Medical Insurance

An Integrated Claims Process Approach

6e

VALERIUS BAYES NEWBY BLOCHOWIAK

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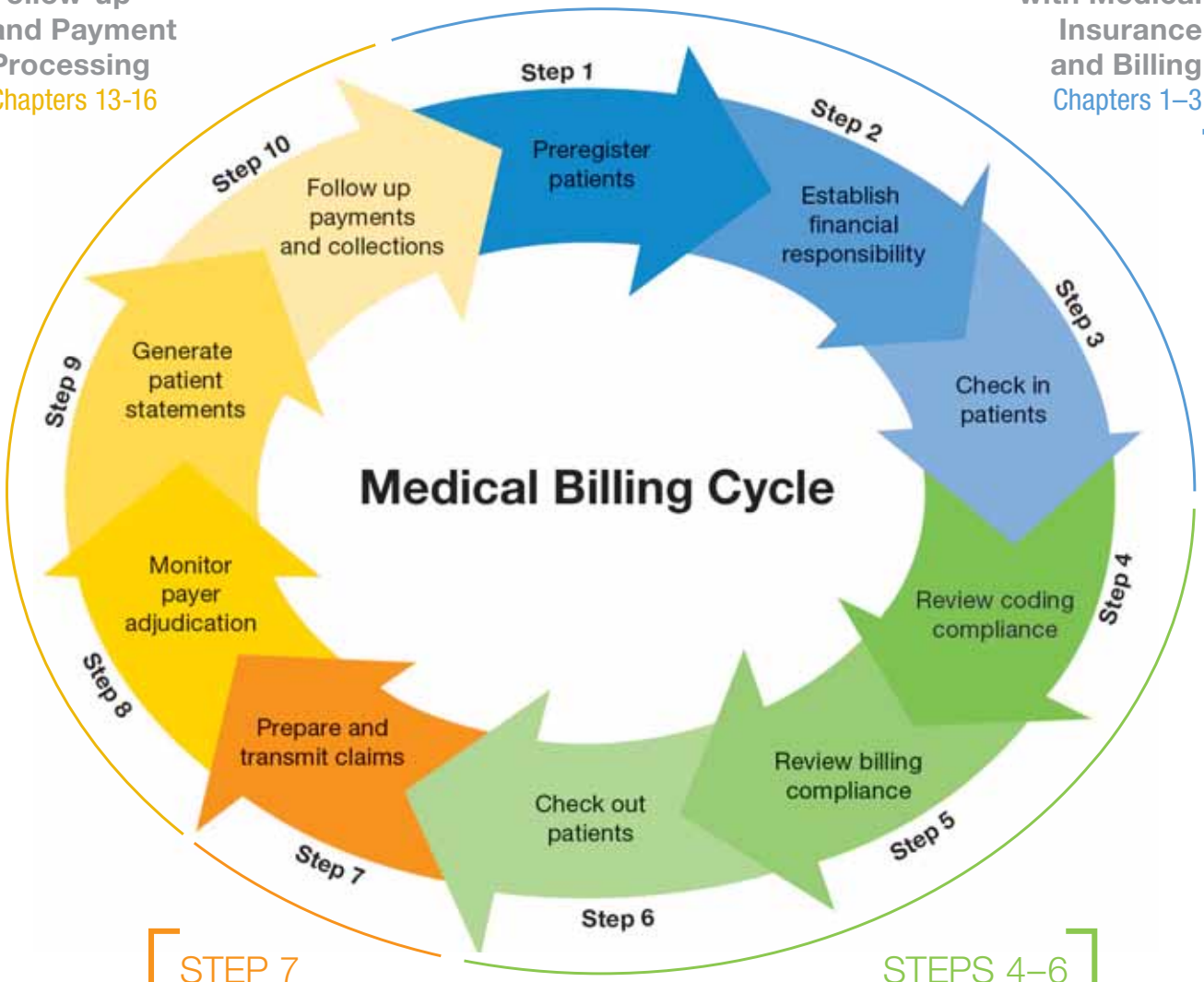
Follow the money with *Medical Insurance: An Integrated Claims Process Approach!*

Medical Billing Cycle

STEPS 8–10
PART 4 **Claim Follow-up and Payment Processing**
Chapters 13-16

STEPS 1–3
PART 1 **Working with Medical Insurance and Billing**
Chapters 1–3



STEP 7
PART 3 **Claims**
Chapters 7-12

STEPS 4–6
PART 2 **Claim Coding**
Chapters 4–6

PLUS...
PART 5 **Hospital Services**
Chapter 17

MEASURABLE LEARNING OUTCOMES

RELEVANT

HIPAA/HITECH TIP

Staying Current with HIPAA

HIPAA laws 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

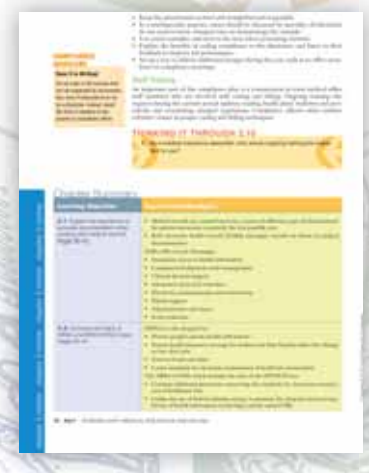
Medical Necessity

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 Payer Information

REINFORCEMENT



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Medical Insurance

Medical Insurance

An Integrated Claims Process Approach Sixth Edition

Joanne D. Valerius, RHIA, MPH
Oregon Health & Science University

Nenna L. Bayes, BBA, MEd
Ashland Community and Technical College

Cynthia Newby, CPC, CPC-P

Amy L. Blochowiak, MBA, ACS, AIAA, AIRC, ARA, FLHC, FLMI, HCSA, HIA, HIPAA, MHP, PCS, SILA-F
Northeast Wisconsin Technical College

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MEDICAL INSURANCE: AN INTEGRATED CLAIMS PROCESS APPROACH,
SIXTH EDITION

This book is printed on acid-free paper.

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The illustrations, instructions, and exercises in *Medical Insurance* are compatible with the Medisoft Advanced Version 17 Patient Accounting software available at the time of publication.

CPT codes are based on CPT 2013.

ICD-9-CM codes are based on ICD-9-CM 2013.

ICD-10-CM codes are based on ICD-10-CM 2013.

All names, situations, and anecdotes are fictitious. They do not represent any person, event, or medical record.

The Internet addresses listed in the text were accurate at the time of publication. The inclusion of a website does not indicate an endorsement by the authors or McGraw-Hill, and McGraw-Hill does not guarantee the accuracy of the information presented at these sites.

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Brief Contents

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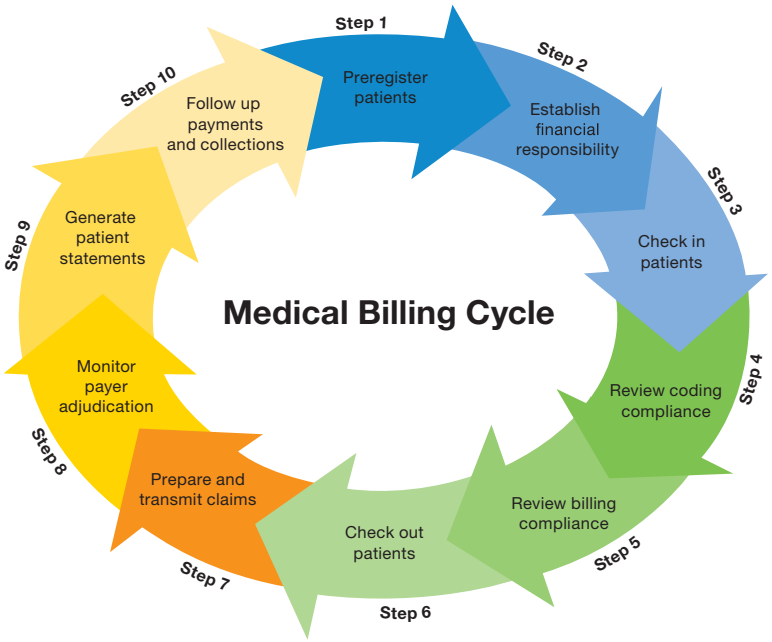
Preface

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.

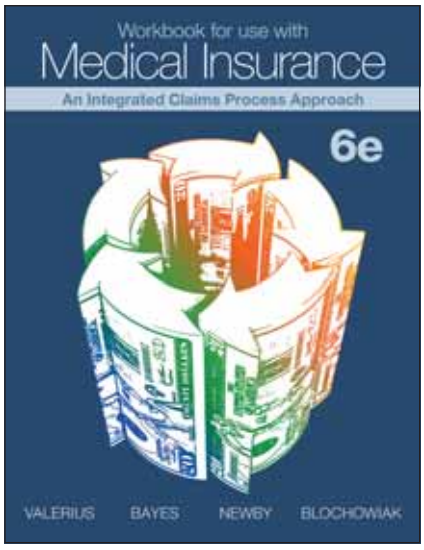
- **Pedagogy**
  - Learning Outcomes are restated to reflect the range of difficulty levels to teach and assess critical thinking about medical insurance and coding concepts and continue to reflect the revised version of Bloom's Taxonomy.
- **HIPAA-Related Updates**
  - 2013 ICD-10-CM and CPT/HCPCS codes 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

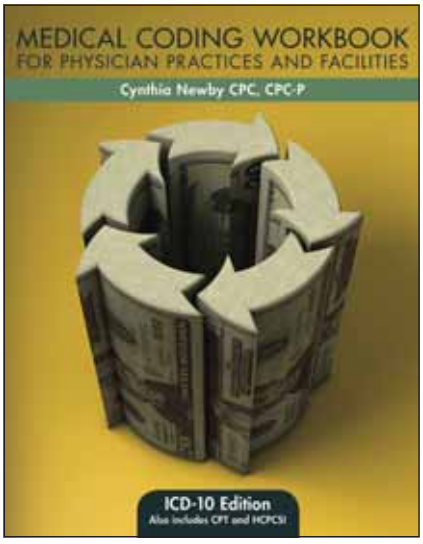
feature box explains the concept of bundled payments: a single payment for an entire episode of care to all providers

- **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:

- Assisted outlining—reinforces the chapter's key points
- 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.

Medical Insurance in the Digital World—Supplementary Materials for the Instructor and Student

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- Ability to add notes

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INSTRUCTORS' RESOURCES

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
Instructor's Manual (organized by Learning Outcomes)	• Lesson Plans • Answer Keys for all exercises • Documentation of Steps and Screenshots for Simulated Medisoft Exercises
PowerPoint Presentations (organized by Learning Outcomes)	• Key Terms • Key Concepts • Teaching Notes
Electronic Testbank	• EZ Test Online (Computerized) • Word Version • Questions tagged for Learning Outcomes, Level of Difficulty, Level of Bloom's Taxonomy, Feedback, ABHES, CAAHEP, CAHIIM, and Estimated Time of Completion.
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 information on the content available through Connect Plus
Medisoft Exercises Resources	• *McGraw-Hill Guide to Success for Medical Insurance* • Technical Support Information • Steps for students completing the simulated exercises in Connect Plus
CMS-1500 and UB-04 Forms	• Electronic versions of both forms

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Acknowledgments

Suggestions have been received from faculty and students throughout the country. This is vital feedback that is relied on with each edition. Each person who has offered comments and suggestions has our thanks. The efforts of many people are needed to develop and improve a product. Among these people are the reviewers and consultants who point out areas of concern, cite areas of strength, and make recommendations for change. In this regard, the following instructors provided feedback that was enormously helpful in preparing the sixth edition.

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.

Cheryl Bordwine, BHA, MBA, RMA, NCICS
College of the Mainland

Carol Charie, AA, CPC
Sanford Brown Institute

Sue Coleman, AS
National College

Rhoda Cooper, CPC, RMC, NCICS
Piedmont Virginia Community College

James Dickerson, AAS, NRCMA
Remington College—Dallas Campus

Amy Ensign, AAS, CMA (AAMA), RMA (AMT)
Baker College of Clinton Township

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Jan Klawitter, AS, CMA (AAMA), CPC
San Joaquin Valley College

Jennifer Leach, CMA, CPR/AED
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Lezlie McHenry, MA, BS, CBCS
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Julie Pepper, CMA, BS
Chippewa Valley Technical College

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Goodwin College
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Sharon Turner, CMC, CMIS, CHI, CBCS, CMAA, BBA, AAS, AS
Brookhaven College

Jean Tyner, RDH, BSAST
Florence Darlington Technical College

Lisa Walker
Midwest Technical Institute

Kari Williams, BS, DC
Front Range Community College

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.

Cynthia Akers Hall, MA
New River Community and Technical College

Yvonne Alles
Davenport University

Donna Appletoft, CMA
Mitchell Technical Institute

Cynthia Bergenstock, LPN, AAS
Berks Technical Institute

Ruth Berger, MS, RHIA
Chippewa Valley Technical College

Karen Bilchak, A.S. MA
Commonwealth Technical Institute

Jen Blair, CPC, CPC-H, CPC-I
AVTEC

Angela Bland, MS, RT(R)
Missouri College Online

Wallace Boeve, EdD, PA-C
Grand Valley State University

Cheryl Bordwine, BHA, MBA, RMA, NCICS
College of the Mainland

Marti Brettler, BSN Nursing, BS Gerontology, AS Mental Health
Anthem Institute

Janeane Brodie, CMA, NREMT-P
Brown Mackie College

Joey Brown, CMA
Great Lakes Institute of Technology

Anita Brownstein, B.S., M.S.
Career Institute of Health & Technology

Mary Cantwell, RHIT, CPC, CPC-I, CPC-H, CPC-P
Metro Community College

Diana Centeno, CLT
San Antonio College

Carol E. Charie, AA, CPC
Sanford Brown Institute

Rhoda Cooper, CPC, RMC, NCICS
Piedmont Virginia Community College

Tiffany Cooper, CPC
Isothermal Community College

Patricia Cormier
Acadiana Technical College

Joyce Cunningham, CPC, CPC-H
Midwest Technical Institute

Sonja Davis, BA, RHIA
Howard College

Ruth Dearborn, CCS, CCS-P
University of Alaska

Brandi DeLeon, RT(R), RMA, BS, ASHI Certified Instructor
Fortis Institute

Lori Deslandes, CPAT, CMA
DPT Business School

Marsha Diamond, CPC, CPC-H, CCS
Fortis College

James Dickerson, AAS Computer Networking, NRCMA
Remington College

Tamarra Disco-Boggs, CPC, CCP, MCS-P
Bluegrass Community and Technical College

Marianne Durling, BSLS focus Psychology, CPC
Piedmont Community College

Jeff Dykes, BS Paramedics
Charter Oak State College

Annette Edwards, AS, BS, MS,
Tennessee Technology Center

Amy Ensign, AAS, CMA (AAMA), RMA (AMT)
Baker College of Clinton Township

Rhonda Epps, CMA (AAMA), RMA
National College of Business and Technology

Dr. Todd Farney, BS, DC, PhD
Wichita Technical Institute

Tim Feltmeyer, MS, AHI
Erie Business Center

Anita Ferguson
Paris Junior College

Jill Ferrari, M.A., MT (ASCP), MLT (ASCP)
Sullivan University

Kim Ford, CMA
Catawba Valley Community College

Donna Fuchs, CPC, RMA
Metro Business College

Nancy Gammons, MEd, CCS-P
Shawnee Community College

Savanna Garrity, MPA
Madisonville Community College

Misty Hamilton, RHIT
Zane State College

Forrest Heredia, CPC-I, BSBA
Pima Medical Institute

Elizabeth Hoffman, CMA, CPT
Baker College of Clinton Township

Cynthia Holiday, CMA, Certified phlebotomist
Medical Assistant Instructor

Traci Hotard, RHIA
SCLTC Young Memorial Campus

Michelle Hughes, AAS
Fortis College

Loretta Jarrett-McDonald, BA, MPS, CPC, CBCS, CMAA, CHI, CEHRS
New Horizons CLC

Jane Jones, M.A.T., MAAC
Mountain Empire Community College

Marcie Jones, BS, CMA (AAMA)
Gwinnettt Technical College

Marilyn Kidd, A.A.S
KCTCS-Hopkinsville Community College

Heather Kies, MHA, CMA (AAMA), RMA (AMT), PBT (ASCP)
Goodwin College

Pat King, RHIA & RHIT
Baker College of Auburn Hills

Jan Klawitter, AS, CMA (AAMA), CPC
San Joaquin Valley College

Jennifer Lame, MPH, RHIT
Southwest Wisconsin Technical College

Jennifer Leach, CMA, BS, MEd IT, CPR/AED First Aid instructor certified
McCann School of Business & Technology

Sharlene Lewis
Brigham Young University

Brandi Lippincott
Merit Training Institute

Tamara Lowe, RHIA, CPC
Baker College

Agustin Lukban, BSBA, MA, NHA Certifications: CBCS, CMAA, CEHRS, CHI
State University of New York

JanMarie Malik, MBA, RHIA
Shasta Community College

Barbara Marchelletta, CPC, CMA, CPT, RHIT
Beal College

Nikki Marhefka, EdM, MT (ASCP), CMA (AAMA)
Central Penn College

Heather Marti, CPC, RMA, CNA, PCT
Carrington College

Vanessa May, BS, MBA
Acadiana Technical College

Lezlie McHenry, MA, BS, CBCS
Kingwood Lonestar College

Pamela McNamara, MHRM, MA
Beckfield College

Roseanna McNeal, RHIT, CCS
Southern State Community College

Lane Miller, MBA/HCM, CHI, CPP
Medical Careers Institute

Vivian Mills, RHIT, CPC, CPAR
Virginia College

Deborah Montgomery
New River Community and Technical College

Carolyn Murry, MBA, RHIT
Medtech College

Tom O'Brien, AS, CST, CCT, CRAT
Central Florida Institute

Karen Patton, AAB, BA, CPC, CMC, CCP
Stautzenberger College

Julie Pepper, CMA, BS
Chippewa Valley Technical College

Kimberly Rash
Gateway Community & Technical College

Sherilyn Reynolds, BS, MS
San Jacinto College

Pamela Roemershauser, CPC
Fortis College

Karen Saba, CPC, Certified AHIMA ICD-10-CM/PCS
Spokane Community College

Wendy Sammons, CMA, AAT, LPN
Lanier Technical College

Lorraine Schoenbeck, MS, CMA (AAMA) CAHI
Lone Star College

Cindy Seel, MSA, RHIA
Southwestern Michigan College

Susan Shear, MHA, CPC
Bluegrass Community and Technical College

Tammy Shick
Great Lakes Institute of Technology

Gene Simon, RHIA, RMD
Florida Career College

Christine Sproles, BSN, MS, BCLS
Pensacola Christian College

Julia Steff, RHIA, CCS, CCS-P
Palm Beach State College

Deanna Stephens, RMA, NCICS, CMOA
Virginia College

Patricia Stich, CCS-P
Waubonsee Community College

Slavica Tumminelli, CPC, CGSC, CHI, CBCS, CEHRS
Advantage Career Institute
Ocean County College

Marilyn Turner, RN, C.M.A. (AAMA)
Ogeechee Technical College

Sharon Turner, CMC, CMIS, CHI, CBCS, CMAA, BBA, AAS, AS
Brookhaven College

Jean Tyner
Florence Darlington Technical College

John Varas, CCS
Florida Career Collage

Janice Vermiglio-Smith, RN, MS, PhD, CM
Central Arizona College

Cindy Ward, CPC, CPC-H, CPMA, CEMC, CCC
Medtech College

Karen Welch, CPS, AS, BS
Tennessee Technology Center at Jackson

Kari Williams, BS, DC
Front Range Community College

Charlotte Winsett, CPC, BS
Brookhaven College

Lori Wright, RHIT, MA
Cambria-Rowe Business College

Julie Young, AAB, CMBS
Professional Skills Institute

Lisa Zepeda, MS, BA
San Joaquin Valley College

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.

Donna Fuchs, CPC, RMA
Metro Business College

Savanna Garrity, MPA
Madisonville Community College

Misty Hamilton, RHIT
Zane State College

Forrest Heredia, CPC-I, BSBA
Pima Medical Institute

Elizabeth Hoffman, CMA, CPT
Baker College of Clinton Township

Susan Shear, MHA, CPC
Bluegrass Community and Technical College

Sharon Turner, CMC. CMIS, CHI, CBCS, CMAA, BBA, AAS, AS
Brookhaven College

Lisa Zepeda, MS, BA
San Joaquin Valley College

Acknowledgments from the Authors

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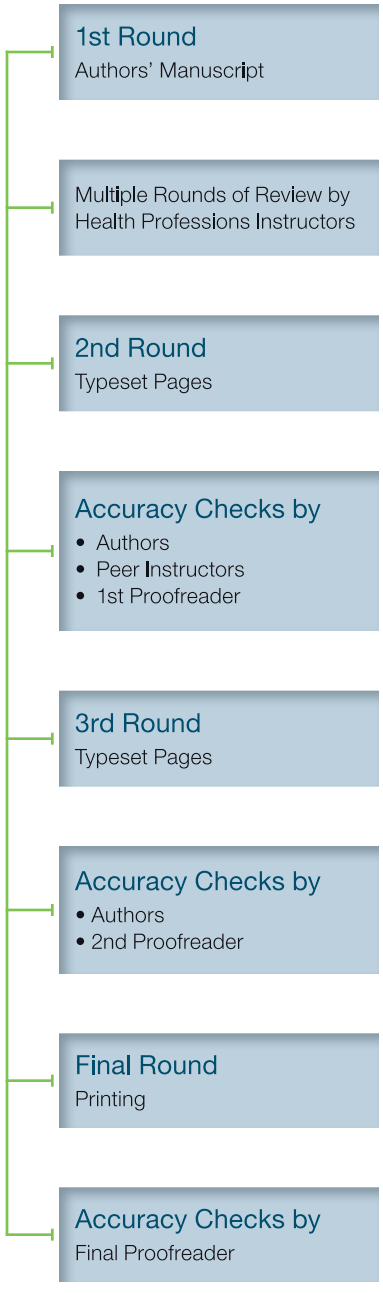

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