Mt. San Jacinto College
Integrated Course Outline of Record

Form B

Submitted by: Velma Borrows **Date:** 03/12/2020

Department	Subject	Course Number	Title
Medical Assisting	Medical Assisting MA	776	Medical Billing and Coding

Units/Hours

Each lecture unit requires 1 hour per week of class time, and 2 hours per week of study outside of class.
Each laboratory unit requires 3 hours per week of class time.
Each activity unit requires 2 hours per week of class time and 1 hour per week of study outside of class.

Lecture Units	Lab Units	Total Units
3.00	1.00	4.00
Lecture Contact Hours	**Lab Contact Hours**	**Total Contact Hours**
48.00 - 54.00	48.00 - 54.00	96.00 - 108.00
Lecture Homework Hours	**Lab Homework Hours**	
96.00 - 108.00	0	

Stand Alone:

Program Applicable

AA/AS Degree General Ed Breadth Area(s):

-none-

General Education Justification:

Maximum Enrollment: 40

Maximum Enrollment Justification: Justification:

Grading Method: Letter Grade or P/NP

TOP code: 1223.10*

Can be Taken 1 **time(s) for credit** (max 4)

- Visual or Performing Arts course that is required to meet major requirements for UC/CSU

- Intercollegiate athletics course
- Academic/vocational competition course

Catalog Description:

(Please do not refer to transferability or degree, certificate, or employment concentration applicability. Please only describe the course).
(**75 words** or less in gray box below).

This course is designed to provide students with the knowledge and skills required to perform procedural and diagnostic coding and prepares the student to take the Certified Billing and Coding Specialists (CBCS) exam offered by the National Healthcareer Association (NHA). Students learn the fundamentals of medical billing and coding, major private and public insurance plans and electronic claims processing.

Schedule Description:

(Please do not refer to transferability or degree, certificate, or employment concentration applicability. Please only describe the course).
(**25 words** or less in gray box below).

This course covers medical billing and coding and prepares students to sit for the National Healthcareer Association exam to become Certified Billing and Coding Specialists.

Need for the course:

MA 776 Medical Billing and Coding is the financial arm of the medical industry and medical assistants are expected to have a clear knowledge of medical insurances and the medical billing, coding and claims process. Medical Billing and Coding has changed with the introduction and usage of ICD 10 and the new CPT coding manuals. Medical Billing and Coding is a necessary part of the Medical Assisting Administrative Certificate program as well as a required course for the Associate Degree in Medical Assisting. This course is designed to meet the changing industry needs.

Prerequisite(s):

Prerequisites go through a separate approval process. See Forms E1-E6 for details.
(For further clarification, contact the Prerequisite Subcommittee)

-none-

Corequisite(s):

Corequisites go through a separate approval process. See Forms E1-E6 for details.

-none-

Recommend Preparation:

Recommended Preparation goes through a separate approval process. See Forms E1-E6 for details.

-none-

Other Enrollment Criteria:

-none-

Learning Objectives:

(please number each objective and express in behavioral terms)
Upon the completion of the course the student will be able to do the following:

1. Outline the typical job responsibilities, academic training, healthcare setting and opportunities of a health insurance specialist.
2. Discuss significant events in healthcare reimbursement and describe medical docomentation.

3. Differentiate between the various public and private insurance plans including Medicare, Medicaid, CHAMPUS, HMO, PPO and POS plans.
4. Explain the life cycle of an insurance claim and utiilize the billing and coding guidelines to complete and insurance claim.
5. Demonstrate competency in coding for medical necessity and develop skills in assigning diagnosis and procedure codes.
6. Apply the rules for proper usage of the ICD-10-CM/PCS, DPT and HCPCS coding manuals and applicable software to accurately assign diagnosis and procedure codes in a manner that meets industry standards.

Course Content:

(please number the outline of main topics and subtopics)

1. Health Insurance Specialist Career
    - Health Insurance Career Opportunities
    - Education, Training, and Job Opportunities
    - Professionalism
2. Health Insurance
    - Major Development in Health Insurance
    - Healthcare Documentation
    - Electronic Health Record
3. Managed Health Care
    - Managed Care Organization and Models
    - Consumer Directed Health Plans
4. Processing an Insurance Claim
    - Managing New and Established Patients
    - Managing Office Insurance Finances
    - Life Cycle of an Insurance Claim
    - Maintaining Insurance Claim Files
5. Legal and Regulatory Issue in Healthcare
    - Federal Laws and Events that Affect Healthcare
    - Retention of Records
    - HIPAA
6. ICD-10-CM Coding
    - ICD-10-CM Coding Conventions
    - ICD-10-CM Index and Tabular List of Diseases and Injuries
    - Official Guidelines for Coding and Reporting
7. CPT Coding
    - CPT Sections, Subsections, Categories and Subcategories
    - CPT Index and Modifiers
    - Coding Procedures and Services
    - Evaluation and Management Codes
    - Anesthesia, Surgery, Radiology, Medicine, Pathology and Laboratory Sections
    - National Correct Coding Initiative
8. HCPCS Level II Coding
    - HCPCS Level II National Codes
    - Assigning HCPCS Level II Codes
    - Determining Payer Responsibility
9. CMS Reimbursement Methodologies
    - CMS Payment System
    - Ambulance Laboratory DME Fee Schedules
    - Ambulatory Surgical Center Payment System
    - Home Health, Hopital Inpatient and Outpatient Prospective Payment System
    - Inpatient Psychiatric and Rehabilitation Facility Prospective Payment System
    - Longterm Acute Care Hospital and Skilled Nursing Facility Prospective Payment System
    - Medicare Physician Fee Scheldule
    - UB-04 Claims

10. Coding for Medical Necessity
    - Applying Coding Guidelines
    - Coding and Billing Considerations
    - Coding From Case scanarios and Patient Reports
11. Essential CMS-1500 Claim Instructions
    - Insurance Billing and optical Scanning Guidelines
    - Entering Patient Information
    - Assignment of Benefits and Acceptance of Assignment
    - Reporting Diagnosis and Procedure Codes
    - Processing Secondary Claims
    - Commor Errors that Delay Claim Processing
    - Maintaining Insuracne Claim Files
12. Commercial Insurance
    - Commercial Claims
    - Commercial Seocndary Coverage
    - Commerical Group Health Plan Coverage
13. BlueCross BlueShield
    - History
    - Insurance Plan
    - Claim Instructions
    - Secondary Coverage
14. Medicare
    - Eligibility and Enrollment
    - Medicare Parts A, B, C and D
    - Medigap
    - Participating and Nonparticipating Providers
    - Claims Instructions
    - Medi-Medi Cross-over Claims
    - Medicare as a Secondary Payer Claims
15. Medicaid
    - Eligibility and Covered Services
    - Claims Instructions
    - Medicaid as a Secondary Payer Claim
    - Mother/Baby Claims
    - SCHIP Claims
16. Tricare
    - Tricare Administration
    - CHAMPVA
    - Tricare Supplemental Plans
    - Claims Instructions
    - Tricare and a Secondary Payer
17. Worker's Compensation
    - Federal Workers' Compensation Program
    - State Workers' Compensation Program
    - Eligibility and Classification of Cases
    - First Report of Injury From a Progress Report
    - Appeals, Adjudication, Fraud and Abuse
    - Claims Consideration

Lab Content:

(please number the outline of main topics and subtopics)

1. Unsurance plans:

- AETNA
- AFLAC
- BlueCross Blue Shield
- MetLife
- Medicare
- Medicaid
- TRICARE
- Worker's Compensation Insurance

1. Review and evaluation of patient records, written in a SOAP format, to properly assign ICD-10-CM diagnosis codes and CPT and HCPCS level II (national) procedure and service codes.
2. Use of CPT, HCPCS level II, ICD-10-CM, and ICD-10-PCS coding to determine rules associated with each manual.
3. Symbols used in the CPT manual.
4. Evaluation and Management (E/M) services guidelines.
5. Anesthesia guidelines
6. Surgery guidelines.
7. Radiology guidelines (including Nuclear Medicine and Diagnostic Ultrasound).
8. Pathology and Laboratory guidelines.
9. Medicine fuidelines
10. General Modifiers
11. Physician Status Modifiers.
12. Modifiers approved for hospital outpatient use.
13. Level II HCPCS/National Codes
14. Place of Service codes.
15. Evaluation and Management for office and other outpatient services codes.
16. Hospital observation services codes.
17. Establish patient services codes.
18. Hospital inpatient services codes.
19. Admission and discharge services codes.
20. Office and outpatient consultation services codes.
21. Inpatient consultation codes.
22. Emergency department services codes.
23. Pediatric critical care patient transport and services codes.
24. inpatient neonatal and pediatric care services codes.
25. Nursing facility services codes.
26. Domiciliary, rest home (boarding home) or custodial care services codes.
27. Prolonged services codes.
28. Preventive medicine services codes.
29. Review of encounter forms to determine place of service.
30. Use of modifier codes to assess charges.
31. Evaluation of patient superbills and medical report in order to determine the diagnosis pointer for a given procedure in establishing coding for necessity requirement.
32. Interpretion of the ICD-10-CM coding conventions to accurately assign ICD codes for diseases.
33. Interpretion of the CPT coding conventions for the selection of diagnostic and therapeutic procedures.
34. Inpatient care methodologies of coding for diseases, procedure and evalutation of management of patients
35. outpatient care methodologies of coding for diseases, procedure and evalutation of management of patients.
36. Primary insurance claims processing.
37. Gap insurance claims processing.
38. Secondary insurance claims processing.
39. Commercial insurance claims processing.
40. Medicare nsurance claims processing.
41. Medicaid/MediCal nsurance claims processing.
42. TRICARE nsurance claims processing for active military and their dependents.
43. Worker's compensation nsurance claims processing.

Simulated Case Studies:

1. Evaluation of the rules for completing a CMS 1500 form for various insurance plans.
2. Patient information
3. Policy holder or insured information.
4. The 32 blocks of information on the CMS 1500 claims form used to determine the correct information to be entered in each block.
5. Examination of patient information to determine information to be placed in each block.
6. Overview of how each insurance plan completed the blocks on the CMS 1500 form.
7. Evaluation of diagnosis and procedure codes in determinining medical necessity.
8. Difference between primary and secondary insurance plan.
9. How to input information for a gap medical insurance plan.
10. Clarification of services and procedures using appropriate modifiers.
11. Injuries related to employment, automobile accidents or other accidents versus those resulting from a medical condition.
12. When a medical insurance is not liable for injuries.
13. Coding, and referencing name, address and NPI number for place of services.
14. Types of providers: referring provider, the ordering provider and the supervising provider and the codes associated with each provider type.
15. Completion of CMS 1500 for commercial insurance plans.
16. Completion of CMS 1500 for BlueCross BlueShield.
17. Completion of CMS 1500 for Medicaid, Medicare and TRICARE federal insurance plans.
18. Evaluation of Medical Gap insurance and determination of primary and secondary payer.

Methods of Instruction:

Methods of instruction may include, but are not limited to the following:

- **Method:** Lecture
  Integration: Lecture will be complimented with audio visual material in the form of video. PowerPoint presentations and video clips will be used to demonstrate topics covered in course content. Lecture is integrated with note taking questions to assess students' understanding of lecture material.
- **Method:** Activity
  Integration: Large and small group cooperative activities will be utilized to review patient documentation in order to assign diagnosis and procedure codes and discuss the coding methodologies used to properly assign accurate codes.
- **Method:** Lab Activities
  Integration: Students will develop Computerlized lab activities to create over 40 insurance claims using a fillable CMS 1500 Claim Form. Student develop practical skills in becoming an insurance billing and coding specialist.
- **Method:** In-class Exercises
  Integration: Students will work in pairs to review source documents including encounter forms, charge masters, patient records, physician consultation reports, and surgery reports to identify elements necessary to complete the CMS 1500 insurance claim and present their findings and final claims form to the class.

Methods of Evaluation:

A student's grade shall be determined by the instructor using multiple measures of performance related to the course objectives. Methods of evaluation may include but are not limited to the following:

- **Method:** Homework
  Integration: Targeted essay and short answer questons used to guide students' understanding of the assigned reading. Students provide individual, oral response to previously assigned questions, will be utilized.
- **Method:** Oral Presentation
  Integration: Students evaluate concepts, issues, and guidelines used in medical insurance reimbursement and articulate their analysis and understanding of these issues and guidelines. Students discuss how the CMS 1500 should be completed and what information should be entered in each block and where to locate that information

in the various source documents.
- **Method:** Simulation
  Integration: Students are evaluated on their ability to use Simclaim or Medisoft software to electonically file insurance claims while applying knowledge of diagnosis and procedure coding guidelines to accurately enter codes for over 40 case studies.
- **Method:** Exams/Tests
  Integration: Weekly Chapter tests and midterm and final exams in the form of multiple choice, matching and free-response quesitons to assess insurance billing, coding and claims processing concepts and application will be utilized.

Examples of Assignments:

Students will be expected to understand and critique college level texts or the equivalent. Reading and writing, as well as out of class assignments are required. These assignments may include but are not limited to the following:

1. Case Studies
   - Accuratley complete CMS 1500 claim forms for over 40 case studies
   - Complete the CMS 1500 form on paper and then progress to using a fillable electronic form to submit the completed CMS 1500 form for each case study.
2. Free Response Questions
   - Evaluate response question from the assigned chapters each week and present responses the following week as an oral presentation to the class.
3. Oral Presentation
   - Work in pairs to present an assigned private or public health insurance and give details of policies, procedures and various managed care models listed under that particular health insurance plan. Determine what information is required on the CMS 1500 for the assigned healthcare plan.

Textbooks:

- Green, Michelle, A (2019). *Understanding Health Insurance A Guide to Billing and Reimbursement 14th* Cengage. ISBN: ISBN-13: 9781337554

Other Resources:

Minimum Qualification

- Health (Masters Required) **and/or**
- Health Information Technology **and/or**
- Health Services Director/ Health Services Coordinator/ College Nurse (Masters Required)