Solution and Answer Guide

Green, Understanding Health Insurance, 2021, ISBN 9780357515587; Chapter 1: Health Insurance Specialist Career

Table of Contents

Review

1. b
2. b
3. b
4. b
5. a
6. c
7. c
8. c
9. c
10. a
11. a
12. a
13. b
14. a
15. b

Solution and Answer Guide

Green, Workbook to Accompany Understanding Health Insurance, 2021, ISBN 9780357515594; Chapter 1: Health Insurance Specialist Career

Table of Contents

Assignments

Assignment 1.1: Interview of a Professional

The student will submit a three-page, double-spaced, word-processed report on an interview of a professional; the paper should be in paragraph form (not written in a question/answer format). Each paragraph should include a minimum of three complete sentences, containing no typographical or grammatical errors. The last paragraph of the paper should summarize the student's reaction to the interview and whether the student would be interested in having this professional's position (along with why or why not). Also, the student should think about the future (in terms of family, employment, and so on).

Assignment 1.2: Ready, Set, Get a Job!

The student will submit a résumé and cover letter, using Figures 1-2 and 1-3 in the Workbook for guidance.

Assignment 1.3: Journal Abstract

The student will submit a one-page, word-processed journal abstract, which should be evaluated to make sure that it contains the following information:

- Name of article
- Name of author
- Name of journal
- Date of journal
- Journal article summary, in double-spaced paragraph format, that summarizes the article's content (and does not include the student's opinion about the content of the article)

Assignment 1.4: Professional Discussion Forums (Listservs)

The student will go to the list.nih.gov website, and click on "About NIH LISTSERV" to learn about online discussion forums (listservs). The student will also select a professional discussion forum from Table 1-2 in the Workbook and follow its membership instructions. If this assignment is completed by a student outside of class, the instructor can require students to submit a summary of the experience (or, if teaching online, to post a discussion).

Assignment 1.5: Learning About Professional Credentials

American Academy of Professional Coders (AAPC)
www.aapc.com

Credential Abbreviation	Meaning of Credential	Education	Experience	Exam Fee	CEU Requirements
CPC	Certified Professional Coder	Associate degree recommended	Two years of coding experience	$300 (member) $380 (nonmember)	36 continuing education units (CEUs) every two years
COC	Certified Outpatient Coder	Associate degree recommended	Two years of coding experience	$300 (member) $380 (nonmember)	36 CEUs every two years
CPC-P	Certified Professional Biller	Associate degree recommended	Not applicable	$300 (member) $380 (nonmember)	36 CEUs every two years

American Health Information Management Association
www.ahima.org

Credential Abbreviation	Meaning of Credential	Education	Experience	Exam Fee	CEU Requirements
CCA	Certified Coding Associate	High School Diploma or GED equivalent	Six months of coding experience directly applying codes	$199 (member) $299 (nonmember)	20 CEUs plus annual assessment, CEU cycle is two years
CCS	Certified Coding Specialist	AHIMA-approved coding program	Minimum two years coding experience	$299 (member) $399 (nonmember)	20 CEUs plus annual coding self-reviews, CEU cycle is two years
CCS-P	Certified Coding Specialist - Physician-based	AHIMA-approved coding program	Minimum two years coding experience	$299 (member) $399 (nonmember)	20 CEUs plus annual coding self-reviews, CEU cycle is two years

Assignment 1.6: Professionalism

1. c
2. a
3. i
4. d
5. e
6. g
7. j
8. f
9. b
10. h

Assignment 1.7: Telephone Messages

a. Case 1

DATE 9/8/YYYY TIME 12:15 P.M.

TO Dr. Al A. Sickmann, M.D.

WHILE YOU WERE OUT

MR./MRS. Faye Slift

FROM

PHONE (123) 934-6857

TELEPHONED	X	PLEASE CALL BACK	X
CALLED TO SEE YOU		WILL CALL AGAIN	
RETURNED YOUR CALL		URGENT	X

MESSAGE: Patient is almost out of her high blood pressure medication. She states that she has only enough to last her the rest of the week. She is requesting that a refill be called in to her pharmacy that is listed in her medical record. She would like someone to call her after.

TAKEN BY (Student Name)

b. Case 2

DATE 9/11/YYYY TIME 12:40 P.M.
TO Dr. Al A. Sickmann, M.D.

WHILE YOU WERE OUT

MR./MRS. Ed Overeels
FROM
PHONE (123) 212-6588

TELEPHONED	X	PLEASE CALL BACK	X
CALLED TO SEE YOU		WILL CALL AGAIN	
RETURNED YOUR CALL		URGENT	X

MESSAGE: New patient, would like to make an appointment for his chronic back pain. Just recently moved to area and is experiencing a flare up due to move. He works evenings so he would prefer a morning appointment as soon as possible.

TAKEN BY (Student Name)

c. Case 3

DATE 9/20/YYYY TIME 1:00 P.M.
TO Dr. Al A. Sickmann, M.D.

WHILE YOU WERE OUT

MR./MRS. Tristan N. Shout
FROM
PHONE (123) 319-6531

TELEPHONED	X	PLEASE CALL BACK	X
CALLED TO SEE YOU		WILL CALL AGAIN	
RETURNED YOUR CALL		URGENT	

MESSAGE: Patient is returning, has new insurance. Would like to schedule an appointment for an annual exam. He is requesting the latest appointment that is available on a Friday.

TAKEN BY (Student Name)

Assignment 1.8: Multiple Choice Review

1. b
2. a
3. b
4. b
5. b
6. c
7. d
8. c
9. d
10. c
11. b
12. d
13. c
14. c
15. a
16. b
17. a
18. c
19. b
20. c

Solution and Answer Guide

Green, Understanding Health Insurance, 2021, ISBN 9780357515617;
SimClaim™ Case Studies

Table of Contents

Note to Instructors

SimClaim™ is an educational tool designed to familiarize students with the basics of CMS-1500 claim form completion. Student practice software is available through the online MindTap program, accessed at **www.cengage.com**. Students should complete a claim for each case study based on the information provided in each case only. The SimClaim cases closely follow the claims processing instructions also found in the *Understanding Health Insurance* textbook.

- CMS-1500 claims answer keys to SimClaim Case Studies: Set One, and SimClaim Case Studies: Set Two are located in this Solution and Answer Guide.
- Students use the SimClaim blank form mode to enter CMS-1500 claims data or they make copies of the blank CMS-1500 claim located on the Student Resource Center. Sign up or sign in at **www.cengage.com** to access the resources for this product.
- SimClaim Case Studies: Set Two requires student assignment of ICD-10-CM, CPT, and HCPCS level II codes. Code answers are located in CMS-1500 claims answer keys in this Solution and Answer Guide.

SimClaim Case Studies: Set One

Case 1-1: Mary S. Hightower

AETNA
PO BOX 45

STILLWATER PA 12345-0045

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLKLUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 272034109

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HIGHTOWER, MARY, S

3. PATIENT'S BIRTH DATE MM DD YY: 08 07 1951 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): HIGHTOWER, WALTER, W

5. PATIENT'S ADDRESS (No., Street): 61 WATER TOWER STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYWHERE STATE: NY

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 12345-1234 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NPW

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 04 09 1951 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 15 YYYY QUAL. 431

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN IM GOODDOC MD

17a.

17b. NPI 5678901234

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 01 10 YYYY TO 01 10 YYYY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I25810 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 10 YYYY		22		93458	26	A	2000 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 117654312

26. PATIENT'S ACCOUNT NO.: 1-1

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 2000 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

IRMINA BRILL MD SIGNED MMDDYYYY DATE

32. SERVICE FACILITY LOCATION INFORMATION
GOODMEDICINE HOSPITAL
1 PROVIDER STREET
ANYWHERE NY 12345-2345

a. 1123456789 b.

33. BILLING PROVIDER INFO & PH # (101) 2013145
IRMINA BRILL MD
25 MEDICAL DRIVE
INJURY NY 12347-2347

a. 2345678901 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov; claim data created by author.

Case 1-2: Ima Gayle

CONNECTICUT GENERAL
PO BOX 1234

HEALTH CA 01234-1234

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLKLUNG [ ] (ID#) OTHER [ ] (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
		210010121	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
GAYLE, IMA	09 30 1945 M [ ] F [X]	GAYLE, IMA	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
101 HAPPY DRIVE	Self [X] Spouse [ ] Child [ ] Other [ ]		
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE	
ANYWHERE / NY			
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)	
12345-1234 ( )		( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
		101	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY SEX	
		09 30 1945 M [ ] F [X]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME	
		CONNECTICUT GENERAL	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* complete items 9, 9a and 9d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 03 01 YYYY QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. R200 B. M1712 C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 01 YYYY	11		99213	25	A	60 00	1		NPI	
2 03 01 YYYY	11		20552		A	75 00	1		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
111397992 [ ] [X]	1-2	[X] YES [ ] NO	$ 135 00	$ 50 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SEJAL RAJA MD SIGNED MMDDYYYY DATE	a. NPI b.	(101) 2022923 SEJAL RAJA MD 1 MEDICAL DRIVE INJURY NY 12347-2347 a. 7890123456 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov; claim data created by author.