Common Course Outline
HIIT 221
Medical Reimbursement Practices and Procedures
3 Credits

Community College of Baltimore County

Description

HIIT 221 – Medical Reimbursement Practices and Procedures introduces reimbursement policies and procedures, payment methodologies, and the revenue cycle. Students apply medical coding skills to validate reimbursement and learn how to determine case mix index and reimbursement procedures for a variety of health insurance and healthcare settings.

3 Credits

Prerequisites: HIIT 102, HIIT 130, HIIT 140, and HIIT 210

Overall Course Objectives

Upon completion of this course students will be able to:

1. identify resources used to research specific insurance reimbursement procedures;
2. describe the historical development of healthcare reimbursement in the United States;
3. explain the difference between outpatient and inpatient claims processes;
4. differentiate between the claims process for a doctor's office and a hospital setting;
5. explain how case mix index is determined for the state of Maryland;
6. identify fraudulent and non-compliant coding practices;
7. compare and contrast reimbursement practices for various types of health insurance, including Blue Cross/Blue Shield, Medicare, Medicaid, Tricare, and HMOs;
8. explain the concept of managed care in terms of cost control and access;
9. evaluate the revenue cycle process;
10. describe the maintenance cycle of the charge description master;
11. describe the relationship between the ambulatory payment classification system and the outpatient prospective payment system;
12. summarize the False Claims Act and explain its role in prosecuting healthcare fraud and abuse;
13. apply policies and procedures for the use of data required in healthcare reimbursement;
14. code electronic and paper-based claims in compliance with federal regulations;
15. perform data quality review to validate code assignment in compliance with federal regulations;
16. discuss coding decisions on health claims;
17. analyze federally approved code sets in compliance with federal regulations; and
18. compile and present data using spreadsheet and database software.

Major Topics

I. Claims Processing
II. Reimbursement Methodologies in Different States
III. Insurance Company Practices and Procedures
IV. Payment Methodologies
    A. Prospective Payment System (PPS)
    B. Resource Based Relative Value Scale (RBRVS)
    C. Case Mix
    D. Medicare Severity Diagnostic Related Groupings (MS-DRGs)
V. Ambulatory Payment Classification
VI. Legal, Ethical, and Regulatory Considerations
VII. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance
VIII. Department of Health and Human Services Office of Inspector General
IX. Centers for Medicare and Medicaid Services
X. Diagnostic Related Groups (DRGs)
XI. International Classification of Diseases 10th Revision, Clinical Modifications (ICD-CM) Coding (ICD-10)
XII. International Classification 10th Revision Procedural Coding System Coding (ICD-10 PCS)
XIII. Current Procedural Terminology (CPT) Coding
XIV. Healthcare Common Procedural Coding Systems (HCPCS) Level II National II Codes
XV. Systematized Nomenclature of Medicine – Clinical Terms (SNOMED-CT)
XVI. Clinical Documentation Improvement and Coding Quality

Course Requirements

Grading procedures will be determined by the individual faculty member but will include the following:

Grading/exams

- A minimum of weekly assignments include case studies
- A minimum of graded discussion board assignments
- A minimum of quizzes
- Written research project with data presentation, minimum 1000 words
- Midterm exam
- Comprehensive final exam

Written Assignments: Students are required to use appropriate academic resources.