

# HARTNELL COLLEGE

## MEDICAL BILLING

### COURSE OUTLINE

#### COURSE DESCRIPTION:

The study of managed health care with an emphasis on medical billing and the accurate completion of claims forms for major nationwide medical insurance programs. The importance of the integration of the health system, including federal, state and private medical insurance programs.

#### COURSE OBJECTIVES:

The student will

1. identify the basic skill requirements of a health information specialist.
2. list and describe the responsibilities of a health information specialist.
3. list the professional health information organizations and describe the credentials of a health information specialist.
4. explain the difference between health care and medical care.
5. describe the difference between disability and liability insurance.
6. discuss the history of health care reimbursement and describe the influence of the major developments in health care reimbursement.
7. compare and contrast managed health care with traditional health care insurance.
8. discuss the history of managed health care.
9. list and summarize managed health care federal legislation.
10. define the role of a managed health care organization.
11. list and describe six models for managed health care.
12. describe the accreditation process for managed health care organizations and distinguish between two accrediting agencies.
13. describe administrative procedures to assimilate managed health care into the physician's practice.
14. describe the life cycle of an insurance claim and the documents that are generated.
15. describe the steps in conducting a new patient interview.
16. describe the steps in processing an established patient return visit insurance claim.
17. describe the steps in performing postclinical checkout procedures.
18. compare and contrast manual and electronic claims processing procedures.
19. describe the processing of claims by an insurance company.
20. interpret information on an explanation of benefits form.
21. maintain insurance claim files.
22. identify problems that cause delinquent claims and determine solutions to those problems.
23. identify publications that contain managed health care legal considerations and regulations.
24. list resources for acquiring information about new laws and regulations regarding health care.
25. describe breaches of confidentiality.
26. compare and contrast methods of obtaining patient information and patient authorizations.
27. develop retention policies and procedures for patient records.
28. compare and contrast various acts affecting managed health care and describe the components of each.
29. describe the universal instructions for entering data on the dms-1500 claim.
30. describe and apply optical scanning guidelines for claim completion.
31. identify common errors made on claims and describe ways to prevent errors.
32. identify reporting guidelines and restrictions for claim items.
33. list the processing steps prior to submitting a completed claim to the payer.
34. describe procedures for maintaining insurance claim files and develop a tickler filing system for completed claims.
35. compare and contrast primary and secondary commercial claims.

36. complete primary commercial and HMO fee-for-service claims accurately.
37. explain the function of the national Blue Cross and Blue Shield Association and the features that differentiate them from other commercial medical insurance programs.
38. compare and contrast the different Blue Cross/Blue Shield plans and riders.
39. differentiate among Preferred Provider Networks, Preferred Provider Organizations, and Point of Service plans.
40. complete accurately BCBS primary and secondary claims forms.
41. list those categories of persons eligible for Medicare coverage and describe the enrollment process.
42. compare and contrast Part A and Part B coverage and list the components of each.
43. compare and contrast Participating providers and nonparticipating providers and list the restrictions of NonPARs.
44. list the five factors included in the formula on which the MFS is based.
45. list the plans that determine when Medicare is eligible as a secondary payor and how billing is affected.
46. list and describe programs that are classified as Medicare Supplemental plans.
47. compare and contrast the managed care programs that Medicare-eligible beneficiaries may contract for and describe the effects on Medicare billing.
48. complete accurately Medicare or Medicare HMO fee-for-service claims forms.
49. list Medicaid federal guidelines.
50. differentiate among services covered under the federal portion of Medicaid assistance and state services not federally mandated.
51. determine if a patient is eligible for Medicaid coverage and if/when Medicaid is a secondary payer.
52. describe the impact of managed care on Medicaid.
53. complete accurately Medicaid claims using the rules for the HCFA (12-90) form.
54. list those categories of persons eligible for TRICARE coverage and describe the enrollment process.
55. list and differentiate among the TRICARE services and primary health insurance types.
56. list and describe the three levels of TRICARE coverage.
57. complete accurately TRICARE claims using the rules for the HCFA 1500) form.
58. list the categories of workers covered by federal compensation program.
59. list the types of workers' compensation available at the state level.
60. describe eligibility categories for workers' compensation claimants and classification of on-the-job injuries.
61. define the OSHA Act of 1970 and describe why it was enacted.
62. complete accurately all workers' compensation claims forms, including the First Report of Injury Report.
63. recognize, spell, and define managed health care terms.

#### COURSE CONTENT:

1. Roles and responsibilities of a health information specialist
  - a. Basic skill requirements of a health information specialist
  - b. Responsibilities of a health information specialist
  - c. Credentials of a health information specialist
2. Introduction to health insurance
  - a. Health care vs. medical care
  - b. Disability and liability insurance
  - c. Major developments in health insurance
  - d. Health insurance coverage statistics
3. Managed health care
  - a. History of managed health care
  - b. Managed care organizations
  - c. Managed care models
  - d. Accreditation of managed health care organizations
  - e. Managed health care and the physician's practice
4. Life cycle and documents of an insurance claim

- a. Development of the claim
- b. New patient interview
- c. Established patient return visit
- d. Postclinical check-out procedure
- e. Claim processing by insurance company
- f. Maintenance of insurance claim files
- g. Handling of delinquent claims
5. Legal and regulatory issues
  - a. Existing and new resources for current and new laws and regulations regarding health care
  - b. Confidentiality of patient information
  - c. Methods of obtaining patient information
  - d. Patient information and health insurance record retention
  - e. Health insurance Acts
6. CMS-1500 Claim Instructions
  - a. General billing guidelines and universal instructions for entering data
  - b. Optical scanning guidelines
  - c. Reporting guidelines and restrictions for claim items
  - d. Processing claims
  - e. Insurance claim file maintenance
7. Commercial Claims
  - a. Filing commercial claims
  - b. Step-by-step instructions for completing all primary commercial and HMO fee-for-service claims
8. Blue Cross and Blue Shield Plans
  - a. History, features, and function of Blue Cross and Blue Shield
  - b. Blue Cross/Blue Shield plans (basic coverage, major medical coverage, riders)
  - c. Preferred Provider Networks, Preferred Provider Organizations, and Point of Service plans
  - d. Step-by-step claim instructions and processing for primary and secondary claims
9. Medicare
  - a. Eligibility categories for Medicare claimants
  - b. Part A and Part B coverage
  - c. Participating providers and nonparticipating providers
  - d. Medicare fee schedule
  - e. Medicare as a secondary payer
  - f. Medicare supplemental plans
  - g. Medicare and an HMO option, employer-sponsored HMO option primary to Medicare, employer-sponsored retiree HMO supplemental plan
  - h. Step-by-step Medicare claim form instructions
10. Medicaid
  - a. Federal guidelines
  - b. Services covered under the federal portion of Medicaid assistance and state services not federally mandated
  - c. Medicaid eligibility and Medicaid as a secondary payer
  - d. Medicaid and managed care
  - e. Medicaid claims using the rules for the HCFA (12-90) form
11. Tricare/Champus
  - a. Eligibility categories for TRICARE claimants
  - b. TRICARE services and primary health insurance types
  - c. Levels of TRICARE coverage
  - d. TRICARE claims using the rules for the HCFA 1500 form
12. Workers' Compensation
  - a. Categories of workers covered by federal compensation program
  - b. Types of workers' compensation available at the state level
  - c. Eligibility categories for workers' compensation claimants and classification of on-the-job injuries
  - d. OSHA Act
  - e. Worker's compensation claims, including the First Report of Injury Report
13. Managed health care and medical billing terms and definitions

