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This program includes classroom instruction, course manual, homework exercises, exam preparation handbook, and certification exam. Participants may take up to four hours to complete the CMIS exam. A passing score of 70% or better is required to earn the CMIS certification designation.

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Fee: $999

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Class Outline

Role and Responsibilities
- Differentiate between medical ethics and medical etiquette
- Learn essential ways to keep insurance and medical knowledge current
- Demonstrate the importance of accurate coding, billing and claims submission

Compliance
- Major categories of security safeguards under HIPAA and civil/criminal non-compliance penalties
- The Privacy Rule and the definition and explanation of protected health information (PHI)
- Definition of fraud and abuse and potential fines/penalties related to fraudulent claims
- Health information technology expansion: ARRA, HITECH and the creation of incentive payments to eligible providers

Basic of Health Insurance
- The difference between an implied and an expressed physician-patient contract
- Actions to prevent problems when given signature authorization for insurance claims
- Physician Fee Schedule - RVUs and EBRVS
- MACRA and repeal of SGR formula

Medical Documentation
- Identify principles and steps of the documentation
- Definitions for common medical, diagnostic and legal terms
- Reasons why an insurance company may decide to perform an external audit

ICD-10-CM Coding
- The purpose and importance of coding diagnoses to the highest level of specificity
- Features and use of ICD-10-CM code book for accurate code selection
- In-class diagnostic coding exercises
- Determine medical necessity by using ICDs and NCDS

Procedural Coding
- The importance and usage of modifiers in procedure coding
- Code problems from worksheet using the CPT® manual
- The difference between CPT, HCPCS, and Category II codes
- Use of the NCCI edits to prevent denials

The Paper Claim: CMS-1500
- Minimize the number of insurance forms returned because of improper completion
- Detailed look at the new CMS-1500 and what each section contains
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Receiving Payments and Insurance Problem Solving
- Objectives of state insurance commissioners/state medical societies
- Communicate problems with insurance commissioners/state medical societies
- Denials and what they mean; how to appeal for maximum reimbursement
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- Guidance on state prompt pay laws and the use of financial reports for more effective collections
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Managed Care Plans
- Explanation of the types of managed care plans
- Types of authorizations for medical services, tests, and procedures
- Patient access to care via Accountable Care Organizations and Patient-centered Medical Homes
- Special issues when patients are insured through the Health Insurance Exchanges

Medicare
- Utilize the lifetime beneficiary claim authorization and information release document
- How to submit claims for Medicare beneficiaries with supplemental insurance
- Proper execution of an Advanced Beneficiary Notice (ABN)
- Medicare as a secondary payer rules

Medicaid and Other State Programs
- Medicaid managed care system guidelines, terminology, abbreviations, eligibility classifications, benefits and non-benefits
- Medicaid claims filing for patients who have other coverage
- Minimize Medicaid rejections due to improper form completion

Workers’ Compensation
- Workers’ compensation insurance vs. employer’s liability insurance
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- Explanation and eligibility requirements for disability benefit programs and insurance plans
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