Medical Coding and Billing II

8389/36 weeks

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Acknowledgments

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Course Description

Suggested Grade Level: 12

Students will learn the health insurance industry and legal and regulatory issues, the principles of medical coding and billing related to reimbursement, claim submission, and payment. Students will examine the International Classification of Diseases (ICD), Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) coding systems. Students will consider the effect of fraud on health care and importance of ethics in medical coding and billing.

Prerequisite: Medical Coding and Billing I (8388)

Task Essentials Table

- Tasks/competencies designated by plus icons (➕) in the left-hand column(s) are essential
- Tasks/competencies designated by empty-circle icons (◯) are optional
- Tasks/competencies designated by minus icons (➖) are omitted
- Tasks marked with an asterisk (*) are sensitive.

<table>
<thead>
<tr>
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**Understanding Issues with Fraud and Abuse**

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<td>Explain solutions for avoiding fraud and abuse.</td>
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Legend: ☑Essential ☐Non-essential ☐Omitted

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**Curriculum Framework**

**Introducing Medical Coding and Billing**

**Task Number 39**

**Identify key job responsibilities in medical coding.**

**Definition**

Identification should include understand coding guidelines and regulations, as well as

- reviewing documentation to ensure compliance with national standards
- adhering to privacy standards as required by Health Insurance Portability and Accountability Act (HIPAA)
- translating patient information into alphanumeric medical code
- collecting, posting, and managing patient account payments
- submitting claims to insurance companies and reporting cases of fraud
- preparing and reviewing patient statements
- reviewing delinquent accounts and calling for collection purposes
- handling information about patient treatment, diagnosis, and related procedures to ensure proper coding
- knowing several different coding systems, including Level 1 Healthcare Common Procedure Coding Systems (HCPCS) and Level 2 HCPCS.

**Process/Skill Questions**

- Why is accuracy important in the medical coding field?
- Why is knowledge of legal and regulatory issues important to a medical coder?
- Why is it important to follow and understand coding guidelines/regulations?
Task Number 40
Identify key job responsibilities in medical billing.

Definition
Identification should include

- adhering to privacy standards as required by HIPAA
- entering data continuously as patients receive diagnostic tests and treatments
- submitting claims to insurance companies and other third-party payers
- processing payments from patient accounts and insurance companies
- posting transactions and reconciling payments to patient ledgers
- identifying past-due bills and recommending collection actions
- ensuring that a healthcare provider is reimbursed for all services provided
- resolving conflicts regarding payments and reimbursements
- writing reports and providing information to government agencies
- responding, in writing and by telephone, to patients’ questions about billing
- providing information and preparing documents for legal inquiries and litigation.

Process/Skill Questions

- How are medical coding and medical billing different?
- When would the positions of medical coder and medical biller be combined?

Task Number 41
Examine state and federal regulatory standards.

Definition
Examination should include

- identifying healthcare industry standards
- explaining Medicare, Medicaid, TRICARE, commercial payers, and self-pay
- comparing the regulatory requirements for each.

Process/Skill Questions

- How would a supplemental policy affect primary care insurance?
- Which insurance is primary if the patient has Medicare coverage?
- What is the proper sequence for patients with multiple insurance coverage (e.g., Medicare, Medicaid, Tricare, commercial)?
Task Number 42

Explain job opportunities in medical coding and billing.

Definition

Explaination may include

- professional coder (CPC)
- certified outpatient coder (COC)
- certified inpatient coder (CIC)
- certified risk adjustment coder (CRC)
- certified professional biller (CPB)
- certified professional medical auditor (CPMA)
- certified physician practice manager (CPPM)
- certified professional compliance officer (CPCO).

Other career opportunities may include

- consultant
- trainer
- auditor
- practice manager
- compliance officer
- hospital coder
- physician/outpatient coder.

Process/Skill Questions

- What are the credentialing organizations for medical coding and/or medical billing?
- Where are potential employment opportunities?
- From where did the International Classification of Diseases (ICD) originate?

HOSA Competitive Events (High School)

- Health Career Display

Introducing Coding Systems

Task Number 43

Examine the International Classification of Diseases (ICD)

ICD-10-CM.

Definition

Examination should include the following:

- History of the ICD
- Transition from ICD-9-CM to ICD-CM/procedure classification system (PCS)
- Contents of each volume of the ICD-10-CM
- Guidelines concerning ICD-10-CM coding
- Common signs and symbols of the ICD-10-CM
- Factors to be aware of when using ICD-10-CM

Process/Skill Questions
- What does the CM represent at the end of the ICD-19?
- How are diabetes codes assigned when type is not specified?
- Why is it important to understand and follow ICD coding guidelines?
- How are sequence codes assigned based on coding guidelines?

Task Number 44

Identify key features of the ICD-10-PCS/CM.

Definition

Identification should include

- ICD-10-PCS codes
  - 1: Medical and Surgical
  - 2: Obstetrics
  - 3: Placement
  - 4: Measurement and Monitoring
  - 5: Extracorporeal Assistance and Performance
  - 6: Extracorporeal Therapies
  - 7: Osteopathic
  - 8: Other Procedures
  - 9: Chiropractic
  - B: Imaging
  - C: Nuclear Medicine
  - D: Radiation Oncology
  - F: Physical Rehabilitation and Diagnostic Audiology
  - G: Mental Health
  - H: Substance Abuse Treatment

- ICD-10-CM codes
  - Chapter I A00 – B99: Certain infectious and parasitic diseases
  - Chapter II C00 – D48: Neoplasms
  - Chapter III D50 – D89: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
  - Chapter IV E00 – E90: Endocrine, nutritional, and metabolic diseases
  - Chapter V F00 – F99: Mental and behavioral disorders
  - Chapter VI G00 – G99: Diseases of the nervous system
  - Chapter VII H00 – H59: Diseases of the eye and adnexa
  - Chapter VIII H60 – H95: Diseases of the ear and mastoid process
  - Chapter IX I00 – I99: Diseases of the circulatory system
  - Chapter X J00 – J99: Diseases of the respiratory system
  - Chapter XI K00 – K93: Diseases of the digestive system
  - Chapter XII L00 – L99: Diseases of the skin and subcutaneous tissue
  - Chapter XIII M00 – M99: Diseases of the musculoskeletal system and connective tissue
  - Chapter XIV N00 – N99: Diseases of the genitourinary system
  - Chapter XV O00 – O99: Pregnancy, childbirth, and the puerperium
  - Chapter XVI P00 – P96: Certain conditions originating in the perinatal period
  - Chapter XVII Q00 – Q99: Congenital malformations, deformations, and chromosomal abnormalities
  - Chapter XVIII R00 – R99: Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified
  - Chapter XIX S00 – T98: Injury, poisoning, and certain other consequences of external causes
  - Chapter XX V01 – Y98: External causes of morbidity and mortality
Process/Skill Questions

- What are the differences between the PCS and CM systems and applications?
- How does knowing the guidelines lead to successful completion of certification exams?
- What is the code structure for ICD-10-CM/PCS? What do the categories identify?

Task Number 45
Identify key features of the CPT.

Definition

Identification should include the following three categories of codes:

- Category I: procedures that are consistent with contemporary medical practice and are widely performed
- Category II: supplementary tracking codes that can be used for performance measures
- Category III: temporary codes for emerging technology, services, and procedures

Process/Skill Questions

- What are the differences between the CPT and ICD-10 systems and applications?
- How does knowing the guidelines lead to the successful completion of certification exams?
- How are CPT codes applied? Why is it important to know the guidelines?

Task Number 46
Identify key features of the HCPCS.

Definition

Identification should include the following types of HCPCS:

- Level I codes: same as CPT codes; when used to bill Medicare or Medicaid, they are considered HCPCS codes
- Level II codes: designed to represent non-physician services such as ambulance rides, wheelchairs, walkers, other durable medical equipment, and other medical services that do not fit readily into Level I codes
- Modifier codes: provide additional information about a procedure or service without redefining the service provided
- What are the differences between the HCPCS, CPT, and ICD-10 systems and applications?
- How does knowing the guidelines lead to the successful completion of certification exams?
- When should an HCPCS code be used vs. a CPT code? Why is it important to know the guidelines?
- When should a modifier be applied?
Task Number 47

Explain the steps used to locate codes.

**Definition**

Explanation should include

- go to the alpha index in each system
- correlate alpha to numeric code.

**Process/Skill Questions**

- What resources are available to locate codes?
- When locating codes, is correct spelling important?
- What system is used to code for a patient diagnosed with influenza? How are codes located?
- What system is used to report open-heart surgery when coding for a surgeon?

Task Number 48

Locate codes based on provider information.

**Definition**

Location should include

- accessing the appropriate reference
- interpreting clinical documentation to assign relevant codes
- assigning codes to procedures and services.
- Why is it important to analyze the clinical documentation with attention to detail?
- What are the ramifications of miscoding?

Task Number 49

Explain reimbursement forms, including the Centers for Medicare and Medicaid Services (CMS) 1500 and UB-04 forms.

**Definition**

Explanation of forms, including the CMS 1500 and UB-04, should include

- key term
- historical development of CMS reimbursement systems
- special rules for the Medicare physician fee schedule payment system
- chargemaster
- hospital revenue cycle management
- appeal process
- completion of forms for
  - workers’ compensation
  - Blue Cross/Blue Shield
  - Medicare
  - Medicaid
  - TRICARE.
Process/Skill Questions

- When is a 1500 form used vs. an UB-04 form?
- What are common mistakes made when filling out forms?
- What is a clean claim vs. a dirty claim?
- What are the steps to an appeal?

Applying Coding and Billing to Medical Diagnosis and Procedures

Task Number 50

Explain the effect of contractual agreements and forms, including the CMS 1500 and UB-04 forms.

Definition

Explanation should include

- participation vs. nonparticipation
- reimbursement agreements
- interpretation of remittance advice
- criminal consequences

Process/Skill Questions

- How does reimbursement differ between participating and nonparticipating programs?
- What safety mechanisms are in place to alert employers to fraudulent activities?

Task Number 51

Explain diagnosis coding specialties.

Definition

Explanation should include examples such as

- cancer and neoplasm
- musculoskeletal
- cardiovascular and circulatory
- respiratory
- immune system
- nervous system
- eye and ear
- genital and urinary systems
- digestive
- endocrine
- obstetrics
- surgical and anesthesia
- lab
- radiology
- pathology
- congenital malformations
- accidents and injuries
- mental health
- morbidity.

**Process/Skill Questions**

- What is the reimbursement code for each specialty area?
- What are the procedures when codes overlap in specialty areas?
- When are status codes used?

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**Task Number 52**

**Demonstrate diagnosis coding specialty procedures.**

**Definition**

Demonstration should include

- cancer and neoplasm
- musculoskeletal
- cardiovascular and circulatory
- respiratory
- immune system
- nervous system
- eye and ear
- genital and urinary systems
- digestive
- endocrine
- obstetrics
- surgical and anesthesia
- lab
- radiology
- pathology
- congenital malformations
- accidents and injuries
- mental health
- morbidity.

**Process/Skill Questions**

- Why is medical terminology important to specialties related to anatomy, physiology, and body organization pertaining to coding and billing treatment or procedures?
- Why is provider information crucial to reimbursement?

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**HOSA Competitive Events (High School)**

- Medical Terminology

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**Understanding Issues with Fraud and Abuse**

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**Task Number 53**
Explain the healthcare fraud and abuse climate.

Definition

Explanation should include

- upcoding
- downcoding
- unbundling
- kitchen sink coding
- inconsistent coding
- inflated charges.

Process/Skill Questions

- How do unbundling and decoding differ?
- How is fraudulent behavior recognized and reported?
- What is the fraud and abuse whistleblower?
- What are the consequences of fraudulent behavior?

HOSA Competitive Events (High School)

- Medical Law and Ethics

Task Number 54

Explain the role of the Department of Health and Human Services in fraudulent activity.

Definition

Explanation should include that the Department of Health and Human Services investigate all sources of potential fraud for waste, abuse, and mismanagement related to their services and programs (e.g., Medicare and Medicaid).

- How much money is lost annually due to fraudulent Medicare and Medicaid claims?
- What are the civil and criminal repercussions of federal fraudulent activity?
- How can a provider lose the privilege to bill Medicare and Medicaid claims?

HOSA Competitive Events (High School)

- Medical Law and Ethics

Task Number 55

Explain the False Claims Act.

Definition

Explanation should include the importance of not knowingly submitting false claims and the potential financial consequences of so doing.

Process/Skill Questions

- What is the Lincoln law?
- Who monitors healthcare fraud?
HOSA Competitive Events (High School)

- Medical Law and Ethics

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Task Number 56

Describe the role of an auditor.

**Definition**

Description should include reviewing documentation to ensure it was billed and coded in accordance with regulatory rules and standards.

**Process/Skill Questions**

- What circumstances will trigger an audit?
- What are the consequences of a failed audit?
- What are the different types of and ways to conduct audits?
- How is an auditor’s role the same as an educator’s? Why should they not be viewed as the enemy?

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Task Number 57

Explain solutions for avoiding fraud and abuse.

**Definition**

Explanation should include strategies to avoid fraudulent behavior and the mismanagement of state and federal funds.

**Process/Skill Questions**

- What precautions can a coder and biller take to protect against an audit?
- What legal and ethical rights do medical coders and billers have?
- What are similarities and differences in each organization’s code of conduct/ethics.

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**SOL Correlations by Task**

<table>
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<th>History and Social Sciences: VUS 14, Govt 7, 8, 9, 15</th>
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| Locate codes based on provider information. | English: 12.5 |
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| Explain solutions for avoiding fraud and abuse. | English: 12.5 |

**Instructional Resources**

American Health Information Management (AHIMA)  
American Association of Professional Coders (AAPC)  
Medical Coding  
Medical Billing  
Medical Association of Billers (MAB)  
Medical Billing Certifications
Appendix: Credentials, Course Sequences, and Career Cluster Information

Industry Credentials: Only apply to 36-week courses

- AAPC Medical Coding Examinations
- Billing Coding Specialist Certification (BCSC) Examination
- Certified Coding and Billing Specialist (CCBS) Examination
- Certified Medical Administrative Assistant (CMAA) Examination
- College and Work Readiness Assessment (CWRA+)
- Electronic Health Record Certification (EHRC) Examination
- Medical Administration Assistant Certification (MAAC) Examination
- Medical Coding and Billing Specialist (MCBS) Examination
- National Career Readiness Certificate Assessment
- National Certified Insurance and Coding Specialist (NCICS) Examination
- Nationally Registered Certified Administrative Health Assistant (NRCAHA) Examination
- Nationally Registered Certified Coding Specialist (NRCCS) Examination
- Workplace Readiness Skills for the Commonwealth Examination

Concentration sequences: A combination of this course and those below, equivalent to two 36-week courses, is a concentration sequence. Students wishing to complete a specialization may take additional courses based on their career pathways. A program completer is a student who has met the requirements for a CTE concentration sequence and all other requirements for high school graduation or an approved alternative education program.

- Medical Coding and Billing I (8388/36 weeks)

Career Cluster: Health Science

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<tr>
<td>Health Informatics</td>
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</tr>
<tr>
<td>Support Services</td>
<td>Data Entry Specialist&lt;br&gt;Front Office Assistant&lt;br&gt;Records Processing Assistant</td>
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