Medical Insurance

An Integrated Claims Process Approach



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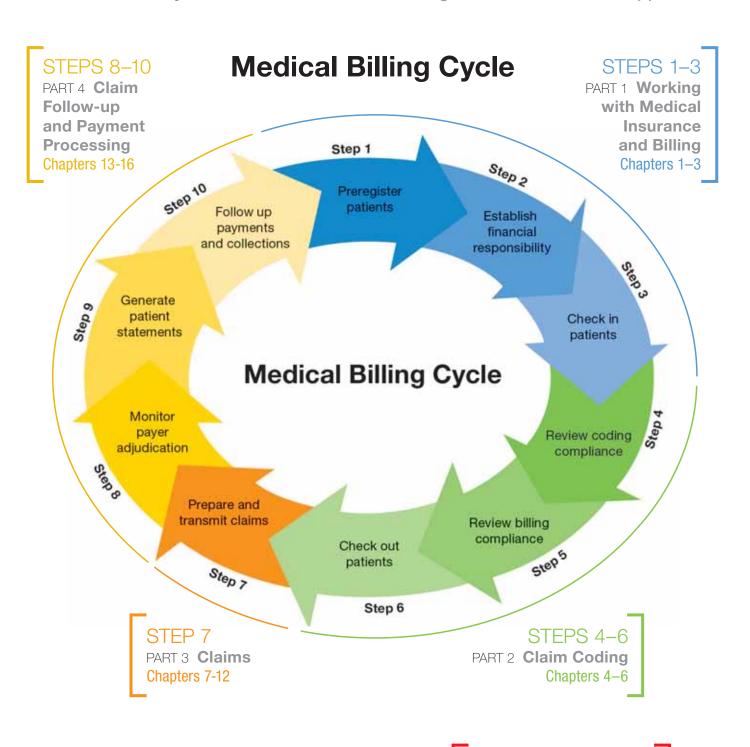
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Follow the money with Medical Insurance: An Integrated Claims Process Approach!



PLUS...
PART 5 Hospital Services
Chapter 17

MEASURABLE LEARNING OUTCOMES



RELEVANT



Staying Current with HIPAA

HIPAA taws have a lengthy review process before being released as final rules. Future changes are expected. Medical insurance specialists need to stay current with those that affect their areas of responsibility.

COMPLIANCE GUIDELINE

Documentation and Billing: A Vital Connection

The connection between documentation and billing is essential: If a service is not documented, it cannot be billed.

BILLING TIP

Medical Necessity

Services are medically necessary when they are reasonable and essential for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Such services must also be consistent with generally accepted standards of care.

REAL WORLD—medisoft[®]



FIGURE 7.2 Example of Medisoft Screen for Player Information

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- 100 Best Corporate Citizens by Corporate Responsibility Magazine for 2011
- Top 25 in 2011 Newsweek Green Rankings list of 500 largest U.S. companies

Medical Insurance



Medical Insurance

An Integrated Claims Process Approach Sixth Edition



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MEDICAL INSURANCE: AN INTEGRATED CLAIMS PROCESS APPROACH, SIXTH EDITION

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Brief Contents

D (
Preface	ΧI
i i ciacc	ΛI

	TICIACC AII
Part 1	WORKING WITH MEDICAL INSURANCE AND BILLING 1
Chapter 1	Introduction to the Medical Billing Cycle 2
Chapter 2	Electronic Health Records, HIPAA, and HITECH: Sharing and Protecting Patients' Health Information 35
Chapter 3	Patient Encounters and Billing Information 77
Part 2	CLAIM CODING 111
Chapter 4	Diagnostic Coding: ICD-10-CM 112
Chapter 5	Procedural Coding: CPT and HCPCS 143
Chapter 6	Visit Charges and Compliant Billing 197
Part 3	CLAIMS 233
Chapter 7	Healthcare Claim Preparation and Transmission 234
Chapter 8	Private Payers/BlueCross BlueShield 277
Chanter 0	Medicare 321

Chapter 9 Medicare 321
Chapter 10 Medicaid 358

Chapter 11 TRICARE and CHAMPVA 381

Chapter 12 Workers' Compensation and Disability/Automotive Insurance 402

Part 4 CLAIM FOLLOW-UP AND PAYMENT PROCESSING 42

Chapter 13 Payments (RAs), Appeals, and Secondary Claims 428

Chapter 14 Patient Billing and Collections 460

Chapter 15 Primary Case Studies 486

Chapter 16 RA/Secondary Case Studies 523

Chapter 17

Hospital Billing and Reimbursement 538

Chapter 18

Diagnostic Coding: Introduction to ICD-9-CM and ICD-10-CM Available at www.mcgrawhillcreate.com

Appendix A: Guide to Medisoft® A-1

Appendix B: The Interactive Simulated CMS-1500 Form B-1

Appendix C: Place of Service Codes C-1 **Appendix D: Professional Websites** D-1

Appendix E: Forms E-1

Abbreviations AB-1

Glossary GL-1

Index IN-1

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Contents



Preface xii

Part 1	
ганы	

WORKING WITH MEDICAL INSURANCE AND BILLING

1

Chapter 1

Introduction to the Medical Billing Cycle 2

- 1.1 Working in the Medical Insurance Field 3
- 1.2 Medical Insurance Basics 7
- 1.3 Healthcare Plans 9
- 1.4 Health Maintenance Organizations 11
- 1.5 Preferred Provider Organizations 14
- 1.6 Consumer-Driven Health Plans 16
- 1.7 Medical Insurance Payers 17
- 1.8 The Medical Billing Cycle 18
- 1.9 Achieving Success 25
- 1.10 Moving Ahead 27
- Chapter Review 29

Chapter 3

Patient Encounters and Billing Information 77

- 3.1 New Versus Established Patients 78
- 3.2 Information for New Patients 78
- 3.3 Information for Established Patients 87
- 3.4 Verifying Patient Eligibility for Insurance Benefits 90
- 3.5 Determining Preauthorization and Referral Requirements 93
- 3.6 Determining the Primary Insurance 95

Chapter 2

Electronic Health Records, HIPAA, and HITECH: Sharing and Protecting Patients' Health Information 35

- 2.1 Medical Record Documentation: Electronic Health Records 36
- 2.2 Healthcare Regulation: HIPAA and HITECH 44
- 2.3 Covered Entities and Business Associates 47
- 2.4 HIPAA Privacy Rule 49
- 2.5 HIPAA Security Rule 57
- 2.6 HITECH Breach Notification Rule 58
- 2.7 HIPAA Electronic Health Care Transactions and Code Sets 60
- 2.8 Fraud and Abuse Regulations 63
- 2.9 Enforcement and Penalties 66
- 2.10 Compliance Plans 68

Chapter Review 70



3.8 Understanding Time-of-Service (TOS) Payments 100	Chapter Review 106
Part 2 CLAIM CODING	11
Chapter 4 Diagnostic Coding: ICD-10-CM 112 4.1 ICD-10-CM 113 4.2 Organization of ICD-10-CM 114 4.3 The Alphabetic Index 115	 5.8 Surgery Codes 173 5.9 Radiology Codes 177 5.10 Pathology and Laboratory Codes 179 5.11 Medicine Codes 180 5.12 Category II and III Codes 182
 4.4 The Tabular List 118 4.5 ICD-10-CM Official Guidelines For Coding and Reporting 123 4.6 Overview of ICD-10-CM Chapters 129 	5.13 HCPCS 183 Chapter Review 189 Chapter 6
4.7 Coding Steps 133 4.8 ICD-10-CM and ICD-9-CM 135 Chapter Review 137	Visit Charges and Compliant Billing 197 6.1 Compliant Billing 198 6.2 Knowledge of Billing Rules 198
Chapter 5	6.3 Compliance Errors 2036.4 Strategies for Compliance 205
Procedural Coding: CPT and HCPCS 143 5.1 Current Procedural Terminology, Fourth Edition (CPT) 144	6.5 Audits 2086.6 Physician Fees 2136.7 Payer Fee Schedules 215
5.2 Organization 1465.3 Format and Symbols 1515.4 CPT Modifiers 154	6.8 Calculating RBRVS Payments 2166.9 Fee-Based Payment Methods 2186.10 Capitation 221
5.5 Coding Steps 157 5.6 Evaluation and Management Codes 159 5.7 Anesthesia Codes 172	6.11 Collecting TOS Payments and Checking Out Patients 222 Chapter Review 225
J./ Alicsuicsia Coucs 1/2	Chapter Review 223

3.7 Working with Encounter Forms 98



3.9 Calculating TOS Payments 102

Chapter 7

Healthcare Claim Preparation and Transmission 234

- 7.1 Introduction to Healthcare Claims 235
- 7.2 Completing the CMS-1500 Claim: Patient Information Section 236
- 7.3 Types of Providers 244
- 7.4 Completing the CMS-1500 Claim: Physician/Supplier Information Section 244
- 7.5 The HIPAA 837 Claim 257
- 7.6 Completing the HIPAA 837P Claim 260
- 7.7 Checking Claims Before Transmission
- 7.8 Clearinghouses and Claim Transmission 268 Chapter Review 270

Chapter 8

Private Payers/BlueCross BlueShield 277

- 8.1 Private Insurance 278
- 8.2 Features of Group Health Plans 280
- 8.3 Types of Private Payers 283
- 8.4 Consumer-Driven Health Plans 286
- 8.5 Major Private Payers and the BlueCross BlueShield Association 289
- 8.6 Participation Contracts 293
- 8.7 Interpreting Compensation and Billing Guidelines 298
- 8.8 Private Payer Billing Management: Plan Summary Grids 303
- 8.9 Preparing Correct Claims 305
- 8.10 Capitation Management 311

Chapter Review 312

Chapter 9

Medicare 321

- 9.1 Eligibility for Medicare 322
- 9.2 The Medicare Program 322
- 9.3 Medicare Coverage and Benefits 324
- 9.4 Medicare Participating Providers 329
- 9.5 Nonparticipating Providers 336
- 9.6 Original Medicare Plan 338

- 9.7 Medicare Advantage Plans 340
- 9.8 Additional Coverage Options 342
- 9.9 Medicare Billing and Compliance 343
- 9.10 Preparing Primary Medicare Claims 347 Chapter Review 350

Chapter 10

266

Medicaid 358

- 10.1 The Medicaid Program 359
- 10.2 Eligibility 359
- 10.3 State Programs 362
- 10.4 Medicaid Enrollment Verification 365
- 10.5 Covered and Excluded Services 369
- 10.6 Plans and Payments 370
- 10.7 Third-Party Liability 372
- 10.8 Claim Filing and Completion Guidelines 372

Chapter Review 375

Chapter 11

TRICARE and CHAMPVA 381

- 11.1 The TRICARE Program 382
- 11.2 Provider Participation and Nonparticipation 382
- 11.3 TRICARE Plans 384
- 11.4 TRICARE and Other Insurance Plans 387
- 11.5 CHAMPVA 388
- 11.6 Filing Claims 392

Chapter Review 394

Chapter 12

Workers' Compensation and Disability/ Automotive Insurance 402

- 12.1 Federal Workers' Compensation Plans 403
- 12.2 State Workers' Compensation Plans 404
- 12.3 Workers' Compensation Terminology 406
- 12.4 Claim Process 408
- 12.5 Disability Compensation and Automotive Insurance Programs 414

Chapter Review 418

Part 4

CLAIM FOLLOW-UP AND PAYMENT PROCESSING

427

Chapter 13

Payments (RAs), Appeals, and Secondary Claims 428

- 13.1 Claim Adjudication 429
- 13.2 Monitoring Claim Status 432
- 13.3 The Remittance Advice (RA) 436
- 13.4 Reviewing RAs 442
- 13.5 Procedures for Posting 443
- 13.6 Appeals 445
- 13.7 Postpayment Audits, Refunds, and Grievances 448
- 13.8 Billing Secondary Payers 449
- 13.9 The Medicare Secondary Payer (MSP)Program, Claims, and Payments 451Chapter Review 455

Chapter 14

Patient Billing and Collections 460

- 14.1 Patient Financial Responsibility 46
- 14.2 Working with Patients' Statements 464
- 14.3 The Billing Cycle 467
- 14.4 Organizing for Effective Collections 468

	14.5	Collection	Regulations an	d Procedures	470
--	------	------------	----------------	--------------	-----

- 14.6 Credit Arrangements and Payment Plans 474
- 14.7 Collection Agencies and Credit Reporting 476
- 14.8 Writing Off Uncollectible Accounts 479
- 14.9 Record Retention 481
- Chapter Review 482

Chapter 15

Primary Case Studies 486

- 15.1 Method of Claim Completion 487
- 15.2 About the Practice 487
- 15.3 Claim Case Studies 493

Chapter 16

RA/Secondary Case Studies 523

- 16.1 Completing Secondary Claims 524
- 16.2 Handling Denied Claims 524
- 16.3 Processing Medicare RAs and Preparing Secondary Claims 526
- 16.4 Processing Commercial Payer RAs and Preparing Secondary Claims 528
- 16.5 Calculating Patients' Balances 530

Part 5

HOSPITAL SERVICES

537

Chapter 17

Hospital Billing and Reimbursement 538

- 17.1 Healthcare Facilities: Inpatient Versus Outpatient 539
- 17.2 Hospital Billing Cycle 540

- 17.3 Hospital Diagnosis Coding 551
- 17.4 Hospital Procedure Coding 552
- 17.5 Payers and Payment Methods 555
- 17.6 Claims and Follow-up 560
- Chapter Review 571



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Chapter 18

Diagnostic Coding: Introduction to ICD-9-CM and ICD-10-CM

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18.1 ICD-9-CM

18.2 Organization of ICD-9-CM

18.3 The Alphabetic Index

Appendix A: Guide to Medisoft® A-1

Appendix B: The Interactive Simulated

CMS-1500 Form B-1

Appendix C: Place of Service Codes C-1

Appendix D: Professional Websites D-1

Appendix E: Forms E-1

Abbreviations AB-1

Glossary GL-1

Index IN-1

18.4 The Tabular List

18.5 Tabular List of Chapters

18.6 V Codes and E Codes

18.7 Coding Steps

18.8 Official Coding Guidelines

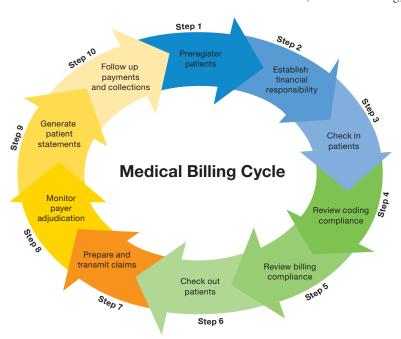
18.9 Introducing ICD-10-CM

Chapter Review

Preface

Follow the Money!

Medical insurance plays an important role in the financial well-being of every healthcare business. The regulatory environment of medical insurance is now evolving faster than ever. Changes due to healthcare reform require medical office professionals to acquire and maintain an in-depth understanding of compliance, electronic health records, medical coding, and more.



The sixth edition of *Medical Insurance:* An Integrated Claims Process Approach emphasizes the **medical billing cycle**—ten steps that clearly identify all the components needed to successfully manage the medical insurance claims process. The cycle shows how administrative medical professionals "follow the money."

Medical insurance specialists must be familiar with the rules and guidelines of each health plan in order to submit proper documentation. This ensures that offices receive maximum, appropriate reimbursement for services provided. Without an effective administrative staff, a medical office would have no cash flow!

The following are some of the key skills covered for you and your students in *Medical Insurance*, 6e:

Skills	Coverage
Procedural	Learning administrative duties important in medical practices as well as how to bill both payers and patients
Communication	Working with physicians, patients, payers, and others using both written and oral communication
Health information management	Using practice management programs and electronic health records technology to manage both patient records and the billing/collections process, to electronically transmit claims, and to conduct research
Medical coding	Understanding the ICD-10, CPT, and HCPCS codes and their importance to correctly report patients' conditions on health insurance claims and encounter forms as well as the role medical coding plays in the claims submission process
HIPAA/HITECH	Applying the rules of HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health act) to ensure compliance, maximum reimbursement, and the electronic exchange of health information

Organization of *Medical Insurance*, 6e

An overview of the book's parts, including how they relate to the steps of the medical billing cycle, follows:

Part	Coverage
1: Working with Medical Insurance and Billing	Covers Steps 1 through 3 of the medical billing cycle by introducing the major types of medical insurance, payers, and regulators, as well as the medical billing cycle. Also covers HIPAA/HITECH Privacy, Security, and Electronic Health Care Transactions/Code Sets/Breach Notification rules.
2: Claim Coding	Covers Steps 4 through 6 of the medical billing cycle while building skills in correct coding procedures, using coding references, and complying with proper linkage guidelines.
3: Claims	Covers Step 7 of the medical billing cycle by discussing the general procedures for calculating reimbursement, how to bill compliantly, and preparing and transmitting claims.
4: Claim Follow-Up and Payment Processing	Covers Steps 8 through 10 of the medical billing cycle by describing the major third-party private and government-sponsored payers' procedures and regulations along with specific filing guidelines. Also explains how to handle payments from payers, follow up and appeal claims, and correctly bill and collect from patients. This part includes two case studies that provide exercises to reinforce knowledge of completing primary/secondary claims, processing payments from payers, and handling patients' accounts. The case studies in Chapter 15 can be completed using Connect Plus for simulated exercises created from Medisoft Advanced Version 17. The case studies in Chapter 16 can be completed using the CMS-1500 form.
5: Hospital Services	Provides necessary background in hospital billing, coding, and payment methods.

New to the Sixth Edition

Medical Insurance is designed around the medical billing cycle with each part of the book dedicated to a section of the cycle followed by case studies to apply the skills discussed in each section. The medical billing cycle now follows the overall medical billing and documentation cycle used in practice management/electronic health records environments and applications.

Because of the mandate to the healthcare industry to adopt ICD-10-CM/PCS on October 1, 2014, students must work to gain expertise using this coding system. For this reason, ICD-10 is the primary diagnostic coding system taught and exemplified in the sixth edition of *Medical Insurance*. An alternate to Chapter 4 on ICD-9-CM (Chapter 18) is provided online for additional study if the instructor elects to cover it in more depth.

Medical Insurance offers several options for completing the case studies at the end of Chapters 8–12 and throughout Chapter 15:

- Paper Claim Form If you are gaining experience by completing a paper CMS-1500 claim form, use the blank form supplied to you (from the back of *Medical Insurance* or printed from a PDF file on the book's Online Learning Center, www.mhhe.com/valerius6e), and follow the instructions in the text chapter that is appropriate for the particular payer to fill in the form by hand.
- Electronic CMS-1500 Form If you are assigned to use the electronic CMS-1500 form, access either the HTML or Adobe Form Filler form at the book's Online Learning Center, www.mhhe.com/valerius6e. See Appendix B, The Interactive Simulated CMS-1500 Form, for further instructions.
- Connect Plus Connect Plus provides simulated Medisoft® exercises in four modes: Demo, Practice, Test, and Assessment. The exercises simulate the use of

Medisoft Advanced Version 17 to complete the claims. If you are assigned this option, you should read Appendix A, Guide to Medisoft, as the first step, and then follow the instructions that are printed in each chapter's case studies. In this version, some data may be prepopulated to allow the students to focus on the key tasks of each exercise. These simulations are autograded.

Key content changes include the following.

Pedagogy

• Learning Outcomes are restated to reflect the range of difficulty levels to teach and assess critical thinking about medical insurance and coding concepts and continue to reflect the revised version of Bloom's Taxonomy.

• HIPAA-Related Updates

- 2013 ICD-10-CM and CPT/HCPCS codes are included.
- The new Notice of Privacy Practices (NPP) that addresses disclosures in compliance with HITECH is illustrated.

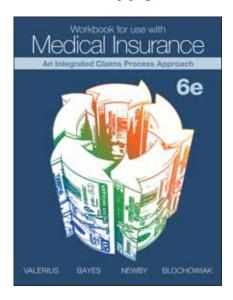
• Chapter-by-Chapter

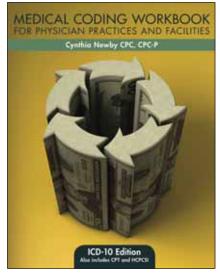
- Chapter 1: New key terms: electronic health records (EHR), health information technology (HIT), revenue cycle management, medical billing cycle, PM/EHR, cash flow, and accounts payable (AP). New Learning Outcome 1.1 emphasizes revenue cycle management and the role played by the medical insurance specialist in this process. The medical billing cycle introduced here has been revised to conform to the EHR-based workflow presented in the medical documentation and billing cycle used in the PM/EHR.
- Chapter 2: New key terms: accountable care organization (ACO), accounting of disclosure, Heath Information Exchange (HIE), meaningful use incentives, medical documentation and billing cycle, Office of E-Health Standards and Services (OESS), and operating rules. New Learning Outcomes 2.1 and 2.2 emphasize EHRs and their meaningful use as part of the discussion of documentation. Increased illustrations that show completed EHR screens rather than paper documents are included. A new OCR breach case and a new OCR physician practice case are provided. The new Notice of Privacy Practices (NPP) that addresses disclosures in compliance with HITECH is presented.
- Chapter 3: New to this chapter are an updated flow chart on EP vs. NP based on CPT 2012; a new patient information form to collect race, ethnicity, and language for meaningful use incentives and compliance with 5010; explanation of how to determine primary coverage when the patient has a group and an individual plan; and ICD-10-CM codes placed on the encounter form illustration. Former learning outcome 3.10 has been moved to Chapter 6 as Learning Outcome 6.11 to follow revised medical billing cycle.
- Chapter 4: This chapter has been completely rewritten to provide instruction
 on correct coding with ICD-10-CM and includes a brief comparison between
 ICD-10-CM and ICD-9-CM and notes on how to research ICD-9 codes when
 required.
- Chapter 5: CPT and HCPCS have been combined into one chapter for consistency and appropriate level of coverage for these code sets (represents Chapters 5 and 6 from the previous edition, and as such, all subsequent chapters have been renumbered). The chapter also defines new modifier 33, provides a new definition of *moderate sedation* (no longer conscious) for E/M code range 99143–99150, and standardizes the use of the term *descriptor*:
- Chapter 6: New key terms: adjustment, bundled payment, and walkout receipt. This chapter proves an explanation of the major global period indicators and a new exercise on accessing the period data by CPT code. The check of outpatient procedures from Chapter 3 has been added to follow the medical billing cycle more precisely. A new Billing Tip explains that some practices use the term *contractual adjustment* rather than *write-off*. A Health Reform

- feature box explains the concept of bundled payments: a single payment for an entire episode of care to all providers
- **Chapter 7:** The CMS-1500 claim completion information for the current Reference Instruction Manual at NUCC.org has been updated. NUCC guidance on reconciling the CMS-1500 with the 5010 format for the 837P is included. According to the NUCC, some item numbers report data that are not reported on the 837P, and the organization recommends not reporting them on the CMS-1500. Following these guidelines requires a number of modifications to instructions, including not reporting the patient's telephone number, patient status, other insured's DOB and employer/school, insured's employer or school name, same/similar illness, balance due, and signature indication. The reference has been changed from 837 to 837P for clarity; the 837I is defined in Chapter 17. Appendix C, Medical Specialties and Taxonomy Codes, that was referenced here has been deleted; the website is more current and should be used. The discussion includes completing the 837P updated for 5010 claim completion requirements, such as no P.O. box or lock box addresses for the billing provider and new information needed for unlisted CPT/HCPCS codes and presents new 5010 definitions for billing provider, pay-to provider, rendering provider, and referring provider.
- Chapter 8: New key term: FAIR Health. Claim completion instructions have been updated to comply with NUCC CMS-1500 guidelines and ICD-10-CM codes.
- Chapter 9: New key terms: annual wellness visit (AWV), cost sharing, Internet-Only Manuals (IOM), Medicare Learning Network (MLN), and United States Preventive Services Task Force (USPSTF). The term *Physician Quality Reporting System (PQRS)* has been updated, as have the recovery auditor program and Zone Program Integrity Contractor (ZPIC). There is a new form and new learning objective on completing the new ABN; 2012 Part A and Part B premium/deductibles/coinsurance; and the section on ACA/USPSTF updates for preventive services coverage have been expanded. New material pulls together the various incentive programs; physician enrollment website information (PECOS) is included; and claim completion instructions have been updated to comply with NUCC CMS-1500 guidelines and ICD-10-CM codes.
- Chapter 10: The material includes coverage of the ACA effect on Medicaid enrollment in 2014 and updates of CHIP terminology and statistics, Medicaid managed care enrollment percentage, and claim completion instructions to comply with NUCC CMS-1500 guidelines and ICD-10-CM codes.
- Chapter 11: Cost sharing for Figure 11.2 and claim completion instructions to comply with NUCC CMS-1500 guidelines and ICD-10-CM codes have been updated.
- Chapter 12: New key terms: automotive insurance policy, personal injury protection, liens, and subrogation. The topic of automotive insurance has been added. ICD-10-CM codes are used.
- Chapter 13: The material uses ICD-10-CM codes and redefines RA/EOB into two parts: the RA for the provider and the EOB for the beneficiary per current industry practice.
- Chapter 14: New key terms: nonsufficient funds (NSF) check, collection ratio. The chapter includes the use of ICD-10-CM. Instructions on processing an NSF and an example of calculating the elements for a payment plan (items from a Truth in Lending form) are presented.
- Chapters 15 and 16: Case studies for ICD-10-CM and for NUCC CMS-1500 guidelines have been updated.
- Chapter 17: New key terms: inpatient-only list, three-day payment window, and ICD-10-PCS. There is a new section on coding with ICD-10-PCS and the use of ICD-10-CM.

For a detailed transition guide between the fifth and sixth editions, visit www .mhhe.com/valerius6e.

Beyond *Medical Insurance:* Opportunities for Your Students to Apply Their Skills





Workbook for use with Medical Insurance: An Integrated Claims Process Approach, Sixth Edition (0077520513, 9780077520519)

The *Workbook for use with Medical Insurance* has excellent material for reinforcing the text content, applying concepts, and extending understanding. It combines the best features of a workbook and a study guide. Each workbook chapter enhances the text's strong pedagogy through:

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- Key terms—objective questions
- Critical thinking—questions that stimulate process understanding
- Guided web activities—build skill in locating and then evaluating information on the Internet
- Applying concepts—reinforce and extend abstracting insurance information, calculating insurance math, and using insurance terms

The workbook matches the text chapter by chapter. It reinforces, applies, and extends the text to enhance the learning process.

Medical Coding Workbook for Physician Practices and Facilities, ICD-10 Edition (0073511048, 9780073513713)

The *Medical Coding Workbook* provides practice and instruction in coding and using compliance skills. Because medical insurance specialists verify diagnosis and procedure codes and use them to report physicians' services, a fundamental understanding of coding principles and guidelines is the basis for correct claims. The coding workbook reinforces and enhances skill development by applying the coding principles introduced in *Medical Insurance*, 6e and extending knowledge through additional coding guidelines, examples, and compliance tips. It offers more than 75 case studies that simulate real-world application. Also included are inpatient scenarios for coding that require compliance with *ICD-10-CM Official Guidelines for Coding and Reporting* sequencing rule, as explained in Chapter 17 of the text.

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You can rely on the following materials to help you and your students work through the material in the book; all are available on the book's website, www.mhhe.com/ valerius6e (instructors can request a password through their sales representative):

Supplement	Features
• •	Lesson Plans
Instructor's Manual (organized by	2000.77.14.10
Learning Outcomes)	Answer Keys for all exercises
	Documentation of Steps and Screenshots for Simulated Medi-
	soft Exercises
PowerPoint Presentations (organized	Key Terms
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	Teaching Notes
Electronic Testbank	EZ Test Online (Computerized)
	Word Version
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Tools to Plan Course	Correlations of the Learning Outcomes to Accrediting Bodies such as ABHES, CAAHEP, and CAHIIM
	Sample Syllabi
	Conversion Guide between fifth and sixth editions
	 Asset Map—recap of the key instructor resources as well as
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Book Reviews

Many instructors reviewed the fifth edition once it was published and/or the sixth edition manuscript, providing valuable feedback that directly impacted the book.

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Market Surveys

Multiple instructors participated in a survey to help guide the revision of the book and related materials, and/or a survey on materials for Connect.

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Technical Editing/Accuracy Panel

A panel of instructors completed a technical edit and review of all content in the book and workbook page proofs to verify their accuracy.

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