HIM-2430: MEDICAL REIMBURSEMENT METHODOLOGIES

Cuyahoga Community College

Viewing: HIM-2430 : Medical Reimbursement Methodologies

Board of Trustees:
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Academic Term:
Fall 2021

Subject Code
HIM - Health Information Management

Course Number:
2430

Title:
Medical Reimbursement Methodologies

Catalog Description:
Reimbursement issues and systems, including: compliance environment payers, reimbursement vocabulary and systems such as Diagnostic Related Groups (DRGs), Resource Based Relative Value Scale (RBRVS), Ambulatory Payment Classifications (APC), and the chargemaster.

Credit Hour(s):
2

Lecture Hour(s):
1

Lab Hour(s):
2

Requisites

Prerequisite and Corequisite
HIM-2160 Coding with ICD-10-CM, and departmental approval.

Outcomes

Course Outcome(s):
Evaluate the revenue cycle management (RCM) and clinical documentation improvement (CD) processes.

Essential Learning Outcome Mapping:
Critical/Creative Thinking: Analyze, evaluate, and synthesize information in order to consider problems/ideas and transform them in innovative or imaginative ways.

Objective(s):
1. Describe components of revenue cycle management and clinical documentation improvement.
2. Analyze medical record documentation and assign accurate codes for reimbursement purposes.
3. Determine when it is appropriate to query clinicians for clarification on healthcare documentation to support diagnosis.
4. Evaluate coding and insurance denials for resolutions.
5. Evaluate the Discharge Not Final Billed (DNFB) report.
6. Evaluate the case-mix index (CMI) for financial impact.

Course Outcome(s):
Summarize regulatory requirements and reimbursement methodologies.

Objective(s):

1. Interpret a chargemaster.
2. Explain hospital revenue cycle management.
3. Examine an UB-04 claim.
4. Explain the historical development of Center for Medicare and Medicaid Services (CMS) reimbursement systems.
5. List and define each CMS payment system (Examples: Home Health Care, Outpatient, RBRVS, Inpatient, Long-term Care).
6. Apply special rules for the Medicare physician fee schedule payment system.

Course Outcome(s):

Coding for medical necessity.

Objective(s):

1. Apply coding for medical necessity guidance when reporting ICD-10-CM, CPT, and HCPCS level II codes on claims.
2. Select and code diagnoses and procedures from case studies and sample reports.
3. Research local and national coverage determinations (LCD and NCD).
4. Apply National Correct Coding Initiative (NCCI) edits to detect unbundling when coding ambulatory surgery cases.

Course Outcome(s):

Apply knowledge of various health insurance coverage to reimbursement.

Objective(s):

1. Discuss introductory health insurance concepts.
2. Differentiate between Managed Health Care organizations, Commercial Insurance companies, Blue Cross Blue Shield, Medicare, Medicaid, Tricare, Workers' Compensation, and others.
3. Define key terms related to CMS-1500 and UB-04 claims.
4. Explain general purposes and completion processes for CMS-1500 and UB-04 claims.

Methods of Evaluation:

1. Quizzes
2. Classroom participation
3. Homework assignments
4. Midterm and Final Exam

Course Content Outline:

1. Introduction to Health Insurance
2. Managed health care
    a. Managed care organizations (MCOs)
    b. Managed care models
    c. Consumer-directed health plans
3. Processing an insurance claim
    a. The life cycle of an insurance claim
    b. Credit and collections
4. Legal and regulatory issues
    a. Federal laws and events that affect health care
5. CMS reimbursement methodologies
    a. CMS payment system
    b. Hospital inpatient prospective payment system
    c. Hospital outpatient prospective payment system
    d. Inpatient psychiatric facility prospective payment system
    e. Inpatient rehabilitation facility prospective payment system
    f. Long-term care facility prospective payment system
    g. Home health prospective payment system
    h. Skilled nursing facility prospective payment system
    i. Ambulatory surgical center payment rates
    j. Medicare physician fee schedule

   k. End-stage renal disease composite rate payment system
   l. Resource-based relative value scale (RBRVS) system
6. Coding for medical necessity, clinical documentation improvement, and compliance programs
   a. Coding from case scenarios and patient reports
   b. NCCI edits
   c. LCD & NCD policies
   d. Revenue cycle management components
   e. Clinical documentation improvement (CDI) process
      i. Physician queries
   f. Case mix index (CMI)
      i. Calculating and analyzing
   g. Compliance programs
      i. Recovery audit program (RAC)
      ii. Medical review
7. Essential CMS-1500 claim instructions
   a. Insurance billing guidelines
   b. Common errors that delay processing
8. Commercial insurance
   a. Commercial claims
   b. Claim form instructions
9. Blue Cross Blue Shield
   a. Claim form instructions
10. Medicare
   a. Medicare part A
   b. Medicare part B
   c. Medicare part C
   d. Medicare part D
   e. Medigap
11. Medicaid
   a. Medicaid covered services
   b. SCHIP claims
12. TRICARE
   a. TRICARE administration
   b. CHAMPVA
   c. TRICARE options
13. Worker's Compensation
   a. First report of injury form (FROI)
   b. Eligibility for worker's compensation coverage
   c. Appeals
   d. Fraud and abuse

Resources

Casto, A. (2018) *Principles of Healthcare Reimbursement*, Chicago: American Health Information Management Assoc.

Sayles, N. and Gordon, L. (2020) *Health Information Management Technology : An applied Approach*, Chicago : American Health Information Management Association.

Green, M. A. (2020) *Understanding Health Insurance*, Boston: Cengage.

Dianna Foley. (2020) *Health Information Management Case Studies*, Chicago: AHIMA.

Resources Other

AHIMA Journal

AHIMA Body of Knowledge - https://bok.ahima.org/

Instructional Services

OAN Number:
Transfer Assurance Guide OHL022

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