

# Solution and Answer Guide

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

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Review	
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# Review

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- 9. c
- **10.** a
- 11. a
- 12. a
- 13. b
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# Solution and Answer Guide

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

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# 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
СРС	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**

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- 2. a
- 3. i
- 4. d
- 5. e
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- 7. j
- 8. f
- 9. b
- 10. h

# **Assignment 1.7: Telephone Messages**

a. Case 1

DATE	9/8/ΥΥΥΥ TIME 12:15 P.M.						
DATE							
TO	Dr. Al A. Síckmann, M.D.						
WHILE YOU WERE OUT							
MR./MRS.	Faye Slift						
FROM							
PHONE	( 123 ) 934-6857						
TELEPHON	EDX PLEASE CALL BACKX						
CALLED TO	SEE YOU WILL CALL AGAIN						
RETURNED	YOUR CALL URGENTX						
	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						
requestu	ng that a refill be called in to her pharmacy						
that is l	that is listed in her medical record. She would like						
someon	e to call her after.						
	TAKEN BY(Student Name)						



### b. Case 2

DATE	9/11/YYYY	TIME 12:40 f	Р.М.					
то	Dr. Al A. Sickm	ann, 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							
RETURNE	YOUR CALL	_ URGENT						
	: New patient, wo							
	ment for his chron							
	o area and is expe							
	e works evenings so	100 C	norning					
appoint	ment as soon as po	ossible.						
TAKEN BY(Student Name)								

#### c. Case 3

DATE	9/20/ΥΥΥΥ 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							
MESSAGE Would li exam. H								
	TAKEN BY(Student Name)							



# **Assignment 1.8: Multiple Choice Review**

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- 2. a
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- 4. b
- 5. b
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- 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<sup>TM</sup> Case Studies

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SimClaim Case Studies: Set One	
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#### **Note to Instructors**

SimClaim<sup>TM</sup> 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 <a href="https://www.cengage.com">www.cengage.com</a>. 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

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PICA										PIC	CA
MEDICARE MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH	PLAN FECA	UNG	1a. INSURED'S I.D. NU	JMBER		(For	Program in Iter	n 1)
(Medicare#)   (Medicaid#)   PATIENT'S NAME (Last Name, Fin	(ID#/DoD#)	(Member ID)	#) X (ID#)	(ID#)	SEX (ID#)	272034109 4. INSURED'S NAME (	I ant Mam	o First Nam	n Middle	Initial)	
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PATIENT'S ADDRESS (No., Street	)			ATIONSHIP TO IN		7. INSURED'S ADDRES					
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	)	Code)				ZIF CODE		(	)	de Alea Code)	
2345-1234 OTHER INSURED'S NAME (Last I	Name, First Name, Middle	Initial)	10. IS PATIENT'S	S CONDITION RE	LATED TO:	11. INSURED'S POLIC	Y GROUP	OR FECA	UMBER		
						NPW					
OTHER INSURED'S POLICY OR	GROUP NUMBER		a. EMPLOYMEN	IT? (Current or Pre	vious)	a. INSURED'S DATE O	F BIRTH			SEX	
				YES X	NO	04 09			M X	F	
RESERVED FOR NUCC USE			b. AUTO ACCIDE		PLACE (State)	b. OTHER CLAIM ID (D	Designated	by NUCC)			
RESERVED FOR NUCC USE			c. OTHER ACCII	YES X	NO	c. INSURANCE PLAN	NAME OF	PROCES	NAME		
TOUR TOUR HOUSE			S. OTTIER ACCII	YES X	NO	AETNA	TAME OF	HOUHAN	AMME		
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NAME OF REFERRING PROVIDING  IM GOODDOC MD  ADDITIONAL CLAIM INFORMAT  DIAGNOSIS OR NATURE OF ILL  I25810  B  A. DATE(S) OF SERVICE From To M DD YY MM DD  1 10 YYYYY  1 10 YYYYY  FEDERAL TAX LD. NUMBER  17654312  SIGNATURE OF PHYSICIAN OR INCLUDING DEGREES OR CRE  INCLUDING DEGREES OR CRE  INCLUDING DEGREES OR CRE	ER OR OTHER SOURCE  ION (Designated by NUCC  ION (Designated by NUCC  ION (Designated by NUCC  ION (Designated by NUCC  INESS OR INJURY Relate  B. C. PLACE OF YY SERVICE EMG  22  22  21  22  23  24  25  27  28  29  20  21  20  21  20  20  21  20  20  20	17a. 17b. 17b. 17c. 17c. 17c. 17c. 17c. 17c. 17c. 17c	URES, SERVICE URES, SERVICE LINE SERVICE LIN	D. L. L. S., OR SUPPLIES UNISTAINES) MODIFIER  27. ACCEPT A (For good, oil) (For good, oil) (X ) VIS N INFORMATION	E. DIAGNOSIS POINTER  A  SSIGNMENT?  In the state of the	FROM  18. HOSPITALIZATION  18. HOSPITALIZATION  FROM 01 10  20. OUTSIDE LAB?  YES X  22. RESUBMISSION  CODE  23. PRIOR AUTHORIZ  F.  \$ CHARGES  2000 00  28. TOTAL CHARGE  \$ 2000  33. BILLING PROVIDE  IRMINA BRILL	DATES FY YY  NO DATES FY YY  N	ORIGINAL  S ORIGINAL  IMBER  H. I. EPSOT ID. Femily QUA  NP  NP  NP  NP  NP  NP  NP  NP  NP  N	CURRETO CURRETO CONTROL CONTRO	RENDERIN PROVIDER II	YYYY
NAME OF REFERRING PROVIDI  N IM GOODDOC MD  ADDITIONAL CLAIM INFORMAT  DIAGNOSIS OR NATURE OF ILL  125810  B  A. DATE(S) OF SERVICE From To M DD YY MM DD  1 10 YYYY  1 10 YYYYY  FEDERAL TAX LD. NUMBER  177654312  SIGNATURE OF PHYSICIAN OR INCLUDING DEGREES OR CRE  SIGNATURE OF PHYSICIAN OR INCLUDING DEGREES OR CRE	BER OR OTHER SOURCE  ION (Designated by NUCC  NESS OR INJURY Relate  B. C.  YY SERVICE EMG  22  SSN EIN 26.F  X 1-1  SUPPLIER DENTIALS  GOOG  1 PI	17a. 17b. 17b. 17b. 17b. 17c. 17c. 17c. 17c. 17c. 17c. 17c. 17c	Ine below (24E  URES, SERVICE  LONG STATE  LONG SERVICE  L	D. L. L. S. OR SUPPLIES UMSTANCES MODIFIER  27. ACCEPTA  27. ACCEPTA  X YES	E. DIAGNOSIS POINTER  A  SSIGNMENT?  In the state of the	FROM  18. HOSPITALIZATION FROM 01 1  20. OUTSIDE LAB?  YES X  22. RESUBMISSION CODE  23. PRIOR AUTHORIZ  F. \$ CHARGES  2000 00  28. TOTAL CHARGE \$ 2000 33. BILLING PROVIDE  IRMINA BRILL 25 MEDICAL IL 25 MEDICAL I	DATES RY YY NO DATES	ORIGINAL  S ORIGINAL  JIMBER  H. I. EPSOT ID. Francis QUA  NP  NP  NP  NP  NP  NP  NP  NP  NP  N	CURRETO CURRETO CONTROL CONTRO	RENDERIN PROVIDER II	YYYY GG D. #
Z NAME OF REFERRING PROVIDION IM GOODDOC MD  3. ADDITIONAL CLAIM INFORMAT  1. DIAGNOSIS OR NATURE OF ILL  1. LIZ5810  2. LIZ5810  3. A. DATE(S) OF SERVICE FROM TO	BER OR OTHER SOURCE  ION (Designated by NUCC  NESS OR INJURY Relate  B. C.  YY SERVICE EMG  22  SSN EIN 26.F  X 1-1  SUPPLIER DENTIALS  GOOG  1 PI	17a. 17b. 17b. 17b. 17b. 17c. 17c. 17c. 17c. 17c. 17c. 17c. 17c	URES, SERVICE URES, SERVICE LINE SERVICE LIN	D. L. L. S. OR SUPPLIES UMSTANCES MODIFIER  27. ACCEPTA  27. ACCEPTA  X YES	E. DIAGNOSIS POINTER  A  SSIGNMENT?  In the state of the	FROM  18. HOSPITALIZATION  18. HOSPITALIZATION  FROM 01 10  20. OUTSIDE LAB?  YES X  22. RESUBMISSION  CODE  23. PRIOR AUTHORIZ  F.  \$ CHARGES  2000 00  28. TOTAL CHARGE  \$ 2000  33. BILLING PROVIDE  IRMINA BRILL	DATES RY YY NO DATES	ORIGINAL  S ORIGINAL  JIMBER  H. I. EPSOT ID. Francis QUA  NP  NP  NP  NP  NP  NP  NP  NP  NP  N	CURRETO CURRETO CONTROL CONTRO	RENDERIN PROVIDER II	YYYY

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



## Case 1-2: Ima Gayle

<b>○(常日</b> 発送数 <b>の終</b> 事		CONNECTICUT GENERAL PO BOX 1234
HEALTH INSURANCE CLAIM FOR	VI	HEALTH CA 01234-1234
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC	02/12	
PICA	ALIEN OPEN STORY	PICA T
	AMPVA GROUP FECA OTHE  ###################################	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	210010121 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
GAYLE, IMA	09 30 1945 M	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	
ANYWHERE	NY 8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code	2.	ZIP CODE TELEPHONE (Include Area Code)
12345-1234		( )
OTHER INSURED'S NAME (Last Name, First Name, Middle Initia	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER  101
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
	YES X NO	09 30 1945 M
. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State	
	YES X NO	
RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
INSURANCE PLAN NAME OR PROGRAM NAME	YES X NO  10d. CLAIM CODES (Designated by NUCC)	CONNECTICUT GENERAL  d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
INSURANCE PLAN NAME OF PROGRAM NAME	Tod. CLAIM CODES (Designated by NOCC)	YES X NO If yes, complete items 9, 9a and 9d.
2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I author to process this claim. I also request payment of government ben- below. SIGNATURE ON FILE	the release of any medical or other information necessar its either to myself or to the party who accepts assignment DATE	IS. 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
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP	15. OTHER DATE MM   DD   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM   DD   YY
03 01 YYYY QUAL 431	QUAL. MM DD YY	FROM TO
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	17b. NPI	FROM TO  20. OUTSIDE LAB? \$ CHARGES
,		YES X NO
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L	service line below (24E) ICD Ind.	22. RESUBMISSION CODE ORIGINAL REF. NO.
A.   <b>R200</b> B.   <b>M1712</b>	C. L D. L	
E F	G H	23. PRIOR AUTHORIZATION NUMBER
J	K. L. L. L. ROCEDURES, SERVICES, OR SUPPLIES E.	- E G H I J
From To PLACE OF	(Explain Unusual Circumstances) DIAGNOS T/HCPCS   MODIFIER POINTER	IS DAYS EPSDT ID. RENDERING
		The state of the s
03 01 YYYY 11 9	9213 25 A	60 00 1 NPI
03 01 YYYY 11 2	0552 A	75 00 1 NPI
		NPI NPI
		NPI NPI
		NPI NPI
	10 1 1 1 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIE	NT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Us
111397992 X 1-2	(For govt. claims, see back)	
1. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERV	CE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( 101 ) 2022923
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		SEJAL RAJA MD 1 MEDICAL DRIVE INJURY NY 12347-2347
SEJAL RAJA MD MMDDYYYY a.	NIDI b.	a. <b>7890123456</b> b.
IGNED DATE	PLEASE PRINT OR TYPE	7070123430

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