PIEDMONT COMMUNITY COLLEGE

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MEDICAL BILLING

CURRICULUM LEARNING OBJECTIVES

The Piedmont Community College Medical Coding and Billing curriculum was developed by credentialed coding and auditing experts with decades of experience working in and teaching medical coding. This ensures you gain the skills you need to earn industry credentials. With Piedmont Community College's affordable tuition prices, you get a quality online education with one-on-one support by phone and email every step of the way. The learning objectives outlined below provides a map as you complete each module. It is required that students complete each module and all assignments for each module.

CONNECT/SMARTBOOK ORIENTATION

- Identify the elements, expectations, and requirements of the course.
- Navigate the program using the pages, menus, and buttons provided in McGraw Hill's Connect.
- Use the program tools, including the tools provided in Connect (ebook/Smartbook, and associated assignments) and Moodle including the gradebook, and contact information for the instructor using various communication tools (phone, email, forums, chat rooms, and social media).

CHAPTER 1: INTRODUCTION TO THE REVENUE CYCLE

- Identify three ways that medical insurance specialists help ensure the financial success of physician practices.
- Differentiate between covered and noncovered services under medical insurance policies.
- Compare indemnity and managed care approaches to health plan organization.
- Discuss three examples of cost containment employed by health maintenance organizations.
- Explain how a preferred provider organization works.
- Describe the two elements that are combined in a consumer-driven health plan.
- Define the three major types of medical insurance payers.
- Explain the ten steps in the revenue cycle.
- Analyze how professionalism, ethics, and etiquette contribute to career success.
- Evaluate the importance of professional certification for career advancement.

CHAPTER 2: ELECTRONIC HEALTH RECORDS, HIPAA, AND HITECH: SHARING AND PROTECTING PATIENTS' HEALTH INFORMATION
CHAPTER 3: PATIENT ENCOUNTERS AND BILLING INFORMATION

- Explain the importance of accurate documentation when working with medical records.
- Compare the intent of HIPAA, HITECH, and ACA laws.
- Describe the relationship between covered entities and business associates.

- Explain the purpose of the HIPAA Privacy Rule.
- Briefly state the purpose of the HIPAA Security Rule.
- Explain the purpose of the HITECH Breach Notification Rule.
- Explain how the HIPAA Electronic Health Care Transactions and Code Sets standards influence the electronic exchange of health information.
- Describe the four final rules in the Omnibus Rule.
- Explain how to guard against potentially fraudulent situations.
- Assess the benefits of a compliance plan.
- Explain the method used to classify patients as new or established.
- Discuss the five categories of information required of new patients.
- Explain how information for established patients is updated.
- Verify patients' eligibility for insurance benefits.
- Discuss the importance of requesting referral or preauthorization approval.
- Determine primary insurance for patients who have more than one health plan.
- Summarize the use of encounter forms.
- Identify the eight types of charges that may be collected from patients at the time of service.
- Explain the use of real-time adjudication tools in calculating time-of-service payments.

CHAPTER 4: DIAGNOSTIC CODING: ICD-10-CM

- Discuss the purpose of ICD-10-CM.
- Describe the organization of ICD-10-CM.
- Summarize the structure, content, and key conventions of the Alphabetic Index.
- Summarize the structure, content, and key conventions of the Tabular List.
- Apply the rules for outpatient coding that are provided in the ICD-10-CM *Official Guidelines for Coding and Reporting*.
- Briefly describe the content of Chapters 1 through 22 of the Tabular List.
- Assign correct ICD-10-CM diagnosis codes.
- Discuss the process of researching ICD-9-CM codes when necessary.

CHAPTER 5: PROCEDURAL CODING: CPT AND HCPCS

- Explain the CPT code set.
- Describe the organization of CPT.
- Summarize the use of format and symbols in CPT.
- Assign modifiers to CPT codes.
- Apply the six steps for selecting CPT procedure codes to patient scenarios.
- Explain how to select CPT Evaluation and Management codes for office visits and for other types of E/M services.
- Explain the physical status modifiers and qualifying circumstances add-on codes used in the Anesthesia section of CPT Category I codes.

- Differentiate between surgical packages and separate procedures in the Surgery section of CPT Category I codes.
- State the purpose of the Radiology section of CPT Category I codes.
- Code for laboratory panels in the Pathology and Laboratory section of CPT Category I codes.
- Code for immunizations using Medicine section CPT Category I codes.
- Contrast Category II and Category III codes.
- Discuss the purpose of the HCPCS code set and its modifiers.

CHAPTER 6: VISIT CHARGES AND COMPLIANT BILLING

- Explain the importance of code linkage on health care claims.
- Describe the use and format of Medicare's Correct Coding Initiative (CCI) edits and medically unlikely edits (MUEs).
- Discuss types of coding and billing errors.
- Appraise major strategies that help ensure compliant billing.
- Discuss the use of audit tools to verify code selection.
- Describe the fee schedules that physicians create for their services.
- Compare the methods for setting payer fee schedules.
- Calculate RBRVS payments under the Medicare Fee Schedule.
- Compare the calculation of payments for participating and nonparticipating providers, and describe how balance billing regulations affect the charges that are due from patients.
- Differentiate between billing for covered versus noncovered services under a capitation schedule.
- Outline the process of patient checkout.

CHAPTER 7: HEALTHCARE CLAIM PREPARATION AND TRANSMISSION

- Distinguish between the electronic claim transaction and the paper claim form.
- Discuss the content of the patient information section of the CMS-1500 claim.
- Compare billing provider, pay-to provider, rendering provider, and referring provider.
- Discuss the content of the physician or supplier information section of the CMS-1500 claim.
- Explain the hierarchy of data elements on the HIPAA 837P claim.
- Categorize data elements into the five sections of the HIPAA 837P claim transaction.
- Evaluate the importance of checking claims prior to submission, even when using software.
- Compare the three major methods of electronic claim transmission.

CHAPTER 9: MEDICARE

- List the eligibility requirements for Medicare program coverage.
- Differentiate among Medicare Part A, Part B, Part C, and Part D.
- Contrast the types of medical and preventive services that are covered or excluded under Medicare Part B.

- Apply the process that is followed to assist a patient in completing an ABN form correctly.
- Calculate fees for nonparticipating physicians when they do and do not accept assignment.
- Outline the features of the Original Medicare Plan.
- Discuss the features and coverage offered under Medicare Advantage plans.
- Explain the coverage that Medigap plans offer.
- Discuss the three parts of the Medicare Integrity program.
- Prepare accurate Medicare primary claims.

CHAPTER 10: MEDICAID

- Discuss the purpose of the Medicaid program.
- Discuss general eligibility requirements for Medicaid.
- Assess the income and asset guidelines used by most states to determine eligibility.
- Evaluate the importance of verifying a patient's Medicaid enrollment.
- Explain the services that Medicaid usually does not cover.
- Describe the types of plans that states offer Medicaid recipients.
- Discuss the claim-filing procedures when a Medicaid recipient has other insurance coverage.
- Prepare accurate Medicaid claims.

CHAPTER 11: TRICARE AND CHAMPVA

- Discuss the eligibility requirements for TRICARE.
- Compare TRICARE participating and nonparticipating providers.
- Explain the features of TRICARE Prime.
- Describe the features of TRICARE Select.
- Discuss the eligibility requirements for CHAMPVA.
- Prepare accurate TRICARE and CHAMPVA claims.

CHAPTER 8: PRIVATE PAYERS/ACA PLANS
CHAPTER 12: WORKERS' COMPENSATION AND DISABILITY/AUTOMOTIVE INSURANCE

- Describe the major features of group health plans regarding eligibility, portability, and required coverage.
- Discuss provider payment under the various private payer plans.
- Contrast health reimbursement accounts, health savings accounts, flexible spending Accounts, and direct primary care.
- Discuss the major private payers.
- Compare the four ACA metal plans.
- Analyze the purpose of the five main parts of participation contracts.
- Describe the information needed to collect copayments and bill for surgical procedures under contracted plans.
- Discuss the use of plan summary grids.

- Prepare accurate private payer claims.
- Explain how to manage billing for capitated services.
- Explain the four federal workers' compensation plans.
- Describe the two types of state workers' compensation benefits.
- Classify work-related injuries.
- List three responsibilities of the physician of record in a workers' compensation case.
- Differentiate between Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).

CHAPTER 13: PAYMENTS (RAS), APPEALS, AND SECONDARY CLAIMS

- Explain the claim adjudication process.
- Describe the procedures for following up on claims after they are sent to payers.
- Interpret a remittance advice (RA).
- Identify the points that are reviewed on an RA.
- Explain the process for posting payments and managing denials.
- Describe the purpose and general steps of the appeal process.
- Assess how appeals, post payment audits, and overpayments may affect claim payments.
- Describe the procedures for filing secondary claims.
- Discuss procedures for complying with the Medicare Secondary Payer (MSP) program.

CHAPTER 14: PATIENT BILLING AND COLLECTIONS

- Explain the structure of a typical financial policy
- Describe the purpose and content of patients' statements and the procedures for working with them.
- Compare individual patient billing and guarantor billing.
- Classify the responsibilities for each position that is typically part of billing and collections.
- Describe the processes and methods used to collect outstanding balances.
- Name the two federal laws that govern credit arrangements.
- Discuss the tools that can be used to locate unresponsive or missing patients.
- Describe the procedures for clearing uncollectible balances.
- Analyze the purpose of a retention schedule.

CHAPTER 15: PRIMARY CASE STUDIES
CHAPTER 16: RA/SECONDARY CASE STUDIES

- For the first ten encounters (Claim Case Studies 15.1 through 15.10), completed patient information forms and encounter forms are supplied. Completion of a correct claim for each encounter based on abstracting information from these forms is required.
- For the second ten encounters (Claim Case Studies 15.11 through 15.20), patient information, a diagnostic statement, and a procedural statement are provided. To prepare correct claims requires

selecting the correct ICD-10-CM and CPT codes for the encounter, abstracting the patient information, and completing a claim.

- This chapter provides case studies covering the revision of denied claims, handling RAs, preparing secondary claims, and calculating patient balances. Instructors may assign the claim cases using the CMS-1500 (02/12) or the simulated Connect.

CHAPTER 17: HOSPITAL BILLING AND REIMBURSEMENT

- Distinguish between inpatient and outpatient hospital services.
- List the major steps relating to hospital billing and reimbursement.
- Contrast coding diagnoses for hospital inpatient cases and for physician office services.
- Explain the coding system used for hospital procedures.
- Discuss the factors that affect the rate that Medicare pays for inpatient services.
- Interpret hospital health care claim forms.