**Western Technical College**

# 10530159 Healthcare Revenue Management

## Course Outcome Summary

### Course Information

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| **Description** | Prepares learners to compare and contrast health care payers, illustrate the reimbursement cycle, and to comply with regulations related to fraud and abuse. Learners assign payment classifications with entry level proficiency using computerized encoding and grouping software. |
| **Career Cluster** | Health Science |
| **Instructional Level** | Associate Degree Courses |
| **Total Credits** | 3 |
| **Total Hours** | 72 |

### Pre/Corequisites

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|---|---|
| Prerequisite | 10530162 Foundations of HIM |
| Prerequisite | 10530199 ICD Procedure Coding |
| Pre/Corequisite | 10530184 CPT Coding |
| Prerequisite | 10530197 ICD Diagnosis Coding |

### Textbooks

*Principles of Healthcare Reimbursement*. 7th Edition. Copyright 2021. Casto, Anne. Publisher: American Health Information Management Association. **ISBN-13**: 978-1-58426-800-0. Required.

*Health Information Management Technology: An Applied Approach - with Access*. 6th Edition. Copyright 2020. Sayles, Nanette B. Publisher: American Health Information Management Association. **ISBN-13**: 978-1-58426-774-4. Required.

*Basic ICD-10-CM and ICS-10-PCs Coding 2022.* Copyright 2022. Schrafenberger, Lou Ann. Publisher:

American Health Information Management Association. **ISBN-13**: 978-1-58426-839-0. Required.

*CPT 2022 – Professional Edition.* Copyright 2021. American Medical Association. Publisher: Rittenhouse Book Distributors, Inc. **ISBN-13**: 978-1-64016-087-3. Required.

**Learner Supplies**

Internet and E-mail access, Microsoft Office (Word, PowerPoint, Access, Excel). Free access with Western student email address from https://login.microsoftonline.com/. **Vendor:** To be discussed in class. Required.

American Health Information Management Association Virtual Lab Subscription. **Vendor:** Campus Shop. Required.

## Success Abilities

1. Cultivate Passion: Expand a Growth-Mindset
2. Refine Professionalism: Act Ethically
3. Refine Professionalism: Improve Critical Thinking
4. Refine Professionalism: Participate Collaboratively

## Program Outcomes

1. HIT - Apply data governance principles to ensure the quality of health data
2. HIT - Apply coding and reimbursement systems
3. HIT - Apply informatics and analytics in data use
4. HIT - Apply organizational management techniques

## Course Competencies

### 1. INVESTIGATE trends that have an impact on the healthcare cost and reimbursement systems

**Assessment Strategies**

1.1. Oral, written or graphic assessment

**Criteria**

*You will know you are successful when*

1.1. you evaluate sociological and governmental trends that affect healthcare cost and reimbursement
1.2. you evaluate the trends in prospective payment and other cost-containing reimbursement methodologies
1.3. you evaluate the role of value based purchasing and other quality of care initiatives that impact healthcare reimbursement

**Learning Objectives**

1.a. Identify legislation influencing healthcare reimbursement (Medicare, Medicaid, managed care, BCBS, prospective payment systems, HIPAA, Affordable Care Act, Improper Payments, etc.).
1.b. Identify trends in cost containment methods (fee-for-service reimbursement, episode of care reimbursement, capitation, global payment, prospective payment, case-based, per diem payment, self-pay).
1.c. Examine the role of quality initiatives impacting healthcare reimbursement (value-based purchasing, pay

for performance, quality reporting programs).

## 2. COMPARE government and non-government payers and payment methodologies

**Assessment Strategies**

2.1. Oral, written or graphic assessment

**Criteria**

*You will know you are successful when*

2.1. you compare eligibility
2.2. you compare benefits
2.3. you compare cost and utilization controls
2.4. you compare payment methodologies
2.5. you compare administration and oversight

**Learning Objectives**

2.a. Differentiate government and non-government payer (Medicare, Medicaid, PACE, CHIP, TANF, TRICARE, VA, Worker's Comp, voluntary insurance, self-pay, employer based plans,etc.).
2.b. Contrast eligibility requirements for government and nongovernment payers.
2.c. Contrast subscriber benefits, coverage and exclusions for government and nongovernment payers.
2.d. Differentiate between Part A, B, C and D Medicare coverage.
2.e. Contrast methods used by government and nongovernment payers to control quality, utilization and costs (utilization review, case management, value based purchasing, pay for performance, etc.).
2.f. Identify funding mechanisms of government and nongovernment payers (insurance, coinsurance, deductible, premium, capitation, fee for service, global payment, prospective payment etc.).
2.g. Identify revenue sources of Medicare Hospital Insurance vs. Supplemental Medical Insurance.
2.h. Differentiate managed care programs (i.e., Health Maintenance Organization, Point of Service Plan, Preferred Provider Organization).
2.i. Identify the role of each state in the administration of its own Medicaid program.
2.j. Identify the role of the Centers for Medicare and Medicaid in the administration of the Medicare and Medicaid programs.
2.k. Contrast administration of various types of managed care programs (i.e., Health Maintenance Organization, Point of Service Plan, Preferred Provider Organization).
2.l. Apply terminology related to healthcare reimbursement.

## 3. ENSURE compliance with regulations related to fraud and abuse

**Assessment Strategies**

3.1. Oral, written or graphic assessment

**Criteria**

*You will know you are successful when*

3.1. you investigate governmental initiatives for identification and resolution of fraud and abuse
3.2. you evaluate coding and billing practices for fraud and abuse
3.3. you provide recommendations to resolve issues associated with fraud and abuse

**Learning Objectives**

3.a. Define fraud as it relates to reimbursement in healthcare.
3.b. Summarize initiatives that address fraud and abuse issues (HIPAA, Balanced Budget Act, False Claims Act, Stark, Whistleblower, Anti-kickback, Improper Payments legislation, unbundling, upcoding).
3.c. Explain the role of oversight agencies in monitoring quality of health care plans and in preventing fraud and abuse (CMS, NCII, NCQA, HEDIS, Workers's Comp, OIG etc.).
3.d. Explain the role of various entities in coding compliance (QIO, CERT, PERM, OIG, RAC audits, etc.).
3.e. Interpret standards to determine whether abuse of the healthcare system has occurred.
3.f. Interpret AHIMA Standards of Ethical Coding.
3.g. Differentiate between clerical, judgmental and systematic auditing and monitoring.
3.h. Explain the importance of correctness, completeness and timeliness of quality coding.
3.i. Determine causes of coding error.
3.j. Determine responsibilities of a Compliance Officer.
3.k. Examine coding compliance issues that influence reimbursement.
3.l. Identify elements of a compliance plan, its mission and policies.
3.m. Summarize corrective action in the enforcement of a coding compliance plans.

3.n. Examine methods Medicare uses to deal with improper payments (RAC audits, PEPPER Reports).
3.o. Apply terminology related to coding compliance.

## 4. APPLY various prospective payment systems (e.g., MS-DRG, APC, RBRVS)

**Assessment Strategies**

4.1. Oral, written or graphic assessment

**Criteria**

*You will know you are successful when*

4.1. your diagnostic/procedural grouping is supported by medical documentation
4.2. your diagnostic /procedural grouping ensures optimal reimbursement
4.3. your diagnostic /procedural grouping selection process is articulated

**Learning Objectives**

4.a. Identify prospective payment systems used to determine reimbursement in various healthcare settings (acute care, ambulatory care, long term care, home health, postacute, other).
4.b. Identify the data elements used to determine reimbursement (diagnosis and procedure codes, UHDDS or other data set elements, Present on Admission Indicator, modifiers, complications/comorbidities, major CCs, etc.).
4.c. Identify major components of the Resource Based Relative Value payment system.
4.d. Identify major components of relative value units.
4.e. Determine the appropriate elements (principal diagnosis surgical procedure, complications, comorbidities, etc.) used in the calculation of a reimbursement group (DRG, APC) to ensure optimal reimbursement.
4.f. Identify the steps in determining prospective payment group.
4.g. Utilize programs and publications (NCCI, Coding Clinic) to ensure correct coding methodologies and to control improper coding leading to inappropriate payment.
4.h. Apply terminology related to revenue cycle, claims submission, reimbursement grouping and charge description master.

## 5. MANAGE the revenue cycle

**Assessment Strategies**

5.1. Oral, written or graphic assessment

**Criteria**

*You will know you are successful when*

5.1. you identify the roles of stakeholders in the revenue cycle
5.2. you collaborate on interdisciplinary revenue cycle activities
5.3. you apply measures to the revenue cycle to ensure efficiency (case mix, DNFB, etc.)
5.4. you manage compliance with regulatory guidance and standards

**Learning Objectives**

5.a. Identify revenue cycle team members and their roles in reimbursement.
5.b. Examine the importance of revenue cycle management for a provider's fiscal stability.
5.c. Describe components of the revenue cycle (preclaims submission activities, claims processing activities, accounts receivable, claims reconciliation and collections).
5.d. Resolve revenue cycle barriers.
5.e. Identify measures of an efficient reimbursement cycle.
5.f. Identify quality measures for each step of the reimbursement cycle
5.g. Calculate Casemix Index.
5.h. Interpret and apply payer specific edits (National Correct Coding Initiative, Outpatient Code Editor).
5.i. Explain the HIPAA Transaction Standards for financial transactions.
5.j. Evaluate compliance with regulatory guidelines and standards for the revenue cycle.
5.k. Apply terminology related to the revenue cycle.

## 6. CONDUCT activities related to revenue cycle audits

**Assessment Strategies**

6.1. Oral, written or graphic assessment

**Criteria**

*You will know you are successful when*

6.1. you interpret the audit report results
6.2. you justify your findings
6.3. you determine if an appeal is necessary
6.4. you respond to an appeal

**Learning Objectives**

6.a. Identify the elements of a Revenue Cycle Audit Program (policies/procedures/guidelines)
6.b. Demonstrate how internal processes (clinical documentation improvement, DRG validation, other internal audits) can improve quality and reduce the risk of audit.
6.c. Interpret audit results from external regulators (eg. Recovery Audit Contractor (RAC) reports, insurance reimbursement vs contractual allowance, etc.)
6.d. Examine reasons for denied claims.
6.e. Analyze a claims denial to determine whether an appeal is warranted.
6.f. Determine appropriate documentation to justify an appeal.
6.g. Develop an appeal letter in response to a denied claim.

## 7. MANAGE the claim processes within the revenue cycle

**Assessment Strategies**

7.1. Oral, written or graphic assessment

**Criteria**

*You will know you are successful when*

7.1. you prepare a claim for reimbursement
7.2. you assess a claim for accuracy
7.3. you resolve claim edits
7.4. you manage claim denials

**Learning Objectives**

7.a. Identify data elements required for billing and reimbursement.
7.b. Differentiate claim forms (UB04, CMS 1500).
7.c. Demonstrate claim form completion.
7.d. Explain the role of a claim processor or patient financial representative
7.e. Analyze claim form quality (clean vs dirty claims).
7.f. Resolve claim edits
7.g. Recommend mitigation strategies to reduce the risk of payment denials (education, documentation, process improvements, systems, etc.)
7.h. Apply terminology related to claims processing

## 8. MANAGE the charge description master (CDM)

**Assessment Strategies**

8.1. Oral, written or graphic assessment

**Criteria**

*You will know you are successful when*

8.1. you recognize the components of the charge master
8.2. you evaluate the charge description master (CDM) for accuracy
8.3. you comply with coding and billing regulations

**Learning Objectives**

8.a. Summarize the structure of the charge description master (charge code, code description, revenue code HCPCS code, charge, active/inactive status).
8.b. Build a Charge Description Master
8.c. Identify risks of improper charge description master maintenance and revision
8.d. Assess a Charge Description Master for compliance
8.e. Differentiate between soft coding and hard coding (CDM)
8.f. Explain the relationship between the CDM and the coding department.

8.g. Evaluate charge master maintenance processes (review of CPT/HCPCS codes, revenue codes, modifiers, payer contract updates, other).
8.h. Summarize CDM team membership and responsibilities
8.i. Apply terminology related to the charge description master.