Appendix A.2

MEDICAL BILLING AND CODING SPECIALIST

WORK PROCESS SCHEDULE
AND
RELATED INSTRUCTION

Appendix A.2

WORK PROCESS SCHEDULE
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 one year with an OJL attainment of 2,500 hours, and supplemented by the required hours of related instruction consistent.

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 in-person and via phone, internet webcam, text or email to ensure that a mentor is available to answer questions and monitor their progress throughout their apprenticeship under the Alaska Primary Care Association registered apprenticeship program.

4. APPRENTICE WAGE SCHEDULE

Apprentices are paid a progressively increasing schedule of wages during their apprenticeship based on the acquisition of increased skill and competence on the job and in related instruction courses. Before an apprentice is advanced to the next segment of training or to journeyworker completion status, the program sponsor will evaluate all progress to determine whether advancement has been earned by satisfactory performance in their on-the-job learning (OJL) and in related instruction courses. In determining whether satisfactory progress has been made, the sponsor shall be guided by the work experience and related instruction records and reports.

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 & Coding Specialist journeyworker completion wage rate, which is: $20.34 per hour.

Period	Percent	Hourly Wage	OJL Hours	Related Instruction
1st	60%	$12.20	1250 hours	Satisfactory progress
2nd	80%	$16.27	1250 hours	Satisfactory progress
	100%	$20.34	2500 hours	Completion

Subject to approval by the program sponsor and registration agency, the current base Medical Billing and Coding Specialist Worker journeyworker completion wage rate may be adjusted regionally by a participating employer if they pay a higher wage rate, and the adjusted base rate will apply equally to all apprentices who are hired by that employer. Such wages will become part of the approved Appendix-E Employer Acceptance Agreement.

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 such instruction and experience, in all branches of the occupation, as is necessary to develop a practical and versatile 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 & Coding Specialist Work Processes	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 & update office procedure manuals 5. Inventory & order office equipment & supplies 6. Develop and maintain multiple files and lists 7. Maintain certifications and professional development files	**250**
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	**250**
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	**250**
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	**250**

E. Payment Adjudication 1. Analyze aging reports 2. Post payments accurately 3. Interpret remittance advice to determine financial responsibility of patient and insurance company 4. Determine reason for insurance company denial	**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	**1,000**
Total Hours	**2,500**

Appendix A.2

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

Related Instruction Provider: Alaska Primary Care Association
Method: Online, Electronic Media

Patty Linduska, R.N.
Senior Director of Training and TA
Alaska Primary Care Association
1231 Gambell St, Ste. 200
Anchorage, AK 99501
Phone: 907-929-2730 Direct
E-mail: PattyL@AlaskaPCA.org
Website: www.alaskapca.org | www.apcaapprentice.com

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

The related instruction outlines the courses that provide the technical ability that supplements the on-the-job training. It is through the combination of both the on-the-job training 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.

Billing and Coding Specialist (BCS) Study Guide	
Chapter 1 - Regulatory Compliance This course gives an introduction to BCS of the appropriate documentation required to release patient information, how to audit billing against medical documentation to prevent fraud and abuse, and how to identify laws and regulations relevant to medical coding. **Objectives:** I. Appropriate Documentation a. Information and implied consent b. Legislation protecting patient privacy II. Billing Audits a. Importance of being compliant	**25 Hours**

III. Laws, Regulations and Administering Agencies a. HIPPA, Stark Law, False Claims Act, Fair Debt Collection Practices Act, Office of the inspector General.	
Chapter 2 - Claims Processing This course the BCS will learn the CMS-1500 form, how to properly fill out the form and how to transmit claims to third party payers. **Objectives:** I. Transmitting Claims a. Correct claim processing b. Populating correct information on a claim c. The procedures for transmitting a claim d. How to identify the cause of transmission errors e. What are clean and dirty claims II. CMS-1500 Form a. Member information b. Rendering provider	**40 Hours**
Course 3 – Front End Duties This course is designed to help the BCS to understand how to collect patient information, determine insurance eligibility and amount due on a bill. **Objectives:** I. Collect patient information a. Collect basic information II. Insurance eligibility a. Identify other patient insurance issues III. Government and commercial Insurance a. What is government insurance b. What id commercial insurance IV. Patient Authorization and Referral forms a. HMO's b. PPO's V. Determine Balance Due a. Deductibles b. Copayments c. Coinsurance	**35 Hours**
Chapter 4 – Payment Adjudication In this chapter the BCS will analyze reports, interpret remittance advice, post payments and determine reasons for insurance company denials. **Objectives:** I. Analyze aging reports a. Manage aging reports b. Assessing the status of accounts II. Interpreting remittance advice a. Components of a RA	**40 Hours**

b. RA's for Medicare participates III. Post payments IV. Determine reasons for insurance company denial a. Managing denials b. Denial code c. Appeals Process	
Chapter 5 – Apply Knowledge of Coding In this chapter the BCS will examine medical terminology. The apprentice will also develop their knowledge of the ICD and the HCPCS. **Objectives:** I. Coding guidelines and conventions for diagnoses and procedures a. Comparing ICD-9-CM and ICD-10-CM b. Procedures codes II. Healthcare Common Procedure Coding Systems (HCPCS) a. CPT HCPCS Level I b. HCPCS Level II III. Abstracting medical documentation a. Transfer information from encounter forms b. Coding abstracted information c. Consulting with physicians IV. Common medical terminology a. Body systems and their functions V. Hospital terminology a. Types of facilities b. Hospital departments c. Laboratory testing d. Identifying health care providers	**12 Hours**
Case Studies – In Practice **Case Study 1: Determine Patient Coverage** **Case Study 2: Billing Mistakes** **Case Study 3: Denied Insurance Form**	**12 Hours**
Total	**164 Hours**