Texas CTE: Health Science

Medical Billing and Coding

Implementation. A

1 The provisions of this section shall be implemented by school districts beginning with the 2022- 2023 school year. A.1

2 School districts shall implement the employability skills student expectations listed in §127.15(d)(2) of this chapter (relating to Career and Technical Education Employability Skills) as an integral part of this course. A.2

General requirements. This course is recommended for students in Grades 11 and 12. Prerequisite: Medical Terminology. Students shall be awarded one credit for successful completion of this course. B

b General requirements. This course is recommended for students in Grades 11 and 12. Prerequisite: Medical Terminology. Students shall be awarded one credit for successful completion of this course. B

Introduction. C

1 Career and technical education instruction provides content aligned with challenging academic standards, industry-relevant technical knowledge, and college and career readiness skills for students to further their education and succeed in current and emerging professions. C.1

2 The Health Science Career Cluster focuses on planning, managing, and providing therapeutic services, diagnostic services, health informatics, support services, and biotechnology research and development. C.2

3 Medical Billing and Coding familiarizes students with the process, language, medical procedure codes, requirements of Health Insurance Portability and Accountability Act (HIPAA), and skills they will need to make accurate records. Students will develop an understanding of the entire process of the revenue cycle and how to effectively manage it. The program is designed to prepare students for employment in a variety of health care settings as entry level coder, medical billing specialist, and patient access representative. C.3

4 Students are encouraged to participate in extended learning experiences such as career and technical student organizations and other organizations that foster leadership and career development in the profession such as student chapters of elated professional associations. C.4

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5 **Statements that contain the word "including" reference content that must be mastered, while those containing the phrase "such as" are intended as possible illustrative examples.** C.5

Knowledge and skills. D

1 **The student explores career opportunities in revenue cycle management. The student is expected to:** D.1

- A identify professional opportunities within the medical billing and revenue cycle management professions; D.1.A
- B demonstrate ethical billing and coding practices as outlined by professional associations guidelines; and D.1.B
- C investigate professional associations applicable to the field of health informatics such as American Academy of Professional Coders (AAPC), American Health Information Management Association (AHIMA), Healthcare Billing and Management Association (HBMA), and American Association of Healthcare Administrative Management (AAHAM). D.1.C

2 **The student explains the ethical and legal responsibilities of personnel in medical billing and coding. The student is expected to:** D.2

- A identify major administrative agencies that affect billing and coding such as Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG); D.2.A
- B identify major laws and regulations that impact health information, including HIPAA, the Stark Law, the Fair Debt Collection Practices Act, and the False Claims Act; D.2.B
- C analyze legal and ethical issues related to medical billing and coding, revenue cycle management, and documentation within the medical record; D.2.C
- D research compliance laws; D.2.D
- E identify appropriate documentation required for the release of patient information; D.2.E
- F differentiate between informed and implied consent; D.2.F
- G compare and contrast use of information and disclosure of information; and D.2.G
- H evaluate cases for insurance fraud and abuse. D.2.H

3 **The student identifies the body systems to support proficiency in billing and coding. The student is expected to:** D.3

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A explain the sections and organizations of the International Classification of Diseases and Related Health Problems, 10th Revision, Clinical Modification (ICD-10-CM) and Current Procedural Terminology (CPT) coding manuals by identifying the anatomy and physiology of body systems and how they apply to medical billing and coding, including: D.3.A

i the integumentary system; D.3.A.I

ii the skeletal system; D.3.A.II

iii the muscular system; D.3.A.III

iv the cardiovascular system; D.3.A.IV

v the respiratory system; D.3.A.V

vi the digestive system; D.3.A.VI

vii the endocrine system; D.3.A.VII

viii the urinary system; D.3.A.VIII

ix the reproductive system; and D.3.A.IX

x the nervous system and special senses; and D.3.A.X

B identify mental, behavioral, and neurodevelopmental disorders and how they apply to medical billing and coding. D.3.B

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4 The student demonstrates proficiency in the use of the ICD-10-CM, CPT, and Healthcare Common Procedure Coding System (HCPCS) coding systems. The student is expected to: D.4

A apply coding conventions and guidelines for appropriate charge capture; D.4.A

B describe the process to update coding resources; D.4.B

C assign and verify diagnosis and procedure codes to the highest level of specificity, and, as applicable, HCPCS level II codes and modifiers in accordance with official guidelines; D.4.C

D describe the concepts of disease groupings and procedure-code bundling; D.4.D

E identify coding compliance, including medical necessity; and D.4.E

F use appropriate medical terminology and abbreviations. D.4.F

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5 The student understands revenue cycle management. The student is expected to: D.5

A define revenue cycle management; D.5.A

B differentiate between various types of employer-sponsored and government-sponsored insurance models, including health maintenance organization (HMO), preferred-provider organization (PPO), Medicare, Medicaid, TRICARE, high deductible health plans, and workers' compensation; D.5.B

C define Medicare Administrative Contractors (MACs) and investigate the administrative services provided by the MAC for Texas; D.5.C

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D describe the patient scheduling and check-in process, including verifying insurance eligibility, obtaining pre-authorization, and processing appropriate patient authorization and referral forms; D.5.D

E describe the sections of the CMS-1500 form to prepare and submit mock clean claims electronically or manually; D.5.E

F differentiate between primary and secondary insurance plans to initially process crossover claims; D.5.F

G interpret remittance advice to determine financial responsibility of insurance company and patient, including a cash-paying patient; D.5.G

H analyze reason for insurance company denials or rejections and determine corrections or appeals required; and D.5.H

J analyze an aging report and how it relates to the revenue cycle. D.5.J