

CHAPTER 18

Medical Insurance

CHAPTER PRE-TEST

Perform this test without looking at the book. This is just to see how well you have understood and can recall the information in this chapter after you have read it, but before you have completed the workbook exercises. You will not be graded on this portion (other than the grade you give yourself). Justify any "false" answers.

1. Managed care has simplified the patient's responsibility for payment. (T or F)
2. With managed care options, there is less emphasis on the medical assistant needing to be accurate and timely when filing insurance claims. (T or F)
3. Preexisting conditions usually require a waiting period. (T or F)
4. Coordination of benefits means that the insurance companies will take care of the paperwork. (T or F)
5. Copayment is the amount the insurance will cost the patient each month. (T or F)

INTRODUCTION

With the growing influence of managed care, many traditional insurance carriers, such as Blue Cross and Blue Shield, are joining health maintenance organizations (HMOs) and other managed care options in transforming the health care insurance industry. Students also discover the medical assistant's important role as a patient educator, helping patients understand the terms and conditions of their health insurance policies.

PERFORMANCE OBJECTIVES

After successful completion of this chapter you will be able to explain the terminology related to medical insurances. You will be able to recall several different examples of medical insurance coverage and discuss their similarities and differences. You will be familiar with several primary managed care organization models and recall the steps involved when screening patients for insurance coverage. You will know about legal and ethical issues related to medical insurance and the physician's office, including the impacts of Health Insurance Portability and Accountability Act (HIPAA) requirements. You will also be aware of the importance of obtaining referrals and

preauthorizations from insurance companies before providing services and the ramifications if the referrals or preauthorizations are overlooked. *The following statements are related to your learning objectives from this chapter. Fill in the blanks in the following paragraph with the appropriate term(s).*

The term used to describe the person who is insured is (1) _____. The amount of money that the insured person must incur before the insurance policy begins to pay is called the (2) _____. Some insurance policies require that the patient pay a certain amount at the time of service. This is called the (3) _____. A disease or disorder the patient has before he or she opens his or her insurance policy may not be covered for a certain amount of time, because it is considered to be a (4) _____ condition. Sometimes insurance policies will not cover procedures and treatments either because they are considered not to be medically necessary or perhaps they have not been proved to be effective. These procedures or treatments are called (5) _____. Before some services are allowed, they must first be approved by the insurance company. The process for getting this approval is called (6) _____. Many traditional insurance policies require patients to choose one physician who will coordinate all their care. This physician is known as their PCP. PCP is an abbreviation for (7) _____. Some policies even limit the physicians from whom patients can seek treatment. The patients must choose their specialists from a list of approved physicians who have contracted with the insurance company. These physicians are considered to be (8) _____. A list of approved medications can be found on the (9) _____. If a medication is not on the list, the patient will have to pay more for it. Fee schedules are determined from a variety of elements, including the (10) _____ or practice expenses, the cost of (11) _____, and the (12) _____ for the services provided by the physician. All of these cost elements combined with the (13) _____ required is used to determine a fee schedule. UCR, or (14) _____ Fee Schedule defines the allowable fees accepted by insurance carriers. Medicare has a system called RBRVS, or (15) _____, in which physician's services are reimbursed based on relative value. This formula takes into consideration not only the physician's overhead expenses, the work involved, and malpractice expenses, but also a (16) _____ practice cost index. (17) _____ is a payment system used by managed care organizations in which a fixed dollar amount is reimbursed to the physician. This type of system requires the physician to practice extensive (18) _____ to be effective. HIPAA stands

for (19) _____ and includes several rules. One of the rules, HIPAA privacy requirements, addresses issues of (20) _____. These rules state that the practice must provide the patient with a (21) _____ form that outlines the provider's privacy practices. Another requirement is that the practice obtain (22) _____ from the patient to use or disclose personal information. The practice must also provide the patient, on request, an accounting of any (23) _____ of protected information.

VOCABULARY BUILDER

Find the words below that are misspelled; circle them, and then correctly spell them in the spaces provided. Then insert the correct vocabulary terms from the list that best fit the descriptions below.

point of service plan	referral
preauthorization	resource-based relative value scale
preferred provider organization	self-insurance
primary care physician/provider	usual, customary, and reasonable
proof of eligibility	Worker's Compensation insurance

_____	_____
_____	_____
_____	_____

1. The _____ is a doctor chosen by the patient who is the first doctor the patient sees and is responsible for making referrals for further treatment by a specialist or for hospitalization.
2. A _____ allows the enrollee to have the freedom to obtain medical care from an HMO provider or to self-refer to a non-HMO provider at a greater cost.
3. In a _____, enrollees obtain services from a network of physicians and hospitals who have contracted with the insurance company.
4. _____ was developed using values for each medical and surgical procedure based on work, practice, and malpractice costs and factoring in the regional differences.
5. _____ requirement means that prior notice and approval needs to be obtained before services will be covered.

LEARNING REVIEW

1. What questions should the medical assistant ask when screening for medical insurance coverage?
 - A. _____
 - B. _____
 - C. _____
 - D. _____

2. List five measures that managed care organizations (MCOs) employ to ensure cost-effective services.
 - A. _____
 - B. _____
 - C. _____
 - D. _____
 - E. _____

3. What are the six MCO models in use?
 - A. _____
 - B. _____
 - C. _____
 - D. _____
 - E. _____
 - F. _____

4. List seven pieces of information that should be maintained in a log regarding preauthorization, precertification, or referral procedures for various insurance carriers.
 - A. _____
 - B. _____
 - C. _____
 - D. _____
 - E. _____
 - F. _____
 - G. _____

5. Identify the three common elements involved in computing a physician's fee schedule.
 - A. _____
 - B. _____
 - C. _____

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6. Which of the following is a problem with work-related health insurance coverage?
 - a. part-time employees are not usually eligible
 - b. medical benefits may not transfer equally
 - c. insurance companies often refuse to provide coverage for some procedures, including experimental treatments
 - d. all of the above
 7. The person covered under the terms of an insurance policy is called the:
 - a. primary
 - b. secondary
 - c. beneficiary
 - d. elector
 8. When more than one policy covers the individual, the _____ determines which of the policies will pay first.
 - a. deductible
 - b. exclusion
 - c. coinsurance
 - d. coordination of benefits
 9. Where does one find the address to which insurance claims are to be sent?
 - a. the telephone book
 - b. on the back of the insurance card
 - c. in the insurance provider manual
 - d. none of the above
 10. Blue Cross and Blue Shield are examples of a:
 - a. managed care organization (MCO)
 - b. health maintenance organization (HMO)
 - c. preferred provider organization (PPO)
 - d. traditional insurance organization

CERTIFICATION REVIEW

These questions are designed to mimic the certification examinations. You can use these questions like a small "Certification Examination Study Guide," but this is not meant to take the place of the more extensive study guides. Use this portion to determine in what areas to concentrate your efforts when studying for the certification examination. Justify any "false" answers.

1. The portion of the medical fees that the patient needs to pay at the time of services is called a:
 - a. copay
 - b. fee for service
 - c. out of pocket expenses
 - d. premium

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2. The cost patients must pay each month (sometimes provided by their employers) is called the:
 - a. out of pocket expenses
 - b. copay
 - c. premium
 - d. relative value scale
 3. HIPAA:
 - a. is about confidentiality, patient privacy, and security of personal health information
 - b. protects health insurance coverage for workers and their families when they change or lose their jobs
 - c. includes national standards for electronic health care transactions
 - d. establishes rules for national identifiers for providers, health plans, and employers
 - e. all of the above
 4. Electronic medical records have made confidentiality easier to protect. (T or F)

CASE STUDY

Lourdes Austen, a one-year survivor of breast cancer, is covered by an HMO. Lourdes's primary care physician, Dr. King, recommends that Lourdes receive a colonoscopy because she has a family history that is positive for colon cancer; medical studies have demonstrated a link between colon and breast cancers in families. Lourdes's HMO requires preauthorization before a specialist's care can be provided. Dr. King supplies the referral to a gastroenterologist who will perform the colon screening test and gives Lourdes the necessary completed referral form to take with her to her scheduled appointment.

During the colonoscopy procedure, one benign polyp is removed, and the gastroenterologist requests that Lourdes return for a follow-up examination in one week. Lourdes makes an appointment with the specialist's administrative medical assistant. When she returns one week later, the medical assistant informs Lourdes that she must have a new referral form for the office visit or the HMO will not approve payment; Lourdes will have to pay for the examination herself. "But we drove 40 minutes to get here, and no one ever told me I'd need another form for this. I thought it was all covered under the colonoscopy," Lourdes says.

Discuss the following:

1. Lourdes's HMO policy requires preauthorization. Is there anything that can be done to secure a proper referral without having to schedule another appointment for the patient or force the patient to pay for the office visit?
2. What is the role of the specialist's administrative medical assistant in this situation? Could the situation have been prevented?

SELF-ASSESSMENT

1. Take a close look at your insurance coverage. If you do not have medical insurance coverage, take a look at the coverage of a close friend or relative or choose a policy you would like to have.
 - A. Does it require a copay?
 - B. How much is the copay for a doctor's visit?
 - C. How much is the copay for a hospital stay? Surgery?
 - D. How much is the copay for medication?
 - E. Does prescribed medication have to be from a formulary list?
 - F. How much is the total amount you would have to pay for any given year?
2. Some people advocate doing away with health insurance for office visits and medications and just having insurance for big expenses such as catastrophic coverage. Discuss this idea with a group of at least three people. These people may be your classmates or friends/family. Write up a list of the advantages and disadvantages.
3. Some people advocate a "socialistic" method of health insurance such as Canada has. Look online for information about Canada's health care system and make a list of the advantages and disadvantages. Which way would you vote if you had a choice?

CHAPTER POST-TEST

This is similar to the Pre-Test. Perform this test without looking at the book. This is just to see how well you have understood and can recall the information presented in this chapter after you have studied it and completed the workbook exercises. You will not be graded on this portion (other than the grade you give yourself), but this is an excellent preparation for your instructor's test. You may use this Post-Test to determine what areas you need to study more. Justify any "false" answers.

1. Managed care has made the patient's responsibility for payment more complex. (T or F)
2. With managed care options, there is more emphasis on the medical assistant needing to be accurate and timely when filing insurance claims. (T or F)
3. Preexisting conditions always require a waiting period. (T or F)
4. Coordination of benefits means that the insurance companies will handle all the paperwork necessary for payment. (T or F)
5. Copayment is the amount the insurance will cost the patient's employer each month. (T or F)

CERTIFICATION CRITERIA CHECKLIST

As you go through your education and training, keep in mind the national certification examination that you will take when you graduate. Each chapter of the textbook and workbook covers a different section of the examination criteria. To keep track of your preparation for the certification examination, turn to the back of this workbook and highlight the following CMA, RMA, or CMAS certification examination criteria (if you have already highlighted them from a previous chapter, put a check mark by the criteria):

CMA

- F. Medicolegal Guidelines & Requirements
 - 2. Legislation
 - 5. Physician-patient relationship
- Q. Managing Practice Finances
 - 3. Third-party billing

RMA

- II. Administrative Medical Assisting
 - A. Insurance

CMAS

- 5. Health Care Insurance Processing, Coding and Billing
 - Insurance processing
 - Insurance billing and finances

COMPETENCY ASSESSMENT

Procedure 18-1 Screening for Insurance

Performance Objectives: To verify insurance coverage and obtain vital information required for processing and billing insurance claim forms. Perform this objective within 15 minutes with a minimum score of 25 points.

Supplies/Equipment: Patient registration forms, clipboard and black ink pen, patient's chart

Charting/Documentation: Enter appropriate documentation/charting in the box.

Instructor's/Evaluator's Comments and Suggestions:

SKILLS CHECKLIST Procedure 18-1: Screening for Insurance

Name _____

Date _____

No.	Skill	Check #1 20 pts ea	Check #2 10 pts ea	Check #3 5 pts ea	Notes
1	Ask patients to bring their insurance cards, and arrive 15-20 minutes before appointment time.				
2	Review completed patient registration form for legibility and completeness.				
3	Make front and back photocopies of patient's insurance card and attach to patient's chart.				
4	Verify proof of eligibility for Medicaid patients.				
5	Each time patient checks in, verify address and insurance coverage. Check insurance card. Determine that their primary care physician is performing the procedure and that the procedure is covered.				
Student's Total Points					
Points Possible		100	50	25	
Final Score (Student's Total Points / Possible Points)					
		Notes			
Start time:					
End time:					
Total time: (15 min goal)					

COMPETENCY ASSESSMENT

Procedure 18-2 Obtaining Referrals and Authorizations

Performance Objectives: To ascertain coverage by the insurance carrier for specific medical services, hospital admissions, inpatient or outpatient surgeries, elective procedures, or when the primary care physician elects to refer the patient to another physician. Perform this objective within 15 minutes with a minimum score of 35 points.

Supplies/Equipment: Patient's medical chart and copy of the patient's insurance card, name of the carrier contact person and telephone number, completed referral form, telephone/fax machine, pen/pencil

Charting/Documentation: Enter appropriate documentation/charting in the box.

Instructor's/Evaluator's Comments and Suggestions:

SKILLS CHECKLIST Procedure 18-2: Obtaining Referrals and Authorizations

Name _____

Date _____

No.	Skill	Check #1 20 pts ea	Check #2 10 pts ea	Check #3 5 pts ea	Notes
1	Collect all necessary documents and equipment.				
2	Determine the service or procedure requiring preauthorization.				
3	Complete the referral form.				
4	Proofread the completed form.				
5	Fax the completed form to the insurance carrier.				
6	Maintain a completed copy of the referral form in the patient's chart.				
7	Maintain a completed copy of the authorization number/code in the patient's chart.				
Student's Total Points					
Points Possible		140	70	35	
Final Score (Student's Total Points / Possible Points)					
		Notes			
Start time:					
End time:					
Total time: (15 min goal)					

EVALUATION OF CHAPTER KNOWLEDGE

Skills	Student Self-Evaluation		
	Good	Average	Poor
I can describe the history of medical insurance in this country and its evolution in recent years.	_____	_____	_____
I can define the terminology necessary to understand and submit medical insurance claims.	_____	_____	_____
I know at least five examples of medical insurance coverage.	_____	_____	_____
I can explain the significance of diagnosis-related groups.	_____	_____	_____
I am comfortable as a patient educator about insurance issues.	_____	_____	_____
