



**Course Syllabus**

**Course #:** HIT 2650 **Course Name:** Medical Reimbursement

**Division:** Business Technologies

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**Class Days:**

**Class Time:**

**Location:** Classroom:

Laboratory:

**Credit Hours:** 3

**Contact Hours:** 3

**Lab Hours:** 0

**Lecture Hours:** 3

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**Division Office/Location:** B104

**Division Fax:**

**Full-time Contact Person:** Mary Kay Blair

**Phone(s):** 419-559-2373

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**Course Description:**

Students are assigned to area health care facilities to work under the supervision of facility personnel. Students will obtain exposure to actual working conditions and gain experience in various aspects of health information management services. Students are introduced to basic terminology regarding medical insurance and how coding systems used in outpatient and inpatient health care settings are used to obtain payment for health care services. A discussion of various third party payers will be presented as well as reimbursement methodologies used by these payers. Students are introduced to claims processing in the physicians' posting payments and claims follow-up. (Spring)

**Prerequisite(s):** HIT 2450

**Corequisite(s):**

**Entry Level Skills and Knowledge:**

**Required Texts, Supplies and Equipment:**

Texts: MEDICAL INSURANCE BILLING AND CODING An Essentials Worktext  
by Marilyn T. Fordney and Linda L. French  
Published by Saunders (affiliate of Elsevier Science) ISBN: 0-7216-9516-7

**Grading:**

A = 90-100

50% = Tests and Homework

B = 80-89

40% = Final Exam

C = 70-79

10% = Participation

D = 60-69

F = 59 and below

**Learning Outcomes:**

## General Education

The purpose of this course is to introduce the student to the roles of the medical billing specialist, the basics of health insurance, the reimbursement cycle, claims submission, claim forms, and the major types of insurance plans. Processes for reimbursement tracking, review and appeal, and patient billing and collection will also be presented.

## Technical Education

Upon completion of this course, the student will have an understanding of the:

1. Roles and responsibilities of an Insurance Billing Specialist
2. Fundamentals of health insurance coverage
3. Health insurance claim forms
4. Medical insurance programs --  
Private insurance      Medicaid      Tricare/Champus VA  
Managed Care      Medicare      Workers Compensation
5. Credit and Collection practices
6. Procedures for tracking reimbursement and filing appeals

## AHIMA Knowledge Cluster Content

### Reimbursement

- Commercial, managed care, and federal insurance plans.
- Payment methodologies and systems (such as capitation, prospective payment systems PPS, RBRVS).
- **Billing processes and procedures (such as claims, EOB, ABN, electronic data interchange).**
- Chargemaster maintenance.
- Regulatory guidelines (such as LMRP, peer review organizations).
- Reimbursement monitoring and reporting.
- Compliance strategies and reporting.

## AHIMA Entry-Level Competencies

- I. Domain: Healthcare Data Management
  - D. Subdomain: Reimbursement Methodologies
    1. Apply policies and procedures for the use of clinical data required in reimbursement and prospective payment systems (PPS) in healthcare delivery.
    2. Support accurate billing through coding, chargemaster, claims management, and bill reconciliation processes.
    3. Use established guidelines to comply with reimbursement and reporting requirements such as the National Correct Coding Initiative.
    4. Compile patient data and perform data quality reviews to validate code assignment and compliance with reporting requirements such as outpatient prospective payment systems.

## **Assessment of Student Learning:**

This course may include a project that is one of several that will be used by faculty to assess student academic performance in the program. A panel of faculty will review all (projects or whatever assessment activity you are doing), then assess and summarize the academic performance of students at this point in the program. The results of this assessment will be shared among the department faculty, used to identify needed changes or improvements, and submitted to the Student Academic Assessment Committee as part of the college's overall student academic assessment effort.

Assessment Project and Measurement in course (if any):

**Plan of Work:**

<b>Sessions</b>	<b>Date</b>	<b>Tests</b>	<b>Assignments and Homework</b>
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**I. PERFORMANCE OBJECTIVES:**

Upon successful completion of HIM-2650, Medical Reimbursement Methodologies, the student should be able to:

- A. Evaluate the major implications of PL 98-21 (Prospective Reimbursement System based on DRGs) with respect to hospitals and services covered.
- B. Identify those facilities covered and exempted from the Prospective Payment System.
- C. Research the development and basis for assignment of DRGs and define MDC (Major Diagnostic Categories).
- D. Compare the physician attestation form to the acknowledgment notice and discuss the elimination of the attestation form.
- E. Define principal diagnosis and principal procedure and understand the importance of proper sequencing of codes.
- F. Using Decision trees and automated grouper, assign the correct MDC (major diagnostic category) and DRG (diagnosis related group) for patients given their case histories.
- G. Differentiate between significant comorbidity and significant complications.
- H. Analyze factors which cause cases to be grouped to DRG 468, 469, and 470,476, and 477.
- I. Assess the physician's responsibilities for the completion of the medical record and appropriate documentation of diagnoses and procedures.
- J. Calculate hospital case mix and the reimbursement formula. Interpret reasons for an increase or decrease in case mix.
- K. Analyze "outliers" and their impact on reimbursement.
- L. Differentiate among transfer, qualified discharge and discharge and outline the reimbursement/billing policies for transfers.
- M. Evaluate the importance of proper and accurate coding and sequencing of all diagnoses and procedures and its impact on DRG assignment and reimbursement.
- N. Assess techniques that advise the medical staff on proper documentation and coding policies and procedures. Assure that the documentation supports the diagnoses and reflects the progress, clinical findings and discharge status.
- O. Analyze the role of the Health Information Manager and the DRG Coordinator in the PPS (Prospective Payment System).
- P. Evaluate components of the UB-92.
- Q. Compare and discuss the three versions of DRGs (Basic DRGs, All Patient DRGs, and All Patient Refined DRGs).
- R. Study the (RBRVS) Resource Based Relative Value System as the prospective payment system for Medicare Part B payments.
- S. Analyze the prospective payment methodology used for reimbursement of ambulatory surgery (ASCs).
- T. Debate the purpose and intended uses of the Outpatient Prospective Payment System for certain financial classes called Ambulatory Patient Groups (APGs).
- U. Assess the purpose and intended uses of the Outpatient Prospective Payment System for Medicare called Ambulatory Payment Classification (APCs).
- V. Assess the purpose and intended uses of the Prospective Payment System for Skilled Nursing Facilities called Resource Utilization Groups (RUGs).
- W. Discuss the major components in negotiating managed care plans for physicians' offices and hospitals.

- X. Analyze an Explanation of Benefits form for accuracy.
- Y. Respond to denial or reductions of benefits.
- Z. Discuss the federal fraud and abuse legislation and the need for a corporate compliance plan.
- AA. Define the terms "fraud" and "abuse" as they pertain to billing and reimbursement.
- BB. Evaluate the components of a corporate and HIM compliance plan.
- CC. Assess the uses of the CDM and monitor accuracy of it.
- DD. Delineate HIM department responsibilities towards complying with standards of CMS in regards to billing and reimbursement.
- EE. Assess the relationship between accurate coding and productivity standards.
- FF. Describe the importance of maintaining a departmental coding manual.
- GG. Define how to assure the quality control of the coding function.
- HH. Describe ho to coordinate training activities and retention activities for coders.
- II. Define benchmarking the staff performance in relation to departmental/facility/external productivity standards.
- JJ. Assess the coding requirements in a healthcare facility to determine compliance with HIPAA standards for code sets.

## II. TOPICAL OUTLINE:

- A. Diagnosis Related Groups (DRGs)
  - 1. Background
    - a. The Amendments to the Social Security Act of 1972
    - b. Tax Equity and Fiscal Responsibility Act of 1982
    - c. The Social Security Amendments of 1983
  - 2. Reasons for a Prospective Payment System
  - 3. Facilities Exempted
  - 4. Basis for Assignment
    - a. principal Diagnosis
    - b. principal Procedure
    - c. patient's Age
    - d. patient's Sex
    - e. discharge Status
  - 5. Major Diagnostic Categories (MDCs)
  - 6. Complications and Comorbidities (CCs)
  - 7. DRG 468, 469, 470, 476, 477
  - 8. Physicians' Attestation (not required)
  - 9. Acknowledgment Notice
  - 10. Reimbursement
  - 11. Case Mix Index
  - 12. Optimization of DRG Reimbursement
  - 13. Special Financial Adjustments
    - a. outliers
    - b. discharge vs transfer
    - c. postacute Transfer Payment Policy (Qualified Discharge)
  - 14. Medicare's 72-hour Payment Window
  - 15. The Medical Staff and Prospective Payment
  - 16. The Health Information Management Department and Prospective Payment

17. UB-92 Billing Form
18. Versions of the DRGs
  - a. Medicare DRGs (DRGs)
  - b. all Patient DRGs (AP-DRGs)
  - c. all Patient Refined DRGs (APR-DRGs)
- B. Accounts Receivable Management
- C. Resource-Based Relative Value System (RBRVS)
  1. Medicare Part B Physician Payment
  2. Relative Value Units (RVUs)
    - a. physicians' Work
    - b. practice Expense
    - c. Malpractice Expense
  3. Geographic Price Cost Indices (GPCIs)
  4. Conversion Factor
- D. Ambulatory Surgery Centers (ASCs)
  1. Medicare Part B Facility Payment
  2. Freestanding ASCs
  3. Ambulatory Surgery in a Hospital
  4. ASC Payment Groups
- E. Ambulatory Patient Classification (APCs)
  1. Comparison of Inpatient and Outpatient PPS
  2. Objectives of APCs
  3. Key Concepts of APCs
  4. HCPCS Level II
  5. Hospitals Excluded Under APCs
  6. Special Provisions
  7. Scope of Services Included
  8. Scope of Services Excluded
  9. Number of APCs
  10. Hospital Outpatient PPS Payment Indicators
  11. Pass-Through Payments
  12. Inpatient Procedures (C List)
  13. PC Reimbursement Data Elements
  14. Packaging
  15. Discounting
  16. Outpatient PPS Edits
    - a. Correct Coding Initiative (CCI)
    - b. OCE (Outpatient Code Editor)
  17. Medical and Procedure Visits on the Same Day
  18. Multiple E & M Visits on the Same Day
  19. Units of Service Edits
  20. Coding for Medical Visits (E &M)
  21. Patient Classification Systems (PCS)
    - a. descriptive model
    - b. quantifiable model
  22. Encoders and Groupers
  23. Modifiers for Hospital Outpatient Use

- F. Resource Utilization Groups (RUGs)
  - 1. Reimbursement for Skilled Nursing Facilities
  - 2. Minimum Data Set (MDS)
  - 3. Resource utilization groups
  - 4. Major categories
- G. Home Health Resource Groups (HHRGs)
  - 1. Reimbursement for Home Health Agencies
  - 2. OASIS Data Set
  - 3. HHRG Domains
- H. Case Mix Groups (CMGs)
  - 1. Reimbursement for Inpatient Rehabilitation Facilities (IRF)
  - 2. Classification as an IRF
  - 3. Effective Date
  - 4. Patient Assessment Instrument (PAI)
  - 5. Case Mix Groups (CMGs)
  - 6. Interrupted Stays
  - 7. Transfer Cases
  - 8. Case-level Adjustments
  - 9. Facility-level Adjustments
- I. Long Term Care-Diagnosis Related Groups (LTC-DRGs)
  - 1. Reimbursement for long term care hospitals
  - 2. LTC-DRGs based Upon DRGs
  - 3. Financial Adjustments
- J. Federal Fraud and Abuse Legislation
- K. Corporate Compliance Program
- L. Coding and Billing in the Physicians' Office Setting
  - 1. Medicare
    - a. part A
    - b. part B
    - c. participating and Non-Participating Providers
    - d. fiscal Intermediaries
    - e. payment
      - (1.) limiting Charge
      - (2.) adjustments
      - (3.) site of Service Limitations
      - (4.) surgical Modifier Circumstances
  - 2. Medicaid
  - 3. Insurance Claims
    - a. processing
    - b. methods of Submission
    - c. laws
    - d. explanation of Benefits
    - e. problems
      - (1.) delinquent
      - (2.) lost
      - (3.) rejected
      - (4.) denied

(5.) assignment

- M. Managed Care and Capitation Contract Negotiations
  - 1. Contracting Tips
  - 2. Evaluation Basics
  - 3. Questions and Answers
- N. Management and Quality Control of the Coding Function
  - 1. Methods for Monitoring Quality Control
  - 2. Corporate Compliance/HIM Compliance Programs
  - 3. Fraud and Abuse
  - 4. Productivity Standards and Accurate Coding
  - 5. Benchmarking
  - 6. Hiring/Training/Retention of Coding Staff
- O. Charge Description Master (CDM)
  - 1. Chargemaster basics
  - 2. Components of the CDM
  - 3. Use of Revenue Codes
  - 4. Importance of Modifiers
  - 5. Chargemaster Applications
  - 6. Chargemaster Maintenance and Management
- P. Local Medical Review Policies

### III. METHODS OF STUDENT EVALUATION MAY INCLUDE ANY OF THE FOLLOWING:

- A. Attendance
- B. Quizzes
- C. Tests
- D. Classroom participation
- E. Homework assignments

#### **Course Requirements:**

50% = Tests and homework

40% = Final Exam

10% = Participation

**Participation/Attendance:** Regular class attendance is necessary for successful completion of the course. Each student is responsible for all material assigned in this syllabus. Poor attendance can reflect in poor achievement. Please make every effort to extend the courtesy of informing the instructor of absences PRIOR to class.

Test will be completed independently in class and submitted for evaluation. Tentative exam dates are provided in the “Plan of Work”. Grading scales are provided on each exam.

**It is the student's responsibility to the instructor to make arrangements for make-up tests. Late exams will reduced by one (1) letter grade per day late. Make-up exams will be dated and taken in the Testing Center in the LRC, Building B, 3<sup>rd</sup> Floor.**

**Computer use:** During class, students are permitted to use the computers for applications relevant to that class only (i.e. no email, games, internet, etc.) Use of other applications may be a distraction to other students.

## **Policies**

**Course Withdrawing:** If for any reason you need to withdraw from this course, be certain that you do so according to College procedure. It is your responsibility to know and follow this procedure. If you simply stop coming to class, without officially withdrawing from the course, your grade is an automatic “F.” Please follow official College procedure for withdrawing from this or any course.

*College Academic Policies are located in the College Catalog. A copy of the current catalog may be picked up in any of the division offices or admissions. The list of college policies is also available online at <https://www.terra.edu/register/Collegecat/policies.asp>.*

**Support Services:** The College offers a number of support services to assist in your success in this course and all courses. Among these services are the Writing & Math Center in B105, the Office of Learning Support Services, which coordinates the campus disability services and tutoring programs, the computer labs, and the computers in the atriums.

Any student who feels he/she may need an accommodation based on the documentation of a disability should contact the Office of Learning Support Services privately to discuss his/her specific issues. Please contact the OLSS at (419) 559-2208 or visit 100 Roy Klay Hall (Building A) to coordinate reasonable accommodations.

***If you have a documented disability and are receiving academic accommodations through the Office of Learning Support Services, please schedule a meeting with your instructor in a timely manner so that we may discuss how these services will be arranged.***

Tutoring services are available to students beginning the second week of every quarter. Students requesting tutoring services should obtain a tutor request form from the OLSS in 100 Roy Klay Hall (Building A) or online at the Terra website. Please note that instructor verification and acceptance of the Student Learner Agreement is necessary for all tutoring requests. All requests should be submitted to 100 Roy Klay Hall (Building A).