JEFFERSON COLLEGE

COURSE SYLLABUS

HIT 250
Healthcare Billing and Reimbursement
3 Credit Hours

Prepared by:
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HIT 250 Healthcare Billing and Reimbursement

I. CATALOGUE DESCRIPTION

A. Prerequisite: HIT 210 with a grade of “C” or better.

B. Credit hour award: 3

C. Description: This course prepares students to review health care payment, illustrate the reimbursement cycle, and comply with regulatory guidelines. Chargemaster maintenance and reimbursement monitoring and reporting are emphasized. Ambulatory Payment Classification Codes (APCs) and other prospective payment systems, the revenue cycle, chargemaster, Resource Based Relative Value Scale (RBRVS), regulatory guidelines and billing processes will be covered. (S)

II. EXPECTED LEARNING OUTCOMES/CORRESPONDING ASSESSMENT MEASURES

<table>
<thead>
<tr>
<th>Expected Learning Outcomes</th>
<th>Assessment Measures</th>
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<tbody>
<tr>
<td>Distinguish between: population and sample, variable and constant, qualitative and quantitative data, ungrouped and grouped data, descriptive and inferential statistics.</td>
<td>Class Discussion/Activity Summative Examination</td>
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<tr>
<td>Explain the relationship between coding and billing.</td>
<td>Class Discussion/Activity Written Project/Paper Summative Examination</td>
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<td>Define specified reimbursement terms.</td>
<td>Class Discussion/Activity Written Project/Paper Summative Examination</td>
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<tr>
<td>Define revenue cycle and state the major steps in the process.</td>
<td>Class Discussion/Activity Written Project/Paper Summative Examination</td>
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<td>Discuss the role of Health Information Technology in each step in the revenue cycle.</td>
<td>Class Discussion/Activity Written Project/Paper Summative Examination</td>
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<tr>
<td>Define, identify, and categorize specified terms and processes into their corresponding steps in the revenue cycle.</td>
<td>Class Discussion/Activity Summative Examination</td>
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<td>Describe the Charge Description Master (CDM) and the typical data types found on it.</td>
<td>Class Discussion/Activity Summative Examination</td>
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<td>Distinguish between the Center for Medicare and Medicaid Services Form 1450 and 1500.</td>
<td>Class Discussion/Activity Summative Examination</td>
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<td>Identify the coded data requirements of the Uniform Billing (UB) Form-04.</td>
<td>Class Discussion/Activity Summative Examination</td>
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<tr>
<td>Discuss the structure of the Ambulatory Payment Classification Code (APCs) system.</td>
<td>Class Discussion/Activity Written Project/Paper Summative Examination</td>
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<tr>
<td>Explain the different claim dispositions.</td>
<td>Class Discussion/Activity Written Project/Paper Summative Examination</td>
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</table>
Review different outpatient code edits.

Describe Prospective Payment Systems (PPS) other than hospital inpatient and outpatient.

Compare the different Prospective Payment Systems (PPS) to Diagnosis Related Group (DRG).

Describe Resource Based Relative Value Scale (RBRVS) and its components.

Calculate the payment after given the Geographic Practice Cost Index, the Relative Value Unit (RVU) tables, the conversion factor, and the name of a procedure.

Describe Ambulatory Surgery Centers and their reimbursement system.

Compare Ambulatory Surgery Centers to hospital outpatient surgery.

### III. COURSE OUTLINE

#### A. Clinical Vocabulary and Classification Systems
1. Introduction
2. History and Importance of Clinical Vocabularies
3. Classifications and Nomenclatures
4. International Classification of Disease
5. Implementation of ICD-10-CM
6. ICD-9-CM to ICD-10-CM transition issues
7. The Coding Process
8. Coding Technology

#### B. Reimbursement Methodologies
1. Introduction
2. History of Healthcare Reimbursement in the United States
3. Pre-Medicare/ Medicaid Campaigns for National Health
4. Medicare/ Medicaid Programs
5. Cost Management
6. Development of Prepaid Health Systems
7. Commercial Insurance
8. Not-for-profit and For-profit Healthcare Plans
9. Blue and Blue Shield Plans
10. Government Sponsored Plans
11. Managed Care
12. Fee-For-Service Reimbursement Methodologies
13. Episode-of-Care Reimbursement Methodologies
14. Capitation
15. Global Payment
16. Prospective Payment
C. Medicare Prospective Payment Systems
   1. Medicare Acute Inpatient Prospective Payment System (IPPS)
   2. Medicare Resource Based Relative Value Scale System (RBRVS)
   3. Medicare Skilled Nursing Facility Prospective Payment System
   4. Medicare and Medicaid Outpatient Prospective Payment System
   5. Ambulatory Surgery Center Prospective Payment System (ASC PPS)
   6. Medicare Home Health Prospective Payment System (HH PPS)
   7. Medicare Ambulance Fee Schedule
   8. Medicare Inpatient Rehabilitation Facility (IRF) Prospective Payment System
   9. Medicare Long Term Hospital (LCH) Prospective Payment System
  10. Medicare Inpatient Psychiatric Facilities (IPFs) Prospective Payment System

D. Processing of Reimbursement Claims
   1. Coordination of Benefits
   2. Submission of Claims
   3. Explanation of Benefits and Medicare Summary Notice Remittance Advice
   4. National Correct Coding Initiative (NCCI)
   5. Electronic Data Interchange

E. Reimbursement Support Process
   1. Management of the Fee Schedules
   2. Management of the Chargemaster
   3. Maintenance of the Chargemaster
   4. Management of the Revenue Cycle
   5. Management of Documentation and Coding Quality

F. Coding and Corporate Compliance
   1. History or Fraud and Abuse and Corporate Compliance in Healthcare
   2. Elements of Corporate Compliance
   3. Relationship between Coding Practice and Compliance

G. Recovery Audit Contractor (RAC) Program
   1. Introduction
   2. Upcoming Trends for the RACs

H. Secondary Data Sources
   1. Introduction
   2. Difference between Primary and Secondary Data Sources
   3. Purposes and Users of Secondary Data Sources
   4. Types of Secondary Data Sources
   5. Processing and Maintenance of Secondary Sources

IV. METHOD(S) OF INSTRUCTION

A. Lecture
B. Readings from textbook
C. Supplemental handouts
D. Peer interactive activities/ discussions in classroom

V. REQUIRED TEXTBOOKS


C. Readings from the Body of Knowledge (BOK) will be selectively assigned and are accessible though the Communities of Practice (COP) available only to members of the American Health Information Management Association.

VI. REQUIRED MATERIALS

A. Textbook

B. A computer with internet access (available through the Jefferson College Labs)

C. Paper, notebooks, pens, pencils with erasers

VII. SUPPLEMENTAL REFERENCES

A. Class Handouts

B. Current internet resources
   1. On-line reference materials
   2. American Health Information Management (AHIMA) web-site

VIII. METHOD OF EVALUATION

A. Quizzes will equal 30% of total course grade

B. Summative Written Examinations – 4 examinations worth up to 60%

C. Attendance/Participation grade will equal 10% of total course grade

D. Grading Scale:
   A = 90-100%
   B = 80-89.9%
   C = 70-79.9%
   D = 60-69.9%
   F = 0-59.9%

IX. ADA STATEMENT

Any student requiring special accommodations should inform the instructor and the Coordinator of Disability Support Services (Library: phone 636-797-3000, ext. 3169).
X. ACADEMIC HONESTY STATEMENT

All students are responsible for complying with campus policies as stated in the Student Handbook. Any student who cheats or plagiarizes will be subject to dismissal from the Health Information Technology program and will be referred to the college for disciplinary action. (See College website, http://www.jeffco.edu/jeffco/index.php?option=com_weblinks&catid=26&Itemid=84)