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Free Trial Offer
Medical Office Specialist Mini Course

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MEDICAL OFFICE SPECIALIST

As a part of the **Medical Office Specialist Training Program**, in this minicourse, you will be learning about the health insurance side of medicine for an overview of the content and style of Meditec training.

Today, it is so important to accurately process health insurance claims since the payers' requirements and information needs has rapidly expanded. The modifications in the government side have increased the challenge to the providers to be accurate and precise, selecting the appropriate information from source documents, accurately representing the facts with correct coding, and processing the information in a timely manner.

1. NEW TERMS FOR NEW JOBS

Health Insurance Specialist and Health Information Specialist - new job descriptions, new terms, both interchangeable. This career field is expanding rapidly, with health insurance specialization a relatively new field. The people who can fulfill this role must understand billing, claims processing, have good coding skills and understanding, know how to successfully appeal inappropriately paid claims, and understand the financial management of a practice.

2. BASIC SKILL REQUIREMENTS

- Medical terminology
- Anatomy and physiology
- Diagnosis and procedure coding skills
- Ability to abstract a patient record
- Attention to detail
- Language of billing reimbursement
- Computer skills to include financial and patient information databases, data entry, spreadsheets, ability to obtain information on the internet
- Good math skills
- Good PR skills
- Good ethics

3. JOB DESCRIPTION

- Review patient record documents to accurately review, provide information for, and code diagnoses, procedures using ICD-9 and CPT or HCPCS level II

- Communicate any of the diagnostic and treatment data to payers and plan to assist patients in obtaining benefits
- Facilitate analysis of a practice's patient base to improve patient care and delivery and efficiency of operations to contain costs
- Research and apply knowledge of insurance rules and regulations
- Accurately post charges, payments, adjustments, and other pertinent information
- Prepare and review claims generated to ensure that all data entered has been accurately reported to formulate prompt reimbursement
- Review explanations of benefits and challenge inappropriately paid claim items
- Correct data entry and any coding errors or modifications and resubmit timely
- Research and prepare appeals
- Rebill claims not paid within the practice profile limits (30 to 45 days typically)
- Communicate with providers and coworkers regarding changes in policies, new laws, coding changes, insurance carrier changes, or other requirements that take place periodically
- Update internal documents, registration forms, billing forms, coding changes and updates as required to meet the dynamics of change in the industry
- Understand or implement good audit systems to make sure all services are billed, that authorizations are acknowledged and accorded
- Work with patients to the extent they understand the benefits, liability, and requirements and rules in their insurance contracts

4. **MEDICAL TERMINOLOGY**

The language of medicine is an inherent requirement in the entire billing and reimbursement process. It is recommended that an aspiring student take our class in terminology prior to commencing coding, billing or health insurance specialist training. Meditech's terminology course is an excellent prerequisite choice for this training. To code effectively, the coder must be able to look up alphabetic diagnoses to obtain the numeric counterpart, and either write or data enter that code into a computer program. Treatment codes likewise are numeric (or alpha-numeric), are indexed in a codebooks to locate the most exact numeric representation of the treatment provided. Revisit us at www.meditec.com for the terminology information.

Basic anatomy and physiology must be a part of the background to assist with understanding fully the medical necessity of any service provided. In addition, an overview of surgical processes, laboratory and x-ray data, and a working knowledge of the pharmacy world.

5. CODING - DIAGNOSES AND PROCEDURES

Every service (test, office visit, injection, surgical procedure, etc.) in the provision of medical care has a numeric code associated with it designed to provide some commonality of terms in order that the companies who pay the claims (health insurance companies, HMOs, etc.) can identify the patient's problem, and the service provided sufficient to allow them to pay on a predetermined basis under the care and coverage limits of an insurance plan. The codes are also used for statistical data. The CPT (Current Procedural Terminology) codes exist for an office call, an injection, an x-ray, right on to the most detailed brain surgery. International Disease Codes (ICD) are the number systems assigned for diagnoses, even patient complaints (headache, upset stomach, etc.). The combination of using these codes, ICD and CPT, tell the payer what was wrong with the patient and what service was performed.

ICD-9-CM - INTERNATIONAL CLASSIFICATION OF CODES - CLINICAL MODIFICATION

Two related classifications of diseases are the International Classification (ICD) published by the World Health Organization (WHO) and is used to code and classify mortality data from death certificates. The other is a clinical modification to the ICD, called the ICD-9-CM (CM for the "clinical modification"). The latter was developed in the United States to code and classify morbidity (disease), signs and symptoms, from inpatient and outpatient records. The health insurance specialist assigns these codes to allow for uniform reporting of the medical reasons for health services provided.

CPT - CURRENT PROCEDURAL TERMINOLOGY

CPTs are a medical code set incorporating physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions.

Both of these code systems are updated annually. In the CPT, updates are within the manual itself with each new year's version, showing deleted codes, new codes, etc., which are marked by a distinguishing mark (provided in the introduction of the books). In addition to the book forms of the codebooks, they are available in electronic versions and on CD-ROMs. Though the use of the updated codes is required by January 1st of the year, the updated codebooks are available by September of the preceding year.

6. HEALTH INSURANCE

Health insurance is a contract between a policy-holder and a payer to reimburse the policy-holder for all or some of the cost of medically necessary treatment, or approved preventive care provided by health care professionals. Health insurance is available through private insurance companies, government (for its employees, and for people who cannot afford to pay for health care - Medicaid, retirees - Medicare), through group plans (typically employer sponsored), individual plans, and prepaid plans (managed care).

MANAGED CARE

Insurance billing and processing moved from a relatively simplistic process, e.g., the caregiver provided service, the patient paid or submitted the charges to a third party payer. This process is known as a "fee-for-service." As medical science magnified, new tests and new procedures were steadily incorporated into the health care process. The costs increased concomitantly. The government became more deeply entrenched in the process, with programs for the elderly, for children, pregnant women, and indigent people. Accordingly a variety of organizations emerged with a variety of plans.

A group devised to manage health care processes and costs is known as a "Managed Care Organization," (MCO). This is an organization devised for the health care of a group of enrollees. Care may be provided by a hospital or a physician group. This plan reimburses providers by a method known as "capitation," using pre-established payments over a specific period of time (usually one year). If the services provided are less than the amount capitated, the provider gets to retain the "profit." If the services cost more than planned, the provider loses money. Some MCOs have abandoned the capitation and returned to a fee for service payment process, though the fees charged generally have to meet a discounted method of payment.

MEDICARE AND MEDICAID PROGRAMS

In 1966, the Social Security Administration enacted Medicare and Medicaid to provide health care services to people over 65 and for low-income persons.

VETERAN PROGRAMS

In 1973, CHAMPVA was authorized by the Veterans Administration to cover civilians and dependents of veterans rated as 100% permanently and totally disabled because of their service in the military, or who had died on duty.

COBRA LAW

In 1985, "COBRA" (Consolidated Omnibus Budget Reconciliation Act) allowed employees to continue their health care plan/coverage in the event they were terminated by a company.

DISABILITY INSURANCE

Disability insurance was designed to cover loss of income due to temporary or permanent injury or illness.

7. PAYMENT OF CLAIMS

All of the various plans as discussed require a working knowledge of how the whole system with all the diverse plans and reimbursement processes works. Providers have acquired the data they need to process claims successfully, and to anticipate payments by the type of plan. When working in the field, this data is available to assist in the specialization process. Health Insurance Specialists learn to calculate what a given plan will pay.

8. EXPLANATION OF BENEFITS

Based on the care and coverage and the processing noted, a transmittal notice is generated and an explanation of benefits (EOB), or in the case of Medicare an "MSN," (Medicare Summary Notice). The information returned on the transmittal/EOB contains

- Patient and provider identification
- A list of procedures, dates and charges on a given claim form
- A list of procedures not included in the insured's benefits

- (denials)
- A list of allowable procedure charges
 - Advice about the deductible which would be subtracted from the payment to be made

9. RECORDKEEPING RULES

In 1987, the federal Omnibus Budget Reconciliation act (OBRA) was passed requiring providers to retain copies of any government insurance claims and the copies of all attachments filed for a period of six years. Retention of medical records is governed under state law and is typically five or more years (each state may be different). It is acceptable to microfilm patient information and insurance records. All other categories of health insurance records are to be maintained in their original form.

10. INSURANCE REGULATION

Insurance companies are regulated by where they are “domiciled,” that is the state in which they are licensed to do business. The state agency (insurance commission) oversees compliance and assesses penalties under the provisions of the code (law) of the state. At times, a practice may have a verifiable complaint about the nature and policy of an insurance company. The state insurance commissioner’s office is contacted for resolution. The regulators do not make determinations on individual claims, rather they enforce the law relating to the operation of the company and its policies.

The foregoing information was designed to provide you a brief overview of course content. With each set of information presented, a quiz is provided. In keeping with that platform, you will now be tested on what you learned.

Go to the next page and read the questions, referring to the information you have read and answer the questions, check your answers, and arrive at a score.

READY? GO!

QUESTIONS

1. insurance processing, billing and collecting copayments from patients is not considered a major function in the economics of a provider office. T F
2. List four of the basic skill requirements in Health Insurance fields:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
3. One of the responsibilities for a Health Insurance Specialist is to review explanations of benefits and challenge inappropriately paid claim items. T F
4. A Health Insurance Specialist really has little to do with direct patient contact. T F
5. One does not need medical terminology to do a Health Insurance Specialist's job description. T F
6. ICD codes are used to describe procedures performed by providers.
T F
7. CPT codes represent the diagnoses derived in the treatment process. T F
8. The ICD and CPT codes are updated annually. T F
9. Health insurance is a contract between a policy holder and a payer to reimburse the policy holder for all of the medical treatment
T F
10. The intent of managed care was to replace fee-for-service plans with affordable quality care. T F
11. An MCO is a _____
12. No profit is permitted in an MCO T F
13. Medicare is a private insurance program designed for those who can afford to pay. T F

14. The CHAMPVA program was started in what year

15. The CHAMPVA covers veterans only. T F

16. COBRA was designed by congress to allow employees to continue their health care plan/coverage in the event they were terminated by a company. T F

17. Disability insurance is designed to cover loss of income due to temporary or permanent injury or illness. T F

18. There is no way to calculate what a given payer will pay on a given claim. T F

19. What does EOB stand for _____

20. Medicare's "EOB" is called _____

21. OBRA stands for _____

22. OBRA was enacted in _____

23. Retention of medical records is governed by Federal law.

T F

24. The average time medical records need to be retained is typically 4 years. T F

25. State rather than federal law governs insurance companies.

T F

ANSWERS

1. False (it definitely is)
2. Any 4 of the following:
 - Review patient record documents to accurately review, provide information for, and code diagnoses, procedures using ICD-9 and CPT or HCPCS level II
 - Communicate any of the diagnostic and treatment data to payers and plan to assist patients in obtaining benefits
 - Facilitate analysis of a practice's patient base to improve patient care and delivery and efficiency of operations to contain costs
 - Research and apply knowledge of insurance rules and regulations
 - Accurately post charges, payments, adjustments, and other pertinent information
 - Prepare and review claims generated to ensure that all data entered has been accurately reported to formulate prompt reimbursement
 - Review explanations of benefits and challenge inappropriately paid claim items
 - Correct data entry and any coding errors or modifications and resubmit timely
 - Research and prepare appeals
 - Rebill claims not paid within the practice profile limits (30 to 45 days typically)
 - Communicate with providers and coworkers regarding changes in policies, new laws, coding changes, insurance carrier changes, or other requirements that take place periodically
 - Update internal documents, registration forms, billing forms, coding changes and updates as required to meet the dynamics of change in the industry
 - Understand or implement good audit systems to make sure all services are billed, that authorizations are acknowledged and accorded
3. T
4. F
5. F
6. F (diagnoses)
7. F (procedures)
8. T
9. F (all or some)

10. T
11. Managed Care Organization
12. False
13. False (government)
14. 1973
15. Civilians, vets and dependents
16. T
17. T
18. F
19. Explanation of Benefits
20. MSN (Medicare Summary Notice)
21. Omnibus Budget Reconciliation Act
22. 1987
23. F (state)
24. F (5+ years)
25. T

SCORING

Determine how you did by dividing total correct answers by 28 (number of questions). If you score 80% or better, you did pretty well, with 85% even better, and 90% or better is outstanding.

SUMMARY:

If you enjoyed your brief entrée into the world of learning the mechanics of capturing, billing, collecting, with all the many rules, seriously consider enrolling in the course. As the wise old owl says:



"He who hesitates is lost!"