El Paso Community College
Syllabus
Part II
Official Course Description

SUBJECT AREA	**Health Information Management**
COURSE RUBRIC AND NUMBER	**HITT 2340**
COURSE TITLE	**Advanced Medical Billing Reimbursement**
COURSE CREDIT HOURS	**3 Credits 1 Lec : 4 Lab**

I. Catalog Description

Develops skills in coding to prepare reimbursement forms in various health care settings for submissions to payers. A grade of "C" or better is required in this course to take the next course. Prerequisite: HITT 1166 and HITT 1270 and HITT 1341 and HITT 1342. **(1:4).**

II. Course Objectives

A. Unit I. Roles and Responsibilities of the Health Insurance Specialist.

1. Define key terms, phrases, and abbreviations associated with the health insurance specialist.
2. Explain the reasons for increasing employment opportunities for health insurance specialists.
3. Prepare a list of career paths for health insurance specialists.
4. List and discuss the basic skill requirements for aspiring health insurance specialists.
5. List and discuss twelve responsibilities of health insurance specialists.
6. Identify three professional organizations dedicated to working with health insurance specialists who are filing claims for physicians and other health care professionals.

B. Unit II. Introduction to Health Insurance

1. Define key terms, phrases, and abbreviations associated with health insurance.
2. Explain why it was necessary to standardize procedural terminology and develop a procedural coding system.
3. Explain why HCFA regulated the use of the HCFA-1500 claim form for Medicare billing.
4. Explain the purpose of the national Correct Coding Initiative (CCI).
5. List four features of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
6. List and describe the four types of third-party reimbursement seen in physician practices across the country today.
7. List and describe four methods of reimbursement seen in today's health care practices.

C. Unit III. Managed Health Care

1. Define key terms, phrases, and abbreviations associated with managed health care.
2. List the eight principles of managed care.
3. List and describe the six managed health care models.
4. List and describe the five HMO models.
5. List the three levels of NCQA accreditation.
6. Describe the influence of managed care programs on medical practices' administrative procedures.

D. Unit IV. Life of an Insurance Claim

1. Define key terms, phrases, and abbreviations.
2. Explain the necessity of conducting a new patient intake interview before the patient in schedule for an initial appointment.
3. Explain how a primary care provider verifies a new patient's eligibility for in-network services.
4. Discuss the authorization process for a patient requesting an initial appointment with a health care specialist.
5. Discuss the process for obtaining authorization for additional treatment by a health care specialist.
6. Discuss the life cycle of an insurance claim, from origination of the charge slip to transfer of charges to the ledger card or computer account, and subsequently, to a claim form.
7. Describe an insurance company's claims review process.
8. Determine the primary and secondary insurance carries or adults and children covered by two insurance plans.

E. Unit V. Legal and Regulatory Considerations

1. Define key terms, phrases, and abbreviations related to legal and regulatory considerations.
2. Provide examples of a statute, rule/regulation, and case law.
3. Explain the use of the *Federal Register*.
4. Describe ways the insurance specialist can obtain information about new laws and regulations.
5. Give examples of breaches of confidentiality.
6. State the importance of obtaining the patient's signature for the "Authorization for Release of Information" statement on the HCFA-1500 form.
7. Identify two classifications of patients who are not required to sing the "Authorization for Release of Information" statement on the HCFA-1500 form.
8. Explain how the authorization for release of information is obtained for electronic claims.
9. Verify a legitimate telephone request for patient information.
10. Process facsimile (fax) requests for patient information.
11. Prepare a confidentiality notice to serve as the first page of faxed information.
12. Establish a patient record retention policy for the physician's office.
13. Summarize the *HCFA Internet Security Policy* and the *Stark II Regulations*.
14. List the components of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and explain the health care impact of each.
15. Outline the elements of the *Compliance Program Guidance for Physician Services*.
16. Implement HCFA's *Correct Coding Initiative (CCI)*.
17. Provide an example of "unbundling."
18. Differentiate among the NPI, Plan ID, EIN, and patient identifier.
19. List the scheduled implementation dates for HCFA's electronic health care standards and privacy standards.

F. Unit VI. ICD-9-CM and CPT Coding Systems

1. Define key terms, phrases, and abbreviations related to ICD-CM and CPT coding systems.
2. Discuss the differences between the terms "primary diagnosis" and "principal diagnosis".
3. Explain the purpose of coding diagnoses on insurance claim forms.
4. Discuss the importance of carefully proofreading all code numbers on the claims form.
5. List and apply the HCFA guidelines in coding diagnoses using the ICD-9-CM coding system.
6. Compare ICD-9-CM to HCPCS and explain why modifiers were developed for HCPCS.
7. Explain how to determine the level of evaluation and management service.
8. List the requirements for assigning emergency department and critical care codes.
9. Discuss the qualifications for a "preventative medicine visit".
10. Define "global surgical period" used in CPT, as applied by the insurance industry.
11. Identify and properly use the special terms, marks, abbreviations, and symbols used in the ICD-9-CM and CPT coding systems.
12. Accurately code all diagnoses using the ICD-9-CM and CPT coding systems.

G. Unit VII. HCPCS Coding System

1. Define key terms, phrases, and abbreviations related to HCPCS Coding System.

2. Discuss coding jurisdictions of the Local Medicare Carrier and the DME Medical Center.
3. Explain the process for determining the correct carrier for HCPCS service.
4. Describe the purpose of the Medicare Manual and the Coverage Issues Manual.

H. Unit VIII. CMS Reimbursement Issues

1. Define key terms, phrases, and abbreviations related to CMS reimbursement issues.
2. Identify sources for the Correct Coding Initiative rules.
3. Explain Billing and Coding Compliance issues.

I. Unit IX. Coding from Source Documents

1. Define key terms, phrases, and abbreviations related to coding from source documents.
2. Abstract and code diagnoses and procedures from source documents for the purpose of completing insurance information on the HCFA-1500 claim form.

J. Unit X. Essential HCFA Claim Forms Instructions

1. Define key terms, phrases, and abbreviations related to HCFA claim forms instructions.
2. Discuss billing guidelines for the following cases: inpatient medical, inpatient/outpatient global surgery, medical/surgical, and minor surgery.
3. Apply optical scanning guidelines when completing claim forms.
4. Discuss the reporting guidelines and restrictions covering the following claim form items: diagnoses, date entry, procedures, modifiers, charges, diagnostic reference numbers, and units.
5. Explain why the billing entity's employer tax identification number (EID) should appear on the claim form rather than the provider's Social Security Number.
6. State the four processing steps that must occur before a completed form can be sent to the insurance company.
7. Describe how to set up a "tickler" filing systems for completes claim forms.

K. Unit XI. Filing Commercial Claims

1. Define key terms, phrases, and abbreviations related to filing commercial claims.
2. Determine the status of primary and secondary commercial claims.
3. Complete commercial primary and secondary and supplemental fee-for-service claims accurately.
4. Create a comparison chart as an aid to mastering the details of completing claim forms.

L. Unit XII. Blue Cross and Blue Shield Plans

1. Define key terms, phrases, and abbreviations related to Blue Cross/Blue Shield (BC/BS) plans
2. Explain the function of the national Blues Cross and Blue Shield Association.
3. List four distinctive features that make BC/BS plans different from other commercial medical insurance programs.
4. Compare and contrast the advantages of a BC/BS participating provider versus a non-participating provider.
5. Describe the features of BC/BS basic benefits.
6. List typical services found in Major Medical coverage.
7. Explain the benefits of special accidental injury riders/clauses.
8. Explain the benefits of a medical emergency rider.
9. Explain the purpose of the BlueCard Program and how a BlueCard patient is identified.
10. Compare and contrast how PARs and nonPARs process BlueCard claims.
11. Compare and contrast the major differences between BC/BS, PPA, and POS plans.
12. Complete BC/BS claims accurately.

M. Unit XIII. Medicare

1. Define key terms, phrases, and abbreviations associate with Medicare.
2. List six categories of persons eligible for Medicare coverage.

3. Describe the coverage of each of the following: Medicare Part A, Medicare Part B, ESRD dialysis cases, heart transplant, hospice care and kidney donor.
4. List and describe six incentives developed by Congress to encourage providers to become Medicare participating providers.
5. List and describe sis restrictions placed on Medicare non PAR providers.
6. Explain the requirements for use of the Medicare Medical Necessity Statement.
7. Explain the requirements governing use of the Surgery Financial Disclosure Statement.
8. List and discuss seven types of insurance programs that are primary to Medicare.
9. List and discuss two types of programs that are classified as Medicare Supplemental plans.
10. Explain how a policy falls into the extra coverage category and how it affects Medicare billing.
11. Explain how a Medicare claim is filed for Medicare patients enrolled in Medicare risk restricted or cost based HMOs.
12. Explain the billing sequence for Medicare patients with employer-sponsored plans, Medigap, Medicare-Medicaid crossover plans and Medicare as secondary coverage.
13. Explain how Medicare's liability as a secondary payor is calculated.
14. Describe the provider's legal responsibility for collecting the patient's deductible and coinsurance obligations.
15. Explain the procedure health care providers mist follow to "opt out" of Medicare.
16. Explain the features of Medicare+choice with regard to the following: private fee-for-service plan, provider-sponsored organizations, and Medicare Savings Accounts.
17. File traditional Medicare and Medicare HMO fee-for-service claims properly.

N. Unit XIV. Medicaid

1. Define key terms, phrases, and abbreviations related to Medicaid.
2. List Medicaid federal guidelines and the services covered under the federal portion of Medicaid assistance.
3. List services covered in Texas that are not federally mandated services.
4. Explain how to verify a patient's Medicaid eligibility.
5. Explain the importance of the spousal impoverishment protection legislation.
6. Describe the preauthorization procedure for services.
7. File a Medicaid claim, using the rules for the HCFA-1500 (12-90) claim form, adhering to appropriate schedules/deadlines.

O. Unit XV. TRICARE

1. Define key terms, phrases, and abbreviations related to TRICARE.
2. List TRICARE eligibility categories.
3. Describe TRICARE coverage for mental health care and substance abuse treatment.
4. List six services that are not covered by TRICARE.
5. List the types of health care insurance services that are and are not primary to the TRICARE program.
6. List and describe the three levels of TRICARE coverage.
7. Describe the deductibles and cost share responsibility for TRICARE Extra, Standard, and the Point of Service options.
8. File the TRICARE Standard and Extra claims properly.

P. Unit XVI. Worker's Compensation

1. Define key terms, phrases, and abbreviations related to Worker's Compensation.
2. List the categories of workers covered by the federal compensation program.
3. List and describe the types of worker's compensation available at state level.
4. List and describe the classifications of federal worker's compensation cases as stipulated by federal law.
5. Select the proper terminology to describe the employee's "diminished capacity" in cases describing pulmonary, heart, abdominal weakness, or spinal disorders; lower extremity disorders; and levels of pain.
6. Identify final destinations for the required copies of the First Report of Injury form.
7. Describe correct billing procedures for worker's compensation cases.

8. Explain the necessity for separating treatment data for work-related injuries from health care data for treatment of diseases and disorders not related to the patient's employment.
9. Identify the forms necessary for the proper filing of compensation claims.
10. File First Report of Injury Reports and Claim forms accurately.

III. THECB Learning Outcomes (WECM)

1. Skill development coding to prepare reimbursement forms in various health care settings for submission to payers.

IV. Evaluation

A. Pre-assessment

The instructor will review and discuss the course prerequisites on the first day of class. Due to specialized admission requirements for the HITT Program, all students should have the necessary prerequisites prior to enrollment.

B. Post-assessment

An exam will be administered to include material discussed in each unit in this course. Quizzes over lecture material and/or assigned reading are at the discretion of the instructor.

Unit activities/assignments will be assigned by the instructor to further enhance student's understanding of the course objectives.

A comprehensive final examination will be administered for this course.

The instructor will maintain a continuous record of each student's progress. Students not performing at a "C" level or better in the course will be referred for tutoring and/or counseling.

Students are encouraged to seek direction and help for those areas in which they experience difficulty. The course instructor may assign remedial or tutorial work designed to enhance student proficiency.

Students not adhering to Health Occupations Criteria for course pursuit may be administratively withdrawn from this course. (See attached)

V. Disability Statement (Americans with/Disabilities Act [ADA])

EPCC offers a variety of services to persons with documented sensory, mental, physical, or temporary disabling conditions to promote success in classes. If you have a disability and believe you may need services, you are encouraged to contact the Center for Students with Disabilities to discuss your needs with a counselor. All discussions and documentation are kept confidential. Offices located: VV Rm C-112 (831-2426); TM Rm 1400 (831-5808); RG Rm B-201 (831-4198); NWC Rm M-54 (831-8815); and MDP Rm A-125 (831-7024).

VI. 6 Drop Rule

Students who began attending Texas public institutions of higher education for the first time during the Fall 2007 semester or later are subject to a 6-Drop limit for all undergraduate classes. Developmental, ESL, Dual Credit and Early College High School classes are exempt from this rule. All students should consult with their instructor before dropping a class. Academic assistance is available. Students are encouraged to see Counseling Services if dropping because exemptions may apply. Refer to the EPCC catalog and website for additional information.

HEALTH OCCUPATIONS DIVISION CRITERIA FOR COURSE PURSUIT

In order to establish guidelines for determining when a student has ceased to pursue the course objectives, the Health Occupations Division has set the following applicable standards.

1. The student must adhere to the attendance requirement of course HITT 1370. In order to pursue the course, the student must attend a minimum of 76 hours of instruction. (Meets a total of 80 hours).

2. The student will not be able to make up theory hours.

3. Tardiness will be defined as being fifteen (15) minutes or more late to theory sessions. Students will be allowed two (2) events of tardiness, after which the tardiness will be considered an absence.

4. If required by instructor/coordinator, student also must follow the standards established in the El Paso Community College Health Occupations Programs Students Handbook for Allied Health Students and/or program addendum. The student is bound by standards in the El Paso Community College Health Occupations Programs Student Handbook for Allied Health Students as evidenced by the return of a signed/dated acknowledgment sheet.

5. Where the student continues to pursue the course objectives but is receiving failing grades, he/she will remain eligible to complete the course, except in instances where unsafe practice occurs.

6. The student must appear for examinations, presentations, or other required class activities and submit required papers, projects, and/or reports as identified in the course syllabus/calendar.

Failure of the student to follow the above will indicate that the student is no longer pursuing the objectives of the course and will result in faculty initiated withdrawal.