ApprenticeshipUSA

Alaska Primary Care
ASSOCIATION

ALASKA PRIMARY CARE ASSOCIATION
1231 GAMBELL STREET, Suite 200
Anchorage, Alaska 99501

Appendix A-2

MEDICAL BILLING AND CODING SPECIALIST

WORK PROCESS SCHEDULE
and
RELATED TECHNICAL INSTRUCTION

O*NET-SOC Code: 29-2071.00 RAPIDS Code : 1114

Appendix A-2

OCCUPATION TITLE: MEDICAL BILLING AND CODING SPECIALIST
O*NET-SOC CODE : 29-2071.00 RAPIDS CODE : 1114 (Medical Coder)

This schedule is attached to and a part of the Standards for the above occupation.

1. TYPE OF OCCUPATION

☒ Time-based ☐ Competency-based ☐ Hybrid

2. TERM OF APPRENTICESHIP

The term of the time-based occupation is approximately one year with an OJL attainment of 2,700 hours, and supplemented by the minimum required hours of related instruction consistent with the National Healthcareer Association.

3. RATIO OF APPRENTICES TO JOURNEYWORKERS

Consistent with proper supervision, training, safety, continuity of employment throughout the apprenticeship, the ratio of apprentices to journeyworker/mentors will be:

Two (2) apprentices may be employed in each medical office for each regularly employed office or business manager or supervisor. Apprentices will be supervised by their employer and mentored via phone, internet, text, or email to insure a mentor is available to answer questions and monitored their progress throughout their apprenticeship under the Alaska Primary Care Association registered apprenticeship program.

4. APPRENTICE WAGE SCHEDULE

Apprentices shall be paid a progressively increasing schedule of wages based on either a percentage or a dollar amount of the current hourly Medical Billing and Coding Specialist journey worker wage rate, which is: $ 21.03 per hour.

1st	3 months + 675 OJL hours = 60%	2nd	3 months + 675 OJL hours = 70%
3rd	3 months + 675 OJL hours = 80%	4th	3 months + 675 OJL hours = 90%

Note: Journeyworker hourly wage rate based on the Alaska mean wage data: http://live.laborstats.alaska.gov/wage).

5. WORK PROCESS SCHEDULE (See attached Work Process Schedule)

6. RELATED INSTRUCTION OUTLINE (See attached Related Instruction Outline)

Appendix A-2

WORK PROCESS SCHEDULE
MEDICAL BILLING AND CODING SPECIALIST
O*NET-SOC CODE : 29-2071.00 RAPIDS CODE : 1114 (Medical Coder)

During the term of apprenticeship, the apprentice shall receive instruction and experience, in all facets of the occupation, as is necessary to develop a practical and versatile skilled and knowable worker. Major processes in which apprentices will be trained (although not necessarily in the order listed) and approximate hours (not necessarily continuous) to be spent in each are as follows:

Medical Billing and Coding Specialist Work Processes	Competency Area	OJL Hours
A. Manage General Office 1. Interact with staff and patients to optimize work flow 2. Coordinate patient/office communication a. Mail, Email, Phone, Fax, and In-Person 3. Provide/coordinate office maintenance 4. Maintain and update office procedure manuals 5. Inventory and order office equipment and supplies 6. Develop and maintain multiple files and lists 7. Maintain certifications and professional development	**I**	**200**
B. Regulatory Compliance 1. Identify documentation required for release of patient information. 2. Audit billing against medical documentation to prevent fraud and abuse. 3. Identify and comply with major laws, regulations and administrative agencies relevant to medical billing. a. HIPPA, Stark Law, Fair Debt Collection, False Claims Act	**II**	**300**
C. Claims Processing 1. Apply procedures for transmitting claims to third party payers 2. Apply specialized coding processes 3. Apply knowledge of the CMS-1500 form to accurately complete the appropriate fields	**III**	**500**

D. Front-End Duties 1. Ensure accurate collection of appropriate patient demographics and insurance information 2. Verify insurance eligibility to determine benefits 3. Compare and contrast government and private insurance 4. Process appropriate patient authorization and referral forms 5. Prior to visit determine appropriate balance due	**IV**	**200**
E. Payment Adjudication 1. Analyze aging reports 2. Post payment accurately 3. Interpret remittance advice to determine financial responsibility of patient and insurance company 4. Determine reason for insurance company denial	**V**	**500**
F. Apply Knowledge of Coding 1. Apply specific coding guidelines and conventions for diagnostics and procedures 2. Abstract the medical documentation by applying knowledge of medical terminology and anatomy and physiology 3. Process and complete all insurance forms; code diagnoses and procedures.	**VI**	**1,000**
	Total Hours	**2,700**

Appendix A-2

RELATED INSTRUCTION OUTLINE
MEDICAL BILLING AND CODING SPECIALIST
O*NET-SOC CODE : 29-2071.00 RAPIDS CODE : 1114 (Medical Coder)

The related technical instruction outlines the courses providing the technical knowledge supplementing the on-the-job learning. It is through the combination of both the on-the-job learning and the related technical instruction that the apprentice can reach the skilled level of the occupation. Under a registered apprenticeship, 144 hours of related instruction each year of the apprenticeship is recommended.. The following is the suggested course curriculum during the term of apprenticeship. Supplemental materials are available as further references and may not be required to complete the apprenticeship program.

Related Technical Instruction Provider: Alaska Primary Care Association (APCA), 1231 Gamble Street Suite 200, Anchorage, Alaska 99501, Phone 907-929-2730

Instructional Guide:

Certified Billing and Coding Specialist Study Guide	National Healthcare Association

Supplemental References:

Understanding Health Insurance: A Guide to Billing and Reimbursement	Michelle Green
Insurance Handbook for the Medical Office	Marilyn Fordney
Step-by-Step Medical Coding	Carol Buck
Principles of Healthcare Reimbursement	Anne Castro
Health Information Management Technology: An Applied Approach	Nanette Sayles,

Program, orientation will be delivered by the APCA Apprenticeship Coordinator who will establish Supervisor, Mentor and Apprentice rolls, duties, expectations and outcomes.

Chapter 1 - Regulatory Compliance – 25 Hours

This course gives an introduction to CMBC of the appropriate documentation required to release patient information, how to audit billing against medical documentation to prevent fraud and abuse how to identify laws and regulations relevant to medical coding.

Objectives:

- Appropriate Documentation
  - Information and implied consent
  - Legislation protecting patient privacy
- Billing Audits
  - Importance of being compliant
- Laws, Regulations and Administering Agencies
  - HIPPA, Stark Law, False Claims Act, Fair Debt Collection Practices Act, Office of the inspector General.

Chapter 2 - Claims Processing - 40 Hours

This course the CBCS will learn the CMS-1500 form, how to properly fill out the form and how to transmit claims to third party payers.

Objectives:

- Transmitting Claims
  - Correct claim processing
  - Populating correct information on a claim
  - The procedures for transmitting a claim
  - How to identify the cause of transmission errors
  - What are clean and dirty claims

- CMS-1500 Form
  - Member information
  - Rendering provider

Course 3 – Front End Duties – 35 Hours

This course is designed to help the CMBC to understand how to collect patient information, determine insurance eligibility and amount due on a bill.

Objectives:

- Collect patient information
  - Collect basic information
- Insurance eligibility
  - Identify other patient insurance issues
- Government and commercial Insurance
  - What is government insurance
  - What id commercial insurance
- Patient Authorization and Referral forms
  - HMO's
  - PPO's
- Determine Balance Due
  - Deductibles
  - Copayments
  - Coinsurance

Chapter 4 – Payment Adjudication - 40 Hours

In this chapter the CMBC will analyze reports, interpret remittance advice, post payments and determine reasons for insurance company denials.

Objectives:

- Analyze aging reports
  - Manage aging reports
  - Assessing the status of accounts
- Interpreting remittance advice
  - Components of a RA
  - RA's for Medicare participates
- Post payments
- Determine reasons for insurance company denial
  - Managing denials
  - Denial code
  - Appeals Process

Chapter 5 – Apply Knowledge of Coding - 12 Hours

In this chapter the CMBC will examine medical terminology. The apprentice will also develop their knowledge of the ICD and the HCPCS.

Objectives:

- Coding guidelines and conventions for diagnoses and procedures
  - Comparing ICD-9-CM and ICD-10-CM
  - Procedures codes
- Healthcare Common Procedure Coding Systems (HCPCS)
  - CPT HCPCS Level I
  - HCPCS Level II
- Abstracting medical documentation
  - Transfer information from encounter forms
  - Coding abstracted information
  - Consulting with physicians
- Common medical terminology
  - Body systems and their functions
- Hospital terminology
  - Types of facilities
  - Hospital departments
  - Laboratory testing
  - Identifying health care providers

Case Studies – In Practice – 12 Hours

Case Study 1: Determine Patient Coverage
Case Study 2: Billing Mistakes
Case Study 3: Denied insurance Form

Total Related Technical Instruction 172 Hours