

COURSE OUTLINE **Medical Billing/Coding**

Course Description

BE 125. Medical Billing/Coding. 3 hours credit. Prerequisite: IS 201 with a C or better or concurrent enrollment. This course will enable the student to develop a basic knowledge of the national diagnostic and procedural coding systems and to simplify the process of filing claim forms. The student will be introduced to the major nationwide medical insurance programs.

Course Relevance

The applications learned in this course will allow the student to effectively utilize current CPT and ICD-9-CM codes in medical billing and complete CMS-1500 medical claim forms. The applications and principles learned in this course are relevant to a career in billing in the medical office. There is a high demand for qualified individuals in the medical billing and coding field.

Required Materials

Green, R. (2008) *Understanding health insurance, a guide to professional billing*, (9th ed.), Albany, NY: Delmar Publishers.

Covell, A. (2009) *2009 Coding workbook for the physician's office*, Albany, NY: Delmar Publishers.

American Medical Association. *Physician's current procedural terminology (CPT)* (current edition)

American Medical Association. *International classification of disease-Clinical modifications (ICD-9-CM)*. (9th Revision). (current edition)

Medical Dictionary

Learning Outcomes

The intention is for the student to be able to

1. Identify the different insurance agencies both private and government sponsored
2. Demonstrate the procedures for filing claims to the different insurance agencies
3. Assign appropriate codes to various procedures and diagnoses

Learning PACT Skills that will be DEVELOPED and/or documented in this course

Through the student's involvement in this course, he/she will develop his/her ability in the following PACT skill areas:

Personal Development Skills

Personal Management

- Through prioritizing classroom tasks, and completing assignments according to the course schedule, the student will demonstrate time management skills.

Analytical Thinking Skills

1. Critical Thinking

- Through applying skills learned in the textbook and class presentations, the student will use these skills to properly code CPT and ICD-9 diagnoses and procedures

Major Summative Assessment Task(s)

These learning outcomes and the Learning PACT skills will be demonstrated by

1. Completing a final project demonstrating the proper assignment of CPT and ICD-9 codes depending on the diagnoses/procedures for both private and government sponsored insurance agencies

Course Content

- I. Themes – Key recurring concepts that run throughout this course:
 - A. Proper use and understanding of CPT and ICD-9-CM manuals
 - B. Proper use of software
 - C. Personal development skills
- II. Issues – Key areas of conflict that must be understood in order to achieve the intended outcome:
 - A. Reading comprehension
 - B. Following instructions
 - C. Completing tasks to the degree of approval
- III. Concepts – Key concepts that must be understood to address the issues:
 - A. Role of the health insurance specialist
 - B. Overall fundamental understanding of the health care system
 - C. Legal and regulatory considerations of medical billing/coding
 - D. Basics of ICD-9 and CPT coding
- IV. Skills/Competencies – Actions that are essential to achieve the course outcomes:
 - A. Demonstrate a basic understanding of a health insurance specialist—role and responsibilities
 1. Define coding
 2. Identify professional organizations
 3. Identify basic and personal skill requirements for aspiring health insurance specialists
 4. List new career paths for health insurance specialists
 5. Explain why there are increasing employment opportunities for health insurance specialists
 6. Define the following terms: CPT-4, HCPCS, AAPC, ICD, ACAP.
 7. Define "hold harmless clause"
 8. List responsibilities of health insurance specialists
 9. Explain effect of managed care contract on a physician's practice
 10. List the skills necessary to be a good coder
 11. Explain effect of managed care contract on a physician's practice

12. List the skills necessary to be a good coder
- B. Demonstrate a basic understanding of health insurance
1. Define the following terms: HIPAA, copayment, APCs, PlanID, PMPM payment, CMS-1500, NPI, HCPCS, HMO, CCI
 2. Define health insurance
 3. Define coinsurance
 4. Explain the difference between CHAMPUS and TRICARE
 5. Define the terms: fee for service, per capita, global surgical fees
 6. List the major coding systems in the US
 7. Define disability insurance
 8. Define liability insurance
 9. Define the terms: deductible, global surgery fee payments
 10. Explain what is included in preventive services
 11. Define group practice according to AMA
 12. Explain HCFA requirements for submitting Medicare claims
 13. Explain HIPAA's requirements
- C. Demonstrate a basic understanding of managed health care
1. Define the following: PPO, URO, EPO, HMO, JCAHO, POS
 2. Define the following: PHO, TPA, EPO
 3. Explain the responsibility of the NCQA
 4. Define primary care provider
 5. Define quality assurance
 6. Define quality improvement system
 7. Define case management
 8. Define second surgical opinion
 9. Explain how managed care works and how long it has been in existence
- D. Demonstrate a basic understanding of the life cycle of an insurance claim
1. Define a nonparticipating provider
 2. Define a new patient
 3. Define authorization and explain who is responsible for obtaining it
 4. Define charge ticket, superbill, encounter form, patient ledger, registration form
 5. Define coinsurance
 6. Define case manager
 7. Explain how the birthday rule works
 8. Define "allowed charges"
 9. Define a primary care physician
 10. Define a preexisting condition
 11. Explain the process of an insurance company handling of a claim
 12. Explain the process of a new patient initial interview and check-in
- E. Demonstrate a basic understanding of the legal and regulatory considerations
1. Define the following terms: contract, fraud, guardian, breach of confidentiality, patient health care contract, unbundling
 2. Explain the HCFA regulations
 3. Explain the exceptions to the required authorization for release of medical information to insurance companies

4. Explain when the signature block may contain a signature
 5. Explain about federal and state statutes
 6. Explain the difference between fraud and abuse and give examples
 7. Explain the precautions needed when faxed medical information
 8. Explain the precautions needed when giving out patient information
 9. Explain the Health Insurance Portability and Accountability Act
 10. Explain the release of information for patients with AIDS/HIV diagnosis
- F. Demonstrate a basic understanding of ICD-9-CM coding
1. Explain what ICD-9-CM system does, when it updated, and how it is setup
 2. Explain the purpose of a fifth digit
 3. Define essential modifiers
 4. Define eponyms
 5. Define secondary malignancy
 6. Explain what WHO does
 7. Define ABN
 8. Explain the difference between an open and a closed fracture
 9. List the 17 chapters of numeric codes and supplemental listings
 10. Explain the responsibilities of NCHS
 11. Explain the difference between concurrent and secondary condition
 12. Explain the following terms: NEC, late effect, secondary malignancy
 13. Identify and properly use the special terms, marks, abbreviations, and symbols used in the ICD-9-CM coding system
 14. Accurately code diagnoses
 15. Define and accurately use V-codes, M-Codes, and E-Codes and Late Effects
- G. Demonstrate a basic understanding of CPT coding
1. Explain the purpose of CPT-4 coding and how it is setup
 2. Explain when CPT-4 is published and by whom
 3. Explain the purpose of modifiers, where they can be found, and how they are presented
 4. List the CPT conventions and explain the rules for using them
 5. List the sections that CPT is divided and tell in what order they are located
 6. Explain how the specific necessity for a procedure or service in relation to the diagnosis is provided
 7. Explain the purpose of Appendix B
 8. Explain the importance of the unique codes found in the medicine section
 9. Explain what the divisions and specialty sections of the medicine section are called
 10. Explain how the index is organized
 11. Explain how to use the index
 12. List the four guidelines used to classify endoscopy
 13. Define medical terms
 14. Match modifier descriptions with correct CPT modifier
- H. Demonstrate a basic understanding of HCPCS coding system
1. Define HCPCS and tell how it is pronounced and when it was introduced
 2. Correctly code the service-procedure
 3. Explain who updates and when the codes found within the D series

4. Define durable medical equipment
 5. Define Rt and Lt and tell when they are used
 6. Define the following acronyms: HPSA, ABN, DME
 7. List the categories and tell what services would be included
 8. List the levels of the HCPCS codes and tell what is for
 9. Explain in what format HCPCS modifiers appear
 10. List the manuals that may be consulted when trying to determine the potential for Medicare payment
- I. Demonstrate a basic understanding of HCFA reimbursement issues
1. Define CIM, MCM RBRVS, RVU, CR BBA, EOMB, Limiting charge, Budget neutrality, MFN, Episode of care, MCO, Fraud, Global period, Global service, fee schedule, incident to, site of service differential, DRGs, and constant attendance
 2. Define modifier –57 and tell when it is used
 3. Explain nonparticipating physicians restrictions
 4. Explain how fees are adjusted for participating physicians
 5. Explain when Medicare would be the secondary payer
- J. Demonstrate a basic understanding of coding from source documents
1. Give the correct abbreviation or description to subjective, objective, assessment, plan, specificity, linking, medical necessity, qualified, primary diagnosis
 2. Define medical record, qualified, E codes, sign, and symptoms, abstracting.
 3. Define primary diagnosis
 4. Define a SOAP note and explain what should be in each section
 5. List the common step in abstracting procedures and services from operative reports
 6. Explain the difference between preoperative and postoperative diagnosis
 7. List the order in which ICD-9-CM codes are listed on claim form
- K. Demonstrate a basic understanding of essential CMS-1500 claim form instructions
1. Explain the Omnibus Reconciliation Act of 1987
 2. Explain the format for typing a form so it can be scanned by an OCR scanner
 3. Define the following: EIN, KISS, billing entity
 4. Explain what should be included when adding an attachment
- L. Demonstrate a basic understanding of filing commercial claims
1. Explain what should be put in each block on the CMS-1500 claim form
 2. Properly fill in the blocks on a claim form for commercial claims
- M. Demonstrate a basic understanding of Blue Cross and Blue Shield plans
1. Explain where dependent names can be found on the card
 2. Explain OPAP and how it works
 3. Explain a guest membership and what it covers
 4. Explain the regulations for for-profit organizations
 5. Explain the regulations for a non-participating physician
 6. Explain when providers must file claims for reimbursement.
 7. Explain how annual deductibles work
 8. Explain how to advertise as member in BlueCross/Blue Shield

9. Explain about additional contracting through Blue Cross/Blue Shield
 10. Explain how special contract clauses work
 11. Explain how coordinate Home Health and Hospice Care works
 12. Explain how a special accidental injury rider works
 13. Define Explanation of Benefits
 14. Properly fill in the blocks on a claim form for BlueCross/Blue Shield
- N. Demonstrate a basic understanding of Medicare
1. Describe the coverage for the following: Medicare Part A, Medicare Part B, hospice care, ESRD dialysis cases, kidney donor, heart transplant
 2. Define Hospice
 3. Explain the cost for Medicare Part B
 4. Explain the requirement governing the use of the Surgery Financial Disclosure Statement
 5. Explain participating providers and what regulations they must follow
 6. Explain what is meant by non-physician providers and what regulations they must follow
 7. State the deadline for filing Medicare claims
 8. Define Medigap, Medical Summary Notice, UPIN, limited license, benefit period, respite care, QBM, and MSP
 9. Explain what Medicare pays
 10. Explain how Medicare HMO works
 11. Explain how traditional Medicare beneficiary identification numbers are assigned
 12. Properly fill in the blocks on a claim form for Medicare
- O. Demonstrate a basic understanding of Medicaid
1. Define Medicaid and how eligibility is determined
 2. Define spend-down, excess income, HCFA place of service code, AFDC
 3. Explain the purpose of Spousal Impoverishment Protection Legislation and its regulations
 4. Properly fill in the blocks on a claim form for Medicaid
- P. Demonstrate a basic understanding of TRICARE
1. Define TRICARE and how eligibility is determined)
 2. Define TRICARE Senior Prime and how eligibility is determined
 3. Define a health care finder
 4. Explain the differences among TRICARE Prime, TRICARE Extra, TRICARE Standard, regular military health care
 5. List the TRICARE regions in the United States
 6. Explain the purpose of TRICARE Management Activity
 7. Explain who might qualify as a TRICARE care manager
 8. Explain when retired TRICARE beneficiaries apply for Medicare Part B
 9. List the covered services of TRICARE plans
 10. Properly fill in the blocks on a claim form for TRICARE
- Q. Demonstrate a basic understanding of Workers' Compensation
1. Define Worker's Compensation
 2. Define OSHA and explain its regulations
 3. Define "The First Report of Injury" and how to file for it

4. Explain the appeal process for a denied claim
5. Define worker's compensation-allowable fee
6. Define on-the-job injury
7. Define commercial insurers and when they can be used
8. Define vocational rehabilitation
9. Define temporary disability and permanent disability
10. Define level of disability and severe and moderate pain
11. Explain how death benefits are computed
12. Properly fill in the blocks of a claim form for worker's compensation

Learning Units

- I. Insurance Specialist—roles and responsibilities
 - A. Employment opportunities
 - B. Basic skill requirements
 - C. Health insurance specialist responsibilities
 - D. Professional certification
- II. Introduction to health insurance
 - A. Definition of health insurance
 - B. Disability and liability insurance
 - C. Major developments in health insurance
 - D. Health insurance coverage statistics
 - E. Third-party reimbursement methods
- III. Managed health care
 - A. History of managed health care
 - B. Managed care organizations
 - C. Six managed case models
 - D. Accreditation of managed care organizations
 - E. Government managed care ventures
 - F. Effects of managed care on administrative procedures in a physician's practice
- IV. Life cycle of an insurance claim
 - A. Development of the claim
 - B. New patient interview and check-in procedure
 - C. Established patient return visit
 - D. Post clinical check-out procedures
 - E. Insurance company processing of a claim
 - F. Maintaining insurance claim files
- V. Legal and regulatory considerations
 - A. Introduction to legal and regulatory considerations
 - B. Confidentiality of patient information
 - C. Claims information telephone inquiries
 - D. Facsimile transmission
 - E. Confidentiality and the internet
 - F. Retention of patient information and health insurance records

- G. Federal False Claims Act
- H. Health Insurance Portability and Accountability Act of 1996

VI. ICD-9-CM coding

- A. ICD-9-CM
- B. HCFA ICD-9-CM coding guidelines
- C. Primary and principal diagnosis coding
- D. Principal versus secondary procedures
- E. Coding qualifying diagnoses
- F. Disease index organization
- G. Basic steps for using the index
- H. Organization of the tabular list
- I. Basic steps for using the tabular list
- J. Working with index to diseases tables
- K. Coding special disorders
- L. Considerations to ensure accurate ICD-9-CM coding
- M. ICD-10-CM diagnostic coding for the future

VII. CPT coding

- A. CPT coding system
- B. CPT format
- C. CPT symbols and conventions
- D. Tabular conventions
- E. Index conventions
- F. CPT index
- G. Basic steps for coding procedures and services
- H. Surgery overview
- I. Coding special surgery cases
- J. Medicine section overview
- K. Radiology section overview
- L. Pathology/laboratory section overview
- M. Evaluation and management section overview
- N. Assigning evaluation and management codes
- O. Evaluation and management categories
- P. CPT modifiers

VIII. HCPCS coding system

- A. Organization of HCPCS coding system
- B. HCPCS national (Level II) codes
- C. Determining carrier responsibility
- D. Assigning HCPCS national (Level II) codes
- E. HCPCS modifiers
- F. Assigning HCPCS national (Level II) modifiers

IX. Reimbursement issues

- A. The Medicare fee schedule

- B. HCFA regulations that impact reimbursement
 - C. Medicare reimbursement
- X. Coding from source documents
 - A. Apply ICD-9-CM coding guidelines
 - B. CPT-HCPCS billing considerations
 - C. Coding clinical scenarios
 - D. Coding medical reports
 - E. Coding operative reports
- XI. Essential CMS-1500 claim form instructions
 - A. General billing guidelines
 - B. Optical scanning guidelines
 - C. National provider identifier
 - D. Reporting diagnoses: ICD-9-CM codes
 - E. Reporting procedures and services: HCPCS
 - F. Federal tax ID number
 - G. Reporting the billing entity
 - H. Processing secondary claims
 - I. Common errors that delay processing
 - J. Final steps in processing paper claims
 - K. Maintaining insurance claim files for the practice
- XII. Filing commercial claims
 - A. Insurance program comparison chart
 - B. Step-by-step instructions for primary commercial claims
 - C. Patient and policy identification
 - D. Diagnostic and treatment data
 - E. Instructions for Block 24
 - F. Provider/billing entity identification
 - G. Commercial secondary coverage
- XIII. Blue Cross and Blue Shield plans
 - A. Brief history
 - B. BCBS Association
 - C. BCBS distinctive features
 - D. Participating providers
 - E. Nonparticipating providers
 - F. Traditional fee-for-service coverage
 - G. National accounts
 - H. Bluecard program
 - I. BCBS and managed care
 - J. Medicare supplemental plans
 - K. Billing information summary
 - L. Step-by-step instructions—primary BCBS claims
 - M. Two BCBS full benefit policies

N. BCBS secondary claims

XIV. Medicare

- A. Medicare eligibility
- B. Medicare enrollment
- C. Part A coverage
- D. Part B coverage
- E. Participating providers
- F. Nonparticipating provider restrictions
- G. Private contracting
- H. Advance beneficiary notices
- I. Medicare fee schedule
- J. Medicare as a secondary payer
- K. Medicare plans
- L. Billing notes
- M. Step-by-step claim form instructions
- N. Primary Medicare with a Medigap policy
- O. Medicare-Medicaid crossover claims

XV. Medicaid

- A. Legislative background of Medicaid
- B. Federal eligibility requirements
- C. Medicaid services
- D. Relationship between Medicaid and Medicare
- E. Medicaid's future
- F. Medicaid as a secondary payer
- G. Participating providers
- H. Medicaid and managed care
- I. Billing information notes
- J. Step-by-step claim form instructions
- K. Secondary Medicaid claims
- L. Mother/baby claims

XVI. TRICARE

- A. History of CHAMPUS and development of TRICARE
- B. TRICARE administration
- C. TRICARE options
- D. TRICARE programs and demonstration projects
- E. TRICARE service centers
- F. Beneficiary counseling and assistance coordinator
- G. TRICARE preauthorization
- H. Covered services—TRICARE Standard
- I. Program for persons with disabilities
- J. Non-covered services—TRICARE
- K. Medical review
- L. CHAMPVA

- M. TRICARE as a secondary payer
- N. TRICARE limiting charges
- O. TRICARE supplemental plans
- P. TRICARE billing information
- Q. TRICARE primary claim instructions
- R. Primary TRICARE with a supplemental policy
- S. TRICARE as secondary payer claim instructions

XVII. Workers' Compensation

- A. Federal compensation programs
- B. State-sponsored coverage
- C. Eligibility
- D. Classification of on-the-job injuries
- E. OSHA Act of 1970
- F. Special handling of Workers' Compensation cases
- G. Workers' Compensation and managed care
- H. First report of injury
- I. Billing information notes
- J. Workers' Compensation claim instructions—patient and policy identification
- K. Diagnostic and treatment data
- L. Provider/billing entity identification

Learning Activities

Learning activities will be assigned to assist the student in applying correct techniques CPT and ICD-9-CM codes, completing CMS-1500 claim forms, and distinguishing between the different features of insurance agencies. These activities will be both independent and collaborative. Demonstrations will allow the student to observe before completing some of the assignments.

Grade Determination

The student will be graded on competencies as demonstrated through learning activities and tests. The student will be graded on learning activities and assessment tasks. Grade determinants may include the following: daily work, quizzes, chapter or unit tests, comprehensive examinations, student projects, student presentations, class participation, and other methods of evaluation employed at the discretion of the instructor.