Perris Union High School District
Course of Study

A. COURSE INFORMATION

Course Title: Medical Office Operations

If revised previous course name if changed

Transcript Course Code/Number: 608030

(To be assigned by Educational Services)

Subject Area:
- ❑ Social Science
- ❑ English
- ❑ Mathematics
- ❑ Laboratory Science
- ❑ World Languages
- ❑ Visual or Performing Arts
- ☒ College Prep Elective
- ❑ Other

Is this classified as a Career Technical Education course?
- X Yes
- ❑ No

Grade Level
- ❑ MS
- ❑ HS
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- 9
- X 10
- X 11
- X 12

Required for Graduation:
- ❑ Yes
- X No

Credential Required to teach this course: Designated Subjects: CTE—Health Science + Medical Technology

To be completed by Human Resources only.

Signature: [signature] Date: 04/27/22

CalPADS CODE 7931

Meets UC/CSU Requirements?
- ☒ Yes
- No

Was this course *previously approved by UC* for PUHSD?
- ❑ Yes
- ☒ No

(Will be verified by Ed Services)

Meets "Honors" Requirements?
- ❑ Yes
- X No

Meets "AP" Requirements?
- ❑ Yes
- X No

Unit Value/Length of Course:
- X 0.5 (half year or semester equivalent)
- ❑ 1.0 (one year equivalent)
- ❑ 2.0 (two year equivalent)
- ❑ Other:

Submitted by: Dian Martin
Site: District
Date: 04.19.2022

Approvals	**Name/Signature**	**Date**
Director of Curriculum & Instruction	[signature]	4/27/22
Asst. Superintendent of Educational Services	[signature]	4/29/22
Governing Board		

Prerequisite(s) (REQUIRED):

None

Corequisite(s) (REQUIRED):

None

Brief Course Description (REQUIRED):

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.

B. COURSE CONTENT

Course Purpose (REQUIRED):
What is the purpose of this course? Please provide a brief description of the goals and expected outcomes. Note: More specificity than a simple recitation of the State Standards is needed.

Medical Office Operations 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 and a required course for the Associate Degree in Medical Assisting. This course is designed to meet the changing industry needs.

Course Outline (REQUIRED):
Detailed description of topics covered. All historical knowledge is expected to be empirically based, give examples. Show examples of how the text is incorporated into the topics covered.

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 documentation.
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 utilize the billing and coding guidelines to complete an 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

Writing Assignments (REQUIRED):
Give examples of the writing assignments and the use of critical analysis within the writing assignments.

1. Outline the typical job responsibilities, academic training, healthcare setting and opportunities of a health insurance specialist.

INSTRUCTIONAL MATERIALS (REQUIRED)	
Textbook #1	
Title: *Understanding Health Insurance A Guide to Billing and Reimbursement*	Edition: *14th*
Author: *Green, Michelle, A (2019)*	ISBN: *13:9781337554*
Publisher: *Cengage*	Publication Date: *2019*
Usage: X Primary Text ❑ Read in entirety or near	
Textbook #2	
Title:	Edition:
Author:	ISBN:
Publisher:	Publication Date:
Usage: ❑ Primary Text ❑ Read in entirety or near	
Supplemental Instructional Materials *Please include online, and open source resources if any.*	

Estimated costs for classroom materials and supplies (REQUIRED). *Please describe in detail.* If more space is needed than what is provided, please attach backup as applicable.	
Cost for class set of textbooks: Approx. $155/textbook x 36 students = $5,580	Description of Additional Costs:
Additional costs:	
Total cost per class set of instructional materials:	$5,580

Key Assignments (REQUIRED):

Please provide a detailed description of the Key Assignments including tests, and quizzes, which should incorporate not only short answers but essay questions also. How do assignments incorporate topics? Include all major assessments that students will be required to complete

1. Case Studies Accurately 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 questions 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.

Instructional Methods and/or Strategies (REQUIRED):

Please list specific instructional methods that will be use.

Method: Lecture Integration: Lecture will be complemented 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 Computerized lab activities to create over 40 insurance claims using a fillable CMS 1500 Claim Form. Students 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.

Assessment Methods and/or Tools (REQUIRED):

Please list different methods of assessments that will be used.

Method: Homework Integration: Targeted essay and short answer questions used to guide students' understanding of the assigned reading. Students providing individual, oral responses 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 electronically 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 questions to assess insurance billing, coding and claims processing concepts and application will be utilized.

COURSE PACING GUIDE AND OBJECTIVES (REQUIRED)				
Day(s)	**Objective**	**CTE Standard(s)**	**Chapter(s)**	**Reference**
	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	Understand and maintain standards of excellence, professional, ethical, and moral conduct required in management of personnel and policy within the healthcare delivery system. C5.1 Understand the alignment of personal and organizational conduct management with ethical and professional standards. C5.2 Know the organizational		

		responsibility to the patient and community and a commitment to lifelong learning and improve		
	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, Hospital Inpatient and Outpatient Prospective Payment System Inpatient Psychiatric and Rehabilitation Facility Prospective Payment System Long Term Acute Care Hospital and Skilled Nursing Facility Prospective Payment System Medicare Physician Fee Schedule Claims			
	10. Coding for Medical Necessity Applying Coding Guidelines Coding and Billing Considerations Coding From Case scenarios 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 Common Errors that Delay Claim			

	Processing Maintaining Insurance Claim Files			
	12. Commercial Insurance Commercial Claims Commercial Secondary Coverage Commercial 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 Crossover 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: 1. Insurance 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.	C2.2 Describe common medical record documentation formats (e.g., Subjective, Objective, Assessment, and Plan [SOAP] notes, admission notes). Follow the model of medical safety practices and processes that can help prevent system medication errors and understand the consequences of mistakes. C7.1 Recognize the major consequences mistakes in health care may cause (e.g.,		

	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 guidelines 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. Interpretation of the ICD-10-CM coding conventions to accurately assign ICD codes for diseases. 33. Interpretation of the CPT coding conventions for the selection of	deaths, lawsuits). C7.2 Recognize the critical nature of accurate and complete documentation (e.g., medical allergies, conflicting prescriptions). C7.3 Identify patients accurately using appropriate strategies (e.g., continual verification). C7.4 Delineate the process for assessing information required by patients, staff, and the community to determine the best course of action. C10.0 Understand common file formats for document and medical imaging, digitizing paper records, and storing medical images. C10.1 Understand basic document and medical imaging concepts (e.g., resolution, colordepth, compression). C10.2 Understand common file formats for document and medical imaging (e.g., tagged image file format [TIFF], joint photographic experts group [JPEG], 2000). C10.3 Demonstrate how to scan paper records. C10.4 Calculate the approximate storage needs for digitized records and images. C10.5 Attach digitized records and medical images to patient records. C14.0 Understand how to transfer information to third-parties. C14.1 Recognize the types of third parties that may need patient information (e.g., specialists, pharmacies, insurance companies). C14.2 Understand the laws and regulations regarding the transfer of information to a third party (e.g., when a		

	diagnostic and therapeutic procedures. 34. Inpatient care methodologies of coding for diseases, procedure and evaluation of management of patients 35. outpatient care methodologies of coding for diseases, procedure and evaluation 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 insurance claims processing. 41. Medicaid/MediCal insurance claims processing. 42. TRICARE insurance claims processing for active military and their dependents 43. Worker's compensation insurance claims processing	company is a covered entity, when a business agreement is required). C14.3 Use various technologies to transmit information securely (e.g., fax, electronic and postal mail). C15.0 Code health information and bill payers using industry standard methods of classification of diseases, current procedural terminology, and common health care procedure coding system. C15.1 Understand the basic concepts of accrual-based accounting (e.g., accounts payable, accounts receivable, credits, debits). C15.2 Understand medical record documentation (e.g., chart notes, injections, medications, lab reports). C15.3 Synthesize required information from a medical record and other medical documents for a variety of purposes upon regulatory or legal request. C15.4 Translate code services (e.g., diagnostic procedures, surgeries) using industry standard methods (e.g., International Classification of Diseases-ninth Ed. [ICD-9], Current Procedural Terminology-fourth Ed. [CPT-4], Healthcare Common Procedure Coding System [HCPCS]). C15.5 Demonstrate how to bill third-party payers (e.g., insurance companies, Medicare). C15.6 Receive and process information from third-party payers (e.g., Explanation of Benefits [EOB], Remittance Advice). C15.7 Audit and analyze coding done by others to		

		determine proper billing		
	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 determining 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 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			

C. HONORS COURSES ONLY
Indicate how much this honors course is different from the standard course.
Not Applicable

D. BACKGROUND INFORMATION
Context for course (optional)
History of Course Development (optional)