Introduction to Health Insurance

CHAPTER OUTLINE

What Is Health Insurance?  |  Health Care Documentation
Health Insurance Coverage Statistics |  Electronic Health Record (EHR)
Major Developments in Health Insurance

OBJECTIVES

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

1. Define key terms.
2. State the difference between medical care and health care, as well as the difference between insurance and health insurance.
3. Discuss the significant events in health care reimbursement from 1850 to the present.
4. Interpret health insurance coverage statistics.
5. List and describe medical documentation concepts.
6. Discuss the advantages to implementing the electronic health record.

KEY TERMS

ambulatory payment classifications (APCs)  |  coinsurance  |  Evaluation and Management (E/M)
Balanced Budget Act of 1997 (BBA)  |  consumer-driven health plans (CDHPs)  |  Federal Employers’ Liability Act (FELA)
CHAMPUS Reform Initiative (CRI)  |  continuity of care  |  fee schedule
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)  |  copayment (copay)  |  Financial Services Modernization Act (FSMA)
Civilian Health and Medical Program—Uniformed Services (CHAMPUS)  |  deductible  |  Gramm-Leach-Bliley Act
Clinical Laboratory Improvement Act (CLIA)  |  diagnosis-related group (DRG)  |  group health insurance
CMS-1500  |  electronic health record (EHR)  |  health care
  |  electronic medical record (EMR)  |  Health Care and Education Reconciliation Act (HCERA)
  |  Employee Retirement Income Security Act of 1974 (ERISA)  |  

Copyright 2015 Cengage Learning. All Rights Reserved. May not be copied, scanned, or duplicated, in whole or in part. Due to electronic rights, some third party content may be suppressed from the eBook and/or eChapter(s). Editorial review has deemed that any suppressed content does not materially affect the overall learning experience. Cengage Learning reserves the right to remove additional content at any time if subsequent rights restrictions require it.
What is health insurance?

To understand the meaning of the term health insurance as used in this text, differentiation must be made between medical care and health care. Medical care includes the identification of disease and the provision of care and treatment to persons who are sick, injured, or concerned about their health status. Health care expands the definition of medical care to include preventive services, which are designed to help individuals avoid health and injury problems. Preventive examinations may result in the early detection of health problems, allowing less drastic and less expensive treatment options. Health care insurance or health insurance is a contract between a policyholder and a third-party payer or government health program to reimburse the policyholder for all or a portion of the cost of medically necessary treatment or preventive care provided by health care professionals. A policyholder is a person who signs a contract with
a health insurance company and who, thus, owns the health insurance policy. The policyholder is the insured (or enrollee). In some cases, the policy might include coverage for dependents. A third-party payer is a health insurance company that provides coverage, such as BlueCross BlueShield. Because both the government and the general public speak of “health insurance,” this text uses that term exclusively. Health insurance is available to individuals who participate in group (e.g., employer sponsored), individual (or personal insurance), or prepaid health plans (e.g., managed care). Chapters 12 to 17 of this textbook contain content about the following types of health insurance, including definitions, claims completion instructions, sample completed CMS-1500 claims, and so on:

- Commercial
- BlueCross BlueShield
- Medicare
- Medicaid
- TRICARE
- Workers’ Compensation

Employees who process patient registrations and insurance claims may be required to assist patients with information about copayments, coinsurance, and so on. For detailed information about the patient’s insurance coverage, it would be appropriate to refer the patient to their health insurance representative.

HEALTH INSURANCE COVERAGE STATISTICS

U.S. Census Bureau data from 2011 estimate that most people in the United States are covered by some form of health insurance:

- Approximately 64 percent are covered by private health insurance
- Approximately 55 percent are covered by employment-based plans

### GLOSSARY OF HEALTH INSURANCE TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group health insurance</td>
<td>Health insurance coverage subsidized by employers and other organizations (e.g., labor unions, rural and consumer health cooperatives). These plans distribute the cost of health insurance among group members so that the cost is typically less per person and broader coverage is provided than that offered through individual health insurance plans. The Patient Protection and Affordable Care Act of 2010 includes a small business health care tax credit to help small businesses and small tax-exempt organizations afford the cost of covering their employees.</td>
</tr>
<tr>
<td>Individual health insurance</td>
<td>Private health insurance policy purchased by individuals or families who do not have access to group health insurance coverage. Applicants can be denied coverage, and they can also be required to pay higher premiums due to age, gender, and/or pre-existing medical conditions.</td>
</tr>
<tr>
<td>Public health insurance</td>
<td>Federal and state government health programs (e.g., Medicare, Medicaid, SCHIP, TRICARE) available to eligible individuals.</td>
</tr>
<tr>
<td>Single-payer system</td>
<td>Centralized health care system adopted by some Western nations (e.g., Canada, Great Britain) and funded by taxes. The government pays for each resident’s health care, which is considered a basic social service.</td>
</tr>
<tr>
<td>Socialized medicine</td>
<td>A type of single-payer system in which the government owns and operates health care facilities and providers (e.g., physicians) receive salaries. The VA health care program is a form of socialized medicine.</td>
</tr>
<tr>
<td>Universal health insurance</td>
<td>The goal of providing every individual with access to health coverage, regardless of the system implemented to achieve that goal.</td>
</tr>
</tbody>
</table>
Approximately 32 percent are covered by government plans (e.g., Medicare, TRICARE)
Approximately 16.5 percent are covered by Medicaid

The reason the insurance coverage breakdown of covered persons is greater than 100 percent is because some people are covered by more than one insurance plan (e.g., employment-based plan plus Medicare). Thus, they are counted more than once when percentages are calculated.

MAJOR DEVELOPMENTS IN HEALTH INSURANCE

Since the early 1900s, when solo practices prevailed, managed care and group practices have increased in number, and health care services (like other aspects of society in this country) have undergone tremendous changes (Table 2-1 and Figure 2-1).

### TABLE 2-1 Significant events in health care reimbursement

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1850</td>
<td>First health insurance policy</td>
<td>The Franklin Health Assurance Company of Massachusetts was the first commercial insurance company in the United States to provide private health care coverage for injuries not resulting in death.</td>
</tr>
<tr>
<td>1908</td>
<td>FELA</td>
<td>President Theodore Roosevelt signed Federal Employers’ Liability Act (FELA) legislation that protects and compensates railroad workers who are injured on the job.</td>
</tr>
<tr>
<td>1916</td>
<td>FECA</td>
<td>The Federal Employees’ Compensation Act (FECA) provides civilian employees of the federal government with medical care, survivors’ benefits, and compensation for lost wages. The Office of Workers’ Compensation Programs (OWCP) administers FECA as well as the Longshore and Harbor Workers’ Compensation Act of 1927 and the Black Lung Benefits Reform Act of 1977.</td>
</tr>
<tr>
<td>1929</td>
<td>Blue Cross</td>
<td>Justin Ford Kimball, an official at Baylor University in Dallas, introduced a plan to guarantee school teachers 21 days of hospital care for $6 a year. Other groups of employees in Dallas joined, and the idea attracted national attention. This is generally considered the first Blue Cross plan.</td>
</tr>
<tr>
<td>1939</td>
<td>Blue Shield</td>
<td>The first Blue Shield plan was founded in California. The Blue Shield concept grew out of the lumber and mining camps of the Pacific Northwest at the turn of the century. Employers wanted to provide medical care for their workers, so they paid monthly fees to medical service bureaus, which were composed of groups of physicians.</td>
</tr>
<tr>
<td>1940</td>
<td>Group health insurance</td>
<td>To attract wartime labor during World War II, group health insurance was offered for the first time to full-time employees. The insurance was not subject to income or Social Security taxes, making it an attractive part of an employee benefit package. Group health insurance is health care coverage available through employers and other organizations (e.g., labor unions, rural and consumer health cooperatives); employers usually pay part or all of the premium costs.</td>
</tr>
<tr>
<td>1946</td>
<td>Hill-Burton Act</td>
<td>The Hill-Burton Act provided federal grants for modernizing hospitals that had become obsolete because of a lack of capital investment during the Great Depression and WWII (1929 to 1945). In return for federal funds, facilities were required to provide services free or at reduced rates to patients unable to pay for care.</td>
</tr>
<tr>
<td>1947</td>
<td>Taft-Hartley Act</td>
<td>The Taft-Hartley Act of 1947 amended the National Labor Relations Act of 1932, restoring a more balanced relationship between labor and management. An indirect result of Taft-Hartley was the creation of third-party administrators (TPAs), which administer health care plans and process claims, thus serving as a system of checks and balances for labor and management.</td>
</tr>
</tbody>
</table>

(continues)
<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1948</td>
<td>ICD</td>
<td>The World Health Organization (WHO) developed the International Classification of Diseases (ICD), a classification system used to collect data for statistical purposes.</td>
</tr>
<tr>
<td>1950</td>
<td>Major medical insurance</td>
<td>Insurance companies began offering major medical insurance, which provided coverage for catastrophic or prolonged illnesses and injuries. Most of these programs incorporate large deductibles and lifetime maximum amounts. A deductible is the amount for which the patient is financially responsible before an insurance policy provides payment. A lifetime maximum amount is the maximum benefits payable to a health plan participant.</td>
</tr>
<tr>
<td>1966</td>
<td>Medicare and Medicaid</td>
<td>Medicare (Title XVIII of the Social Security Amendments of 1965) provides health care services to Americans over the age of 65. (It was originally administered by the Social Security Administration.) Medicaid (Title XIX of the Social Security Amendments of 1965) is a cost-sharing program between the federal and state governments to provide health care services to low-income Americans. (It was originally administered by the Social and Rehabilitation Service [SRS].)</td>
</tr>
<tr>
<td>1966</td>
<td>CHAMPUS</td>
<td>Amendments to the Dependents’ Medical Care Act of 1956 created the Civilian Health and Medical Program–Uniformed Services (CHAMPUS), which was designed as a benefit for dependents of personnel serving in the armed forces as well as uniformed branches of the Public Health Service and the National Oceanic and Atmospheric Administration. The program is now called TRICARE.</td>
</tr>
<tr>
<td>1966</td>
<td>CPT</td>
<td>Current Procedural Terminology (CPT) was developed by the American Medical Association in 1966. Each year an annual publication is prepared, which includes changes that correspond to significant updates in medical technology and practice.</td>
</tr>
<tr>
<td>1970</td>
<td>Self-insured group health plans</td>
<td>Self-insured (or self-funded) employer-sponsored group health plans allow large employers to assume the financial risk for providing health care benefits to employees. The employer does not pay a fixed premium to a health insurance payer, but establishes a trust fund (of employer and employee contributions) out of which claims are paid.</td>
</tr>
<tr>
<td>1970</td>
<td>OSHA</td>
<td>The Occupational Safety and Health Administration Act of 1970 (OSHA) was designed to protect all employees against injuries from occupational hazards in the workplace.</td>
</tr>
<tr>
<td>1973</td>
<td>CHAMPVA</td>
<td>The Veterans Healthcare Expansion Act of 1973 authorized Veterans Affairs (VA) to establish the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) to provide health care benefits for dependents of veterans rated as 100 percent permanently and totally disabled as a result of service-connected conditions, veterans who died as a result of service-connected conditions, and veterans who died on duty with less than 30 days of active service.</td>
</tr>
<tr>
<td>1973</td>
<td>HMOs</td>
<td>The Health Maintenance Organization Assistance Act of 1973 authorized federal grants and loans to private organizations that wished to develop health maintenance organizations (HMOs), which are responsible for providing health care services to subscribers in a given geographic area for a fixed fee.</td>
</tr>
<tr>
<td>1974</td>
<td>ERISA</td>
<td>The Employee Retirement Income Security Act of 1974 (ERISA) mandated reporting and disclosure requirements for group life and health plans (including managed care plans), permitted large employers to self-insure employee health care benefits, and exempted large employers from taxes on health insurance premiums. A copayment (copay) is a provision in an insurance policy that requires the policyholder or patient to pay a specified dollar amount to a health care provider for each visit or medical service received. Coinsurance is the percentage of costs a patient shares with the health plan. For example, the plan pays 80 percent of costs and the patient pays 20 percent.</td>
</tr>
</tbody>
</table>
TABLE 2-1  (continued)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1977</td>
<td>HCFA</td>
<td>To combine health care financing and quality assurance programs into a single agency, the Health Care Financing Administration (HCFA) was formed within the Department of Health and Human Services (DHHS). The Medicare and Medicaid programs were also transferred to the newly created agency. (HCFA is now called the Centers for Medicare and Medicaid Services, or CMS.)</td>
</tr>
<tr>
<td>1980</td>
<td>DHHS</td>
<td>With the departure of the Office of Education, the Department of Health, Education and Welfare (HEW) became the Department of Health and Human Services (DHHS).</td>
</tr>
<tr>
<td>1981</td>
<td>OBRA</td>
<td>The Omnibus Budget Reconciliation Act of 1981 (OBRA) was federal legislation that expanded the Medicare and Medicaid programs.</td>
</tr>
<tr>
<td>1983</td>
<td>DRG</td>
<td>The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) created Medicare risk programs, which allowed federally qualified HMOs and competitive medical plans that met specified Medicare requirements to provide Medicare-covered services under a risk contract. TEFRA also enacted a prospective payment system (PPS), which issues a predetermined payment for inpatient services. Previously, reimbursement was generated on a per diem basis, which issued payment based on daily rates. The PPS implemented in 1983, called diagnosis-related groups (DRG), reimburses hospitals for inpatient stays.</td>
</tr>
<tr>
<td>1984</td>
<td>HCFA-1500</td>
<td>HCFA (now called CMS) required providers to use the HCFA-1500 (now called the CMS-1500) to submit Medicare claims. The HCFA Common Procedure Coding System (HCPCS) (now called Healthcare Common Procedure Coding System) was created, which included CPT, level II (national), and level III (local) codes. Commercial payers also adopted HCPCS coding and use of the HCFA-1500 claim.</td>
</tr>
<tr>
<td>1985</td>
<td>COBRA</td>
<td>The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows employees to continue health care coverage beyond the benefit termination date.</td>
</tr>
<tr>
<td>1988</td>
<td>TRICARE</td>
<td>The CHAMPUS Reform Initiative (CRI) of 1988 resulted in a new program, TRICARE, which includes options such as TRICARE Prime, TRICARE Extra, and TRICARE Standard. (Chapter 16 covers TRICARE claims processing.)</td>
</tr>
<tr>
<td>1988</td>
<td>CLIA</td>
<td>Clinical Laboratory Improvement Act (CLIA) legislation established quality standards for all laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test was performed. The Medicare Catastrophic Coverage Act mandated the reporting of ICD-9-CM (now ICD-10-CM) diagnosis codes on Medicare claims; in subsequent years, private third-party payers adopted similar requirements for claims submission.</td>
</tr>
<tr>
<td>1991</td>
<td>CPT E/M codes</td>
<td>The American Medical Association (AMA) and HCFA (now called CMS) implemented major revisions of CPT, creating a new section called Evaluation and Management (E/M), which describes patient encounters with providers for the purpose of evaluation and management of general health status.</td>
</tr>
<tr>
<td>1992</td>
<td>RBRVS</td>
<td>A new fee schedule for Medicare services was implemented as part of the Omnibus Reconciliation Acts (OBRA) of 1989 and 1990, which replaced the regional “usual and reasonable” payment basis with a fixed fee schedule calculated according to the Resource-Based Relative Value Scale (RBRVS) system. The RBRVS payment system reimburses physicians’ practice expenses based on relative values for three components of each physician’s service: physician work, practice expense, and malpractice insurance expense. Usual and reasonable payments were based on fees typically charged by providers according to specialty within a particular region of the country. A fee schedule is a list of predetermined payments for health care services provided to patients (e.g., a fee is assigned to each CPT code). The patient pays a copayment or coinsurance amount for services rendered, the payer reimburses the provider according to its fee schedule, and the remainder is a “write off” (or loss).</td>
</tr>
</tbody>
</table>

(continues)
### TABLE 2-1  (continued)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>RBRVS (continued)</td>
<td><strong>EXAMPLE:</strong> A patient received preventive care evaluation and management services from his family practitioner. The total charges were $125, and the patient paid a $20 copayment during the office visit. The third-party payer reimbursed the physician the fee schedule amount of $75. The remaining $30 owed is recorded as a loss (write off) for the business.</td>
</tr>
<tr>
<td>1996</td>
<td>NCCI</td>
<td>The National Correct Coding Initiative (NCCI) was created to promote national correct coding methodologies and to eliminate improper coding. NCCI edits are developed based on coding conventions defined in the American Medical Association’s Current Procedural Terminology (CPT) manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.</td>
</tr>
<tr>
<td>1996</td>
<td>HIPAA</td>
<td>The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates regulations that govern privacy, security, and electronic transactions standards for health care information. The primary intent of HIPAA is to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs.</td>
</tr>
<tr>
<td>1997</td>
<td>SCHIP</td>
<td>The Balanced Budget Act of 1997 (BBA) addresses health care fraud and abuse issues. The DHHS Office of the Inspector General (OIG) provides investigative and audit services in health care fraud cases. The State Children’s Health Insurance Program (SCHIP) was also established to provide health assistance to uninsured, low-income children, either through separate programs or through expanded eligibility under state Medicaid programs.</td>
</tr>
<tr>
<td>1998</td>
<td>SNF PPS</td>
<td>The Skilled Nursing Facility Prospective Payment System (SNF PPS) is implemented (as a result of the BBA of 1997) to cover all costs (routine, ancillary, and capital) related to services furnished to Medicare Part A beneficiaries. The SNF PPS generates per diem payments for each admission; these payments are case-mix adjusted using a resident classification system called Resource Utilization Groups (RUGs), which is based on data collected from resident assessments (using data elements called the Minimum Data Set (MDS)) and relative weights developed from staff time data.</td>
</tr>
<tr>
<td>1999</td>
<td>HH PPS</td>
<td>The Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCE-SAA) of 1999 amended the BBA of 1997 to require the development and implementation of a Home Health Prospective Payment System (HH PPS), which reimburses home health agencies at a predetermined rate for health care services provided to patients. The HH PPS was implemented October 1, 2000, and uses the Outcomes and Assessment Information Set (OASIS), a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.</td>
</tr>
<tr>
<td>1999</td>
<td>FSMA</td>
<td>The Financial Services Modernization Act (FSMA) (or Gramm–Leach–Bliley Act) prohibits sharing of medical information among health insurers and other financial institutions for use in making credit decisions.</td>
</tr>
</tbody>
</table>
Chapter 2

2000 OPPS The Outpatient Prospective Payment System (OPPS), which uses Ambulatory Payment Classifications (APCs) to calculate reimbursement, is implemented for billing of hospital-based Medicare outpatient claims.

BIPA The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required implementation of a $400 billion prescription drug benefit, improved Medicare Advantage (formerly called Medicare+Choice) benefits, required faster Medicare appeals decisions, and more.

CDHPs Consumer-driven health plans (CDHPs) are introduced as a way to encourage individuals to locate the best health care at the lowest possible price with the goal of holding down health care costs. These plans are organized into three categories:
1. Employer-paid high-deductible insurance plans with special health spending accounts to be used by employees to cover deductibles and other medical costs when covered amounts are exceeded.
2. Defined contribution plans, which provide a selection of insurance options; employees pay the difference between what the employer pays and the actual cost of the plan they select.
3. After-tax savings accounts, which combine a traditional health insurance plan for major medical expenses with a savings account that the employee uses to pay for routine care.

2001 CMS On June 14, 2001, the Centers for Medicare and Medicaid Services (CMS) became the new name for the Health Care Financing Administration (HCFA).

2002 IRF PPS The Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) is implemented (as a result of the BBA of 1997), which utilizes information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case- and facility-level adjustments.

QIOs CMS announced that quality improvement organizations (QIOs) will perform utilization and quality control review of health care furnished, or to be furnished, to Medicare beneficiaries. QIOs replaced peer review organizations (PROs), which previously performed this function.

EIN The employer identification number (EIN), assigned by the Internal Revenue Service (IRS), is adopted by DHHS as the National Employer Identification Standard for use in health care transactions.

2003 MMA The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) adds new prescription drug and preventive benefits, provides extra assistance to people with low incomes, and calls for implementation of a Medicare contracting reform (MCR) initiative to improve and modernize the Medicare fee-for-service system and to establish a competitive bidding process to appoint MACs. The Recovery Audit Contractor (RAC) program was also created to identify and recover improper Medicare payments paid to health care providers under fee-for-service Medicare plans. (RAC program details are in Chapter 5 of this textbook.)

MCR The Medicare contracting reform (MCR) initiative was established to integrate the administration of Medicare Parts A and B fee-for-service benefits with new entities called Medicare administrative contractors (MACs). MACs replaced Medicare carriers, DMERCS, and fiscal intermediaries to improve and modernize the Medicare fee-for-service system and establish a competitive bidding process for contracts.

TABLE 2-1 (continued)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>OPPS</td>
<td>The Outpatient Prospective Payment System (OPPS), which uses Ambulatory Payment Classifications (APCs) to calculate reimbursement, is implemented for billing of hospital-based Medicare outpatient claims.</td>
</tr>
<tr>
<td>2000</td>
<td>BIPA</td>
<td>The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required implementation of a $400 billion prescription drug benefit, improved Medicare Advantage (formerly called Medicare+Choice) benefits, required faster Medicare appeals decisions, and more.</td>
</tr>
<tr>
<td>2000</td>
<td>CDHPs</td>
<td>Consumer-driven health plans (CDHPs) are introduced as a way to encourage individuals to locate the best health care at the lowest possible price with the goal of holding down health care costs. These plans are organized into three categories: 1. Employer-paid high-deductible insurance plans with special health spending accounts to be used by employees to cover deductibles and other medical costs when covered amounts are exceeded. 2. Defined contribution plans, which provide a selection of insurance options; employees pay the difference between what the employer pays and the actual cost of the plan they select. 3. After-tax savings accounts, which combine a traditional health insurance plan for major medical expenses with a savings account that the employee uses to pay for routine care.</td>
</tr>
<tr>
<td>2001</td>
<td>CMS</td>
<td>On June 14, 2001, the Centers for Medicare and Medicaid Services (CMS) became the new name for the Health Care Financing Administration (HCFA).</td>
</tr>
<tr>
<td>2002</td>
<td>IRF PPS</td>
<td>The Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) is implemented (as a result of the BBA of 1997), which utilizes information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case- and facility-level adjustments.</td>
</tr>
<tr>
<td>2002</td>
<td>QIOs</td>
<td>CMS announced that quality improvement organizations (QIOs) will perform utilization and quality control review of health care furnished, or to be furnished, to Medicare beneficiaries. QIOs replaced peer review organizations (PROs), which previously performed this function.</td>
</tr>
<tr>
<td>2002</td>
<td>EIN</td>
<td>The employer identification number (EIN), assigned by the Internal Revenue Service (IRS), is adopted by DHHS as the National Employer Identification Standard for use in health care transactions.</td>
</tr>
<tr>
<td>2003</td>
<td>MMA</td>
<td>The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) adds new prescription drug and preventive benefits, provides extra assistance to people with low incomes, and calls for implementation of a Medicare contracting reform (MCR) initiative to improve and modernize the Medicare fee-for-service system and to establish a competitive bidding process to appoint MACs. The Recovery Audit Contractor (RAC) program was also created to identify and recover improper Medicare payments paid to health care providers under fee-for-service Medicare plans. (RAC program details are in Chapter 5 of this textbook.)</td>
</tr>
<tr>
<td>2003</td>
<td>MCR</td>
<td>The Medicare contracting reform (MCR) initiative was established to integrate the administration of Medicare Parts A and B fee-for-service benefits with new entities called Medicare administrative contractors (MACs). MACs replaced Medicare carriers, DMERCS, and fiscal intermediaries to improve and modernize the Medicare fee-for-service system and establish a competitive bidding process for contracts.</td>
</tr>
</tbody>
</table>

(continues)
### TABLE 2-1 (continued)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>IPF PPS</td>
<td>The Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) is implemented as a requirement of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). The IPF PPS includes a patient classification system that reflects differences in patient resource use and costs; the new system replaces the cost-based payment system with a per diem IPF PPS. About 1,800 inpatient psychiatric facilities, including freestanding psychiatric hospitals and certified psychiatric units in general acute care hospitals, are impacted.</td>
</tr>
<tr>
<td>2009</td>
<td>NPI</td>
<td>The Standard Unique Health Identifier for Health Care Providers, or National Provider Identifier (NPI), is implemented.</td>
</tr>
<tr>
<td>2009</td>
<td>ARRA</td>
<td>The American Recovery and Reinvestment Act of 2009 (ARRA) authorized an expenditure of $1.5 billion for grants for construction, renovation, and equipment, and for the acquisition of health information technology systems. DHHS established electronic health record (EHR) meaningful use objectives and measures during three stages to achieve the goal of improved patient care outcomes and delivery as well as data capture and sharing (2011–2012), advance clinical processes (2014), and improved outcomes (2016). Effective 2011, Medicare provided annual incentives to physicians and group practices for being a “meaningful EHR user”; Medicare will ultimately decrease Medicare Part B payments to physicians who are eligible to be, but fail to become, “meaningful EHR users.”</td>
</tr>
<tr>
<td>2010</td>
<td>HITECH Act</td>
<td>The Health Information Technology for Economic and Clinical Health Act (HITECH Act) (included in American Recovery and Reinvestment Act of 2009) amended the Public Health Service Act to establish an Office of National Coordinator for Health Information Technology (ONC) within HHS to improve health care quality, safety, and efficiency. HealthIT rules and regulations include the CLIA Program and HIPAA Privacy, Patients’ Access to Test Reports (amending CLIA of 1988 to specify that a laboratory may provide patient access to completed test reports that, using the laboratory’s authentication process, can be identified as belonging to that patient); HIPAA Privacy, Security, and Enforcement Rules modifications; HITECH Breach Notification; Standards and Certification Criteria for Electronic Health Records; and Meaningful Use of Electronic Health Records.</td>
</tr>
<tr>
<td>2010</td>
<td>PPACA</td>
<td>The Patient Protection and Affordable Care Act (PPACA) focuses on private health insurance reform to provide better coverage for individuals with pre-existing conditions, improve prescription drug coverage under Medicare, and extend the life of the Medicare Trust fund by at least 12 years. Its goal is to provide quality affordable health care for Americans, improve the role of public programs, improve the quality and efficiency of health care, and improve public health. Americans will purchase health coverage that fits their budget and meets their needs by accessing the health insurance marketplace (or health insurance exchange) in their state. Individuals complete one application that allows them to view all options and enroll. Individuals will be able to determine if they can lower the costs of current monthly premiums for private insurance plans and qualify for lower out-of-pocket costs. The marketplace also indicates if individuals qualify for free or low-cost coverage available through Medicaid or the Children’s Health Insurance Program (CHIP). Open enrollment began October 1, 2013, for coverage effective January 1, 2014. PPACA also amended the time period for filing Medicare fee-for-service (FFS) claims to one calendar year after the date of service. PPACA resulted in creation of risk adjustment, reinsurance, and risk corridors programs to help ensure that insurance plans compete on the basis of quality and service (and not on the basis of attracting the healthiest individuals). The result is improved coverage so that consumers—whether they are healthy or sick—can select the best plan for their needs.</td>
</tr>
</tbody>
</table>
Chapter 2

Health care providers are responsible for documenting and authenticating legible, complete, and timely patient records in accordance with federal regulations (e.g., Medicare Conditions of Participation) and accrediting agency standards (e.g., The Joint Commission). The provider is also responsible for correcting or altering errors in patient record documentation. A patient record (or medical record) documents health care services provided to a patient and includes patient demographic (or identification) data, documentation to support diagnoses and justify treatment provided, and the results of treatment provided. The primary purpose of the record is to provide for continuity of care, which involves documenting patient care services so that others who treat the patient have a source of information to assist with additional care and treatment. The record also serves as a communication tool for physicians and other patient care professionals, and assists in planning individual patient care and documenting a patient’s illness and treatment.

Secondary purposes of the record do not relate directly to patient care and include:

- Evaluating the quality of patient care
- Providing data for use in clinical research, epidemiology studies, education, public policy making, facilities planning, and health care statistics

### TABLE 2-1 (continued)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>HCERA</td>
<td>The Health Care and Education Reconciliation Act (HCERA) amended the PPACA to implement health care reform initiatives, such as increasing tax credits to buy health care insurance, eliminating special deals provided to senators, closing the Medicare “donut hole,” delaying taxes on “Cadillac health care plans” until 2018, implementing revenue changes (e.g., 10 percent tax on indoor tanning services effective 2010), and so on. HCERA also modified higher education assistance provisions, such as implementing student loan reform.</td>
</tr>
</tbody>
</table>
| 2011 | i2 Initiative | The Investing in Innovations (i2) Initiative is designed to spur innovations in health information technology (health IT) by promoting research and development to enhance competitiveness in the United States. Examples of health IT competition topics include applications that:
  - Allow an individual to securely and effectively share health information with members of his or her social network
  - Generate results for patients, caregivers, and/or clinicians by providing them with access to rigorous and relevant information that can support real needs and immediate decisions
  - Allow individuals to connect during natural disasters and other periods of emergency
  - Facilitate the exchange of health information while allowing individuals to customize the privacy allowances for their personal health records |
| 2012 | ACOs | Accountable care organizations (ACOs) help physicians, hospitals, and other health care providers work together to improve care for people with Medicare. Under the new Medicare Shared Savings Program (Shared Savings Program), 27 ACOs entered into agreements with CMS, taking responsibility for the quality of care furnished to Medicare beneficiaries in return for the opportunity to share in savings realized through improved care. The Shared Savings Program and other initiatives related to ACOs were made possible by the PPACA (Affordable Care Act) of 2010. Participation in an ACO is purely voluntary for providers and beneficiaries, and Medicare beneficiaries retain their current ability to seek treatment from any provider they wish. |
In a teaching hospital, general documentation guidelines allow both residents and teaching physicians to document physician services in the patient’s medical record.

- A teaching hospital participates in an approved Graduate Medical Education Residency Program in medicine, osteopathy, dentistry, or podiatry.
- A teaching physician is a physician, other than an intern or resident, who involves residents in patient’s care. Generally, the teaching physician must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire service (for services to be payable under the Medical Physician Fee Schedule).

Documentation in the patient record serves as the basis for coding. The information in the record must support codes submitted on claims for third-party payer reimbursement processing. The patient’s diagnosis must also justify diagnostic and/or therapeutic procedures or services provided. This is called medical necessity and requires providers to document services or supplies that are:

- Proper and needed for the diagnosis or treatment of a medical condition
- Provided for the diagnosis, direct care, and treatment of a medical condition
Chapter 2

- Consistent with standards of good medical practice in the local area
- Not mainly for the convenience of the physician, patient, or health care facility

It is important to remember the familiar phrase “If it wasn’t documented, it wasn’t done.” The patient record serves as a medico-legal document and a business record. If a provider performs a service but does not document it, the patient (or third-party payer) can refuse to pay for that service, resulting in lost revenue for the provider. In addition, because the patient record serves as an excellent defense of the quality of care administered to a patient, missing documentation can result in problems if the record has to be admitted as evidence in a court of law.

**EXAMPLE:**

**Missing Documentation:** A representative from XYZ Insurance Company reviewed 100 outpatient claims submitted by the Medical Center to ensure that all services billed were documented in the patient records. Upon reconciliation of claims with patient record documentation, the representative denied payment for 13 services (totaling $14,000) because reports of the services billed were not found in the patient records. The facility must pay back the $14,000 it received from the payer as reimbursement for the claims submitted.

**Lack of Medical Necessity:** The patient underwent an x-ray of his right knee, and the provider documented “severe right shoulder pain” in the record. The coder assigned a CPT code to the “right knee x-ray” and an ICD-10-CM code to the “right shoulder pain.” In this example, the third-party payer will deny reimbursement for the submitted claim because the reason for the x-ray (shoulder pain) does not match the type of x-ray performed. For medical necessity, the provider should have documented a diagnosis such as “right knee pain.”

**Support of Medical Necessity:** The patient underwent a chest x-ray, and the provider documented “severe shortness of breath” in the record. The coder assigned a CPT code to “chest x-ray” and an ICD-10-CM code to “severe shortness of breath.” In this example, the third-party payer will reimburse the provider for services rendered because medical necessity for performing the procedure has been shown.

**Problem-Oriented Record (POR)**

The problem-oriented record (POR) is a systematic method of documentation that consists of four components:

- Database
- Problem list
- Initial plan
- Progress notes

The POR database contains the following information collected on each patient:

- Chief complaint
- Present conditions and diagnoses
- Social data
- Past, personal, medical, and social history
- Review of systems
- Physical examination
- Baseline laboratory data

The POR problem list serves as a table of contents for the patient record because it is filed at the beginning of the record and contains a numbered list of the patient’s problems, which helps to index documentation throughout the record.

The POR initial plan contains the strategy for managing patient care, as well as any actions taken to investigate the patient’s condition and to treat and educate him or her. The initial plan consists of three categories:

- Diagnostic/management plans (plans to learn more about the patient’s condition and the management of the conditions)
- Therapeutic plans (specific medications, goals, procedures, therapies, and treatments used to treat the patient)
- Patient education plans (plans to educate the patient about conditions for which he or she is being treated)

The POR progress notes are documented for each problem assigned to the patient, using the SOAP format:

- Subjective (S) (patient’s statement about how he or she feels, including symptomatic information [e.g., “I have a headache”])
- Objective (O) (observations about the patient, such as physical findings, or lab or x-ray results [e.g., chest x-ray negative])
- Assessment (A) (judgment, opinion, or evaluation made by the health care provider [e.g., acute headache])
- Plan (P) (diagnostic, therapeutic, and education plans to resolve the problems [e.g., patient to take Tylenol as needed for pain])

**ELECTRONIC HEALTH RECORD (EHR)**

Although the terms electronic health record (EHR) and electronic medical record (EMR) are often used interchangeably, the electronic health record (EHR) is a more global concept that includes the collection of patient information documented by a number of providers at different facilities regarding one patient. The EHR uses multidisciplinary (many specialties) and multi-enterprise (many facilities) recordkeeping approaches to facilitate record linkage, which allows patient information to be created at different locations according to a unique patient identifier or identification number. The electronic health record:

- Provides access to complete and accurate patient health problems, status, and treatment data
- Allows access to evidence-based decision support tools (e.g., drug interaction alerts) that assist providers with decision making
- Automates and streamlines a provider’s workflow, ensuring that all clinical information is communicated
- Prevents delays in health care response that result in gaps in care (e.g., automated prescription renewal notices)
- Supports the collection of data for uses other than clinical care (e.g., billing, outcome reporting, public health disease surveillance/reporting, and quality management)

**NOTE:** Some disadvantages of the EHR include concerns about initial purchase costs, direct and indirect training costs, and ongoing maintenance costs; issues of privacy and security expressed by patients and providers; and the possibility that evaluation and management elements not actually performed during an encounter will be automatically documented (populated) by the software.
The electronic medical record (EMR) has a more narrow focus because it is the patient record created for a single medical practice using a computer, keyboard, mouse, optical pen device, voice recognition system, scanner, and/or touch screen. The electronic medical record:

- Includes a patient’s medication lists, problem lists, clinical notes, and other documentation
- Allows providers to prescribe medications, as well as order and view results of ancillary tests (e.g., laboratory, radiology)
- Alerts the provider about drug interactions, abnormal ancillary testing results, and when ancillary tests are needed

Total practice management software (TPMS) (Figure 2-2) is used to generate the EMR, automating the following medical practice functions:

- Registering patients
- Scheduling appointments
- Generating insurance claims and patient statements
- Processing payments from patient and third-party payers
- Producing administrative and clinical reports

Physician Incentive Payments for “Meaningful EHR Users”

Effective 2011, Medicare provides annual incentives to physicians and group practices for being a meaningful EHR user, which is defined by Medicare as:

- Physicians who demonstrate that certified EHR technology is used for the purposes of electronic prescribing, electronic exchange of health information in accordance with law and health information technology (HIT) standards, and submission of information on clinical quality measures (Table 2-2)
- Hospitals that demonstrate that certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care (e.g., promoting care coordination) and that certified EHR technology is used to submit information on clinical quality measures according to stages of meaningful use (objectives and measures that achieve goals of improved patient care outcomes and delivery through data capture and sharing, advance clinical processes, and improved patient outcomes) (Table 2-3)

The secretary of the Department of Health and Human Services determines whether physicians and hospitals have satisfactorily demonstrated “meaningful EHR use,” and the secretary also selects criteria upon which clinical quality measures are based.

Meaningful Use Measures

The American Recovery and Reinvestment Act (ARRA), enacted in 2009, implemented measures to modernize the nation’s infrastructure, including the Health Information Technology for Economic and Clinical Health (HITECH) Act, which supports the concept of EHRs/meaningful use. Meaningful use requires the use of certified EHR technology in a meaningful manner (e.g., electronic prescribing) to ensure that certified EHR technology is connected so as to provide for the electronic exchange of health information to improve the quality of care.
FIGURE 2-2 Total practice management software (TPMS) data flow.
Health care providers that use certified EHR technology must submit information about quality of care and other measures to the Secretary of Health and Human Services (HHS). The concept of meaningful use includes the following health outcomes policy priorities:

- Engaging patients and families in their health
- Ensuring adequate privacy and security protection for personal health information
- Improving care coordination
- Improving population and public health
- Improving quality, safety, and efficiency and reducing health disparities

CMS implemented an incentive payment to eligible professionals (EPs) and eligible hospitals (EHs) that demonstrate they have engaged in efforts to adopt, implement, or upgrade certified EHR technology. To encourage widespread EHR implementation.
TABLE 2-4 Reduction in Medicare Part B payments to providers who do not implement an EHR

<table>
<thead>
<tr>
<th>Year</th>
<th>Reduction in Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>1% if physician is an e-prescriber</td>
</tr>
<tr>
<td></td>
<td>2% if physician is not an e-prescriber</td>
</tr>
<tr>
<td>2016</td>
<td>2%</td>
</tr>
<tr>
<td>2017 and later</td>
<td>3%</td>
</tr>
</tbody>
</table>

Physician Payment Reductions for Non-EHR Use

Physicians will receive decreased Medicare Part B payments beginning in 2015 if they were eligible to be “meaningful EHR users” by 2015 but did not implement an electronic health record (EHR) (Table 2-4). After 2017, Medicare Part B payments may be reduced an additional 1 percent for each year in which less than 75 percent of physicians eligible to be “meaningful EHR users” are using electronic health records. The maximum Medicare Part B payment decrease is 5 percent, and the DHHS may exempt physicians for whom becoming a “meaningful EHR user” would be a “significant hardship.” Such an exemption will end after five years.

SUMMARY

Health insurance is a contract between a policyholder and a third-party payer or government program for the purpose of providing reimbursement of all or a portion of medical and health care costs.

The history of health care reimbursement can be traced back to 1850, when the Franklin Health Assurance Company of Massachusetts wrote the first health insurance policy. Subsequent years, through the present, have seen significant changes and advances in health care insurance and reimbursement, from the development of the first BlueCross and BlueShield plans to legislation that resulted in government health care programs (e.g., to cover individuals age 65 and older), payment systems to control health care costs (e.g., diagnosis-related groups), and regulations to govern privacy, security, and electronic transaction standards for health care information.

A patient record (or medical record) documents health care services provided to a patient, and health care providers are responsible for documenting and authenticating legible, complete, and timely entries according to federal regulations and accreditation standards. The records include patient demographic (or identification) data, documentation to support diagnoses and justify treatment provided, and the results of treatment provided. The primary purpose of the record is to provide for continuity of care, which involves documenting patient care services so that others who treat the patient have a source of information to assist with additional care and treatment. The problem-oriented record (POR) is a systematic method of documentation that consists of four components: database, problem list, initial plan, and progress notes (documented using the SOAP format).
The electronic health record (EHR) is a global concept (as compared with the EMR) that includes the collection of patient information documented by a number of providers at different facilities regarding one patient. The EHR uses multidisciplinary (many specialties) and multi-enterprise (many facilities) recordkeeping approaches to facilitate record linkage, which allows patient information to be created at different locations according to a unique patient identifier or identification number. The personal health record (PHR) is a web-based application that allows individuals to maintain and manage their health information (and that of others for whom they are authorized, such as family members) in a private, secure, and confidential environment. The electronic medical record (EMR) has a more narrow focus (as compared with the EHR) because it is the patient record created for a single medical practice and uses total practice management software (TPMS) to generate the EMR and automate medical practice functions.

**INTERNET LINKS**

- Consolidated Omnibus Budget Reconciliation Act (COBRA)
  Go to [www.cobrainsurance.com](http://www.cobrainsurance.com) to learn more about COBRA.

- Healthcare Insurance Marketplace—Taking health care into your own hands
  Go to [www.healthcare.gov](http://www.healthcare.gov) to shop for health insurance that meets your needs.

- InteliHealth—In partnership with the Harvard Medical School to provide clinically accurate and relevant medical content
  Go to [www.intelihealth.com](http://www.intelihealth.com), and click on Look It Up to explore the website’s health care resources.

- THOMAS (Library of Congress)
  Go to [http://thomas.loc.gov](http://thomas.loc.gov) and browse House of Representatives and Senate bills to determine their current status. (The name THOMAS was selected “in the spirit of Thomas Jefferson” to provide legislative information available from the Library of Congress.)

**STUDY CHECKLIST**

- Read this textbook chapter and highlight key concepts.
- Create an index card for each key term.
- Access the chapter Internet links to learn more about concepts.
- Answer the chapter review questions, verifying answers with your instructor.
- Complete the 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. Which was the first commercial insurance company in the United States to provide private health care coverage for injuries not resulting in death?
   a. Baylor University Health Plan
   b. BlueCross and BlueShield Association
   c. Franklin Health Assurance Company
   d. Office of Workers’ Compensation Program
2. Which replaced the 1908 workers’ compensation legislation and provided civilian employees of the federal government with medical care, survivors’ benefits, and compensation for lost wages?
   a. Black Lung Benefits Reform Act
   b. Federal Employees’ Compensation Act
   c. Longshore and Harbor Workers’ Compensation Act
   d. Office of Workers’ Compensation Programs

3. The first Blue Cross policy was introduced by
   a. Baylor University in Dallas, Texas.
   b. Harvard University in Cambridge, Massachusetts.
   c. Kaiser Permanente in Los Angeles, California.
   d. American Medical Association representatives.

4. The Blue Shield concept grew out of the lumber and mining camps of the _____ region at the turn of the century.
   a. Great Plains
   b. New England
   c. Pacific Northwest
   d. Southwest

5. Health care coverage offered by _____ is called group health insurance.
   a. a state
   b. CMS
   c. employees
   d. employers

6. The Hill-Burton Act provided federal grants for modernizing hospitals that had become obsolete because of a lack of capital investment during the Great Depression and WWII (1929 to 1945). In return for federal funds,
   a. facilities were required to provide services free or at reduced rates to patients unable to pay for care.
   b. medical group practices were formed to allow providers to share equipment, supplies, and personnel.
   c. national coordinating agencies for physician-sponsored health insurance plans were created.
   d. universal health insurance was provided to those who could not afford private insurance.

7. Third-party administrators (TPAs) administer health care plans and process claims, serving as a
   a. clearinghouse for data submitted by government agencies.
   b. Medicare administrative contractor (MAC) for business owners.
   c. system of checks and balances for labor and management.
   d. third-party payer (insurance company) for employers.

8. Major medical insurance provides coverage for ____ illnesses and injuries, incorporating large deductibles and lifetime maximum amounts.
   a. acute care (short-term)
   b. catastrophic or prolonged
   c. recently diagnosed
   d. work-related

9. The government health plan that provides health care services to Americans over the age of 65 is called
   a. Medicare.
   b. Medicaid.
   c. CHAMPUS.
   d. TRICARE.
10. The percentage of costs a patient shares with the health plan (e.g., plan pays 80 percent of costs and patient pays 20 percent) is called  
   a. coinsurance.  
   b. copayment.  
   c. deductible.  
   d. maximum.

   a. ambulatory payment classifications  
   b. diagnosis-related groups  
   c. fee-for-service reimbursement  
   d. resource-based relative value scale system

12. The Clinical Laboratory Improvement Act (CLIA) established quality standards for all laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results.  
   a. only at hospitals and other large institutions.  
   b. regardless of where the test was performed.

13. The National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and eliminates improper coding. NCCI edits are developed based on coding conventions defined in ____ , current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.  
   a. CPT  
   b. ICD-10-CM  
   c. HCPCS level II  
   d. NDC

14. The primary intent of HIPAA legislation is to  
   a. combine health care financing and quality assurance programs into a single agency.  
   b. create better access to health insurance, limit fraud and abuse, and reduce administrative costs.  
   c. provide health assistance to uninsured, low-income children by expanding the Medicaid program.  
   d. protect all employees against injuries from occupational hazards in the workplace.

15. Effective 2002, the utilization and quality control review of health care furnished, or to be furnished, to Medicare beneficiaries is performed by  
   a. consumer-driven health plans.  
   b. peer review organizations.  
   c. professional standards review organizations.  
   d. quality improvement organizations.

16. Which is a primary purpose of the patient record?  
   a. ensure continuity of care  
   b. evaluate quality of care  
   c. provide data for use in research  
   d. submit data to third-party payers

17. The problem-oriented record (POR) includes the following four components:  
   a. chief complaint, review of systems, physical examination, laboratory data  
   b. database, problem list, initial plan, progress notes  
   c. diagnostic plans, management plans, therapeutic plans, patient education plans  
   d. subjective, objective, assessment, plan
18. The electronic health record (EHR) allows patient information to be created at different locations according to a unique patient identifier or identification number, which is called
a. evidence-based decision support.
b. health data management.
c. record linkage.
d. surveillance and reporting.

19. When a patient states, “I haven’t been able to sleep for weeks,” the provider who uses the SOAP format documents that statement in the _____ portion of the clinic note.
   a. assessment
   b. objective
   c. plan
   d. subjective

20. The provider who uses the SOAP format documents the physical examination in the _____ portion of the clinic note.
   a. assessment
   b. objective
   c. plan
   d. subjective