

Health Insurance Specialist Career

CHAPTER OUTLINE

Health Insurance Overview
Education and Training

Job Responsibilities
Professional Credentials

OBJECTIVES

Upon successful completion of this chapter, you should be able to:

1. Define key terms.
2. Identify career opportunities available in health insurance.
3. Discuss the education and training requirements of a health insurance specialist.
4. Describe the job responsibilities of a health insurance specialist.
5. Differentiate among the three professional organizations that support health insurance specialists, and identify professional credentials offered by each.

KEY TERMS

American Academy of Professional Coders (AAPC)

American Health Information Management Association (AHIMA)

American Medical Billing Association (AMBA)

bonding insurance

Centers for Medicare and Medicaid Services (CMS)

coding

Current Procedural Terminology (CPT)

electronic claims processing

electronic data interchange (EDI)

embezzle

errors and omissions insurance
ethics

explanation of benefits (EOB)

HCPCS level II codes

Healthcare Common Procedure Coding System (HCPCS)

health care provider

health information technician

health insurance claim

health insurance specialist

hold harmless clause

independent contractor

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

liability insurance

medical malpractice insurance

medical necessity

national codes

preauthorization

professional liability insurance

property insurance

reimbursement specialist

remittance advice (remit)

respondeat superior

scope of practice

workers' compensation
insurance

INTRODUCTION

The career of a health insurance specialist is a challenging one with opportunities for professional advancement. Individuals who understand claims processing and billing regulations, possess accurate coding skills, and can successfully appeal underpaid or denied insurance claims are in demand. A review of medical office personnel help-wanted advertisements indicates the need for individuals with these skills.

NOTE: Reimbursement specialist is another title for health insurance specialist.

HEALTH INSURANCE OVERVIEW

Most health care practices in the United States accept responsibility for filing health insurance claims, and some third-party payers (e.g., Blue Cross/Blue Shield) and government programs (e.g., Medicare) require providers to file claims. A **health insurance claim** is the documentation submitted to a third-party payer or government program requesting reimbursement for health care services provided. In the past few years, many practices have increased the number of employees assigned to some aspect of claims processing. This increase is a result of more patients having some form of health insurance, many of whom require **preauthorization** (prior approval) for treatment by specialists and documentation of post-treatment reports. If preauthorization requirements are not met, payment of the claim is denied. If the insurance plan has a **hold harmless clause** (patient is not responsible for paying what the insurance plan denies) in the contract, the health care provider cannot collect the fees from the patient. In addition, patients referred to nonparticipating providers (e.g., a physician who does not participate in a particular health care plan) incur significantly higher out-of-pocket costs than anticipated. Competitive insurance companies are fine-tuning procedures to reduce administrative costs and overall expenditures. This cost-reduction campaign forces closer scrutiny of the entire claims process, which in turn increases the time and effort medical practices must devote to billing and filing claims according to the insurance policy filing requirements. Poor attention to claims requirements will result in lower reimbursement rates to the practices and increased expenses.

A number of managed care contracts are signed by health care providers. A **health care provider** is a physician or other health care practitioner (e.g., physician's assistant). Each new provider-managed care contract increases the practice's patient base, the number of claims requirements and reimbursement regulations, the time the office staff must devote to fulfilling contract requirements, and the complexity of referring patients for specialty care. Each insurance plan has its own authorization requirements, billing deadlines, claims requirements, and list of participating providers or networks. If a health care provider has signed 10 participating contracts, there are 10 different sets of requirements to follow and 10 different panels of participating health care providers from which referrals can be made.

Rules associated with health insurance processing (especially government programs) change frequently; to remain up-to-date, insurance specialists should be sure they are on mailing lists to receive newsletters from third-party payers. It is also important to remain current regarding news released from the **Centers for Medicare and Medicaid Services (CMS)**, formerly HCFA or the Health Care Financing Administration), which is the administrative agency within the federal Department of Health and Human Services (DHHS). The Secretary of the

DHHS is often reported by the news media as having announced the implementation of new regulations.

Another reason for the increased hiring of insurance specialists is a direct result of employers' attempts to reduce the cost of providing employee health insurance coverage. Employers renegotiate benefits with existing plans or change third-party payers altogether. The employees often receive retroactive notice of these contract changes and, in some cases, once notified may have to wait several weeks before new health benefit booklets and new insurance identification cards are issued. These changes in employer-sponsored plans have made it necessary for the health care provider's staff to check on patients' current eligibility and benefit status at each office visit.

Career Opportunities

According to the *Occupational Outlook Handbook* published by the U.S. Department of Labor—Bureau of Labor Statistics, health care facilities and insurance companies will hire claims examiners (health insurance specialists) to process routine medical claims at an increased rate of 9 to 17 percent through the year 2014.

Health insurance specialists (or **reimbursement specialists**) review health-related claims to determine the medical necessity for procedures or services performed before payment (reimbursement) is made to the provider. **Medical necessity** involves *linking every procedure or service code reported on the claim to an ICD-9-CM condition code that justifies the necessity for performing that procedure or service.*

NOTE: Health insurance specialists employed by insurance companies use guidelines (e.g., expected treatment practices) when processing claims for reimbursement. They also review claims for completeness and accuracy before authorizing the appropriate payment or referring the claim to an investigator for a more thorough review.

EXAMPLE 1: Procedure: Knee x-ray

Diagnosis: Shoulder pain

In this example, the provider is not reimbursed because the reason for the x-ray (shoulder pain) does not match the type of x-ray performed (knee). For medical necessity, the provider would need to document a diagnosis such as “fractured patella (knee bone).”

EXAMPLE 2: Procedure: Chest x-ray

Diagnosis: Severe shortness of breath

In this example, the provider is reimbursed because medical necessity for performing the procedure is demonstrated.

Software used to process third-party payer claims has resulted in automation of insurance specialist functions requiring a background in word processing and other computer applications as well as anatomy and physiology, medical terminology, and health insurance processing. Providers who implement **electronic claims processing** send data in a standardized machine-readable format to an insurance company via disk, telephone modem, or cable. The insurance company receives the data, reviews it, and sends an acknowledgment to the provider. This mutual exchange of data between the provider and insurance company is called **electronic data interchange (EDI)**, and is often used by claims clearinghouses. (EDI must be in compliance with HIPAA regulations, as discussed in Chapter 4.)

NOTE: In addition to many other functions, health information technicians perform insurance specialist functions by assigning codes to diagnoses and procedures and, when employed in a provider's office, by processing claims for reimbursement. **(Health information technicians** manage patient health information and medical records, administer computer information systems, and code diagnoses and procedures for health care services provided to patients.) The *Occupational Outlook Handbook* states that physician offices offer the fastest employment growth and majority of new jobs for health information technicians because of an increasing demand for detailed records, especially in large group practices.

NOTE: On December 31, 2003, CMS phased out the use of local codes, previously known as HCPCS level III codes.

In addition to an increase in insurance specialist positions available in health care practices, opportunities are also increasing in other settings such as

- **Claims benefit advisors in health, malpractice, and liability insurance companies.**
- **Coding or insurance specialists in state, local, and federal government agencies, legal offices, private insurance billing offices, and medical societies.**
- **Educators in schools and companies specializing in medical office staff training.**
- **Writers and editors of health insurance textbooks, newsletters, and other publications.**
- **Self-employed consultants who provide assistance to medical practices with billing practices and claims appeal procedures.**
- **Consumer claims assistance professionals, who file claims and appeal low reimbursement for private individuals. In the latter case, individuals may be dissatisfied with the handling of their claims by the health care provider's insurance staff.**
- **Practices with poorly trained health insurance staff who are unwilling or unable to file a proper claims appeal.**
- **Private billing practices dedicated to claims filing for elderly or disabled patients.**

Coding is the process of reporting diagnoses, procedures, and services as numeric and alphanumeric characters on the insurance claim. Two systems used are ICD-9-CM and HCPCS. The *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*, often abbreviated as ICD, is the coding system used to report diagnoses (e.g., conditions, diseases, signs, symptoms) and reasons for encounters (e.g., annual physical examination, surgical follow-up care) on physician office claims. Codes reported are numerical or alphanumeric and include a decimal (e.g., 401.9 is the code for hypertension; V20.2 is the code for a well-child office visit). The **Healthcare Common Procedure Coding System (HCPCS)**, pronounced “hick picks”) consists of two levels: (1) **Current Procedural Terminology (CPT)**, which is published by the American Medical Association and includes five-digit numeric (e.g., 99203) and alphanumeric codes (e.g., 1015F) and descriptors for procedures and services performed by providers; and (2) **national codes**, commonly referred to as **HCPCS level II codes**, which are published by CMS and include five-digit alphanumeric codes for procedures, services, and supplies not classified in CPT (e.g., J codes are assigned for the supply of drugs administered to the patient).

EDUCATION AND TRAINING

Training and entry requirements vary widely for health insurance specialists, and the *Occupational Outlook Handbook* states that opportunities will be best for those with a college degree. Academic programs should include coursework (Table 1-1) in general education (e.g., anatomy and physiology, English composition, oral communications, human relations, computer applications, and so on) and health insurance specialist education (e.g., health information management, medical terminology, pharmacology, coding and reimbursement, insurance processing, and so on). The characteristics of a successful health insurance specialist include an ability to work independently, a strong sense of ethics, attention to detail, and ability to think critically. The *American Heritage Concise Dictionary* defines **ethics** as the principles of right or good conduct, and rules that govern the conduct of members of a profession.

TABLE 1-1 Training requirements for health insurance specialists

COURSEWORK	DESCRIPTION
Anatomy and Physiology	Knowledge of anatomic structures and physiological functioning of the body is necessary to recognize abnormal conditions (pathophysiology).
Coding	Understanding the rules, conventions, and applications of coding systems ensures proper selection of codes, which are reported on insurance claims for reimbursement purposes. EXAMPLE: Patient undergoes simple suture treatment of 3 cm facial laceration. When referring to the CPT index, there is no listing for “Suture, facial laceration.” There is, however, an instructional notation below the entry for “Suture” that refers the coder to “Repair.” When “Repair” is referenced in the index, the coder must then locate the subterms “Skin,” “Wound,” and “Simple.” The code range in the index is reviewed, and the coder must refer to the tabular section of the coding manual to select the correct code.
Communication	Health insurance specialists need to explain complex insurance concepts and regulations to patients and effectively communicate with providers regarding documentation of procedures and services (to reduce coding and billing errors). Written communication skills are necessary when preparing effective appeals for unpaid claims.
Critical Thinking	Differentiating among technical descriptions of similar procedures requires critical thinking skills. EXAMPLE: Patient is diagnosed with <i>spondylosis</i> , which is defined as any condition of the spine. A code from category 721 of ICD would be assigned. If the specialist read the diagnosis as <i>spondylolysis</i> , which is a defect of the articulating portion of the vertebra, and assigned a code from ICD category 756 (if congenital) or 738 (if acquired), the coder would be in error.
Data Entry	Federal regulations require electronic submission of most government claims, which means that health insurance specialists need excellent keyboarding skills and basic finance and math skills. Because insurance information screens with different titles often contain identical information, the health insurance specialist must carefully and accurately enter data about patient care. EXAMPLE: Primary and secondary insurance computer screens require entry of similar information. Claims are rejected by insurance companies if data is missing or erroneous.
Internet Access	Online information sources provide access to medical references, insurance company manuals, and procedure guidelines. The federal government posts changes to reimbursement methodologies and other policies on Web sites. Internet forums allow health insurance specialists to network with other professionals.
Medical Terminology	Fluency in the language of medicine and the ability to use a medical dictionary as a reference are crucial skills. Health insurance specialists assign codes to diagnoses and procedures documented in patient records, which are reported on insurance claims for reimbursement purposes.

JOB RESPONSIBILITIES

This section provides an overview of major responsibilities delegated to health insurance specialists. In practices where just one or two persons work with insurance billing, each individual must be capable of performing all the listed responsibilities. In multispecialty practices that employ many health insurance specialists, each usually processes claims for a limited number of insurance companies (e.g., an insurance specialist may be assigned processing only Medicare claims). Some practices have a clear division of labor, with specific

individuals accepting responsibility for only a few assigned tasks. Typical tasks are listed in the following job description.

Health Insurance Specialist Job Description

1. Review patient record documentation to accurately code all diagnoses, procedures, and services using ICD-9-CM for diagnoses and CPT and HCPCS level II for procedures and services.

The accurate coding of diagnoses, procedures, and services rendered to the patient allows a medical practice to

- **communicate diagnostic and treatment data to a patient's insurance plan to assist the patient in obtaining maximum benefits.**
 - **facilitate analysis of the practice's patient base to improve patient care delivery and efficiency of practice operations to contain costs.**
2. Research and apply knowledge of all insurance rules and regulations for major insurance programs in the local or regional area.
 3. Accurately post charges, payments, and adjustments to patient accounts and office accounts receivable records.
 4. Prepare or review claims generated by the practice to ensure that all required data are accurately reported and to ensure prompt reimbursement for services provided (contributing to the practice's cash flow).
 5. Review all insurance payments and remittance advice documents to ensure proper processing and payment of each claim. The patient receives an **explanation of benefits (EOB)**, which is a report detailing the results of processing a claim (e.g., payer reimburses provider \$80 on a submitted charge of \$100). The provider receives a **remittance advice** (or **remit**), which is a notice sent by the insurance company that contains payment information about a claim. (EOBs and remits are further discussed in Chapter 4.)
 6. Correct all data errors and resubmit all unprocessed or returned claims.
 7. Research and prepare appeals for all underpaid, unjustly recoded, or denied claims.
 8. Rebill all claims not paid within 30 to 45 days, depending on individual practice policy and the payers' policies.
 9. Inform health care providers and the staff of changes in fraud and abuse laws, coding changes, documentation guidelines, and third-party payer requirements that may affect the billing and claims submission procedures.
 10. Assist with timely updating of the practice's internal documents, patient registration forms, and billing forms as required by changes in coding or insurance billing requirements.
 11. Maintain an internal audit system to ensure that required pretreatment authorizations have been received and entered into the billing and treatment records. Audits comparing provider documentation with codes assigned should also be performed.
 12. Explain insurance benefits, policy requirements, and filing rules to patients.
 13. Maintain confidentiality of patient information.

NOTE: One way to determine independent contractor status is to apply the common law “right to control” test, which includes five factors: (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 occupation and skills required. The Internal Revenue Service applies a 20-factor independent contractor test to decide whether an organization has correctly classified a worker as an independent contractor for purposes of wage withholdings. 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 Standards Act.

Scope of Practice and Employer Liability

Regardless of employment setting, health insurance specialists are guided by a **scope of practice** that defines the profession, delineates qualifications and responsibilities, and clarifies supervision requirements (Table 1-2). Health insurance specialists who are self-employed are considered independent contractors. The *Lectric Law Library’s Lexicon* defines an **independent contractor** as “a person who performs services for another under an express or implied agreement and who is not subject to the other’s control, or right to control, of the manner and means of performing the services. The organization that hires an independent contractor is not liable for the acts or omissions of the independent contractor.”

Independent contractors should purchase **professional liability insurance** (or **errors and omissions insurance**), which provides protection from claims that contain errors and omissions resulting from professional services provided to clients as expected of a person in the contractor’s profession. Professional associations often include a membership benefit that allows purchase of liability insurance coverage at reduced rates.

EXAMPLE: The American Health Information Management Association makes information about the purchase of a professional liability plan available to its membership. If a member is sued for malpractice, the plan covers legal fees, court costs, court judgments, and out-of-court settlements. The coverage includes up to \$2 million per incident and up to \$4 million in any one policy year.

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**, Latin for “let the master

TABLE 1-2 Scope of practice for health insurance specialists

Definition of Profession:	One who interacts with patients to clarify health insurance coverage and financial responsibility, completes and processes insurance claims, and appeals denied claims.
Qualifications:	Graduate of health insurance specialist certificate or degree program or equivalent. One year of experience in health insurance or related field. Detailed working knowledge and demonstrated proficiency in at least one insurance company’s billing and/or collection process. Excellent organizational skills. Ability to manage multiple tasks in a timely manner. Proficient uses of computerized registration and billing systems and personal computers, including spreadsheet and word processing software applications. Certification through AAPC, AHIMA, or AMBA.
Responsibilities:	Use medical management computer software to process health insurance claims, assign codes to diagnoses and procedures/services, and manage patient records. Communicate with patients, providers, and insurance companies about coverage and reimbursement issues. Remain up-to-date regarding changes in health care industry laws and regulations.
Supervision Requirements:	Active and continuous supervision of health insurance specialist is required. However, the physical presence of the supervisor at the time and place responsibilities are performed is not required.

TABLE 1-3 Types of professional insurance purchased by employers

INSURANCE	DESCRIPTION
Bonding insurance	<p>An insurance agreement that guarantees repayment for financial losses resulting from an employee's act or failure to act. It protects the financial operations of the employer.</p> <p>NOTE: Physician offices should bond employees who have financial responsibilities. The U.S. Department of Commerce estimates \$500 billion in annual losses to all types of employers due to employees who embezzle (steal).</p>
Liability insurance	<p>Protects business assets and covers the cost of lawsuits resulting from bodily injury (e.g., customer slips on wet floor), personal injury (e.g., slander or libel), and false advertising. Medical malpractice insurance is a type of liability insurance, which covers physicians and other health care professionals for liability as to claims arising from patient treatment.</p> <p>NOTE: Liability insurance does <i>not</i> protect an employer from nonperformance of a contract, sexual harassment, race and gender discrimination lawsuits, or wrongful termination of employees.</p> <p>NOTE: An alternative to purchasing liability insurance from an insurance company is to <i>self-fund</i>, which involves setting aside money to pay damages or paying damages with current operating revenue should the employer ever be found liable. Another option is to join a <i>risk retention</i> or <i>risk purchasing group</i>, which provides lower-cost commercial liability insurance to its members. A third option is to obtain coverage in a <i>surplus lines market</i> that has been established to insure unique risks.</p>
Property insurance	Protects business contents (e.g., buildings and equipment) against fire, theft, and other risks.
Workers' compensation insurance	Protection mandated by state law that covers employees and their dependents against injury and death occurring during the course of employment. Workers' compensation is not health insurance, and it is not intended to compensate for disability other than that caused by injury arising from employment. The purpose of workers' compensation is to provide financial and medical benefits to those with work-related injuries, and their families, regardless of fault.

answer,” which means that the employer is liable for the actions and omissions of employees as performed and committed within the scope of their employment. Employers purchase many types of insurance to protect their business assets and property (Table 1-3).

EXAMPLE: Linda Starling is employed by Dr. Pederson's office as a health insurance specialist. As part of her job, Linda has access to confidential patient information. While processing claims, she notices that her mother-in-law has been a patient, and she later tells her husband about the diagnosis and treatment. Her mother-in-law finds out about the breach of confidentiality and contacts her lawyer. Legally, Dr. Pederson can be sued by the mother-in-law. Although Linda could also be named in the lawsuit, it is more likely that she will be terminated.

PROFESSIONAL CREDENTIALS

The health insurance specialist who becomes affiliated with one or more professional associations receives useful information available in several formats, including professional journals and newsletters, access to members-only Web sites, notification of professional development, and so on. A key feature of mem-

bership is an awareness of the importance of professional certification. Once certified, the professional is responsible for maintaining that credential by fulfilling continuing education requirements established by the sponsoring association.

The **American Academy of Professional Coders (AAPC)** offers five certification exams. The AAPC was established to provide a national certification and credentialing process, to support the national and local membership by providing educational products and opportunities to network, and to increase and promote national recognition and awareness of professional coding. The *Certified Professional Coder Apprentice (CPC-A)* and *Certified Professional Coder—Hospital Apprentice (CPC-HA)* designations are available to applicants who have not yet met the required medical field experience for certification as a CPC or CPC-H. The *Certified Professional Coder (CPC)* is available for physician practice and clinic coders, and the *Certified Professional Coder—Hospital (CPC-H)* examination is for outpatient facility coders. The *Certified Professional Coder—Payer (CPC-P)* is available for those employed by third-party payers and government programs. (Specialty exams leading to advanced CPC and CPC-H credentials are also offered.) Contact the AAPC at (800) 626-2633, or e-mail at info@aapc.com. The mailing address is 2480 South 3850 West, Suite B, Salt Lake City, UT 84120.

The **American Health Information Management Association (AHIMA)** sponsors three certification exams for coding specialists. AHIMA represents more than 40,000 health information management professionals who work throughout the health care industry. Health information management professionals manage, analyze, and utilize patient care data, making it accessible to health care providers when needed. AHIMA's *Certified Coding Associate (CCA)* fulfills the need for an entry-level coding credential. The *Certified Coding Specialist (CCS)* demonstrates competence in ICD-9-CM and CPT Surgery coding, as well as in patient documentation and data integrity/quality issues, anatomy, physiology, and pharmacology. The *Certified Coding Specialist—Physician-Based (CCS-P)* demonstrates expertise in multispecialty CPT, ICD-9-CM, and HCPCS national (level II) coding. For information on membership and certification, call AHIMA at (312) 233-1100, or e-mail inquiries to info@ahima.org. The mailing address is 233 N. Michigan Avenue, 21st Floor, Chicago, IL 60611-5800.

The **American Medical Billing Association (AMBA)** offers the *Certified Medical Reimbursement Specialist (CMRS)* exam, which recognizes the competency of members who have met high standards of proficiency. According to AMBA, Certified Medical Reimbursement Specialists (CMRS) are skilled in facilitating the claims reimbursement process from the time a service is rendered by a health care provider until the balance is paid. The CMRS is knowledgeable in ICD, CPT, and HCPCS coding; medical terminology; insurance claims and billing; appeals and denials; fraud and abuse; Health Insurance Portability and Accountability Act (HIPAA) regulations; Office of the Inspector General (OIG) compliance; information and Internet technology; and reimbursement methodologies. Contact the AMBA by calling (580) 622-5809. The mailing address is 4297 Forrest Drive, Sulphur, OK 73086.

SUMMARY

A health insurance specialist career is challenging and requires professional training to understand claims processing and billing regulations, possess accurate coding skills, and develop the ability to successfully appeal underpaid or denied insurance claims. A health insurance claim is submitted to a third-party payer or government program to request reimbursement for health care services provided. Many health insurance plans require preauthorization for treatment provided by specialists.

While the requirements of health insurance specialist programs vary, successful specialists will develop skills that allow them to work independently and ethically, focus on attention to detail, and think critically. Medical practices and health care facilities employing health insurance specialists require them to perform various functions. Smaller practices and facilities require specialists to process claims for all types of payers, while larger practices and facilities expect specialists to process claims for a limited number of payers.

Health insurance specialists are guided by a scope of practice, which defines the profession, delineates qualification and responsibilities, and clarifies supervision requirements. Self-employed health insurance specialists are independent contractors who should purchase professional liability insurance. Health care providers and facilities typically purchase bonding, liability, property, and workers' compensation insurance to cover their employees. The AAPC, AHIMA, and AMBA offer exams leading to professional credentials. Becoming credentialed demonstrates competence and knowledge in the field of health insurance processing as well as coding and reimbursement.

INTERNET LINKS

- American Academy of Professional Coders (AAPC)
www.aapc.com
- American Health Information Management Association (AHIMA)
www.ahima.org
- American Medical Billing Association (AMBA)
www.ambanet.net
- Centers for Medicare and Medicaid Services (CMS)
www.cms.hhs.gov
- State of Wisconsin Office of the Commissioner of Insurance
www.oci.wi.gov

STUDY CHECKLIST

- Read this textbook chapter and highlight key concepts. (Use colored highlighter sparingly throughout chapter.)
- Create an index card for each key term. (Write the key term on one side of the index card and the concept on the other. Learn the definition of each key term, and match the term to the concept.)
- Access chapter Internet links to learn more about concepts.
- Answer the chapter review questions, verifying answers with your instructor.
- Complete WebTutor assignments and take online quizzes. (Refer to WebTutor content in Preface.)
- Complete Workbook chapter, verifying answers with your instructor.
- Form a study group with classmates to discuss chapter concepts in preparation for an exam.

REVIEW

MULTIPLE CHOICE Select the most appropriate response.

1. The document submitted to the payer requesting reimbursement is called a(n)
 - a. explanation of benefits.
 - b. health insurance claim.
 - c. remittance advice.
 - d. preauthorization form.

2. **The Centers for Medicare and Medicaid Services (CMS) was previously called the**
 - a. Department of Health and Human Services.
 - b. Health, Education and Welfare Agency.
 - c. Health Care Financing Administration.
 - d. Office of the Inspector General.
3. **A health care practitioner is also called a:**
 - a. dealer.
 - b. provider.
 - c. purveyor.
 - d. supplier.
4. **The mutual exchange of data between provider and payer is called electronic**
 - a. claims processing.
 - b. data interchange.
 - c. information analysis.
 - d. statistical investigation.
5. **The process of assigning diagnoses, procedures, and services using numeric and alphanumeric characters is called**
 - a. coding.
 - b. data processing.
 - c. programming.
 - d. reimbursement.
6. **If health plan preauthorization requirements are not met by providers,**
 - a. administrative costs are reduced.
 - b. patients' coverage is cancelled.
 - c. payment of the claim is denied.
 - d. they pay a fine to the health plan.
7. **Which coding system is used to report diagnoses and conditions on claims?**
 - a. CPT
 - b. HCPCS
 - c. ICD
 - d. national codes
8. **The CPT coding system is published by the**
 - a. ADA.
 - b. AHIMA.
 - c. AMA.
 - d. CMS.
9. **National codes are associated with**
 - a. CDT.
 - b. CPT.
 - c. HCPCS.
 - d. ICD.
10. **Which report is sent to the patient to detail the results of claims processing?**
 - a. explanation of benefits
 - b. health insurance claim
 - c. preauthorization form
 - d. remittance advice

11. **A remittance advice contains:**
 - a. payment information about a claim.
 - b. provider qualifications and responsibilities.
 - c. detected errors and omissions from claims.
 - d. documentation of medical necessity.
12. **Which type of insurance guarantees repayment for financial losses resulting from an employee's act or failure to act?**
 - a. bonding
 - b. liability
 - c. property
 - d. workers' compensation
13. **Medical malpractice insurance is a type of _____ insurance.**
 - a. bonding
 - b. liability
 - c. property
 - d. workers' compensation
14. **Which mandates workers' compensation insurance to cover employees and their dependents against injury and death occurring during the course of employment?**
 - a. state
 - b. federal
 - c. local
 - d. workers' compensation coverage is optional
15. **The American Medical Billing Association offers which certification exam?**
 - a. CCS
 - b. CMRS
 - c. CPC
 - d. RHIT