**Date: 14-02-2023**

**Overview of US Healthcare (How healthcare in US started)**

In the early days there was very little focus on medical care in the US but during the civil war,the government started to build hospitals in each state for their soldiers. The government also started many public healthcare provisions which made a huge impact. Since then healthcare in the US has grown a lot.

The President established medicare and medicaid programs. Initially these programs were started as basic insurance programs for those who don't have health insurance.

The Medicare program provides health coverage if your age is above 65 or you have a disability no matter what your income is .

The Medicaid program provides health coverage if you have a low income.

If you are eligible for both you can have both. They will work together to provide you health coverage with low cost.

**Why do we need such a streamline system for US health care?**

In a developed country like the US, Time is more precious than money. All the work which can be automated or done by building a system is avoided .People don't have to think about the transactions and billings because these things are handled by the system itself. As we know that the US citizens are very concerned about their health. So we have to maintain proper records for each individual so that they can use their past diagnosed data for their future treatments.

Because of that streamline system user can avail many benefits which are mentioned below

**Accessibility:** A systematic healthcare system ensures that healthcare services are accessible to all individuals. Without a systematic approach, it can be difficult for some individuals to receive healthcare services.

**Quality:** A systematic approach to healthcare ensures that patients receive high-quality care.

**Cost-effectiveness:** A systematic healthcare system can help to reduce healthcare costs by streamlining processes.

In the U.S. an average expense of medication was $12,914 in 2021, which was over $5,000 more than any other high-income nation. So it is very difficult for an individual to cope up with their medical expenses. So it is very important for them to have a medical insurance plan which can help them when it is needed .

For maintaining all the data, We need a proper system for that and for the working of that system huge capital is required.

**Which entities are included in US healthcare and how are they connected?**

IN US healthcare we have covered entities and business associates for the streamline functioning of the system .

Covered entities are any individual , organization or corporation that handles the PHI data of patients and transmits health information in electronic form .Some examples of covered entities are Hospitals , doctors office health insurance providers etc.

Business associates are the person or an organization that performs certain functions that involve the use or disclosure of protected health information on behalf of or provides services to a covered entity.

If a covered entity is disclosing PHI to another covered entity for treatment healthcare and payment operations then they don’t have to sign a Business associate agreement.

All healthcare organizations, healthcare clearinghouses, and health plans who engage in electronic transmissions of the PHI come under covered entities. Due to the expensiveness of the medical facilities in the US it is difficult for a person to cope up with all the expenses to solve this issue insurance companies and insurance schemes come into play. In insurance a consumer pays a premium to a health insurance company and that payment allows you to share risk with lots of other people who are making similar payments. Since most people are healthy most of the time, the premium dollars paid to the insurance company can be used to cover the expenses of the small number of individuals who get sick or are injured.

**Date: 15-02-2023**

**While opting an insurance what points we have to keep in our mind**

**At what places , I can receive care**

To control the cost, insurance companies provide a limited access of providers to the payers. Providers include physicians, hospitals, laboratories, pharmacies, and other entities. Most insurance companies contract with a specified network of providers that have agreed to supply services to individuals at better pricing.If an individual goes to a provider which is not a member of that specific network . Then the insurance company will not pay for the individual’s expense or will only pay a small amount of money and the rest of the money has to be paid by the individual.

## **What things the plan will cover?**

Because of the Affordable Care Act all the health plans in the US have to offer a number of essential health benefits which is the same in all the health plans.

Emergency services,Hospitalization,Laboratory tests etc.

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## **How much will it cost?**

In any insurance plan we don’t have to pay the premium only but we also have to pay when we receive the service and that payments are known as deductibles, coinsurance, or copays. While opting a insurance we have to keep in mind that more you pay the premium less you have to pay while accessing service

**What is HIPAA?**

HIPAA (Health Insurance Portability and Accountability Act) is a law in the U S .The purpose of HIPAA is to protect the privacy and security of an individual's health information. HIPAA has two main components: the Privacy Rule and the Security Rule. The Privacy Rule helps in the protection of an individual's health information. It tells how healthcare providers and other covered entities should protect an individual's health information. The Security Rule has standards for the protection of electronic health information. It requires healthcare providers and other covered entities to ensure the confidentiality, integrity, and availability of health information.

HIPAA also includes provisions for breach notification, In this covered entities have to notify individuals if any of the PHI is leaked.

HIPAA applies to covered entities as well as business associates if they handles the PHI of the individuals

Overall, HIPAA is an important law that helps to protect the privacy and security of an individual's health information. It ensures that individuals have control over their own health information and that healthcare providers and other covered entities are responsible for protecting that information.

## **HIPAA business associate agreement**

While working with the PHI data of the patients sometimes we have to make use of third party services. But how can we ensure that the particular service provider will maintain the same level of integrity and confidentiality like us. This issue can be resolved by business associate agreement

A business associate agreement is a legal contract between covered entities and business associates or between a business associate and a business associate subcontractor to make sure that the provided PHI data and health information is secured and protected.

Covered entities can only work with those business associated with whom they have signed a HIPAA BAA

Business associate subcontractors are the entities to whom the business associates share the protected information for performing certain operations.

A BASA (Business Associate Subcontractor Agreement) is held between business associates and business associate subordinators to ensure when a Business Associate shares PHI with a Business Associate Subcontractor, the same standards are maintained towards PHI.

Examples of business associate subcontractors are

* Accounting Services
* Law firms
* email encryption service

**What if a business associate fails to secure the PHI ?**

If a business associate fails to protect or secure the PHI then he has to face the criminal penalties for violating HIPAA laws and regulations just like the covered entities have to face.

Generally, the criminal penalties for HIPAA violation can include imprisonment from 12 months to 10 years and the penalty for violating the law ranges between 50,000 $ to 1.5 million $.

**Date: 16-02-2023**

**Types of health insurance plans available in US**

Before understanding types of health insurance lets first understand what is Open Enrollment and Special Enrollment

**Open enrollment** is the time period that comes once in a year where you can change your plan , choose a new plan, adjust and cancel your plan.

**Special Enrollment**  If you had certain life events in your life like losing health coverage, moving, getting married, having a baby, or adopting a child, or if your household income is below a certain amount. And you missed the open enrollment then you can apply under special enrollment

Health insurance are divides by the level of benefits they offer and are divided into bronze,silver,gold and platinum

### **ACA Marketplace health insurance plans**

The affordable care act health insurance plans are available on the healthcare marketplaces

ObamaCare and Individual & Family Plans are some examples of ACA marketplaces health insurance plans. An individual can buy these plans alone; they don’t have to buy it through an organization or by any government programs like medicare and medicaid.These insurances are subsidized by the government so if you fall under that income slab then you have to pay a low premium.

In this plan if you have a pre existing health disease then they can’t charge you more for that

And can’t refuse to cover you.

A qualifying life event can affect your health insurance which is having a baby , moving in to a new state etc If such things are happening in your life than you can get a new insurance during Special enrollment period

**Short term health insurance plans**

If you are having a gap between your insurance and you want to fill that gap then the short term insurance gives you limited coverage for a limited period of time. But the short term health insurance plans don’t cover you from pre existing diseases.

**Medicare**

It is a centrally funded health insurance program which covers individuals whose age is above 65 and those who have disabilities and are under 65 are also covered under this plan. This program is divided into four parts: A, B, C and D, and is the same nationwide.

1. Medicare Part A – hospital coverage
2. Medicare Part B – medical coverage
3. Medicare Part C – Medicare Advantage
4. Medicare Part D – prescription drug coverage

Medicare advantage plans are private plans which are similar to original medicare plans but it covers everything whereas medicare plans cover what is needed. Having a medicare advantage plan has its own perks and benefits.

# **HMO, PPO, EPO and POS health insurance plans**

### **Provider networks**

It is a network of hospitals, doctors and healthcare providers which agreed to provide service to insured people at negotiated rates.

There are basically four types of network providers;

1. Health maintenance organizations
2. Preferred provider organizations
3. Exclusive provider organizations
4. Point of service plan

**Medicaid**

Medicaid is a way to get health care at a lower cost or sometimes free to you. Medicaid is managed by each state, so the eligibility requirements can change from state to state.

The Medicaid program provides health coverage if you have a low income.

If you are eligible for both you can have both. They will work together to provide you health coverage with low cost.

**Date: 17-02-2023**

**Money we pay other than premium (cost sharing)**

Whenever we get any service we have to pay some amount of money which is different from the premium and this is known as cost sharing. The amount we have to pay while receiving service depends on the type of plan we have.

**Copay :** It is a fixed amount which we have to pay whenever we are getting a service.

**Coinsurance:** It is a fixed percentage of the total amount that we have to pay after getting the service.

**Deductible:** In this we have to pay all the expenses till the deductible limit is reached and after reaching that deductible the health insurance company will cover all the expenses for the whole year.

**Out of the pocket maximum:** It is the maximum amount an individual will pay including both deductibles and cost sharing in a year.

**Date: 20-02-2023**

**CPT (current procedural terminology )**

CPT was created by the American Medical Association, These codes are used to identify the service and procedure which is provided by the provider to the payer. We have unique codes for every medical procedure and service . Length of these codes are five, alphanumeric characters. Every year these codes are revised to add the newly founded procedures and to remove the outdated procedures also. These codes are used for healthcare as well as management procedures eg: claim processing and developing medical guidelines.

**Types of CPT**

There were three categories before in CPT but now in recent times a new category has been added.

**Category 1:** These are the five digit long numeric codes which are used to describe the medical procedures and services.

**Category 2**: These are the five digit long alphanumeric long codes. These codes are used to measure the performance and quality of care. These are the optional codes not the substitute of category 1 codes.

**Category 3**: These codes are reserved for emerging and new procedures which are currently not a part of category 1. These are the temporary codes for data collection , evaluation and payment of new procedures which are not the part of category 1.

**Proprietary Laboratory Analysis codes:** These codes are used by the manufacturers and the laboratories to specifically identify their tests. And these tests must be requested by the laboratory which offers the test.

**International classification of diseases (ICD)**

These codes are used to identify the diseases or the treatment which the patient has received. These codes are used by the insurance companies to know how much they have to pay for that particular disease. These are the set of codes which are used to communicate or represent diseases and other patient’s diagnosis which is accepted universally.These set of codes are known as ICD 10 because it is the 10th edition. There are more than 70,0000 ICD codes available and every code describes a particular disease or diagnosis

ICD codes are also required for medical billing , claiming insurance and for many more tasks.

Insurance companies require ICD codes for settling the bills with the provider because these codes tell us what the disease was and how much amount should be paid for diagnosis of that particular disease.

The ICD and CPT code both should align with each other ,If not then check the ICD code on the medical bill.

**Date: 21-02-2023**

**Primary care physician**

He is the first person to contact or we can say that he is a bridge between insurance company and the patient. When a patient comes to a primary care physician then he will monitor the patient's health and will solve most of the problems or he will recommend the patient to another doctor.

In a plan like HMO the patient can choose his own primary care physician for a list of doctors provided by the insurance company.

**How do insurance really work(Basic flow of an insurance):**

Working with insurance is pretty simple in US healthcare.

1. Firsty if a person wants to buy insurance , he can buy it from different marketplaces. Government provided insurance is also available for some individuals.
2. Then an individual buys insurance and pays a premium which is based on the type of insurance.
3. If there is a case of emergency then the patient has to be admitted then PCP should be informed but in general emergency care should be avoided.
4. If an individual has to visit a doctor or wants to have some medication which is an out-patient case then he first has to visit his PCP(Primary care physician) which is provided by the insurance company for some health plans.
5. Then the PCP will look into the matter and decide whether he can solve the issue or else he will send(refer) the patient to the doctor which is a part of the network.
6. After getting the doctor, We first take permission from the insurance company for that particular doctor. If that doctor is in the network then only the insurance company will pay the bill and give us the approval for that visit.
7. Then that individual has to book an appointment with the referred doctor.
8. After reaching the doctor, the patient will get his treatment. After the treatment he has to pay a copay or co-insurance depending on his plan and the rest of the money is paid by the insurance company.
9. Then after the treatment a list of the prescribed medicines are sent to the store which is chosen by the user.
10. Health insurance doesn't cover all the medicines and those medicines which are covered by the insurance are known as formulary. Different insurance plans have different formulary. If the plan doesn’t cover the prescribed medicine then the patient has to pay the full bill otherwise he only has to pay the copay or coinsurance.

**Date: 22-02-2023**

## **What is the medical billing process And who are medical billers?**

It is a process in which the provider submits claims on the behalf of patients for the service they have provided to the insurance company.

The person who submits bills to the insurance company or to the patients and makes sure that the provider receives the payment for the service is known as a medical biller.

Main role of a medical biller is to follow up until the provider receives the payment.

**Who are the medical coders**

Medical coders are the people who take data of the patient and convert it into codes. This coding process involves all the data which include what was the reason for the patient visit , which services are given by the doctors and much more data is collected and gets converted into the codes which will help in settling the claims and the provider will get its reimbursement. The medical biller and the coders can be same or can be different

**Step by step process of medical billing**

1. **Registering new patient:** If a patient is visiting for the first time then a lot of health insurance and background data about the patient is collected to make sure that the patient is able to receive service by the provider under his insurance and if the patient is already registered then there is no need to receive all the information again.
2. **Verifying patient insurance:** Second step is to confirm whether the patient’s insurance is active or notand the reason for visit is covered under the insurance.

If the insurance is not covering that particular reason of visit then they should inform the patient about the status.

1. **Record patient details during visit:** during or after the patient visit make proper audio or video notes of what services were provided , what was the disease , what was prescribed by the doctor. This information is needed for medical coding. It is better to store the information in an electronic medical record system.
2. **Medical billing team will review the document:** The recorded data of the patient is sent to the medical billing team and they will make a formal document to make sure other people can read that document or script.
3. **Medical coders will code the information:** The medical coders will code the patient information into ICT and OCD codes so that it is easy for the insurance company to understand and make claims and reimbursement faster.
4. **Charge entry:** In this process we make an entry for the charges of the diagnosis and the service provided by the provider to the patient.While charging we must list the CPT code with it and if the patient is liable to pay the money then we must inform the patient.
5. **Checking the CPT codes:** before applying for claims we must first check the CPT codes and for checking that we have some automated softwares.
6. **Payer approves or rejects the claim:** here the insurance company accepts the claims or rejects the claims and also sends the reasons of rejection with it.
7. **Denial from the insurance company:** There are three possibilities after applying the claims paid pending and denial . If the status is denied because of the reason that the insurance company doesn't cover that particular treatment then the insurance company should inform the patient about the money they owe to the provider.
8. **Follow up for the payment:** If the claim was approved then its good but if the payment is not received then make sure to follow up for the payment until the reimbursement is made.