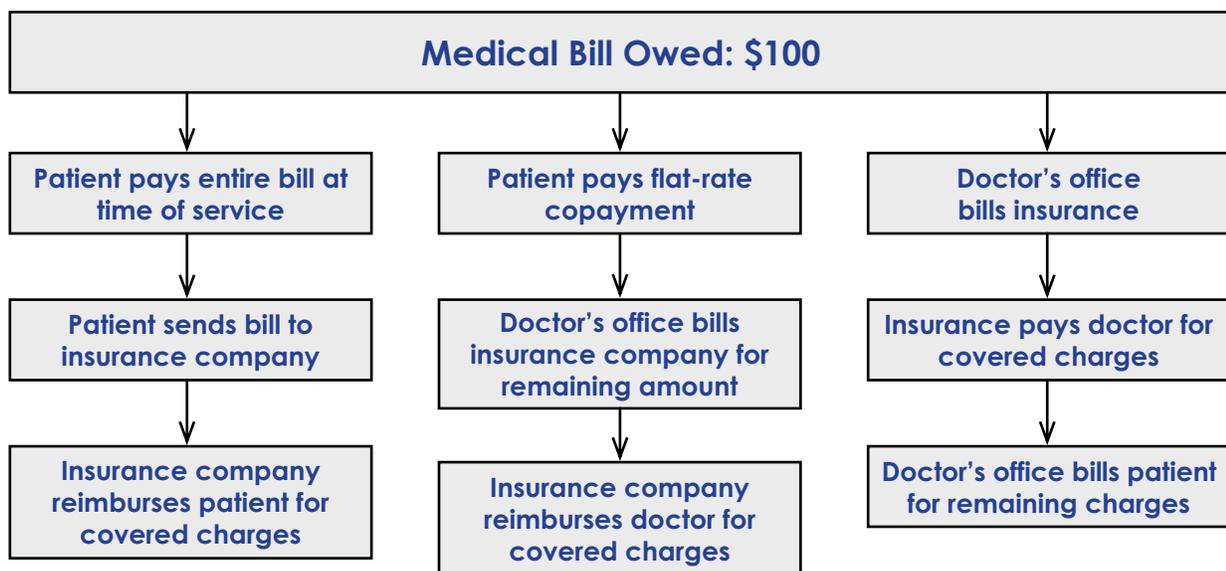
Processing the bill is slightly different depending on the manner in which the patient pays—either before or after the insurance company pays.

If, as the patient, you pay the entire bill on the day of your treatment, then, generally, it is up to you to send the bill to your insurance company. The provider is not obligated to submit claims to an insurance company unless it has a contract with that company or the federal government requires it. However, the provider often submits claims as a courtesy to the patient. The insurance company then reimburses you, the patient, for any covered charges.

If your bill is \$100 and the insurance pays 80 percent, you receive an \$80 reimbursement. The difference between paying at the time of service and the provider billing the insurance company is that when the patient pays at the time of service, the insurance company pays the patient directly.

If the provider bills the insurance company first, then usually the patient leaves the office without paying any of the bill or only a copayment. The insurance company receives the doctor's request for payment and pays the covered amount, which varies according to the insured's policy. Then, after the provider receives the insurance payment, her office bills the patient for any balance due.

If your bill was \$100 and your insurance policy covered 80 percent of the bill, the provider would receive \$80 from the insurance company and bill you the remaining \$20.



When submitting a claim, you are sending the bill to insurance companies that request payment in accordance with the appropriate insurance policies. It's important that the bill is correct. This course will give you the knowledge to be accurate and thorough—two essential qualities for success!

Step 8: Accurate and Thorough

Being accurate means free from error or defect, while thorough is complete with regard to every detail. In the healthcare profession, being accurate and thorough are necessary for proper reimbursement. The demand for healthcare services is greater every year, and the ever-increasing number of patients, insurance claims and hospital admissions means more work for you! Let's take a look at how being accurate and thorough affect the reimbursement.

- A three-dimensional view x-ray of a patient's ankle confirms a fracture. The diagnosis code submitted for the claim indicates an ankle fracture and the CPT submitted is for an x-ray of the hand. The diagnosis is correct, but the CPT is not. The insurance company will not pay for this service; therefore the claim is denied.
- Polly receives an EOB from her insurance company indicating payment was made to a claim submitted earlier that month. Polly has not been to the doctor for several months, so she contacts her insurance company to alert them. The insurance company contacts the doctor's office requesting a refund. After researching the situation, the office determines the services were linked to the wrong patient. The money was refunded to Polly's insurance, and the claim resubmitted for the correct patient, delaying payment for the services.

When claims include mistakes, they may delay payments a month or more, delay processing and cost the provider in denied claims, resubmission costs and reduced payments. Providers rely on accuracy—which is one of the great aspects of this career. People will always need doctors, and doctors will always need support staff to transcribe or edit, code and/or file claims for their services.

Being accurate and thorough can increase doctors' collections by as much as 10 to 15 percent! That's why the healthcare support staff plays such an important role in the healthcare industry.

Step 9: Practice Exercise 2-2

Select the best answer from the choices provided.

1. **When an insurance company pays for medical services, it _____ either the insured or the provider.**
 - a. gerrymanders
 - b. processes
 - c. collects from
 - d. reimburses
2. **A form used by some doctors that contains the most common codes performed by that doctor is called a(n) _____.**
 - a. account-easing document
 - b. easy-accounting bill
 - c. encounter form
 - d. claim form

Medical Coding and Billing

3. A patient may simply make a copayment for a visit and then the _____.
 - a. provider bills the insurance company for the remainder of the bill
 - b. provider considers the remainder of the bill uncollectible
 - c. patient sends a bill to the insurance company
 - d. provider sends out a full bill to the patient in 10 days' time
4. An error on the claim form may _____ reimbursement.
 - a. delay
 - b. not impact
 - c. speed up
 - d. improve
5. Diagnosis codes are contained in the _____ manual.
 - a. CPT
 - b. HCPCS Level II
 - c. ICD-10-CM

Step 10: Review Practice Exercise 2-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 11: Types of Health Insurance

Hundreds of private insurance companies provide medical coverage for individuals and groups. These private insurance companies generally follow standards similar to government programs. This next part of the lesson is designed to introduce you to the many types of government-sponsored insurance programs and each program's requirements for coverage, along with the basic types of private insurance.

Centers for Medicare and Medicaid Services

The **Centers for Medicare and Medicaid Services (CMS)** is a branch of the U.S. Department of Health and Human Services and is the administrator for Medicaid and Medicare. CMS mainly acts as a purchaser of healthcare services for the Medicaid and Medicare programs. The agency also assures that contractors and state agencies properly administer Medicaid and Medicare, assesses the quality of healthcare services and establishes policies for reimbursement to healthcare providers.

Medicare

Medicare is a federally administered, federally funded health insurance program for people age 65 or older, people under age 65 with certain disabilities and people of all ages with end-stage renal disease.¹

Medicare Part A generally pays for medically necessary inpatient care in a general hospital, skilled nursing facility care, home health care, hospice care and nursing home care. Medicare Part A is financed by the Social Security payroll withholding tax paid by workers and their employers. Those with Medicare Part A coverage don't have to pay a premium.

Medicare Part B helps pay for a wide range of medical services and supplies not covered by Medicare Part A, such as medical expenses, clinical laboratory services, home health care, outpatient hospital treatment and blood, if medically necessary. Medicare Part B is financed by monthly premiums paid by people who choose to enroll in the program.

Medicare Advantage Plan, previously known as Medicare Part C, is a plan that Medicare-approved private companies offer. Medicare pays a fixed amount for care every month to the companies offering Medicare Advantage Plans. These companies must follow the rules Medicare sets, although the out-of-pocket costs and referral rules may vary depending on each private company.

Medicare Part D is a program that includes prescription drug coverage. The program does not cover all of the costs associated with prescription drugs but assists in the yearly out-of-pocket expenses. Coverage for Medicare Part D may include a monthly premium, yearly deductible and copayments.

Medicaid

Medicaid is a federally mandated program that provides medical and health related services to those who cannot afford them. In 1965, Title XIX of the Social Security Act became federal law to establish Medicaid officially. Although Medicaid is federally mandated, each state runs its own Medicaid program. Within the federal government guidelines, each state establishes its own eligibility standards; determines the type, amount, duration and scope of services; sets the rate of payment for services; and administers its own program.

Military Insurance

The **Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)** was established in 1966 to provide healthcare coverage for the families of members of the uniformed services. CHAMPUS was developed to control the rising costs of healthcare coverage and to standardize healthcare benefits. Many changes have taken place in the military healthcare system in the past several years. The most important of these changes is the transition from CHAMPUS to the TRICARE healthcare system. Although this transition has officially taken place, you may still see references to CHAMPUS in your work as a healthcare professional.

The Department of Defense healthcare program, known as **TRICARE**, provides healthcare coverage for active duty service members, retired service members, National Guard and Reserve members, family members and survivors worldwide.² There are many programs available, and coverage depends on who you are and where you live. In addition, TRICARE has a program for Medicare eligible military retirees known as TRICARE for Life. Finally, CHAMPVA is healthcare for families of veterans with permanent, service-connected disabilities.

Workers' Compensation

Workers' compensation, also known as work comp, provides coverage to employees and their dependents if the employees suffer a work-related accident causing injury, illness or death. An **accident** is described as an unplanned or unexpected happening causing injury or death not due to any fault of the employee.

Two sets of laws govern workers' compensation: federal compensation laws and state compensation laws.

Federal compensation laws cover miners, maritime workers and civilian employees of the federal government.

State compensation laws cover employers and employees within each state. State compensation laws vary from state to state.

Private Health Insurance

Health insurance provided to employees by an employer or by an association to its members is called group coverage. Health insurance you buy on your own—not through an employer or association—is called individual coverage. Together, these are known as private health insurance, as opposed to the government coverage you just learned about. Private health insurance spending was reported at \$1.1 trillion in 2015.³ That's quite a sum! People are living longer, and the population continues to grow. As a result, more people need health care, whether it's preventive care, such as annual physical exams, or intervention care, such as cancer or illness treatments.

These days, consumers have many options for healthcare insurance. One of those choices is to purchase a private health insurance policy. **Private health insurance** offers a variety of healthcare plans that require the subscriber to pay premiums. These companies operate for profit, meaning they have stockholders that benefit from the profits.

The concept of prepayment is the basis of many private insurance carriers. When you **prepay** premiums, you pay in advance for coverage of specified services should the need for those services arise. You are paying a small fee *in case* the need for health care arises. The **subscriber**, also called the insured, is the person who prepays the fee for insurance coverage. When a subscriber purchases insurance coverage, he purchases a policy. The insurance policy describes the subscriber's benefits and details of coverage.

Managed Care

Managed care has boomed because of skyrocketing healthcare costs. Health insurance providers constantly seek ways to hold down costs, and also to predict them. Managed care gives insurance companies a basis for predicting these costs by establishing set fees and costs for healthcare services.

As insurance companies and employers searched for ways to budget for healthcare costs, several managed care programs evolved.

Health Maintenance Organizations

HMOs represent the most popular choice in managed care. The **health maintenance organization (HMO)** is a prepaid health plan in which individuals receive medical services from participating providers. Patients cannot see just any physician. Instead, they must see a physician within the HMO. HMOs have their own specialists and general practitioners. Typically, a general practitioner refers a patient to a specialist. A **referral** is an authorization by one physician for a patient to see another physician for a specific health problem.

Preferred Provider Organization

PPOs are similar to HMOs, but there are some key differences. Members of a **preferred provider organization (PPO)** can choose their own doctors and treatment facilities. However, there is some motivation for members to choose PPO participating medical care providers. When a member seeks care from a PPO participant, the member's benefits increase. Likewise, when a nonparticipating provider or a nonparticipating facility treats that same member, the benefits are less than they would be through a participating provider.

With a PPO, the member must pay between 15 and 25 percent of each bill until the member reaches a threshold limit. The **threshold limit** is the amount at which the copayment drops. Look at the following example for a better understanding of this concept.

Bill belongs to a PPO with a 20 percent coinsurance up to a \$5,000 threshold limit. Bill must pay the first 20 percent of every bill in a year until his total of bills is \$5,000. After that, the PPO pays 100 percent of covered charges.

Step 12: Practice Exercise 2-3

Select the best answer from the choices provided.

1. **Managed care gives insurance providers a basis for _____ healthcare costs.**
 - a. increasing
 - b. predicting
 - c. eliminating
 - d. superseding

2. **HMO stands for _____.**
 - a. healthcare management organization
 - b. home medical option
 - c. health maintenance organization
 - d. health management organization

3. **The program that provides managed healthcare coverage for military service families is called _____.**
 - a. DEERS
 - b. HCFA
 - c. TRICARE
 - d. CHAMPVA

4. **The program that provides health care for the families of veterans with permanent, service-related disabilities is called _____.**
 - a. CHAMPVA
 - b. TRICARE
 - c. DEERS
 - d. HCPCS

Medical Coding and Billing

Determine the term(s) to complete each sentence.

5. A(n) _____ is described as an unplanned or unexpected happening causing injury or death not due to any fault of the employee.
6. An advance payment for coverage of potential services is termed _____.
7. The insured is also known as the _____.

Step 13: Review Practice Exercise 2-3

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 14: Summary

You now have a foundation to stand on in the world of insurance. Insurance is very important in the medical field. Insurance companies have many regulations, including preauthorization requirements. It's essential that you keep up to date with these procedures and requirements. This lesson introduced you to some insurance terminology, such as copayment and deductibles. You also got an overview of the billing process, and caught a glimpse of two common claim forms, the CMS-1500 and UB-04. You are familiar with the basics of diagnostic and procedure codes. Keep in mind that this lesson was a brief overview of how insurance and the coding and billing process work. As you move through this course, you will see how these concepts apply to your future career.

Step 15: Quiz 2

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Endnotes

¹ "Medicare Program General Information." *Centers for Medicare & Medicaid Services*, 25 July 2014. Accessed 1 May 2017. Web.

² "TRICARE Choices in the United States." *Department of Defense*, August 2016. Accessed 1 May 2017. Web.

³ "NHE Fact Sheet." *Centers for Medicare & Medicaid Services*. Accessed 1 May 2017. Web.