HIM 252 Healthcare Payment Systems

Credit Hours:
3 hours

Instructor:
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Description:
Overview of the management of healthcare payment systems including insurance, billing/collection processes, case mix analysis, corporate compliance, HIPAA, and other current reimbursement issues.

Textbooks:
Casto and Forrestal. Principles of Healthcare Reimbursement, 5th ed. ISBN: 978-1-58426-434-7

Please note: You must have a new paper textbook to get access to the electronic student workbook. The unique student code for the student workbook is revealed once s/he scratches off the sticker provided in the paper textbook.

Evaluation:
The final course grade will be derived from percentage of achieved points accumulated from quizzes, tests, and assignments (exercises) in relation to total points possible.

The following Grade System will be used:

100% - 90%	A
89% - 80%	B
79% - 70%	C
69% - 60%	D
59% - 0%	F

To calculate your ongoing grade in the class, divide the points you receive by total possible points for what you have completed.

Example: If you have received 71 points out of a possible 80 points, calculate 71 divided by 80 (71/80= .8875) and multiply by 100. In the example, the grade would be rounded to 89% or a high "B".

Course Access:

Course can be accessed on Blackboard through the http://www.wku.edu website or https://blackboard.wku.edu/.

You must download a free copy of Respondus Lockdown Browser, which is available from the Blackboard Software tab at the top of your screen. For help with this process contact the IT Helpdesk at 270- 745-7000. You must use Respondus will taking quizzes and exams.

Due Date:

This class is self-paced. All class assignments and quizzes (chapters 1-5) and midterm exam must be completed by Friday, March 24th, at NOON. All class assignments and quizzes (chapters 6-10) and final exam must be completed by Wednesday, May 10th, at NOON. NO EXTENSIONS WILL BE GRANTED. Do not wait until the last few days to complete the course. By following this advice, technical difficulties can be addressed. If you choose to wait to complete the course requirements right before each deadline there is no guarantee that technical difficulties will not occur or that they can be corrected prior to the deadline. Technical difficulties do not extend the course completion deadline.

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Student Learning Outcomes:

At the conclusion of this course, the student should be able to meet the following 2011 AHIMA HIM Associate Degree Entry-Level Competencies, Domains, Subdomains, and Tasks:

Associate Degree

Domain I: Health Data Management

I.C. Clinical Classification Systems

- Use and Maintain electronic applications and work processes to support clinical classification and coding (I.C.1)
- Adhere to current regulations and established guidelines in code assignment. (I.C.4)
- Validate coding accuracy using clinical information found in the health record. (I.C.5)
- Use and maintain applications and processes to support other clinical classification and nomenclature systems (such as DSM IV, SNOMED-CT). (I.C.6)

- Resolve discrepancies between coded data and supporting documentation. (I.C.7)

I.D. Reimbursement Methodologies

- Apply policies and procedures for the use or clinical data required in reimbursement and prospective payment systems (PPS) in healthcare delivery. (I.D.1)
- Apply policies and procedures to comply with the changing regulations among various payment systems for healthcare services such as Medicare, Medicaid, managed care, and so forth. (I.D.2)
- Support accurate billing through coding, change master, claims management, and bill reconciliation processes. (I.D.3)
- Use established guidelines to comply with reimbursement and reporting requirements such as the National Correct Coding Initiative. (I.D.4)
- Compile patient data and perform data quality reviews to validate code assignment and compliance with reporting requirements such as outpatient prospective payment systems. (I.D.5)

Domain III: Health Services Organization and Delivery

III.B. Healthcare Privacy, Confidentiality, Legal and Ethical Issues

- Apply and promote ethical standards of practice. (III.B.5)

Domain IV: Information Technology & Systems

IV.A. Information and Communication Technologies

- Use technology, including hardware and software, to ensure data collection, storage, analysis, and reporting of information. (IV.A.1)
- Use common software apps such as spreadsheets, databases, word processing, graphics, presentation, e-mail, and so on in the execution of work processes. (IV.A.2)
- Use specialized software in the completion of HIM processes such as record tracking, release of information, coding, grouping, registries, billing, quality improvement, and imaging. (IV.A.3)

Domain V: Organizational Resources

V.B. Financial and Resource Management

- Monitor coding and revenue cycle processes. (V.B.3)

Baccalaureate Degree

Domain I: Health Data Management

I.C. Subdomain: Clinical Classification Systems

- Select electronic applications for clinical classification and coding. (I.C.1)
- Implement and manage applications and processes for clinical classification and coding. (I.C.2)
- Maintain processes, policies, and procedures to ensure the accuracy of coded data. (I.C.3)

I.D. Subdomain: Reimbursement Methodologies

- Manage the use of clinical data required in prospective payment systems (PPS) in healthcare delivery. (I.D.1)
- Manage the use of clinical data required in other reimbursement systems in healthcare delivery. (I.D.2)
- Participate in selection and development of applications and processes for chargemaster and claims management. (I.D.3)
- Participate in revenue cycle management. (I.D.5)

Domain III. Health Services Organization and Delivery
III.B. Subdomain: Healthcare Privacy, Confidentiality, Legal, and Ethical Issues

- Apply and promote ethical standards of practice. (III.B.7)

At the conclusion of this course, the student should be able to meet the following 2011 AHIMA Knowledge Clusters at the indicated taxonomic level. Blackboard Assignments for those clusters are also included below. Lack of a taxonomic level indicates that cluster is not taught at the highest taxonomic level in this course.

Curriculum Components:

Associate Degree

Domain I: Health Data Management
I.C. Clinical Classification Systems

- Diagnostic and procedural groupings (such as DRG, APC, RUGs, SNOMED)
- Casemix analysis and indexes (4) [Blackboard Assignment: Case Mix Analysis]
- Severity of illness systems
- Coding compliance strategies, auditing, and reporting (such as CCI, plans)
- (5) [Blackboard Assignments: Compliance Plan and Revenue Cycle Part 1]

I.D. Reimbursement Methodologies

- Commercial, managed care and federal insurance plans (4) [Blackboard
- Assignments: Affordable Care Act, CMS Tutorial World of Medicine,
- Medicaid Assignment, and Managed Care Contract Evaluation]
- Compliance strategies and reporting (3) [Blackboard Assignments:
- Compliance Plan and Blackboard Assignment: Revenue Cycle Part 1]
- Payment methodologies and systems (such as capitation, prospective payment systems PPS, RBRVS) (4) [Blackboard Assignments: CMS Tutorial Acute Inpatient PPS Hospital and Medicaid Assignment]
- Billing processes and procedures (such as claims, EOB, ABN, EDI) (4)
- [Blackboard Assignment: CMS Tutorial CMS Form 1500; CMS Tutorial
- HIPAA EDI; CMS Tutorial UB04, and Revenue Cycle Part 2]
- Chargemaster maintenance
- Regulatory guidelines (such as NCDs and QIOs) (3) [Blackboard

- Assignment: Revenue Cycle]
- Reimbursement monitoring and reporting (5) [Blackboard Assignment: Revenue Cycle Part 1 and Part 2]

Domain III. Health Services Organization and Delivery

III.B. Healthcare Privacy, Confidentiality, Legal and Ethical Issues

- Professional and practice-related ethical issues (5) [Blackboard Assignment: CMS Tutorial Fraud and Abuse]

Domain IV: Information Technology & Systems

Domain IV.A. Information and Communication Technologies

- Health information systems (such as administrative, patient registration,
- ADT, EHR, personal health record (PHR), lab, radiology, pharmacy)

Domain V. Organizational Resources

V.B. Financial and Resource Management

- Revenue cycle monitors (4) [Blackboard Assignment: Revenue Cycle Part 1 and Part 2]

Baccalaureate Degree

Domain I: Health Data Management

I.C. Subdomain: Clinical Classification Systems

- Severity of illness systems
- CCI, electronic billing, X12N, 5010 (Applying, 3) [Blackboard Assignment: CMS Tutorial CMS Form 1500; CMS Tutorial HIPAA EDI; and CMS Tutorial UB04]

I.D. Subdomain: Reimbursement Methodologies

- Clinical data and reimbursement management (Evaluating, 5) [Blackboard Assignment: Revenue Cycle Part 1 and Part 2]
- Chargemaster management
- Case mix management (Analyzing, 4) [Blackboard Assignment: Case Mix Analysis]
- Payment systems (such as PPS, DRGs, APCs, RBRVS, RUGs, MSDRGs) (Analyzing, 4) [Blackboard Assignments: CMS Tutorial Acute Inpatient PPS Hospital and Medicaid Assignment]
- Commercial, managed care, and federal insurance plans (Analyzing, 4) [Blackboard Assignments: Affordable Care Act, CMS Tutorial World of Medicine, Medicaid Assignment, and Managed Care Contract Evaluation]
- Revenue cycle process (Analyzing, 4) [Blackboard Assignment: Revenue Cycle Part 1 and Part 2]

Domain III: Health Services Organization and Delivery

III.B. Subdomain: Healthcare Privacy, Confidentiality, Legal, and Ethical Issues

- Professional ethical issues (Evaluating, 5) [Blackboard Assignment: CMS Tutorial Fraud and Abuse]

Disability Accommodations:

In compliance with University Policy, students with disabilities who require accommodations academic adjustments and/or auxiliary aids or services for this course must contact the Office for Student Disability Services, Room DSU-1074. The OFSDS telephone number is (270) 745-5004 V/TDD. Please Do Not request accommodations directly from the professor or instructor without a letter of accommodations from the Office for Student Disability
Services

Disclaimer:

References to external websites are provided for the convenience of the student. These sites may contain articles on politically and socially controversial topics and are presented from the prospective of providing information. The instructor is not responsible for the content of these external sites and does not necessarily endorse the views or agree with the information held on these sites; the instructor does not take moral stances on issues.
Revised 9/2015

HIM 252 HEALTHCARE PAYMENT SYSTEMS RECOMMENDED CLASS SCHEDULE

DUE DATES: This class is self-paced. All class assignments and quizzes (chapters 1-5) and midterm exam must be completed by Friday, March 24th, at NOON. All class assignments and quizzes (chapters 6-10) and final exam must be completed by Wednesday, May 10th, at NOON. NO EXTENSIONS WILL BE GRANTED.

Weeks	**TOPIC**	**ASSIGNMENT**
Week 1 and 2	Ch. 1- Healthcare Reimbursement Methodologies	Complete Assignment "Affordable Care Act" Complete Quiz Chapter 1
Week 3 and 4	Ch. 2- Clinical Coding and Coding Compliance	Complete Assignment 1: CMS "Medicare Fraud and Abuse: Prevention, Detection, and Reporting" Complete Assignment 2: Compliance Plan Complete Quiz Chapter 2
Week 5	Ch. 3 - Voluntary Healthcare Insurance Plans	Complete CMS "HIPPA EDI" online training Complete Quiz Chapter 3
Week 6	Ch. 4- Government- Sponsored Healthcare Programs	Complete Assignment CMS "World of Medicare" online training Complete Quiz Chapter 4
Week 7	Ch. 5- Managed Care Plans	Complete Assignment "Managed Care Contract Evaluation" Complete Quiz Chapter 5
Week 8	**SPRING BREAK**	
Week 9		**Complete MIDTERM**
Week 10	Ch. 6- Medicare-Medicaid PPS for Inpatients	Complete Assignment 1: CMS "Uniform Billing UB-04" online Training AND Assignment 2: Case Mix Calculations & Analysis Complete Quiz Chapter 6
Week 11 & 12	Ch. 7- Ambulatory and Other Medicare-Medicaid Reimbursement Systems	Complete Assignment 1: CMS "Your Office in the World of Medicare" AND Assignment 2: CMS "CMS Form: 1500" Online Training Complete Quiz Chapter 7

Week 13	Ch. 8- Medicare-Medicaid PPS for Postacute Care	Complete CMS "Acute Inpatient PPS Hospital" Complete Quiz Chapter 8
Week 14 & 15	Ch. 9- Revenue Cycle Management AND Ch. 10- Value-Based Purchasing	Complete Assignment 1: Revenue Cycle Part 1 Complete Assignment 2: Revenue Cycle Part 2 (EOB Analysis) Complete Quiz Chapter 9 Complete Quiz Chapter 10
Week 16		**Complete FINAL by Wednesday, May 10**

Class Schedule Revised: 01/2017

HIM 252 Course Content

I. Introduction to Healthcare Reimbursement
    A. Health Insurance
    B. Historical Perspectives
        1. Health Insurance and Employment
        2. Compensation for Healthcare
        3. Third-Party Payment
        4. Characteristics of Reimbursement Methods
        5. Healthcare Reform

II. The Clinical Coding-Reimbursement
    A. The International Classification of Diseases
        1. ICD-10-CM/PCS
        2. ICD-9-CM
    B. Healthcare Common Procedure Coding System CPT (HCPCS Level I)
    C. HCPCS Level II

III. Coding Compliance and Reimbursement
    A. Fraud and Abuse
    B. Oversight of Medicare Claims Payment
        1. Comprehensive Error Rate Testing Program
        2. Office of Inspector General Reports
        3. National Recovery Audit Program
    C. Other Third-Party Payer Reviews
    D. Coding Compliance Plan
        1. Policies and Procedures
        2. Education and Training
        3. Auditing and Monitoring
        4. Focus Areas
            a. Case Mix Index Analysis
            b. MS-DRG Relationships Reporting
            c. Site of Service: Inpatient versus Outpatient
            d. Evaluation and Management Facility Coding in the Emergency

IV. Department

V. Types of Healthcare Reimbursement Methodologies
    A. Fee-for-Service Reimbursement
        1. Self-Pay
        2. Traditional Retrospective Payment
            a. Fee Schedules
            b. Discounted Fee-for-Service Payment

        3. Managed Care Methods

a. Features of Managed Care
b. Purposes of Managed Care
c. Forms of Managed Care

B. Episode-of-Care Reimbursement
1. Capitated Payment Method
2. Global Payment Method
3. Prospective Payment Methods
a. Per Diem Payment
b. Case-Based Payment

VI. Medicare
A. Medicare Part A for Inpatients
B. Medicare Part B
C. Medicare Part C
D. Medicare Part D
E. Medigap

VII. Medicaid
A. Qualifications
B. Funding

VIII. Other Government-Sponsored Healthcare Programs
A. The Temporary Assistance for Needy Families Program
B. Programs of All-Inclusive Care for the Elderly
C. State Children's Health Insurance Program
D. TRICARE
1. TRICARE Prime and TRICARE Prime Remote
2. TRICARE Standard and TRICARE Extra
3. TRICARE for Life
E. CHAMPVA
F. The Indian Health Service
G. Workers' Compensation

IX. Managed Care Organizations
A. Benefits and Services of MCOs
B. Characteristics of MCOs 1. Quality Patient Care
a. Selection of Providers
b. Care Management Tools
c. Quality Assessment and Improvement Cost Controls
d. Medical Necessity and Utilization
e. Gatekeeper Role of Primary Care Provider
f. Prior Approval
g. Utilization Review

2. Case Management

C. Types of MCOs
   1. Health Maintenance Organization
      a. Staff Model
      b. Group Practice Model
      c. Network Model
      d. Independent Practice Model
   2. Preferred Provider Organization
   3. Point-of-Service Plan
   4. Exclusive Provider Organization
   5. Managed Care and Medicaid and State Children's Health Insurance Program
   6. Medicare Advantage

X. Prospective Payment Systems (PPSs)
   A. Acute-Care Prospective Payment System
      1. Diagnosis Related Group Classification System
   B. Other Care Settings
      1. Post-acute Care
      2. SNFs
      3. LTC
      4. IRF
      5. HH

XI. Ambulatory Payment Systems
   A. Resource-Based Relative Value Scale for Physician and Professional Payments
   B. Ambulance Fee Schedule
   C. Hospital Outpatient Prospective Payment System (HOPPS)
   D. Ambulatory Surgical Center (ASC) Prospective Payment System
   E. End-Stage Renal Disease Prospective Payment System
   F. Payment for Safety-Net Providers
   G. Hospice Services Payment System

XII. Revenue Cycle Management
   A. Components of the Revenue Cycle
      1. Preclaims Submission Activities
      2. Claims Processing Activities
      3. Order Entry
      4. Charge Description Master
      5. CDM Maintenance
      6. Coding by HIM
      7. Auditing and Review
      8. Submission of Claims
      9. Accounts Receivable

XIII. Value-Based Purchasing and Pay-for-Performance Systems

A. Value-based Purchasing
B. Pay-for-Reporting
C. Pay-for-Performance
D. Paying for Value

Rev. 1/2014

HIM 252 Course Objectives

I. Healthcare Reimbursement Methodologies
   - A. To understand the history of the healthcare payment systems in the United States
   - B. To identify trends in healthcare reimbursement in the United States
   - C. To use basic language associated with healthcare reimbursement methodologies
   - D. To differentiate payment methods on unit of payment, time frame, and risk
   - E. To recognize use of health information and communication technologies in the reimbursement process.
   - F. To define key terms

II. Clinical Coding and Coding Compliance
   - A. To differentiate the different code sets approved by the Health Insurance Portability and

III. Accountability Act of 1996
   - A. To describe the structure of approved code sets
   - B. To examine coding compliance issues that influence reimbursement (Coding Compliance Plan and NCCI)
   - C. To identify fraud and abuse and ethical issues
   - D. To describe legislative initiatives and agencies to combat fraud and abuse and to extend the Medicare Trust Fund (False Claims Act, Operation Restore Trust, BBA of 1997, Medicare Integrity Program, RACs, CERTs)
   - E. To define National Coverage Determinations and Local Coverage Determinations
   - F. To identify how legislative initiatives can be utilized by hospitals to monitor compliance
   - G. To define key terms

IV. Voluntary Healthcare Insurance Plans
   - A. To differentiate major types of voluntary healthcare insurance plans
   - B. To define basic language associated with reimbursement by commercial healthcare insurance plans and by Blue Cross and Blue Shield plans
   - C. To describe processes such as coordination of benefits, determination of coverage, and appeals
   - D. To identify elements of the insurance identification card
   - E. To describe processing of a claim
   - F. To identify items located on a Remittance Advice or Explanation of Benefits
   - G. To understand the Affordable Care Act and it's provisions
   - H. To define key terms

V. Government-Sponsored Healthcare Programs
   - A. To differentiate among and to identify the various government-sponsored healthcare programs (Medicare Part A, B, C, and D, Medigap, Medicaid, TRICARE, CHAMPVA, Indian Health Services, and Federal and State Worker's Compensation)

B. To understand Medicare Part A services based on setting related to benefit period and patient responsibility for payments
C. To understand the history of the Medicare and Medicaid programs in America
D. To recognize the impact that government-sponsored healthcare programs have on the American healthcare system
E. To define key terms

VI. Managed Care Plans
A. To describe origins of managed care
B. To trace evolution of managed care
C. To identify characteristics, case management tools, and cost controls of managed care
D. To describe types of MCOs
E. To define key terms

VII. Medicare-Medicaid Prospective Payment Systems for Inpatients
A. To describe the Medicare prospective payment systems for acute-care inpatients
B. To define basic language associated with the IPPS
C. To identify the components, adjustments, and provisions of the MS-DRG system
D. To recall the steps for MS-DRG assignment
E. To describe and calculate case mix index
F. To describe payment structure for transfer cases
G. To recall the payment determination steps for IPPS payment
H. To describe the inpatient psychiatric facilities prospective payment system
I. To identify the components, adjustments, and provisions of the IPF system
J. To recall the payment determination steps for IPF payment
K. To define key terms

VIII. Ambulatory and Other Medicare-Medicaid Reimbursement Systems
A. RBRVS
1. To outline the history and development of the Resource-Based Relative Value Scale (RBRVS) for physician and other health professional payments
2. To describe the structure of the payment system
3. To identify adjustments to payment structure ((budget neutrality, clinician type, modifiers, underserved populations, quality measures, technology)
4. To calculate a payment under the RBRVS
5. To define key terms

B. Ambulance Fee Service
1. To outline the history and development of the ambulance fee schedule
2. To identify components and provisions of the ambulance fee schedule

C. Outpatient
1. To describe the Hospital Outpatient Prospective Payment System

2. To identify the components, adjustments (payment status indicators, discounting, high-cost outliers, rural adjustments, cancer adjustment, pass-through payments) and provisions of the APC system
3. To identify the types of APCs
4. To identify excluded facilities
5. To recall the steps for APC assignment
6. To recall the payment determination steps for OPPS payment
7. To define key terms

D. Ambulatory Surgical Center
1. To describe the Ambulatory Surgical Center Prospective Payment System
2. To describe inclusions and exclusions from the payment system

E. End-stage Renal Disease
1. To describe the end stage renal disease prospective payment system
2. To identify the components, adjustments, and provisions of the ESRD system
3. To recall the payment determination steps for ESRD payment
4. To define key terms

F. Safety-net Providers
1. To outline the history of major safety-net providers
2. Identify examples of safety-net providers
3. To describe the payment systems for safety-net providers
4. To define key terms

G. Hospice
1. To outline the background of the hospice payment system
2. To identify coverage requirements for hospice
3. To describe the hospice services payment system
4. To define key terms

IX. Medicare-Medicaid Prospective Payment Systems for Post-acute Care

A. Skilled Nursing Facility
1. To describe the skilled nursing facility prospective payment system (SNF PPS)
2. To identify the major features and requirements of the SNF PPS
3. To calculate a payment under the SNF PPS
4. To identify the collection tool and process for SNFs

B. Long-term Care Hospital
1. To describe the long-term care hospital prospective payment system (LTCH PPS)
2. To identify covered organizations, payment groups, and requisite payment system.
3. To calculate a payment under the LTCH PPS
4. To identify the collection tool for LTC

C. Inpatient Rehabilitation Hospital
   1. To outline the development of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)
   2. To define participating facilities
   3. To describe the processes of collecting data and assigning codes
   4. To calculate a payment under the IRF PPS
   5. To identify the collection tool for IRH

D. Home Health PPS
   1. To summarize the history and development of the Home Health Prospective Payment System (HHPPS)
   2. To describe characteristics of the payment system
   3. To calculate a payment under the HHPPS
   4. To identify the collection tool and process for HH

X. Revenue Cycle Management
   A. To identify and describe the basic components of the revenue cycle
   B. To describe charge capture techniques (order entry, Charge Master, coding)
   C. To explain the relationship between the revenue cycle and positive hospital finance
   D. To identify how the revenue cycle ties into the hospital compliance plan
   E. To define revenue cycle management (RCM)
   F. To identify basic key performance indicators for RCM improvement
   G. To verbalize the importance of effective RCM
   H. To identify key terms

XI. Value-Based Purchasing
   A. To describe the origins and evolution of value-based purchasing and pay for performance
   B. To describe models of pay for performance
   C. To explain models of the Centers for Medicare and Medicaid Services