Western Technical College

10530185 Healthcare Reimbursement

Course Outcome Summary

Course Information

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 Diagnosis Related Groups (DRGs), Ambulatory Payment Classifications (APCs) and Resource Utilization Groups (RUGs) with entry level proficiency using computerized encoding and grouping software. Student will participate in online discussion and mandatory in class hours.
Career Cluster	Health Science
Instructional Level	Associate Degree Courses
Total Credits	2
Total Hours	54

Textbooks

Principles of Healthcare Reimbursement. 6th Edition. Copyright 2018. Casto, Anne. Publisher: American Health Information Management Association. **ISBN-13**: 978-1-58426-646-4. Required.

Health Information Management Technology: An Applied Approach - with Access. 5th Edition. Copyright 2016. Sayles, Nanette B. Publisher: American Health Information Management Association. **ISBN-13**: 978-1-58426-488-0. Required.

Basic ICD-10-CM and ICD-10-PCs Coding 2020. Copyright 2020. Schrafenberger, Luann. Publisher: American Health Information Management Association. **ISBN-13**: 978-1-58426-744-7. Required.

CPT 2020 – Professional Edition. Copyright 2020. Publisher: American Medical Association. **ISBN-13**: 978-1-62202-898-6. 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.

Course Competencies

1. Compare non-government payers (i.e. commercial insurance, managed care)

Assessment Strategies

1.1. by reporting findings of your comparison

Criteria

Your performance will be successful when:

1.1. comparison contrasts eligibility
1.2. comparison contrasts benefits
1.3. comparison contrasts cost and utilization controls
1.4. comparison contrasts funding
1.5. comparison contrasts administration

Learning Objectives

1.a. Identify eligibility requirements for nongovernment payers.
1.b. Define terms (subscriber, enroll).
1.c. Contrast subscriber benefits/coverage for nongovernment payers.
1.d. Define terms (benefit, exclusion, policy, Blue Cross/ Blue Shield, managed care).
1.e. Describe methods used by nongovernment payers to control quality, utilization and costs (utilization review, case management).
1.f. Define terms (utilization review, preadmission certification, continued stay review, discharge indicators, criteria).
1.g. Identify funding mechanisms of given nongovernment payers.
1.h. Define terms (deductible, coinsurance, premium, capitation, fee for service, global payment, prospective payment).
1.i. Contrast administration of various types of managed care programs (i.e., Health Maintenance Organization, Point of Service Plan, Preferred Provider Organization).
1.j. Discuss the role of the NCQA and HEDIS in monitoring quality of managed care plans.
1.k. Contrast administration of traditional vs. Blue Cross/Blue Shield insurance.
1.l. Discuss legislation influencing the development of managed care.
1.m. Contrast individual and employer based health care plans.

2. Compare government payers (i.e., Medicare/Medicaid)

Assessment Strategies

2.1. by reporting findings of your comparison

Criteria

Your performance will be successful when:

2.1. comparison contrasts eligibility
2.2. comparison contrasts benefits
2.3. comparison contrasts cost and utilization controls
2.4. comparison contrasts funding
2.5. comparison contrasts administration

Learning Objectives

2.a. Identify eligibility requirements for government payers (i.e., Medicare, Medicaid, Tricare, Champ VA, Worker's Comp)
2.b. Differentiate between Part A, B and C Medicare coverage.
2.c. Describe benefits/coverage under Medicaid.
2.d. Describe benefits/coverage under Tricare and Champ VA.
2.e. Describe coverage under Worker's Compensation.
2.f. Define prospective payment.
2.g. Identify prospective payment systems used for various healthcare settings (acute care, ambulatory care, long term care, home health, post acute, other).
2.h. Describe how prospective payment systems control costs (value based purchasing, pay for performance, other)

2.i. Describe mechanisms used by the Worker's Compensation program to prevent fraud and abuse.
2.j. Identify revenue sources of Medicare Hospital Insurance vs. Supplemental Medical Insurance.
2.k. Describe the role of Social Security in Medicare program funding.
2.l. Describe how Medicaid is funded.
2.m. Describe how Worker's Compensation is funded.
2.n. Discuss legislation which led to the development of Medicare and Medicaid programs.
2.o. Describe the role of the Centers for Medicare and Medicaid in the administration of the Medicare and Medicaid programs.
2.p. Describe the role of each state in the administration of its own Medicaid program
2.q. Describe the role of the government in the administration of the Worker's Compensation program.
2.r. Discuss the use of managed care in state Medicaid, CHIP and Medicare programs

3. Comply with regulations related to fraud and abuse

Assessment Strategies

3.1. Action plan completion in response to selected scenarios

Criteria

Your performance will be successful when:

3.1. action plan identifies fraud and abuse
3.2. action plan identifies applicable regulatory agencies
3.3. action plan follows a compliance plan
3.4. action plan shows application of National Correct Coding Initiative
3.5. action plan shows application of AHIMA Standards for Ethical Coding
3.6. action plan includes an explanation of why the decision was made

Learning Objectives

3.a. Define fraud as it relates to reimbursement in healthcare.
3.b. Follow standards to determine whether abuse of the healthcare system occurred.
3.c. Discuss the role of the Office of Inspector General in compliance.
3.d. Describe initiatives that address fraud and abuse issues (HIPAA, Balanced Budget Act, False Claims act).
3.e. Identify elements of a compliance plan, its mission and policies.
3.f. Describe responsibilities of a Compliance Officer.
3.g. Identify minimal coding resources.
3.h. Differentiate between various levels of qualified coders (CCA, CCS, CCS-P, RHIT, RHIA).
3.i. Describe the purpose of the National Correct Coding Initiative.
3.j. Differentiate between Correct Coding Initiative edits and Outpatient Code Editor edits
3.k. Follow the AHIMA Standards of Ethical Coding.
3.l. Differentiate between clerical, judgmental, and systematic auditing and monitorimg.
3.m. Discuss the importance of correctness, completeness, and timeliness in quality coding.
3.n. Discuss causes of coding error.
3.o. Discuss corrective action in enforcement of compliance policies.
3.p. Examine coding compliance issues that influence reimbursement
3.q. Review various code sets approved by HIPAA

4. Assign Diagnostic Related Groups (DRGs)

Assessment Strategies

4.1. homework or test requiring student to list DRG number(s)

Criteria

Your performance will be successful when:

4.1. Diagnosis Related Group(s) is supported by medical documentation
4.2. Diagnosis Related Group(s) ensures optimal reimbursement
4.3. Diagnosis Related Group(s) selection process is articulated
4.4. reilmbursement group is assigned using manual or computerized grouping system

Learning Objectives

4.a. Describe the applicability of MS-DRGs.
4.b. Describe the maintenance of the MS-DRG system.
4.c. Apply Uniform Hospital Discharge Data Set (UHDDS) definitions.

4.d. Identify data elements used to determine MS-DRGs.
4.e. Illustrate the steps in manual MS-DRG assignment.
4.f. Calculate payment under MS-DRGs.
4.g. Describe Casemix and Casemix Index.
4.h. Calculate Casemix Index
4.i. Describe applicability of the HINN (Hospital Issued Notice of Noncoverage).
4.j. Define Present on Admission Indicator (POA)
4.k. Identify when POA is required
4.l. Describe the potential affect of POA on Medicare Reimbursement for Inpatients

5. Assign Ambulatory Payment Classifications (APCs)

Assessment Strategies

5.1. homework assignment or test requiring student to list APC number(s)

Criteria

Your performance will be successful when:

5.1. Ambulatory Payment Classification(s) is supported by medical documentation
5.2. Ambulatory Payment Classification(s) ensures optimal reimbursement
5.3. Ambulatory Payment Classification(s) selection process is articulated
5.4. reimbursement group is assinged using manual or computerized grouping system

Learning Objectives

5.a. Describe the applicability of APCs.
5.b. Identify the data elements used to determine APCs.
5.c. Describe the maintenance of the APC system.
5.d. Explain the importance of HCPCS modifiers in APC assignment.
5.e. Define CCI Edits.
5.f. Define OCE Edits.
5.g. Explain the purpose of ICD-9-CM coding as it relates to APC assignment.
5.h. Illustrate the steps in APC assignment.
5.i. Calculate APC payment.
5.j. Describe applicability of the ABN (Advance Beneficiary Notice).

6. Compare other prospective payment systems (i.e. Resource Unitlization Groups (RUGs), fee for service, Case Mixed Groups (CMG), Resource Based Relative Value Scale (RBRVS))

Assessment Strategies

6.1. Report

Criteria

Your performance will be successful when:

6.1. comparison describes which health care providers get reimbursed under the payment system
6.2. comparison contrasts components used to determine payments

Learning Objectives

6.a. Identify the various Medicare PPS systems.
6.b. Describe the applicability of the various Medicare PPS systems.
6.c. Identify data elements used to determine the various Medicare PPS systems.
6.d. Describe the maintenance of the various Medicare PPS systems.
6.e. Correlate healthcare settings to the appropriate prospective payment (PPS) methodology under Medicare.
6.f. Identify elements of Relative Value Units and major components of the RBRV payment system

7. Illustrate the reimbursement cycle

Assessment Strategies

7.1. Drawing/Illustration of the reimbursement cycle

Criteria

Your performance will be successful when:

7.1. illustration reveals the flow of information from coding to closing of account

7.2. illustration describes the use and maintenance of the charge description master (CDM)
7.3. illustration describes fee schedule
7.4. illustration shows the relationship of one function to another with in the reimbursement cycle
7.5. illustration clarifies the importance of accuracy

Learning Objectives

7.a. Describe components of the revenue cycle
7.b. Explain the HIPAA Transaction Standards.
7.c. Identify data elements required for billing and reimbursement.
7.d. Explain the various claim forms and transactions.
7.e. Define condition code.
7.f. Describe claim form completion
7.g. Define clean claim.
7.h. Assess claim form data quality
7.i. Describe the charge description master (CDM).
7.j. Compare the relationship between the CDM and the coding department.
7.k. Identify key players and their roles in the reimbursement cycle.
7.l. Identify measures of an efficient reimbursement cycle.
7.m. Identify barriers to an efficient reimbursement cycle.
7.n. Describe a Reimbursement (Revenue) Cycle Team.
7.o. Differentiate between Remit Advice and Explanation of Benefits
7.p. Describe the importance of revenue cycle management for a provider's fiscal stability