HIM 252 Healthcare Payment Systems

Credit Hours: 3 hours

Instructor:
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Course Communication Tools:

- Email (Use the following format when emailing the instructor---Subject: HIM252-Your Name-Topic)
- Blackboard Collaborate (aka Bb Collaborate or Web Meeting)

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 WKU Website or BlackBoard Website.
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 when taking quizzes and exams.**

Due Dates:

This class is self-paced. All class assignments and quizzes (chapters 1-5) and midterm exam must be completed by **Friday, March 23rd, at NOON**. All class assignments and quizzes (chapters 6-10) and final exam must be completed by **Wednesday, May 9th, 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.

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 Accessibility Services in DSU-1074 of the Student Success Center in Downing University Center. 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 accommodation from the Office for Student Accessibility Services.

Once accessibility services/accommodations have been granted and initiated, please contact me with any questions or concerns. Also, if you believe that you are not receiving the disability services to which you are entitled, please address this concern with me immediately so discussion and/or adjustments can occur.

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 01/2018

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 23rd, at NOON. All class assignments and quizzes (chapters 6-10) and final exam must be completed by Wednesday, May 9th, at NOON. NO EXTENSIONS WILL BE GRANTED.

WEEKS	TOPICS	ASSIGNMENTS
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 Noon, Wednesday, May 9th**

Class Schedule Revised: 01/2018

Student Learning Outcomes:

At the conclusion of this course, the student should be able to meet the following 2014 AHIMA HIM Associate Degree and Bachelor Degree Entry-Level Competencies

HIM 252 AS CAHIIM 2014 Competencies

Domain IV. Revenue Management		
Subdomain IV. A. Revenue Cycle and Reimbursement		
1. Apply policies and procedures for the use of data required in healthcare reimbursement, 3	* Payment methodologies and systems (Capitation, PPS, RBRVS, case mix, indices, MSDRGs, healthcare insurance policies, Accountable Care Organizations)	Case Mix Analysis, CMS Tutorial World of Medicare, CMS Tutorial Acute Inpatient PPS Hospital , Medicaid Assignment
	* Utilization review/management (Case Management)	
2. Evaluate the revenue cycle management processes, 5	* Billing processes and procedures (Claims, EOB, ABN, electronic data interchange, coding, chargemaster, bill reconciliation process; hospital inpatient and outpatient, physician office and other delivery settings)	Revenue Cycle Part 1 & 2 (EOB Analysis)
	* Utilization review/management	
Domain V. Compliance		
Subdomain V.A. Regulatory		
3. Adhere to the legal and regulatory requirements related to health information management, 3	* Legislative and regulatory processes (Coding quality monitoring, compliance strategies, and reporting)	Compliance Plan, Revenue Cycle Part 1 & 2 (EOB Analysis), CMS Tutorial CMS Form 1500; CMS Tutorial,HIPAA EDI; CMS Tutorial UB04
Subdomain V.C. Fraud Surveillance		
1. Identify potential abuse or fraudulent trends through data analysis, 3	* False Claims Act * Whistle blower, STARK, Anti-Kickback, unbundling, upcoding * Role of OIG, RAC (Fraud/Abuse)	CMS Tutorial Fraud & Abuse
Subdomain VI.F. Strategic and Organizational Management		

3. Describe the differing types of organizations, services and personnel and their interrelationships across the health care delivery system, 2	* Managed care organizations * ACO's * Payers/providers, all delivery settings * Payers' impact to each delivery setting	Affordable Care Act, CMS Tutorial World of Medicine, Medicaid Assignment, and Managed Care Contract Evaluation
Subdomain VI.H. Ethics		
1. Comply with ethical standards of practice, 5	* Professional and practice-related ethical issues	CMS Tutorial Fraud & Abuse
	* AHIMA Code of Ethics	

HIM 252 BS CAHIIM 2017 Competencies

Domain IV. Revenue Management		
Subdomain IV.A. Revenue Cycle and Reimbursement		
2. Take part in selection and development of applications and processes for chargemaster and claims management (4)	* Chargemaster management	
4. Implement processes for revenue cycle management and reporting (3)	* CCI-Electronic Billing X12N	CMS Tutorial CMS Form 1500; CMS Tutorial HIPAA EDI; and CMS Tutorial UB04
	* Audit process (Compliance and reimbursement)	Compliance Plan and Revenue Cycle Part 1
	* Revenue cycle process	Revenue Cycle Part 1 & 2 (EOB Analysis)
	* Utilization and resource management	
Domain V. Compliance		
Subdomain V.A. Regulatory		
1. Appraise current laws and standards related to health information initiatives (5)	* Compliance strategies and reporting * Elements of compliance programs	Compliance Plan
Subdomain V.B. Coding		
3. Identify severity of illness and its impact on healthcare payment services (3)	* Case Mix Management	Case Mix Analysis
	* Payment Systems (PPS, DRG, RBRVS, RUG, VBP, MSDRG, commercial, managed care, federal plans)	CMS Tutorial Acute Inpatient PPS Hospital Medicaid Assignment
Subdomain VI.F. Strategic and Organizational Management		
5. Identify the different types of organizations, services and	* Payers' impact to each delivery setting	

personnel and their interrelationships across the health care delivery system (3)		
Subdomain VI.H. Ethics		
1. Comply with ethical standards of practice (5)	* Professional ethics issues	CMS Tutorial Fraud & Abuse
	* Ethical decision making process	
	* AHIMA Code of Ethics	

Bloom's Taxnomic Levels:

1- Remember
2- Understand
3- Apply
4- Analyze
5- Evaluate
6- Create

HIM 252 Course Content

Healthcare Reimbursement Methodologies

Introduction to Healthcare Reimbursement

a. National Models of Healthcare Delivery
b. US Healthcare Sector
c. Dominance of Federal Healthcare Payment Methods
d. Health Insurance
e. Historical Perspectives
    i. Health Insurance and Employment
    ii. Compensation for Healthcare
    iii. Third-Party Payment
    iv. Characteristics of Reimbursement Methods

Types of Healthcare Reimbursement Methodologies

a. Fee-for-Service Reimbursement
    i. Self-Pay
    ii. Traditional Retrospective Payment
        1. Fee Schedule
        2. Discounted Fee-for-Service Payment
        3. Uncertainty for Third-Party Payers
        4. Criticism of Fee-for-Service Reimbursement
    iii. Managed Care
        1. Features of Managed Care
        2. Purposes of Managed Care
        3. Forms of Managed Care
        4. Criticisms of Managed Care
b. Episode-of-Care Reimbursement
    i. Capitated Payment Method
    ii. Global Payment Method
    iii. Prospective Payment Method
        1. Per Diem Payment
        2. Case-Based Payment
    iv. Criticisms of Episode-of-Care Reimbursement

Trends in Healthcare Reimbursement

a. Constantly Increasing Healthcare Spending
b. Healthcare Reform
    i. Background
    ii. Affordable Care Act
        1. Purposes
        2. Provisions
        3. Implementation

c. Use of Health Information and Communication Technologies
d. Medical Tourism
e. Transparency

Clinical Coding and Coding Compliance

The Clinical Coding-Reimbursement Connection

a. The *International Classification of Diseases*
    i. ICD-10-CM/PCS
        1. Structure of ICD-10-CM
        2. Structure of ICD-10-PCS
        3. Maintenance of ICD-10-CM/PCS
        4. ICD-10-CM/PCS Coding Guidelines
b. Healthcare Common Procedure Coding System
    i. CPT (HCPCS Level I)
        1. Structure of CPT
        2. Maintenance of CPT
        3. Requesting a Code Modification for CPT
        4. CPT Coding Guidelines
    ii. HCPCS Level II
        1. HCPCS Level II Permanent Codes
        2. HCPCS Level II Temporary Codes
        3. HCPCS Level II Modifiers
        4. Maintenance of HCPCS Level II Coding System
        5. Requesting a Code Modification for HCPCS Level II
        6. HCPCS Level II Coding Guidelines
c. Coding Systems as Communication Facilitators

Coding Compliance and Reimbursement

a. Fraud and Abuse
    i. Legislative Background
    ii. False Claims Act
    iii. Office of Inspector General (OIG) Compliance Program Guidance
    iv. Operation Restore Trust
    v. Health Insurance Portability and Accountability Act of 1996
    vi. Balanced Budget Act of 1997
    vii. Improper Payments Legislation
b. Oversight of Medicare Claims Payment
    i. Comprehensive Error Rate Testing Program
    ii. Office of Inspector General Reports
    iii. National Recovery Audit Program
        1. RAC Program
c. Other Third-Party Payer Reviews
d. Coding Compliance Plan
    i. Policies and Procedures

ii. Education and Training
iii. Auditing and Monitoring

Voluntary Healthcare Insurance Plans

Chapter Outline

Objectives

Key Terms

Introduction to Voluntary Healthcare Insurance

a. Types of Voluntary Healthcare Insurance
b. Confusing Terminology
c. Individual (Private) Healthcare Plans
d. Employer-Based (Group) Healthcare Plans
e. Blue Cross and Blue Shield Plans
    i. Nonprofit v. Profit Status
    ii. Types of Blue Cross and Blue Shield Accounts
        1. Geographic Plans
        2. Federal Employee Program
f. State Healthcare Plans for the Medically Uninsurable

Provisions and Functioning of Healthcare Insurance Plans

Sections of a Healthcare Insurance Policy

a. Definitions
b. Eligibility and Enrollment
c. Benefits
d. Limitations
    i. Cost Sharing Provisions
        1. Coinsurance
        2. Copayment
        3. Tiered Benefits
    ii. Benefit Cap
e. Exclusions
f. Riders and Endorsements
g. Procedures
    i. Prior Approval
    ii. Coordination of Benefits and Other Party Liability
h. Appeals Processes

Determination of Covered Services

Elements of Healthcare Insurance Identification Card

Filing a Healthcare Insurance Claim

Remittance Advice or Explanation of Benefits

Trends

a. Implementation of Affordable Care Act
    i. Provisions Effective in 2014
    ii. Provisions Effective Beyond 2015
b. Increasing Costs in Voluntary Healthcare Insurance
    i. Effects on Consumers
    ii. Effects on Providers
    iii. Effects on Healthcare Insurers
        1. Consumer-Directed Healthcare Plan
        2. Value-Based Insurance Design
        3. Wellness Programs

Government-Sponsored Healthcare Programs

Medicare

a. Medicare Part A for Inpatients
b. Medicare Part B
c. Medicare Part C
d. Medicare Part D
e. Medigap

Medicare Market Basket Updates: Reductions and Productivity Adjustments

Medicaid

Other Government-Sponsored Healthcare Programs

a. The Temporary Assistance for Needy Families Program
b. Programs of All-Inclusive Care for the Elderly
c. Children's Health Insurance Program
d. TRICARE
e. Veterans Health Administration
f. CHAMPVA
g. The Indian Health Service
h. Workers' Compensation

Managed Care Programs

Managed Care Organizations

Benefits and Services of MCOs

Characteristics of MCOs

i. Quality Patient Care
    1. Selection of Providers
    2. Health of Populations
    3. Care Management Tools

4. Quality Assessment and Improvement

ii. Cost Controls
    1. Medical Necessity and Utilization Management
    2. Gatekeeper Role of Primary Care Provider
    3. Prior Approval
    4. Second and Third Opinions
    5. Case Management
    6. Prescription Management

iii. Episode-of-Care Reimbursement
    1. Capitation
    2. Global Payment

iv. Financial Incentives

b. Contract Management

c. Types of MCOs
    i. Health Maintenance Organization
        1. Staff Model
        2. Group Practice Model
        3. Network Model
        4. Independent Practice Model
    ii. Preferred Provider Organization
    iii. Point-of-Service Plan
    iv. Exclusive Provider Organization
    v. Managed Care and Medicaid and Children's Health Insurance Program
    vi. Medicare Advantage
    vii. Special Needs Plan

Integrated Delivery Systems

a. Integrated Provider Organization
b. Group (Practice) Without Walls
c. Physician-Hospital Organization
d. Management Service Organization
e. Medical Foundation

Consolidation

Medicare-Medicaid Prospective Payment Systems for Inpatients

Introduction to Inpatient Prospective Payment Systems (PPSs)

Acute-Care Prospective Payment System

a. Conversion from Cost-Based Payment to Prospective Payment
    i. Concept of Prospective Payment
    ii. Prospective Payment Legislation
b. Diagnosis Related Group Classification System
    i. Classification System Development
    ii. Severity Refinement to DRGs
    iii. Structure of the DRG System
c. Assigning Medicare Severity Diagnosis Related Groups
    i. Step One: Pre-MDC Assignment
    ii. Step Two: MDC Determination
    iii. Step Three: Medical/Surgical Determination
    iv. Step Four: Refinement
    v. Invalid Coding and Data Abstraction
d. Provisions of the MS-DRG System
    i. Disproportionate Share Hospital
    ii. Indirect Medical Education
    iii. High-Cost Outlier Cases
    iv. New Medical Services and New Technologies
    v. Transfer Cases
e. IPPS Payment
    i. Step One: Establishment of Initial Payment Rate
    ii. Step Two: Medicare-Severity Diagnosis-Related Group Assignment
    iii. Step Three: Policy Adjustments for Hospitals that Qualify
    iv. Step Four: Add-on for High Cost Outlier and New Medical Service and Technology
        1. Pricer Software
    v. Maintenance of the MS-DRG System

Inpatient Psychiatric Facility Prospective Payment System

a. Patient-Level Adjustments
    i. Length of Stay Adjustment
    ii. Medicare-Severity Diagnosis-Related Group Adjustment
    iii. Comorbid Conditions
    iv. Older Patients
    v. Electroconvulsive Therapy
b. Facility-Level Adjustments
    i. Wage Index Adjustment

ii. Cost-of-Living Adjustment
iii. Rural Location Adjustment
iv. Teaching Hospital Adjustment
v. Emergency Facility Adjustment

c. Provisions of the Inpatient Psychiatric Facility Prospective Payment System
    i. Outlier Payment Provision
    ii. Initial Stay and Readmission Provisions
    iii. Medical Necessity Provision
d. Payment Steps

Ambulatory and Other Medicare-Medicaid Reimbursement Systems

Introduction to Prospective Payment Systems (PPSs) for Nonhospitalized Patients and for Physicians

Resource-Based Relative Value Scale for Physician and Professional Payments

a. Background
b. Structure of Payment
    i. Relative Value Unit and Geographic Practice Cost Index
    ii. Conversion Factor
c. Calculation
    i. Potential Adjustments
        1. Budget Neutrality
        2. Clinician Type
            a. Participating versus Nonparticipating
            b. Anesthesiologists
            c. Nonphysician Providers
        3. Special Circumstances
        4. Underserved Area
        5. Quality
        6. Technology
d. Operational Issues
    i. Coding and Documentation
    ii. Unnecessary Administrative Costs
e. Summary

Ambulance Fee Schedule

a. History
b. Reimbursement for Ambulance Services
    i. Nonemergency Transport
    ii. Immediate Response Payment
    iii. Payment Adjustment for Regional Variations
    iv. Multiple-Patient Transport
    v. Transport of Deceased Patients
    vi. Use of HCPCS Level II Modifiers

vii. Payment Steps

c. Office of Inspector General Report
d. Medical Conditions List
e. Future Updates

Hospital Outpatient Prospective Payment System (OPPS)

a. Hospital Outpatient Prospective Payment Methodology
    i. Reimbursement for Hospital Outpatient Services
    ii. Reporting of Services and Supplies under OPPS
    iii. Excluded Facilities
    iv. Maintenance of the Hospital Outpatient Prospective Payment System
b. Ambulatory Payment Classification System
    i. Partially Packaged System Methodology
    ii. Structure of the APC System
    iii. Copayment
    iv. New Technology Ambulatory Payment Classifications
    v. Composite Ambulatory Payment Classifications
        1. Observation Services
    vi. Partial Hospitalization
    vii. Provisions of the APC System
        1. Discounting
        2. Interrupted Services
        3. High-Cost Outlier
        4. Rural Adjustment
        5. Cancer Hospital Adjustment
        6. Pass-Through Payments
        7. Transitional Outpatient Payments and Hold-Harmless Payments
    viii. APC Assignment
c. Payment Determination

Ambulatory Surgical Center (ASC) Prospective Payment System

a. Medicare Certification Standards
b. Payment for ASC Services
c. Criteria for ASC Procedures
d. Ambulatory Payment Classifications and Payment Rates
e. Separately Payable Services
    i. Radiology Services
    ii. Brachytherapy Sources
    iii. Drugs and Biological Agents
    iv. Implantable Devices with Pass-Through Status under OPPS
    v. Corneal Tissue Acquisition
f. Device-Intensive Procedures
g. Multiple and Bilateral Procedures
h. Interrupted Procedures

i. ASC PPS Payment

End-Stage Renal Disease Prospective Payment System

a. Legislative Background
b. Definition of Renal Dialysis Services
    i. Facility Level Adjustments
        1. Wage Index Adjustment
        2. Low-Volume Adjustment
    ii. Patient Level Adjustments
        1. Patient Age
        2. Body Surface Area and Body Mass Index
    iii. New Patient Adjustment (Onset of Dialysis)
    iv. Comorbidity Adjustment
    v. Pediatric Patients
c. Outlier Policy
d. Self-Dialysis Training
e. Payment Steps

Payment for Safety-Net Providers

a. Background
b. Characteristics of Federally Qualified Health Centers and Rural Health Clinics
c. Reimbursement
    i. Medicare
        1. Federally Qualified Health Center Prospective Payment System
        2. Rural Health Clinic All-Inclusive Rate
        3. Medicare Cost Sharing
    ii. Medicaid
d. Summary

Hospice Services Payment System

a. Background
b. Reimbursement
    i. Structure of Payment
        1. Category Standard Daily Base Payment Rate
        2. Geographic Adjustment Factors
    ii. Calculation
c. Implementation

Medicare-Medicaid Prospective Payment Systems for Postacute Care

Introduction to Prospective Payment Systems in Postacute Care

1. Skilled Nursing Facility Prospective Payment System
    a. Background
    b. Data Collection and Reporting

c. Structure of Payment
    i. Base Rate (Per Diem)
    ii. Adjustments to Base Rate
d. Payment
e. Other Applications
f. Summary

Long-Term Care Hospital Prospective Payment System

2. Background
3. Data Collection and Reporting
4. Structure of Payment
5. Standard Federal Rate (Base Rate)
6. Adjustments to Standard Federal Rate
7. Geographic Adjustments
8. Adjustments for Patient Case Mix
9. Adjustments for Individual Discharges
10. Payment
11. Implementation
12. Summary

Inpatient Rehabilitation Facility Prospective Payment System

a. Background
b. Data Collection and Reporting
    i. Types of Patient Information
    ii. Assignment of Codes
        1. Impairment Group Code
        2. Etiologic Diagnosis
        3. Comorbidities and Complications
        4. Other Reporting
    iii. Functional Independence Assessment
    iv. Time Frame and Electronic Submission
c. Structure of Payment
    i. Standard Payment Conversion Factor
    ii. Adjustments to the Standard Payment Conversion Factor
        1. Geographic Adjustments
        2. Adjustments for Case Mix
        3. Adjustments for Policies on Qualifying Facilities
        4. Potential Adjustments for Outliers
d. Payment
    i. Health Insurance Prospective Payment System (HIPPS) Code
    ii. Calculation
e. Implementation
f. Summary

Home Health Prospective Payment System

a. Background
    i. Benefit
    ii. Eligibility Criteria
    iii. Consolidated Payment
b. Data Collection and Reporting
    i. Outcome Assessment Information Set
    ii. Coding for Home Health
    iii. Other Data Collection
    iv. Electronic Collection and Transmission
c. Structure of Payment
    i. National Standardized Episode Rate
    ii. Adjustments to the National Standardized Episode Rate
        1. Adjustments for Case Mix
        2. Geographic Adjustments
        3. Potential Adjustments for Special Circumstances
d. Payment
    i. Percentage Payments
    ii. Health Insurance Prospective Payment System (HIPPS) Code
    iii. Calculation
e. Implementation

Revenue Cycle Management

Introduction to Revenue Cycle Management

Multidisciplinary Approach

Components of the Revenue Cycle

a. Preclaims Submission Activities
b. Claims Processing Activities
    i. Order Entry
    ii. Charge Description Master
    iii. CDM Maintenance
    iv. Coding by HIM
    v. Auditing and Review
    vi. Submission of Claims
c. Accounts Receivable
    i. Insurance Processing
    ii. Benefits Statements
    iii. Remittance Advice
d. Claims Reconciliation and Collection
e. CDM Structure, Maintenance, and Compliance
    i. CDM Structure
        1. Charge Code
        2. Department Code

3. Revenue Code
4. CPT/HCPCS Code
5. Charge Description
6. Charge (Price)
7. Modifier
8. Charge Status (Active or Inactive)
9. Payer Identifier

ii. CDM Maintenance
1. Maintenance Plan
2. Working with Hospital Departments
3. Understanding Services
4. Understanding the CDM
5. Components of a CDM Maintenance Plan
6. Ongoing Maintenance
7. CPT Updates
8. HCPCS Level II Updates
9. Prospective Payment System Updates
10. Policy Alerts
11. Payer Updates
12. Other Maintenance
13. Monitoring Rejections and Denials
14. Human Errors
15. System Errors in Bill Production or Bill Transmission
16. Automation of Chargemaster Maintenance

iii. Compliance
1. Compliance Guidance
2. Medicare Claims Processing Manual
3. CMS Program Transmittals
4. National and Local Coverage Determinations
5. National Correct Coding Initiative
6. Integrated Outpatient Code Editor
7. Payer-Specific Edits

Revenue Cycle Management Team

a. Revenue Cycle Analysis
i. Case-Mix Index Analysis
ii. MS-DRG Relationships Reporting
iii. Site of Service: Inpatient versus Outpatient
iv. Evaluation and Management Facility Coding in the Emergency Department
v. Outpatient Code Editor Edit Review for Hospital Outpatient Services
1. OCE Edit 41
2. OCE Edit 38

Value-Based Purchasing

Introduction to Value-Based Purchasing and Pay-for-Performance Systems

1. Definitions
2. Goals
3. Background
    a. Drivers
    b. International Movement
    c. Research on Impact
4. Advantages and Disadvantages
5. Models
    a. Design Considerations
    b. Patient-Centered Medical Home (PCMH)
    c. Accountable Care Organization (ACO)
6. Operations
    a. Allocation and Reward of Incentives
    b. Types of Incentives
    c. Method of Implementation
    d. Performance Dimensions and Targets
    e. Performance Measures
    f. Information Systems

Centers for Medicare and Medicaid Services-Linking Quality to Reimbursement

a. Value-Based Purchasing
b. Pay-for-Reporting
    i. Hospital Inpatient Quality Reporting
    ii. Hospital Outpatient Quality Reporting
    iii. Ambulatory Surgical Center Quality Reporting Program
    iv. Long Term Care Hospital Quality Reporting Program
    v. Inpatient Rehabilitation Hospital Quality Reporting Program
    vi. Hospice Quality Reporting Program
    vii. Home Health Quality Reporting
    viii. Physician Quality Reporting System
c. Pay-for-Performance
    i. Hospital Value Based Purchasing
    ii. ESRD Quality Incentive Program
d. Paying for Value
    i. Hospital-Acquired Condition Reduction Program

2. Physician Feedback Program/Value-Based Payment

HIM 252 Course Objectives

Healthcare Reimbursement Methodologies

A. To differentiate common national models of healthcare delivery.
B. To appreciate the size and complexity of the US healthcare delivery sector
C. To appreciate the influence of the federal government in the US healthcare sector
D. To define health insurance
E. To differentiate payment methods on unit of payment, time frame, and risk
F. To identify types of healthcare reimbursement methodologies
G. To differentiate fee-for-service reimbursement from episode-of-care reimbursement
H. To describe trends in the healthcare sector
I. To define terms associated with healthcare reimbursement methodologies

II. Clinical Coding and Coding Compliance

A. To differentiate the different code sets approved by the Health Insurance Portability Act of 1996
B. To describe the structure of approved code sets
C. To examine coding compliance issues that influence reimbursement
D. To explain the roles of various Medicare improper payment review entities

III. Voluntary Healthcare Insurance Plans

A. To discuss major types of voluntary healthcare insurance plans
B. To differentiate individual healthcare plans from employer-based healthcare plans
C. To describe types of Blue Cross and Blue Shield plans
D. To describe state healthcare plans for the medically uninsurable
E. To explain the provisions of healthcare insurance policies and the elements of a healthcare insurance identification card

IV. 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 recall the history of the Medicare and Medicaid programs in America
C. To describe the effect that government-sponsored healthcare programs have on the American healthcare system

V. Managed Care Plans

A. To define managed care
B. To trace origins of managed care
C. To delineate characteristics of managed care in terms of quality and cost-effectiveness
D. To describe common care management tools used in managed care

E. To depict accreditation processes and performance improvement initiatives used in managed care
F. To define cost controls used in managed care
G. To discuss contract management and carve-outs
H. To define types of managed care plan s along a continuum of control
I. To describe the use of managed care in states' Medicaid programs, children's Health Insurance Program, and Medicare
J. To discuss types of integrated delivery systems
K. To define terms commonly used in managed care

VI. Medicare-Medicaid Prospective Payment Systems for Inpatients
A. To differentiate major types of Medicare prospective payment systems for acute-care inpatients
B. To define basic language associated with the IPPS
C. To explain common models and policies of payment for inpatient Medicare and Medicaid PPS.
D. To describe the elements of the IPPS
E. To explain the elements of the inpatient psychiatric PPS

VII. Ambulatory and Other Medicare-Medicaid Reimbursement Systems
A. To differentiate major types of Medicare and Medicaid reimbursement systems for beneficiaries
B. To define basic language associated with reimbursement under Medicare and Medicaid healthcare payment systems
C. To explain common models and polices of payment for Medicare and Medicaid healthcare payment systems for physicians and outpatient settings
D. To identify the elements of the relative value unit and the major components of the resource-based relative value scale payment systems
E. To describe the elements of the ambulance fee schedule
F. To explain the elements of the outpatient PPS and the ambulatory surgical center payment system
G. To describe the end-stage renal disease PPS
H. To describe the elements of the payment systems for federally qualified health centers and rural health clinics.
I. To explain the elements of the hospice services payment system

VIII. Medicare-Medicaid Prospective Payment Systems for Post-acute Care
A. To define the post-acute care settings
B. To differentiate Medicare and Medicaid prospective payment systems for healthcare services delivered to patients in post-acute care
C. To describe Medicare's all-inclusive per diem rate for skilled nursing facilities
D. To describe Medicare's prospective payment systems for long-term care hospitals and inpatient rehabilitation facilities
E. To describe Medicare's per-episode payment system for home health agencies

F. To differentiate the specialized collection instruments, standardized base rates, and case-mix groups that exist in post-acute care
G. To define basic language associated with reimbursement under Medicare and Medicaid prospective payment systems in post-acute care
H. To explain the grouping models and payment formulae associated with reimbursement under Medicare and Medicaid prospective payment systems in post-acute care

IX. Revenue Cycle Management
A. To describe the basic components of the revenue cycle
B. To define revenue cycle management (RCM)
C. To describe the importance of effective revenue cycle management for a provider's fiscal stability

X. Value-Based Purchasing
A. To describe the origins and evolution of value-based purchasing and pay for performance
B. To describe models of value-based purchasing and pay for performance
C. To explain models of value-based purchasing implemented by the Centers for Medicare and Medicaid Services for various healthcare settings and payment systems
D. To describe how compliance with the Centers for Medicare and Medicaid Services value-based purchasing programs affects healthcare reimbursement for a facility, entity, or professional