Chapter 1 - Health Insurance Specialist Career

TRUE/FALSE

1. A health insurance claim is the documentation submitted to the patient requesting reimbursement for health care services provided.

   ANS: F
   The correct answer is submitted to a third-party payer or government program.

   PTS: 1

2. Health insurance specialists (or reimbursement specialists) review health-related claims to determine the medical necessity for procedures or services performed before reimbursement is made to the provider.

   ANS: T PTS: 1

3. Coding is the process of assigning ICD-9-CM and CPT/HCPCS codes to diagnoses, procedures, and services.

   ANS: T PTS: 1

4. The patient receives a remittance advice, which is a report that details the results of processing a claim.

   ANS: F
   The correct answer is the patient receives an explanation of benefits (EOB).

   PTS: 1

5. A health care facility (or physician) that employs health insurance specialists is legally responsible for employees' actions performed within the context of their employment. This is called *respondeat superior*.

   ANS: T PTS: 1

6. Medical malpractice insurance is a type of liability insurance that covers physicians and other health care professionals for liability as to claims arising from patient treatment.

   ANS: T PTS: 1

7. The AAPC, AHIMA, and AMBA offer exams leading to professional credentials.

   ANS: T PTS: 1

8. The Department of Labor uses the "economic reality" test to determine worker status for purposes of compliance with the minimum wage and overtime requirements of the Fair Labor Provision Act.

   ANS: F
   The correct answer is the Fair Labor Standards Act.

   PTS: 1

9. The accurate coding of diagnoses, procedures, and services rendered to the patient allows a medical practitioner to communicate diagnostic and treatment data to a patient's insurance plan to assist the patient in obtaining maximum benefits.

   ANS: T PTS: 1

10. Fluency in the language of medicine and the ability to use a medical dictionary as a reference are not necessary skills for a health insurance specialist.

    ANS: F
    The correct answer is that they are necessary skills.

    PTS: 1

11. To reduce coding and billing errors, health insurance specialists need to explain complex insurance concepts and regulations to patients and effectively communicate with providers regarding documentation of procedures and services.

    ANS: T PTS: 1

12. Coding is the process of reporting diagnoses, procedures, and services as numeric and alphanumeric characters on the explanation of benefits (EOB).

    ANS: F
    The correct answer is on the insurance claim.

    PTS: 1

13. The Healthcare Common Procedure Coding System (HCPCS) consists of three levels.

    ANS: F
    The correct answer is two levels—the CPT and HCPCS Level II codes.

    PTS: 1

14. Medical necessity involves linking every procedure or service code reported on the claim to an HCPCS code that justifies the necessity for performing that procedure or service.

ANS: F
The correct answer is to a condition code.

PTS: 1

15. One reason for the increased hiring of insurance specialists is a direct result of employer's attempts to reduce the cost of providing employee health insurance coverage.

ANS: T PTS: 1

MULTIPLE CHOICE

1. If the insurance plan has a hold harmless clause; it means
   a. the health care provider can collect his/her fees from the patient
   b. the patient is not responsible for paying what the insurance plan denies
   c. the patient referred to nonparticipating providers has lower out-of-pocket expenses
   d. the patient is responsible for paying what the insurance plan denies

   ANS: B PTS: 1

2. To remain up-to-date with the frequent changes of health insurance processing, health insurance specialists should
   a. make certain that they are on mailing lists to receive newsletters from third-party payers
   b. remain current on news released by the CMS
   c. stay current with the DHHS updates
   d. all of the above

   ANS: D PTS: 1

3. The process of reporting diagnoses, procedures, and services as numeric and alphanumeric characters on the insurance claim is called
   a. data entry
   b. work
   c. health information technology
   d. coding

   ANS: D PTS: 1

4. Accurate coding of diagnoses, procedures, and services rendered to the patient allows a medical practice to
   a. facilitate analysis of the practice's patient base for improvement and efficiency
   b. communicate diagnostic and treatment data to insurance plans for maximum recovery of benefits
   c. process claims for a limited number of insurance companies
   d. both a and b

   ANS: D PTS: 1

5. Which of the following is not a professional association for health insurance specialists?
   a. American Health Information Management Association
   b. American Medical Billing Association
   c. American Medical Association
   d. American Academy of Professional Coders

   ANS: C PTS: 1

6. A claims examiner employed by a third-party payer reviews health-related claims to determine whether the charges are reasonable and for
   a. payment
   b. medical necessity
   c. billing to the patient
   d. resubmission

   ANS: B PTS: 1

7. Another name for health insurance specialist is
   a. coder
   b. reimbursement specialist
   c. biller
   d. medical records clerk

   ANS: B PTS: 1

8. Each new provider-managed care contract increases the
   a. practice's patient data base
   b. number of claims requirements and reimbursement regulations
   c. time the office staff must devote to fulfilling contract requirements
   d. all of the above

   ANS: D PTS: 1

9. According to *Occupational Outlook Handbook* published by the U.S. Department of Labor—Bureau of Labor Statistics, health care facilities and insurance companies will hire health insurance specialists at an increased rate per year of
   a. 9–17%
   b. 20–25%
   c. 10–20%
   d. 8–11%

   ANS: A PTS: 1

10. What involves linking every procedure or service code reported on the claim to a condition code that justifies the necessity of performing that procedure or service?
   a. diagnosis coding
   b. procedure coding
   c. medical necessity
   d. both a and c

   ANS: C PTS: 1

11. Health insurance specialists and medical assistants obtain employment in
   a. clinics
   b. clearinghouses
   c. physician's offices
   d. all of the above

   ANS: D PTS: 1

12. ICD-9-CM stands for
   a. International Center for Diseases, Ninth Revision, Clinical Modification
   b. International Classification of Diseases—Ninth Revision, Clinical Modification
   c. International Clarification of Diseases—Ninth Revision, Clinical Modification
   d. International Classification of Diseases—Ninth Report, Clinical Modification

   ANS: B PTS: 1

13. What does CPT stand for?
   a. Codes Posted via Telephone
   b. Clinical Procedure Tests
   c. Current Procedural Terminology
   d. None of the above

   ANS: C PTS: 1

14. The CPT manual is published by
   a. American Billing Association
   b. American Medical Association
   c. American Board of Physicians
   d. American Health Information Management

   ANS: B PTS: 1

15. A successful health insurance specialist should have which of the following characteristics?
   a. attention to details
   b. strong sense of ethics
   c. ability to work independently
   d. all of the above

   ANS: D PTS: 1

MATCHING

Match each item to a definition listed below.

a. Coding
b. Health care provider
c. Preauthorization
d. Medical malpractice insurance
e. EOB
f. Remittance advice
g. Health information specialist
h. AAPC
i. Professional liability insurance
j. ICD-9-CM
k. Hold harmless clause
l. *Respondeat Superior*
m. Ethics
n. CPT
o. HCPCS Level II codes

1. Prior approval
2. Patient not responsible for paying what the plan denies
3. Physician
4. Reimbursement specialist
5. Diagnostic codes
6. HCPCS Level I codes
7. Principles of right or good conduct

8. Results of processing a claim sent to patient
9. Provider’s notification regarding payment of claim
10. Physician’s legal responsibility for actions of employees
11. Certified Professional Coder
12. Liability insurance for providers
13. Errors and omissions insurance
14. National codes
15. Reporting diagnoses, procedures, and services

1. ANS: C PTS: 1
2. ANS: K PTS: 1
3. ANS: B PTS: 1
4. ANS: G PTS: 1
5. ANS: J PTS: 1
6. ANS: N PTS: 1
7. ANS: M PTS: 1
8. ANS: E PTS: 1
9. ANS: F PTS: 1
10. ANS: L PTS: 1
11. ANS: H PTS: 1
12. ANS: D PTS: 1
13. ANS: I PTS: 1
14. ANS: O PTS: 1
15. ANS: A PTS: 1

SHORT ANSWER

1. List some of the job duties performed by a health insurance specialist.

   ANS:
   1. Review health-related claims for accuracy.
   2. Determine medical necessity for procedures or services performed.
   3. Refer claim to an investigator for a more thorough review.
   4. Check patient’s current eligibility and benefit status at each office visit.
   5. Assign codes to diagnoses and procedures.
   6. Process claims for reimbursement.

   PTS: 1

2. Explain what is meant by “*respondeat superior*.”

   ANS:
   A health care facility (or physician) that employs health insurance specialists is legally responsible for employees’ actions performed within the context of their employment.

   PTS: 1

3. Explain medical malpractice insurance and why it is important to physicians and other health care professionals.

   ANS:
   Medical malpractice insurance is a type of liability insurance that covers physicians and other health care professionals for liability as to claims arising from patient treatment.

   PTS: 1

4. Name three professional associations that offer credentials for health insurance specialists.

   ANS:
   1.The American Academy of Professional Coders (AAPC)
   2. The American Health Information Management Association (AHIMA)
   3. The American Medical Billing Association (AMBA)
   4. The Medical Association of Billers (MAB)
   5. The National Electronic Billers Alliance (NEBA)

   PTS: 1

5. Explain what is meant by medical necessity and give an example.

   ANS:
   Medical necessity involves linking every procedure or service code reported on the claim to a condition code that justifies the necessity for performing that procedure or service.

   PTS: 1

6. Explain why independent contractors should purchase professional liability insurance.

   ANS:
   Professional liability insurance provides protection from claims that contain errors and omissions.

   PTS: 1

7. Explain the importance of ethics in the professional workplace.

   ANS:
   Ethics are the principles of right or good conduct and rules that govern the conduct of members of a profession.

   PTS: 1

8. List the levels of the Healthcare Common Procedure Coding System.

   ANS:
   1. Current Procedural Terminology (CPT)
   2. HCPCS Level II (national codes)

   PTS: 1

9. List the five ways to determine independent contractor status according to the common law "right to control" test.

   ANS:
   1. Amount of control the hiring organization exerted over the worker's activities
   2. Responsibility for costs of operation (e.g., equipment and supplies)
   3. Method and form of payment and benefits
   4. Length of job commitment made to the worker
   5. Nature of the occupation and skills required

   PTS: 1

10. What is meant by scope of practice?

    ANS:
    Health insurance specialists are guided by a scope of practice, which defines the profession, delineates qualifications and responsibilities, and clarifies supervision requirements.

    PTS: 1

11. List the four types of insurance that health care providers and facilities typically purchase to cover their employees.

    ANS:
    1. Bonding
    2. Liability
    3. Property
    4. Workers' compensation

    PTS: 1

12. Why is preauthorization important?

    ANS:
    Preauthorization, or prior approval for treatment by specialists, is important because if the requirements are not met, the payment for the claim will be denied.

    PTS: 1

13. Explain what is meant by a hold harmless clause.

    ANS:
    A hold harmless clause means that the patient is not responsible for what the insurance plan denies. The health care provider cannot collect the fees from the patient.

    PTS: 1

14. Describe what is meant by coding.

    ANS:
    Coding is the process of reporting diagnoses, procedures, and services as numeric and alphanumeric characters on the insurance claim.

    PTS: 1

15. Explain what is the ICD-9-CM manual.

    ANS:
    The *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) is the coding system used to report diagnoses (e.g., conditions, diseases, signs, and symptoms) and reasons for encounters (e.g., annual physical examinations, surgical follow-up care) on physician office claims.

    PTS: 1