AAPC

CPB

Certified Professional Biller (CPB)®

STUDY GUIDE

2026

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AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual, redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not rewritten or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially, they are as one would find them in a coding setting.

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Chapter 1

Introduction to Healthcare

Introduction

AAPC would like to introduce the Study Guide for the Certified Professional Biller Examination. This material was developed to help billers and other medical professionals prepare for the Certified Professional Biller Exam necessary to obtain the Certified Professional Biller (CPB)® credential.

AAPC has prepared a study guide aimed at providing the most up-to-date information related to billing, including HIPAA, consumer driven health plans, ICD-10-CM, CPT®, accounts receivable (A/R), and health plans (governmental and commercial) to assist in the preparation for the Certified Professional Biller (CPB)® examination.

The objectives for this chapter include:

- Understand a background in healthcare
- Provide an overview of HIPAA including privacy standards and transaction and code set standards
- Recognize standards for Conditions of Participation (CoP)
- Recognize the difference between fraud and abuse
- Identify how the False Claims Act (FCA) affects billing practices
- Review Federal regulations including Stark Law, Anti-Kickback, Healthcare Fraud Statute, and Federal Civil Penalties Inflation Adjustment Act Improvements Act
- Understand how the Truth in Lending Act affects collection efforts

Background of Healthcare

The business of medicine is highly complex, ever changing, and tightly regulated. Healthcare providers are subject to many guidelines and requirements, as implemented by insurers and government agencies. These rules cover a wide range of issues, from how providers must handle medical records, to the documented diagnoses or clinical indications a patient must demonstrate if an insurer is to pay for a procedure and regulations for payment timelines and refunds.

Until the 1940s, healthcare insurance was not commonplace for Americans. During World War II, wage and price controls were placed on employers by the 1942 Stabilization Act. Congress limited the wages that could be offered but allowed the adoption of employee insurance plans. The 1954 Internal Revenue Code stated employer contributions to employee health plans were exempt from employee taxable income, making the demand for health insurance even more appealing.

Medicare was signed into law on July 30, 1965 by President Lyndon B. Johnson under title XVIII of the Social Security Act. Beneficiaries could sign up for the program on July 1, 1966. U.S. citizens were automatically enrolled in Part A Medicare at age 65, which covered hospital stays, and they had an option to choose to enroll in Part B Medicare, which covered physician services.

The Health Maintenance Organization Act of 1973 (P. L. 93-222) was proposed under the Nixon Administration to try to help control healthcare costs. It authorized $375 million to assist in establishing and expanding HMOs. The act also overrode state laws that prohibited the establishment of prepaid health plans and required employers with 25 or more employees to offer an HMO option if they furnished healthcare coverage to their employees. According to the Rand Corporation, HMO enrollment went from 3 million in 1970 to over 80 million in 1999, representing a 12 percent increase every year.

Preferred Provider Organizations (PPO) then emerged. A PPO is within the framework of managed care health insurance. PPOs set up a group of doctors, hospitals, and other healthcare providers to create a network and negotiate predetermined fees with a given carrier. PPOs offer members more options in that they do not have to maintain a primary care physician, nor do they require referrals.

The addition of these - and more - types of health plans led to a high level of complexity in the business of medicine. Hospitals, clinics, and private physician practices all contend with many issues to stay in business. This has led to the expansion in the healthcare field of medical professionals with the skillsets necessary to keep the business side running smoothly.

Healthcare Regulations

Healthcare regulations are not always definitive and may vary by payer, geographic area, and the setting in which patient care is provided. To be effective, the biller must distinguish and comprehend the precise regulatory requirements that apply in a particular circumstance. The healthcare regulations that affect medical billing will be reviewed in this chapter.

Medicare Coverage, Deductibles, and Coinsurances

Part A Medicare covers hospital care, skilled nursing facility care, nursing home care, hospice, and home health services.

Part B Medicare covers medically necessary services, such as physician visits, ambulance services, durable medical equipment, and mental health services.

Part B has also greatly expanded coverage for preventive services. The following are covered under Medicare Part B:

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Annual Wellness Visit (AWV)
- Blood-based biomarker tests
- Bone mass measurement or bone densitometry (DEXA)
- Cardiovascular disease screening
- Cardiovascular disease (behavioral therapy)
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Depression screening
- Diabetes screening and prevention program
- Diabetes self-management training
- Glaucoma tests
- Hepatitis B and C virus screening
- HIV screening
- Lung cancer screening
- Mammograms (screening)
- Nutrition therapy services
- Obesity screening and counseling
- Initial Preventive Physical Exam (IPPE)
- Prostate cancer screening
- Sexually transmitted infections screening and counseling
- Flu shots, hepatitis B shots, pneumococcal shots
- COVID-19 vaccine
- Tobacco use cessation counseling

BILLING TIP

Medicare screening services will often have specific diagnosis requirements. When billing preventive services, understand the full policy set by Medicare for screening services.

Below are the deductibles and coinsurances for 2024.

Part A	Part A	Part B	Part B
Inpatient deductible	$1,632 per benefit period (days 1-60)	Annual deductible	$240 per calendar year
Co-insurance days	$0 per benefit period (days 1-60) $408 per day (days 61-90)	Co-insurance amount	20% of Medicare approved amount
Lifetime Reserve days	$816 per each lifetime reserve day (days 91–150) Beyond lifetime reserve days: all costs	Limiting Charge	15% above the Medicare approved amount
Skilled Nursing Co-insurance	$204 per day (days 21-100) per benefit period	Premiums	$174.70 per month regardless of effective date (potentially higher depending on income)

EXAMPLE

A patient is seen in the office and CPT® code 99214 is billed to Medicare Part B for $150.00. A Medicare Remittance Advice (RA) is received at the office listing the allowed amount as $107.83. Medicare paid 80 percent or $86.26 as the patient had met his deductible. The patient's coinsurance amount is $21.57. $42.17 is a contractual write-off taken by the provider.

Medicaid

Medicaid is a health insurance program for low-income individuals and families who cannot afford healthcare costs. There are different types of Medicaid coverage available for individuals with different needs. Primary oversight is performed federally, but each state establishes its own eligibility standards, determines the type and scope of services, sets the rate of payment for services, and administers its own Medicaid program.

Medicaid Eligibility

A person may be eligible for Medicaid if the individual:

- Is a U.S. citizen or provides proof of eligible immigration status, unless applying for emergency services
- Has a Social Security number or has applied for one
- Meets the requirements for the Temporary Assistance for Needy Families (TANF) program; or is a child under the age of 6 whose family incomes are at or below 133% of the federal poverty level (FPL)
- Is a pregnant woman with family income below 133% of the FPL
- Receives Supplemental Security Income (SSI)
- Is a recipient of adoption or foster care assistance under Title IV of the Social Security Act
- Falls under a special protected group such as those who lose cash assistance due to earnings from work or from increased Social Security benefits
- Is under 19 years of age and in a family with incomes at or below the FPL

States may choose to provide Medicaid coverage to other groups that share some characteristics with those above, but are more broadly defined, the aged, blind, or disabled adults with incomes below the FPL, or low-income institutionalized individuals.

Medicaid Coverage, Deductibles, and Coinsurances

Although the individual states decide what their Medicaid plans will cover, there are some mandatory federal requirements the state must meet to receive federal matching funds. These services include:

- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home healthcare for persons eligible for skilled-nursing services
- Laboratory and X-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health-center (FQHC) services and ambulatory services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21

There are also optional approved Medicaid services that a state may provide and receive matching federal funds, including optometry services, clinic services, prosthetics, and physical therapy.

Medicaid provides some enrollees benefits under a fee-for-service delivery system. CMS reviews all state plan reimbursement methodologies to make sure reimbursement is consistent with federal statutes and regulations. States usually develop their payment rates based on the costs of providing the service, a review of commercial payer reimbursement, and a percentage of what Medicare pays for equivalent services.

Many states now offer a managed care program for Medicaid benefits as an option. In some states, the plans are a requirement for enrollees. These managed care programs include:

- Managed Care Organizations (MCOs): Like HMOs, these companies agree to provide most Medicaid benefits to enrollees in exchange for a monthly payment from the state.
- Limited benefit plans: These companies are like HMOs, but only provide one or two Medicaid benefits.
- Primary Care Case Managers: These are individual providers or groups of providers who agree to act as an individual's primary care provider. They receive a small monthly payment for helping coordinate referrals and other medical services.

Some states use Managed Long-Term Services and Supports (MLTSS) to offer services. This type of program delivers long term services and supports through capitated Medicaid managed care programs. The number of states with these types of programs is increasing.

States have the option to charge premiums and out-of-pocket spending requirements for enrollees, which may include copayments, coinsurances, deductibles, and other similar charges. Certain groups, like pregnant women and children, are exempt from most out-of-pocket costs and cannot be charged coinsurances and copayments for certain services.

The Children's Health Insurance Program, or CHIP, is designed to offer free or low-cost health insurance coverage to those whose incomes are too high to qualify for Medicaid but cannot afford private coverage. The states administer it, like Medicaid, but it is jointly funded by the federal government and the states.

It is important to photocopy or scan the front and back of the patient's insurance card(s) and file the copy in the patient's financial record. The patient's completed registration form and front and back of the patient's photo ID card should also be kept on file. This information is used for identification purposes.

PATIENT INFORMATION

Date: _____

Patient name: First _____ Middle initial _____ Last _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of birth: _____ Age: _____ Sex ____ Marital status _____ Social Security #: _____

Phone #: _____ Cell #: _____ Email address: _____ Work #: _____

Employer: _____ Employer's address _____

Emergency Contact: _____ Relationship to patient: _____

Phone #: _____ Cell #: _____ Work #: _____

Referring provider's name: _____ Phone #: _____

RESPONSIBLE PARTY INFORMATION

Name: First _____ Middle initial _____ Last _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of birth: _____ Age: _____ Sex: _____ Marital status: _____ Social Security #: _____

Relationship to patient: _____ Home phone #: _____Work phone #:_____

Employer: _____ Employer's address: _____

INSURANCE INFORMATION

Are you covered by health insurance? _____ If no, please make payment arrangements with our business office.

Primary Insurance: _____ Policy # _____ Group #: _____

Policyholder Name: _____ Policyholder Date of Birth: _____

Social Security Number: _____ Copay: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policyholder Name: _____ Policyholder Date of Birth: _____

Social Security Number: _____ Copay: _____

CONSENT FOR PAYMENT

I hereby authorize payment of medical benefits billed to my insurance to the ABC Physicians. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if the ABC Physicians does not participate with my insurance. I hereby authorize ABC Physicians to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, the ABC Physicians can refuse to treat me. I understand this authorization can only be revoked in writing, if I revoke my consent, such revocation will not affect any actions that the ABC Physicians took before receiving my revocation.

_____

Signature of Patient or Patient's Representative _____ Date _____

Printed Name of Patient: _____ Relationship of representative to patient: _____

Insurance Coverage Validation

An insurance ID card is a card sent by the insurance company to each person covered on the plan. This card identifies the information needed for a claim to be processed. The insurance ID card should be presented at each visit.

How to Read an Insurance Card

Insurance cards are issued to each person covered by the insurance carrier. Although insurance cards come in different sizes, materials, and colors, they all contain the same type of information:

Policyholder name—The policyholder's name may be the patient's name or subscriber's name. Some insurance ID cards show both the patient's name and the subscriber's name. Some ID cards may provide the names of all family members covered under the policy on one card, others may state whether the employee (EMP), child (CH), or Spouse (SP) is covered without listing the names of those covered.

Identification Number—The identification number is also known as the policy number.

Benefits—This section lists the type of coverage the patient has. For example, medical, dental, and vision.

Pharmacy-Rx—This area lists the copayment amount for prescriptions.

Deductible—A deductible is the amount of expenses that must be paid by the patient before an insurer will pay any expenses. The amount of the annual deductible will be listed here.

Copayment—A copayment is a fixed amount that a patient is responsible to pay for a covered health service. Multiple copayment amounts may be listed on the insurance ID card as there may be a different amount for primary care physicians, specialists, and the emergency department. In the example below, there are separate lines for office, urgent care, and hospital visits.

Coinsurance—Instead of, or in addition to, a copayment, some insurance carriers have a coinsurance for the patient's cost share. This is a percentage of the allowed amount due by the patient. For example, Medicare Part B has a 20 percent coinsurance. This means the Medicare patient is responsible for 20 percent of the Medicare allowed amount after the deductible has been met.

Front

Your Health Insurance Company		
Policy Holder Name		**ID:**
Benefits		Pharmacy–Rx
Deductible:	$2,500	$25.00
CoPays:		
Office:	$35.00	
InstaCare:	$50.00	
Hospital:	$7.00	

Back

Your Health Insurance Company
Questions? Call 800-123-4567 Hours: Mon-Fri 7:00 am to 8:00 pm Submit Claims to: Address City, State, Zip

The back of the insurance ID card shows the contact information for the insurance company. In this example, the phone number, hours of operation, and the address of where the claims should be submitted is shown on the insurance card.

BILLING TIP

Practices should make a copy of the front and back of the insurance ID card and keep it in the patient's chart.

Insurance Coverage Verification

Verifying patient coverage is a step that can save a practice time and money. Insurance coverage can be verified by phone or by an electronic eligibility verification tool with the insurance company. The patient's demographics and insurance information need to be available when verifying the insurance. If the patient is not eligible with the insurance company given, the patient needs to be contacted for updated insurance information. If the patient believes the information is correct and should be covered, the patient should contact the insurance company to have the eligibility files updated. When this occurs, allow the patient to decide if they want to reschedule their appointment or to be considered a self-pay patient and pay for the service out of pocket.

Verification of Benefits

Verification of benefits provides information concerning the patient's coverage. This step verifies eligibility effective dates; patient coinsurance, copay, and deductible amounts; and plan benefits as they pertain to specialty and place of service. Benefit information allows staff to be informed and ready to collect the appropriate copay, deductible, coinsurance, or full balance due at the patient's visit. It is also important to record the effective and termination dates of coverage in the PMS that will automatically bill insurance companies based on the effective dates.

Primary vs. Secondary Insurance

Patients may be covered under more than one health insurance policy. When this happens, determine which insurance is primary and which is secondary. If the patient is the subscriber on their insurance plan, that is their primary insurance. If the patient is also covered under another insurance, for instance from a spouse, it would be a secondary insurance.

Birthday rule—When a child is covered by insurance plans from both parents, the "birthday rule" is used to determine the primary and secondary insurance. According to the National Association of Insurance Commissioners, under the birthday rule, the health plan of the parent whose birthday comes first in the calendar year is designated as the primary plan. The year of birth is not a factor in this rule. The month and day are the only factors the health plan considers.

MSP form—Medicare provides a Medicare Secondary Payer form for providers to determine if Medicare is a secondary insurance for a patient who has Medicare and another insurance. This will be discussed later in the curriculum.

Authorization Form

HIPAA—Section 164.508 of the final privacy rule states that covered entities may not use or disclose protected health information without a valid authorization, except as otherwise permitted or required in the privacy rule. This form should be updated no less than once a year. Below is an example of an authorization form.

Authorization to Use or Disclose Health Information

Patient Name _____ Date of Birth _____

Health record number _____

I authorize the use of disclosure of the above-named individual's health information as described below.

AAPC Physicians is authorized to make the disclosure.

The type of information to be used or disclosed is as follows:

____ Problem list ____ Medication list

____ List of allergies ____ Immunization records

____ Most recent history ____ Most recent discharge summary

____ Lab results (dates or types) _____

____ X-ray and imaging reports (dates or types) _____

____ Consultation reports from _____

____ Entire record

____ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: _____ Phone #: _____

Address: _____

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire on _____.

Signature of patient or legal representative _____. Date _____.

If signed by legal representative, relationship to patient _____

Signature of witness _____. Date _____.

Chapter 9 Questions

1. What is a claim submitted with all the information necessary to process the claim is considered?

   A. A clean claim
   B. A closed claim
   C. A delinquent claim
   D. An open claim

2. Which is the hospital-specific master list that includes all hospital procedures, services, supplies, and medications that are billed to payers?

   A. A day sheet
   B. An encounter form
   C. A chargemaster
   D. A superbill

3. Which electronic transmission is done using a very high-speed connection that uses the same wires as a regular telephone line?

   A. Compact disc media
   B. DSL
   C. Extranet
   D. Dial-up

4. Based on the EDI report below, what step should the biller take next for Clarence Rockford?

   ABC EDI Daily Claim Processing Report

   Provider Tax ID:

Type	Claim ID	Patient Name	DOS	Charge	Payer	AEDI Claim ID	Ref. Date	Status
OT01	65418	Timmins, Randy	07/14/20XX	150.00	123 Ins	0630201401	06/27/20XX	ACK
OT01	84351	Rockford, Clarence	07/14/20XX	75.00	123 Ins	0630201402	06/27/20XX	REJ

   ERROR: Missing or invalid subscriber ID

   Print | Close | Mark As Reviewed

   REJ—claim rejected, make corrections, and rebill

   ACK = acknowledged—claim forwarded to the payer

   A. Nothing, the claim has been forwarded to the insurance payer for processing.
   B. Pull the patient's medical record to verify medical necessity of the services.
   C. Transfer the balance to the patient.
   D. Pull the patient's insurance ID card to verify the information in the system is correct.

5. Based on the CDM example, what would the charge be for a thyroid sonogram?

Dept. #	Item #	Description	CPT®/HCPCS Code	Revenue Code	GL number	Charge	Modifier
12	12678	Foot X-ray, minimum 3 views	73630	0540	6	150.00	LT
12	12680	Thyroid Sonogram	76536	0540	6	250.00	
12	12685	Echoencephalogram	76506	0540	6	1,500.00	

A. $150.00
B. $250.00
C. $540.00
D. $1500.00

6. A child seen in the office has insurance coverage through both his mother and his father. The father has BCBS (DOB 10/08/87) and the mother has Aetna (DOB 06/01/88). Which insurance is primary?

A. Aetna is primary
B. BCBS is primary
C. Either insurance can be billed as primary
D. The insurance of the person who brought the patient in is primary for that visit

7. What are the consequences of an inpatient stay being billed as an outpatient stay in error?

A. Payment is made based on the diagnoses instead of the procedures reported.
B. Payment is made based on the procedures reported instead of the diagnoses reported.
C. The claim is paid the same regardless of whether it is inpatient or outpatient.
D. The claim is rejected for additional information.

8. Which is an entity that processes or facilitates the processing of claims for providers and healthcare plans?

A. Workers' compensation
B. Subrogation
C. Clearinghouse
D. Medicare

9. Which is a four-digit numeric code established by the National Uniform Billing Committee (NUBC) that classifies a line item in the chargemaster?

A. Item number
B. CPT® code
C. GL number
D. Revenue code

Medications: None.

Allergies: No known drug allergies.

Physical Examination: Vital Signs: Blood pressure 138/86, pulse 67, temperature is 97, respiratory rate 18, 02 100. HEENT: Eyes: Right eye vision 20/25; left eye 20/20; both eyes 20/20. No foreign bodies seen. PERRLA at 2–3 mm. Both eyes continue to weep, and conjunctivae are inflamed bilaterally. The oral mucosa is moist and appears normal. Neck: The neck is supple, and the trachea is midline. Respiratory: Equal chest wall excursion. There are no intercostal retractions or the use of accessory muscles with respirations. Breath sounds are clear and symmetrical. There are no wheezes, rales, or rhonchi.

Cardiovascular: The chest wall is normal in appearance. The heart has a regular rate and rhythm. Integumentary: Inspection of the left index finger reveals a 4 cm laceration of the dorsal surface extending into the deeper layers of the subcutaneous tissue. The abdomen is soft and nondistended. There is no tenderness to palpation, rebound or guarding. Skin: There is no significant rash or ulceration. Neurologic: Grossly normal/baseline. Musculoskeletal: Strength and tone are grossly normal to the upper and lower extremities.

Diagnostic Impression: Wound left index finger, intermediate. Eye inflammation, conjunctivitis due to exposure.

Urgent Care Course: The 4 cm wound was injected with 1% lidocaine without epinephrine achieving complete numbing of the area. The wound was irrigated with Betadine and normal saline and surrounding skin prepped with Betadine. The wound was explored to base using pickups to visualize and palpate. No foreign body noted. No evidence of major vascular or nerve injury identified. Wound edges approximated and closed in layers with 6 running 4-0 Vicryl, 7 interrupted sutures with 6-0 Nylon. Bacitracin ointment and dry sterile dressing applied. The patient tolerated the procedure well. Gentamicin ophthalmic drops were administered OU. Inflammation beginning to subside prior to discharge.

Final Diagnosis: Finger laceration, 4.5 cm, intermediate repair; inflammation of eyes with redness and discharge.

Robert Swift, MD

Practice: Urgent Care Clinic

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 779873113B

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

3. PATIENT'S BIRTH DATE MM DD YY: 10 06 1952 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 12347 MORNING CIRCLE DR

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

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

CITY: ANYWHERE STATE: MO

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 877671234 TELEPHONE (Include Area Code): ( )

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

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] 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 *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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 29 XX 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 [ ] NO [X] $ CHARGES

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

A. S61211A B. H1089 C. H018 D. W260XXA

E. Y93G1 F. Y92009 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	05	03	XX	05	03	XX	11		12042	F6	A	185 00	1		NPI	78977878331
2	05	03	XX	05	03	XX	11		99203	25	B	135 00	1		NPI	78977878331
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 23789812

26. PATIENT'S ACCOUNT NO.: LS0097

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

28. TOTAL CHARGE: $ 320 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.)

ROBERT SWIFT MD

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
URGENT CARE CLINIC
597 PARKWAY
ANYWHERE MO 87767

a. 1267787006 b.

33. BILLING PROVIDER INFO & PH # ( )
URGENT CARE CLINIC
597 PARKWAY
ANYWHERE MO 87767

a. 1267787006 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** **APPROVED OMB-0938-1197 FORM 1500 (02-12)**

46. Review the chart note and the claim form that is provided for this patient. Are there any elements that are incorrect?

    I. Primary insurance

    II. Primary insurance ID number

    III. Signature on File

    IV. Place of service

    V. Date of service or date of injury

    VI. Billing provider information

    VII. CPT® codes

    VIII. Modifier

    IX. Diagnosis code

A. I, VII, VIII
B. III, IV, V, VIII
C. III, VII, VIII, IX
D. II, III, IV, VI, VII

Case 2

Benefit Category

Screening Pap Smear

Screening Pelvic Exam

Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Indications and Limitations of Coverage

CIM 50-20.1

Screening Pap Smear

A screening Pap smear and related medically necessary services provided to a woman for the early detection of cervical cancer (including collection of the sample of cells and a physician's interpretation of the test results) and pelvic examination (including clinical breast examination) are covered under Medicare Part B when ordered by a physician (or authorized practitioner) under one of the following conditions:

- She has not had such a test during the preceding two years or is a woman of childbearing age (§1861(nn) of the Act).
- There is evidence (on the basis of her medical history or other findings) that she is at high risk of developing cervical cancer and her physician (or authorized practitioner) recommends that she have the test performed more frequently than every two years.
- High risk factors for cervical and vaginal cancer are:
- Early onset of sexual activity (under 16 years of age).
- Multiple sexual partners (five or more in a lifetime).
- History of sexually transmitted disease (including HIV infection).
- Fewer than three negative or any Pap smears within the previous seven years; and
- DES (diethylstilbestrol)—exposed daughters of women who took DES during pregnancy.

Chapter 1

1. **Answer:** D. False Claims Act

   Rationale: This act would violate the "reverse false claims" section of the Act, which provides for liability if a person acts improperly to avoid paying money owed to the government.

2. **Answer:** C. Covered entity

   Rationale: A covered entity under HIPAA is defined as health plans, healthcare clearinghouses, and any healthcare provider who transmits health information in an electronic format.

3. **Answer:** C. Minimum necessary standard

   Rationale: The minimum necessary standard in HIPAA requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected healthcare information to the minimum necessary to accomplish the intended purpose. To copy all the notes is unnecessary when only three dates of service were requested.

4. **Answer:** A. ICD-10-CM, ICD-10-PCS, HCPCS, and CPT®

   Rationale: The standardized code sets adopted under HIPAA for all transactions are: HCPCS, CPT®, ICD-10-CM, ICD-10-PCS, NDC, and CDT.

5. **Answer:** D. Fraud

   Rationale: CMS defines fraud as making false statements or misrepresenting facts to obtain an undeserved benefit or payment from a federal healthcare program. As the drugs were given for free, they cannot be billed to Medicare.

6. **Answer:** B. *Qui tam action*

   Rationale: A *qui tam* action is a civil action on behalf of a person and the U.S. government. If there is a recovery, the relator may be awarded 15-25 percent of the dollar amount recovered through the *qui tam* action.

7. **Answer:** D. Truth in Lending Act

   Rationale: The Truth in Lending Act is a federal law that was enacted to protect consumers in their dealings with lenders or creditors. If the office is going to charge finance charges on outstanding balances, they are considered a creditor and subject to the law.

8. **Answer:** C. Business associate

   Rationale: Business associates perform certain functions or activities which involve the use or disclosure of individually identifiable health information on behalf of another person or organization. These services include claims processing or administration, data analysis, utilization review, billing, benefit management, and re-pricing.

9. **Answer:** A. Abuse

   Rationale: Abuse is defined by CMS as an action that results in unnecessary costs to a federal healthcare program, either directly or indirectly.

10. **Answer:** B. ASC X12 Version 5010 and NCPDP

    Rationale: If a covered entity under HIPAA conducts any transactions electronically, they must use the adopted standard - ASC X12 Version 5010 or NCPDP (used for certain pharmacy transactions) for each transaction.

Chapter 2

1. **Answer:** B. MCO

   Rationale: A managed care organization (MCO) combines the functions of health insurance, delivery of care, and administration.

2. **Answer:** D. HMO

   Rationale: A group model HMO contracts with a multi-specialty group that provides care to the members. The HMO pays an established rate, which is distributed to the individual physicians as part of their salaries. The group may work solely with the HMO or may offer services to other patients.

3. **Answer:** B. $14.62

   Rationale: Since the office accepts assignment, they must write off the difference between what is billed and what is approved. Since $73.08 is approved, a write-off of $26.92 must be taken. Medicare pays 80 percent of the approved amount, in this case $73.08 and the patient is responsible for the 20 percent coinsurance, or $14.62.

4. **Answer:** A. Flexible spending account (FSA)

   Rationale: An FSA is an account an individual contributes money into that is used to pay for certain out-of-pocket healthcare costs. For the most part, if the money is not used during the plan year, it is forfeited.

5. **Answer:** C. NPI number

   Rationale: A National Provider Identifier, or NPI, is a unique 10-digit identification number required by HIPAA and is used on electronic HIPAA compliant transactions.

6. **Answer:** D. State Children's Health Insurance Program (SCHIP)

   Rationale: The State Children's Health Insurance Program, or SCHIP, is designed to offer free or low-cost health insurance coverage to those whose incomes are too high to qualify for Medicaid but cannot afford private coverage.

7. **Answer:** B. Health savings account (HSA)

   Rationale: An HSA combines high deductible health insurance with a tax-advantaged savings account. The money put in the account can pay for the deductible, and once met, the money left in the account earns interest. They can be funded by employers or employees and are portable.

1. **Answer:** A. Veterans with service-connected disabilities and their families

   Rationale: The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) covers veterans who are permanently and totally disabled due to a service-related disability and their spouse and children.

2. **Answer:** B. The employer's group health plan

   Rationale: The health insurance plan is billed first and then through the process of subrogation it will be determined if a liability payer should be considered primary.

3. **Answer:** D. Medicare Part A, B & C

   Rationale: Medicare Part A, B & C are all administered by private companies that contract with CMS as Medicare Administrative Contractors or MACs.

4. **Answer:** C. A flat amount paid to the healthcare provider when the policyholder is seen for an office visit.

   Rationale: Co-payments are paid at the time the policyholder is seen for an office visit. Co-insurance is the percentage the policyholder pays for covered services after deductible has been reached and copayment has been paid. The premium is paid every month by the policyholder to maintain insurance coverage.

5. **Answer:** B. The non-PAR limiting charge is 115% of the non-PAR Medicare Physician Fee Schedule.

   Rationale: Per CMS, the non-PAR limiting charge is 115% of the non-PAR Medicare Physician Fee Schedule.

6. **Answer:** A. A policy that covers healthcare services that Medicare does not cover.

   Rationale: Medigap was designed by the federal government but marketed by private commercial insurance companies to supplement coverage to fill in the "gaps" of Medicare's deductibles, copayments, and coinsurance costs.

7. **Answer:** C. ESRD and meet certain requirements

   Rationale: Medicare Part A coverage is available to individuals below the age of 65 who have: 1) received Social Security or RRB disability benefits for 24 months, 2) End-Stage Renal Disease and meet certain requirements.

8. **Answer:** C. Medicaid programs receive matching federal funding only if certain healthcare services are provided to eligible individuals.

   Rationale: Medicaid programs must provide certain healthcare services to eligible individuals in order to receive matching federal funds known as Federal Medical Assistance Percentage (FMAP). The percentage is determined on a year-to-year basis using a formula that compares the state's per capita average income with the national average. States with lower average income per capita receive a higher FMAP.

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