# El Paso Community College
# Syllabus
# Part II
# Official Course Description

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| **SUBJECT AREA** | **Medical Assisting Technology** |
| **COURSE RUBRIC AND NUMBER** | **MDCA 1443** |
| **COURSE TITLE** | **Medical Insurance** |
| **COURSE CREDIT HOURS** | **4 Credits  3 Lec : 3 Lab** |

## I. Catalog Description

Emphasizes medical office coding for payment and reimbursement by patient or third party payers for ambulatory care settings. A grade of "C" or better is required in this course to take the next course. **(3:3). Lab fee.**

## II. Course Objectives

A. Unit I. Career Role and Responsibilities

1. Identify the background and importance of insurance claims completion, coding, and billing.
2. Name at least three skills possessed by insurance billing specialists.
3. List personal qualifications and skills to be acquired by an insurance billing specialist.
4. Specify the educational requirement for a job as an insurance billing specialist and as a coder.
5. Differentiate the differences between medical ethics and medical etiquette.
6. List various types of insurance fraud and define abuse as it relates to the subject of insurance claims.
7. Incorporate proper medical terminology.

B. Unit II. The Claims Process

1. Describe the history of insurance in the United States.
2. Distinguish between the three major classes of health insurance contracts.
3. Explain the difference between an implied and an expressed physician/patient contract.
4. Describe in general terms the importance federal, state, and private health, insurance plans.
5. Handle insurance claims in the physician’s office to obtain payment and minimize their rejection by insurance carriers.
6. Explain the process of a physician based insurance claims from obtaining patient data, claim form completion, insurance carrier processing, and payment received, including recording the proper information and posting the patient’s ledger after claim submission and payment received.
7. Explain reasons medical documentation is required.
8. Define common medical diagnostic, and legal terms.
9. Prepare legally correct medicolegal forms and letters.
10. Identify principles for release and retention of medical records.
11. Respond appropriately to the subpoena of a witness and records.

12. Explain the purpose and importance of coding diagnoses and purpose of coding for professional services.
13. Use diagnostic and procedural code books properly and obtain accurate codes.
14. Define procedural code terminology.
15. Explain the importance and usage of modifiers in procedure coding.
16. Define two types of claims submission.
17. Explain the difference between clean, pending, rejected, incomplete, and invalid claims and explain why claims are rejected.
18. Execute general guidelines for completing the HIFA-1500 claim form for federal, state, and private payer insurance contracts.
19. Specify differences between manual and electronic claim submission.
20. List prevention measures to retain computer confidentiality.
21. State the job duties of an electronic claims professional.
22. Describe the use of patient encounter forms, crib sheets, and scannable encounter forms in electronic claims submission.
23. Describe situations for filling appeals.
24. Define credit and collection terminology.
25. Describe office billing procedures.
26. Discuss ways to determine fees and describe and office's fee policies.
27. Define accounts receivable and explain how it is handled.
28. Perform oral and written communication collection techniques.
29. List possible solutions to collection problems.
30. Prepare charts.
31. Maintain password security.
32. Utilize Microsoft Office software.
33. Utilize EMR software.
34. Search internet sites.
35. Store and retrieve information.
36. Scan (file) EMRs (Electronic Medical Records).
37. Make copies.
38. Obtain doctor registration and license numbers.
39. Audit records.

C. Unit III. Health Care Payers

1. Identify types of managed care health plans.
2. Explain health maintenance organization benefits and eligibility requirements.
3. Name and state reasons for professional review organizations.
4. Identify four types of authorizations for medical services, tests, and procedures.
5. Explain eligibility criteria for Medicare and name important information to abstract from a patient's Medicare card.
6. Identify the benefits and nonbenefits of Medicare.
7. Differentiate between an HMO Risk Plan and an HMO Cost plan.
8. Name the federal laws that relate to cost containment of health services and to reduction of fraud and abuse issues.
9. Define a Medicare mandated prepayment screen.
10. Determine the time limit for submitting a Medicare form.
11. Identify the benefits and nonbenefits of Medicaid.
12. Name the two Medicaid eligibility classifications.
13. List important information to abstract from the patient's Medicaid card.
14. State eligibility requirements and claims procedures for the Maternal and Child Health Programs.
15. Explain basic operation of a Medicaid managed care system.
16. Describe basic Medicaid claim procedure guidelines.
17. File Medicaid claims and minimize the number of insurance forms rejected because of improper completion.
18. State eligibility and terminology for Tricare and ChampVA. Dacum,

19. Identify the difference between the Tricare program and ChampVA.
20. Explain the benefits and nonbenefits of Tricare and ChampVA and list the circumstances when a nonavailability statement is required.
21. Describe how to process claims for individuals who are covered by Tricare and ChampVA.
22. State the purpose of workers' compensation laws and verify insurance.
23. Differentiate between worker's compensation and employers' liability insurance.
24. Define non-disability, temporary disability, and permanent disability claims.
25. Differentiate between SSDI and SSI.
26. State eligibility requirements, benefits, and limitations of state disability plans.
27. Recognize forms used for processing state disability plans.
28. List guidelines for federal, state, individual, and group disability claim procedures.
29. Name federal disability benefit programs.

D. Unit IV. Inpatient and Outpatient Billing
1. Name qualifications require to work in the financial section of a hospital.
2. List criteria used for admission screening.
3. Define the 72 hour rule.
4. Define common terms related to hospital billing.
5. State the role of ICD-9-CM Volume 3 in hospital billing.
6. State reimbursement methods made to hospitals under managed care contracts.
7. State when the Uniform Bill, UB-92, claim form may and may not be used.
8. Edit and complete insurance claims in both hospital inpatient and outpatient settings to minimize their rejection by insurance carriers.
9. State the general guidelines for completion of Uniform Bill (UB-92) claim forms.
10. Identify how payment is made based on diagnosis-related groups.
11. State how payment is made based on the ambulatory payment classification system.
12. Name the four types of ambulatory payment classifications.
13. Post billing charges.
14. Balance daily log.
15. Balance petty cash.
16. Deposit funds.
17. Send patient results.
18. Prepare chart.
19. Use demographics.

E. Unit V. Employment
1. Prepare to find a position as an insurance billing specialist, claims assistance professional, or electronic claims processor.
2. Conduct a job search by listing prospective employers.
3. Compose a letter of introduction to accompany the resume.
4. Identify illegal interview questions.
5. Contact computerized job search databases for online services.
6. Explore the business aspects of self-employment.
7. State types of certification and registration available to insurance billers, coders, and administrative medical assistants.

## III. THECB Learning Outcomes (WECM)

Upon completing this course, the student will be able to:

1. Code procedures and bill for services using both electronic and manual methods.
2. Compare and contrast insurance plans.
3. Define common terms used to file third party reimbursement forms.

## IV. Evaluation

A. The lecture grade will be determined as follows:
- 4 written exams worth 100 points each = 400 points
- Attendance and participation, worth = 100 points
- Professional and ethical behavior = 100 points
- Total of 600 points for the lecture grade

B. The lab grade will be determined as follows:
- There will be five case studies, worth 100 points each = 500 points
- One unannounced pop quiz, worth 100 points = 100 points
- Total of 600 points for the lab grade

The lecture and the final lab grades will be combined and averaged to determine the final grade, and you need to pass both the lecture and the lab portion to pass the course:

Key (used to determine grade)
540 – 600 points = A (90 – 100 %)
480 – 539 points = B (80 – 89 %)
420 – 479 points = C (70 – 79 %)
419 or less points = F*

***A grade of "D" or "F" will need to be repeated for all Health Occupation Classes in order to graduate.** Rounding off of Grades Each grade will initially be determined in decimals to the tenths. They will only be recorded in whole numbers. The guide used will round .1 through .4 to the lower whole number, and .5 through .9 are raised to next whole number. Example: If a student earns 87.4 the grade will be reflected as 87%. If the student earns 87.6 the grade is rounded to 87%. No decimals will be shown on the grade scanners.

## 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.

## VII. Title IX and Sex Discrimination

Title 9 (20 U.S.C. 1681 & 34 C.F.R. Part 106) states the following "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance." The Violence Against Women Act (VAWA) prohibits stalking, date violence, sexual violence, and domestic violence for all students, employees and visitors (male and female). If you have any concerns related to

discrimination, harassment, or assault (of any type) you can contact the Assistant to the Vice President for Student and Enrollment Services at 915-831-2655. Employees can call the Manager of Employee Relations at 915-831-6458. Reports of sexual assault/violence may also be reported to EPCC Police at 915-831-2200.