ANSWERS TO EXERCISES IN TEXTBOOK – Chapter 8

ANSWERS TO THINKING IT THROUGH

Thinking It Through 8.1 page 280

1. Such a plan could cause cash flow to be reduced because patients may be more reluctant to seek medical care with such a low annual benefit.

Thinking It Through 8.2 page 282

1. On the ninety-first day

2. A newborn child would be enrolled as a late enrollee.

3. No

4. Because group health plan coverage depends on employment status, it may end on the last day of the month in which the employee's active full-time service ends, such as for disability, layoff, or termination. Thus, the employee may no longer qualify as a member of the group. For example, some companies do not provide benefits for part-time employees. If a full-time employee changes to part-time employment, the coverage ends. An eligible dependent's coverage may end on the last day of the month in which the dependent status ends, such as the month the dependent reaches the age limit stated in the policy.

Thinking It Through 8.3 page 286

1. It is very important for medical insurance specialists to be able to determine the type of plan a patient has so that they will know what types of payments will be required, and to know how to bill the payer and how to expect to be reimbursed.

Thinking It Through 8.4 page 289

1. Consumer-driven health plans are attractive to payers because they require patients to be conscious of the costs of their health care and, in most cases, actively seek to keep them low. While answers will vary, students may agree with the rationale, stating that this method is an effective cost-controlling method for patients and payers alike, or may disagree, thinking that patients should not be reluctant to pursue health care when necessary because of the cost.

Thinking It Through 8.5 page 293

1. Students may suggest points under the groupings of contact information, utilization guidelines, claims submission information, plan coverage matrixes, patient financial responsibilities, or other topics.

2. Based on the benefits statement, most preventive care benefits require an office visit level of copayment in-network and the deductible and coinsurance out-of-network. Medical care is similar. Preauthorization is needed for both in-network and out-of-network hospital care.

Thinking It Through 8.6 page 297

1. A. Physician's responsibilities
B. Introductory
C. Compensation and billing guidelines
D. Physician's responsibilities
E. Plan obligations
F. Compensation and billing guidelines
G. Contract purpose and covered medical services

Thinking It Through 8.7 page 303

1. A. If a specialist recommends any additional treatment or tests that are covered benefits, for all hospital admissions and outpatient surgery (except in emergencies), and coverage for services from nonparticipating providers.

   B. A prior referral from the member's PCP and prior authorization by the plan.

   C. 1. Yes.

2. Coverage for services from nonparticipating providers requires prior authorization by the plan in addition to a special nonparticipating referral from the PCP.

3. The applicable cost-sharing charges still apply.

Thinking It Through 8.8 page 305

1. A. Preauthorization is used by the plan to (1) verify eligibility verification, (2) determine coverage, (3) coordinate the member's transition from the inpatient setting to the next level of care (discharge planning), (4) register members for specialized programs, and (5) inform physicians, members, and other health care providers about cost-effective programs and alternative therapies and treatments.

   B. The definition of "self-refer" should cover the patient's (plan member's) option to arrange an encounter independently of a provider's recommendation or authorization.

   C. If a patient's plan covers self-referrals to network or out-of-network providers and the patient can self-refer for covered benefits, it is the member's responsibility to contact the plan to preauthorize those services. Otherwise, it is the provider's task to do so.

Thinking It Through 8.9 page 311

1. Item number 1a—insured ID number missing

2. Item number 2—verify that the child's proper name is Jimmy, not James

3. Item number 11a—insured date of birth missing

4. Item number 13—signature or SOF needed

5. Item number 24B—place of service code needed

6. Item number 28—charges incorrectly added, the amount should be $324

7. Item number 33—need 9-digit Zip code

Thinking It Through 8.10 page 312

1. No, none of these procedures would be billable, because they are either covered preventive or medical care.

ANSWERS TO REVIEW QUESTIONS

Matching page 314

1. E
2. A
3. F
4. B
5. D
6. I
7. C
8. H
9. J
10. G

Multiple Choice page 315

1. C
2. B
3. B
4. D
5. A
6. B
7. B
8. C
9. B
10. A

Completion page 316

1. Introductory section, contract purpose and covered services, physician's responsibilities, managed care plan obligations, and compensation and billing guidelines

2. Step 1 Preregister patients
Step 2 Establish financial responsibility for visits
Step 3 Check in patients
Step 4 Review coding compliance
Step 5 Review billing compliance

Step 6 Check out patients
Step 7 Prepare and transmit claims

ANSWERS TO APPLYING YOUR KNOWLEDGE

Case 8.1 page 316

Precertification Form

Insurance Carrier: *Horizon PPO*

Certification for…*[x]* surgery

Patient name: *Elizabeth R. Sinowitcz*

Street address: *45 Maple Hill Rd., Apt. 12-B*

City/state/zip: *Rangeley, MN 55555*

Telephone: *555-123-9887* DOB: *08/02/1943*

Subscriber name: *Elizabeth R. Sinowitcz*

Employer: *Argon Electric Company*

Member number: *65-PO*

Admitting physician: *Dr. Hank R. Ferrara*

Provider number: *349-00-G*

Hospital/facility: *Mischogie Hospital Outpatient Clinic*

Planned admission/procedure date: *05/10/2016*

Diagnosis/symptoms: *H25.012*

Treatment/procedure: *66894*

Estimated length of stay: *1 day*

Case 8.2 page 316

A. Dr. Sundaram submits the claim.

B. The claim is submitted to Dr. Sundaram's local plan in Portland, Oregon.

Case 8.3 pages 317-318

A. 1. $400

2. $68

3. $340

B. 1. Plan pays $933.78; patient owes $233.45

2. Plan pays $30.48; the patient owes $1210.16

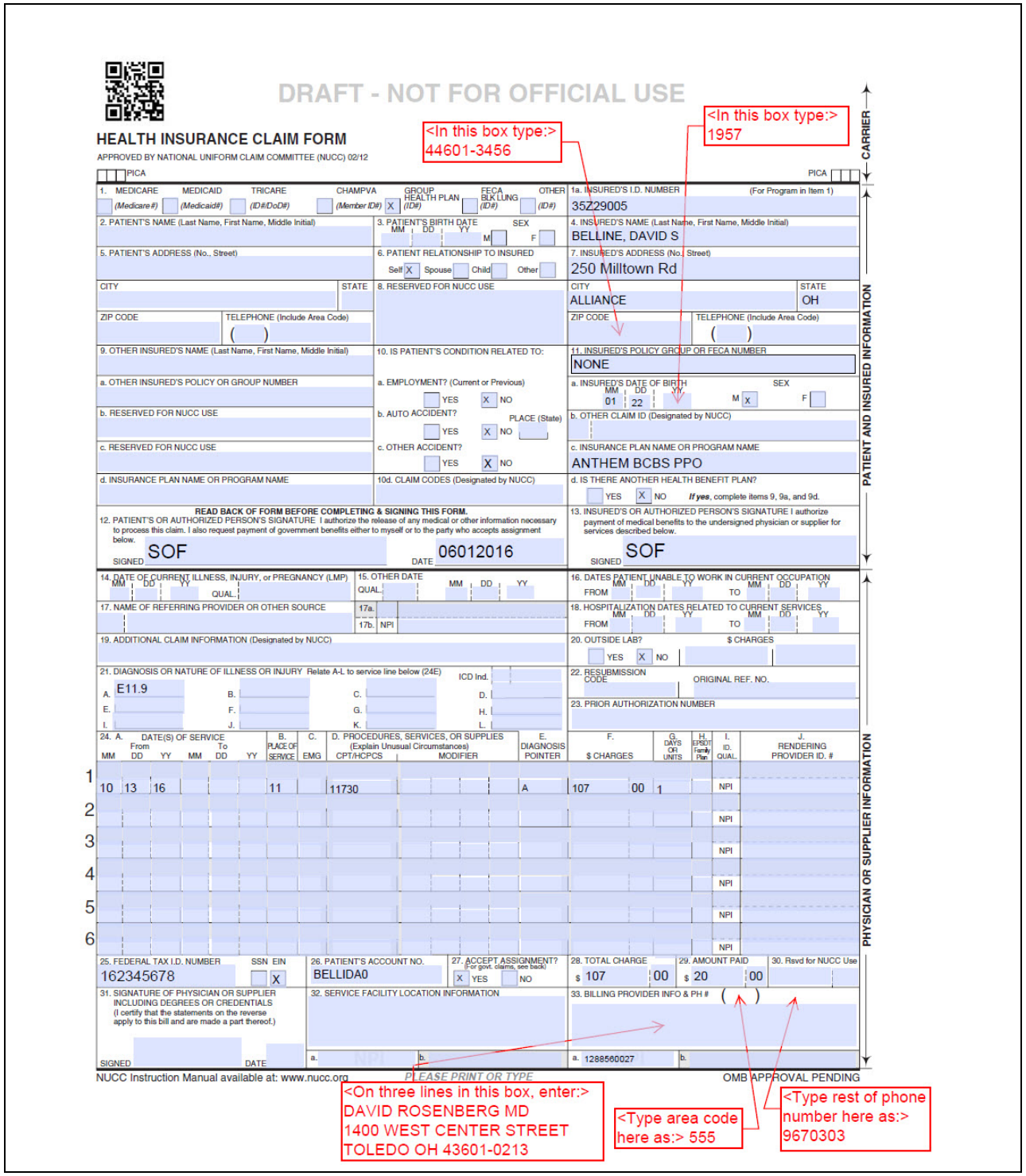
3.

Code	Description	New Plan
29871	Knee arthroscopy, surgical	$557.82
29876	Major synovectomy	$671.84
29877	debridement	$632.02
29880	w/meniscectomy, medial + lateral	$714.39
29881	w/meniscectomy, medial OR lateral	$661.30

Cases 8.4 A and B pages 318-320

Cases 8.4 A and B require claim completion. Students may complete paper CMS-1500 forms by hand or by using the electronic CMS-1500 form. They may also use the simulated Medisoft Connect Plus exercises to create and print the claims. The claim case answer keys provided in this Instructor's Manual are based on completion of paper CMS-1500 claim forms using the electronic form.

Case 8.4 A



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HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 35Z29005

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): BELLINE, DAVID S

5. PATIENT'S ADDRESS (No., Street)

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

7. INSURED'S ADDRESS (No., Street): 250 Milltown Rd

CITY | STATE

8. RESERVED FOR NUCC USE

CITY: ALLIANCE | STATE: OH

ZIP CODE | 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: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY: 01 22 SEX M X F

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: ANTHEM BCBS PPO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *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: SOF DATE: 06012016

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: SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

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

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. E11.9 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	10	13	16			11		11730		A	107 00	1		NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 162345678 SSN EIN X

26. PATIENT'S ACCOUNT NO.: BELLIDA0

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

28. TOTAL CHARGE: $ 107 00

29. AMOUNT PAID: $ 20 00

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.)
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
a. 1288560027 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<In this box type:> 44601-3456

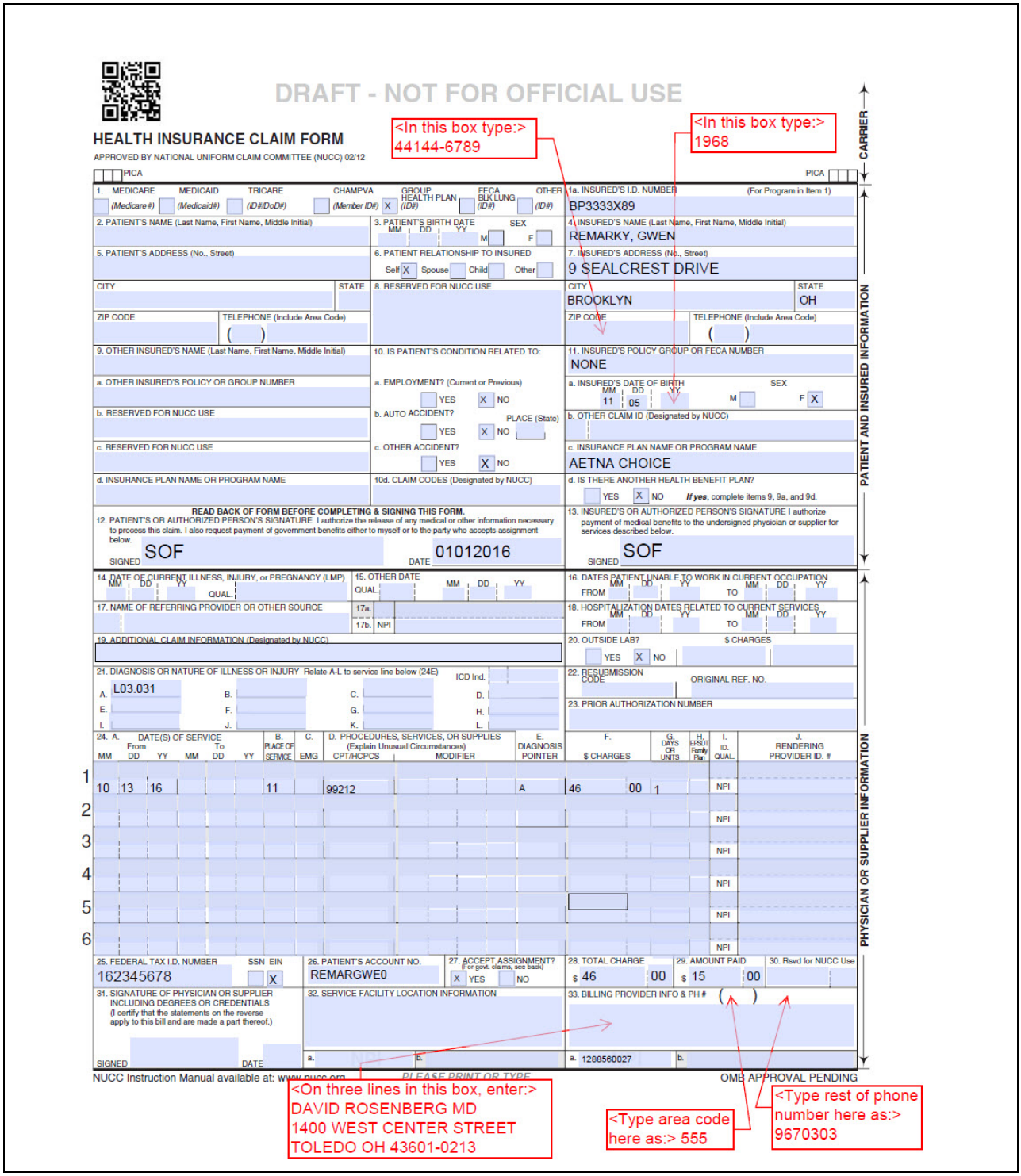
<In this box type:> 1957

<On three lines in this box, enter:>
DAVID ROSENBERG MD
1400 WEST CENTER STREET
TOLEDO OH 43601-0213

<Type area code here as:> 555

<Type rest of phone number here as:> 9670303

Case 8.4 B



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HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) X | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): BP3333X89

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

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REMARKY, GWEN

5. PATIENT'S ADDRESS (No., Street)

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

7. INSURED'S ADDRESS (No., Street): 9 SEALCREST DRIVE

CITY | STATE

8. RESERVED FOR NUCC USE

CITY: BROOKLYN | STATE: OH

ZIP CODE | 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: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM 11 DD 05 YY | SEX M | F X

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA CHOICE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO *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 SOF DATE 01012016

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 SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

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 | X NO $ CHARGES

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

A. L03.031 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 10 13 16		11		99212		A	46 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 162345678 SSN | EIN X

26. PATIENT'S ACCOUNT NO.: REMARGWE0

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

28. TOTAL CHARGE $ 46 00

29. AMOUNT PAID $ 15 00

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.)
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH # ( )
a. 1288560027 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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<In this box type:> 44144-6789

<In this box type:> 1968

<On three lines in this box, enter:>
DAVID ROSENBERG MD
1400 WEST CENTER STREET
TOLEDO OH 43601-0213

<Type area code here as:> 555

<Type rest of phone number here as:> 9670303