# CHAPTER 2: CODING AND REIMBURSEMENT

## INSTRUCTIONAL AND LEARNING OBJECTIVES:

After completing this chapter, students should have the skills to:

1. Spell and define the key words, medical terms, and abbreviations relating to reimbursement. (Remember)
2. Describe the types of healthcare payers. (Understand)
3. Explain the importance and content of documentation. (Understand)
4. Describe the life cycle of an insurance claim. (Understand)
5. Summarize the most common reimbursement methods for physicians, inpatient hospitals, and outpatient hospitals. (Understand)
6. Recognize the major healthcare claims formats. (Understand)
7. Explain the federal compliance initiatives. (Understand)

## CHAPTER OUTLINE

* Healthcare Payers
* Documentation
* Life Cycle of an Insurance Claim
* Reimbursement Methods
* Healthcare Claims
* Federal Compliance
* Health Information Technology

## RESOURCES

* Student textbook, Chapter 2
* Instructor’s Manual with Lesson Plans
* Chapter 2 PowerPoint Lecture
* Chapter 2 Image Library

## DETAILED LESSON PLANS

### Learning Objective 2.1:

Spell and define the key words, medical terms, and abbreviations relating to reimbursement.

#### Concepts for Lecture:

1. The key terms listed at the beginning of the chapter are important concepts for students to know, and appear in blue boldface type throughout the chapter.
2. Students should also become familiar with the terms listed within tables in the chapter.
3. Supplemental terms that appear in black boldface throughout the chapter are defined in the glossary.

### Teaching Notes

#### Teaching Resource:

***Pearson’s Comprehensive Medical Coding: A Path To Success,* Chapter 2**

Page 13

#### PowerPoint Lecture Slides:

#### Teaching Notes/Tips:

Point out to students that even if their ultimate jobs do not directly involve billing, they still want to have a basic understanding of how their work as coders impacts reimbursement so they can become valuable team members.

### Learning Objective 2.2:

Describe the types of healthcare payers.

#### Concepts for Lecture:

1. Third-party payers are entities other than the patient or physician that pay for healthcare services. Coders need to understand the various types of third-party payers because each has separate, and sometimes conflicting, rules about coding and billing.
2. Health benefit plans funded by federal or state governments are entitlement programsfor whichbeneficiaries qualify based on specific criteria.
3. Medicare is the single largest payer of healthcare services in the United States and pays for healthcare services for most people age 65 and over, people of any age with end-stage renal disease (E S R D), and people with disabilities. Medicare offers four programs, called Part A, hospital insurance; Part B, medical insurance; Part C, managed care; and Part D, prescription drug insurance.
4. Medicaid is a program for low-income families that is funded two-thirds by the federal government and one-third by state governments.
5. Other government programs include Tricare, State Children’s Health Insurance Program, and the Veteran’s Health Administration.
6. Private health insurance is coverage for healthcare services offered by private corporations, such as Aetna, Cigna, or United Health Care, and not-for-profit organizations, such as Blue Cross and Blue Shield.
7. Group health plans are offered by employers and unions, which contract with a private insurance company to provide a specific list of benefits to their employees or members.
8. Individual health insurance plans are those that people purchase directly from a health insurance company, such as people who are self-employed or do not have benefits through an employer or government program.
9. Workers’ compensation plans pay for medical costs due to employment-related injuries or illnesses, and vary from state to state.
10. Automobile insurance policies often include medical payments or personal injury protection, which pays for medical expenses incurred during an automobile accident.
11. Managed care plans contract with physicians, hospitals, and other providers to offer services for a lower fee to health plans; then they contract with private health insurance companies and self-insured plans to promote an exclusive network of preferred providers

### Teaching Notes

#### Teaching Resource:

***Pearson’s Comprehensive Medical Coding: A Path To Success*, Chapter** **2**

Pages 14–16

#### PowerPoint Lecture Slides:

#### In-Class Activities:

Discuss the following questions as a class or in small groups. Consider assigning each group a different payer to discuss.

* What are the advantages and disadvantages of each type of payer for physicians or hospitals?
* What are the advantages and disadvantages of each type of payer for patients?

#### Teaching Notes/Tips:

It is important that students understand the relationship between coding and reimbursement. Tailor this part of the lecture to the needs of students. When students have had reimbursement course(s) previously, a quick review may be all that is necessary. When students have had little or no previous coursework, more time will be required.

#### Homework Assignment:

Coding Practice, Exercise 2.1, Healthcare Payers, #1–3

### Learning Objective 2.3:

Discuss the importance and content of documentation.

#### Concepts for Lecture:

1. *Medical necessity* is establishing the medical need for services.
2. Payers establish medical necessity rules to avoid paying unscrupulous providers who might provide a service just so they could receive payments, rather than because the patient actually needs the service or would benefit from it.
3. The medical record is the comprehensive collection of all information on a patient at a particular facility.
4. The diagnosis and procedure codes reported on the health insurance claim form or billing statement must be supported by information in the medical record for each encounter.
5. *Documentation* is the written or electronic record of medical care and services provided, and may refer to the overall medical record as well as to progress notes.

### Teaching Notes

#### Teaching Resource:

***Pearson’s Comprehensive Medical Coding: A Path To Success*, Chapter** **2**

#### PowerPoint Lecture Slides:

#### Tables:

1. Examples of Medical Necessity Criteria
2. Elements of a Progress Note and Their Use in Coding
3. Elements of a Medical Record and Their Use in Coding

#### Figures:

1. Example of a paper-based medical record.
2. Example of an electronic health record.

#### In-Class Activities:

Review the examples in Table 2-1. Discuss the following question as a class, in small groups, or on an online discussion board:

* What are other examples of appropriate and inappropriate medical services?

#### Teaching Notes/Tips:

Stress that coders should not manipulate codes in a way that distorts or alters the diagnoses and procedures as documented in the medical record. Coders need to be certain they are accurately describing everything that was done for the patient and the reasons for which the services were provided.

#### Homework Assignment:

Coding Practice, Exercise 2.2, Documentation, #1–3

### Learning Objective 2.4:

Describe the life cycle of an insurance claim.

#### Concepts for Lecture:

1. Each step involved in converting a patient encounter into a paid insurance claim needs to be completed in a timely and accurate manner in order for providers to receive correct payment for their services
2. Although providers do not code or bill for scheduling an appointment, the appointment begins when providers begin collecting insurance information.
3. After completing registration information, a patient sees the physician and/or receives the treatments and procedures needed. The physician documents the patient’s problem in a progress note and may check off services and diagnoses on an encounter form or charge slip.
4. The encounter is coded based on a charge slip or information directly from the medical record; then the bill is prepared and submitted to the insurance company.
5. When payers receive electronic claims, the computer system first performs a front-end edit check, which scans the claims for valid data including the policy number, patient name, provider number, diagnosis codes, and procedure codes.
6. A rejected claim is one that is not accepted into the insurance company’s computer system for processing due to missing or invalid data.
7. Clean claims are those which pass the front-end edit checks and have no missing or invalid information. Most clean claims are processed using automatic adjudication, a process in which the computer automatically determines benefits and payment.
8. Some claims are suspended from the automatic process for manual review in order to gather more information before payment is determined.
9. After the payer has processed the claim, the provider receives a check or electronic deposit and an E O B.
10. If payment was denied for one service or for the entire claim, an accounts receivable specialist needs to investigate the reason.
11. After all insurance payments are received and follow-up is complete, the office sends the patient a bill for any deductible, coinsurance, or patient responsibility amounts that have not been paid.

### Teaching Notes

#### Teaching Resource:

***Pearson’s Comprehensive Medical Coding: A Path To Success*, Chapter** **2**

#### PowerPoint Lecture Slides:

#### Tables:

1. Coding Problems Causing Rejected or Denied Claims

#### In-Class Activities:

As a class, or in small groups, create a flow chart that illustrates each step in the life cycle of an insurance claim. Active participation and visualization help students understand a complex process.

#### Teaching Notes/Tips:

1. Point out to students that the billing and coding procedures are not exactly the same in every office and every hospital, but the general process is similar.
2. A student intern or new coder can bring immense value to an organization by offering to follow up on problem and unpaid claims. Positive financial results are almost always seen on claims that are reactivated. In addition, new coders can learn a tremendous amount about coding and the payment process by doing insurance follow-up.

#### Homework Assignment:

Coding Practice, Exercise 2.3, Life Cycle of an Insurance Claim, #1–3

### Learning Objective 2.5:

Summarize the most common reimbursement methods for physicians, inpatient hospitals, and outpatient hospitals.

#### Concepts for Lecture:

1. The healthcare industry uses many different reimbursement or payment methods for services. The methods vary by type of payer; the setting, such as physician’s office, outpatient hospital, or inpatient hospital; and the type of service. It is important to understand the terminology associated with reimbursement.
2. *Fee schedule* is a list of services with charges.
3. *Negotiated rate schedule* or a *discounted fee schedule* specify lower, reduced rates, or rates agreed upon by the payer and the type of setting.
4. *Prospective payment system* (P P S) is a reimbursement method in which payment is made based on a predetermined fixed amount per case.
5. Medicare uses the inpatient prospective payment system (I P P S).
6. Medicare also uses the outpatient prospective payment system (O P P S).
7. *Capitation* is a prospective payment system in which physicians are paid a fixed amount per month for each member assigned to them, regardless of whether that person requests services.
8. Physician Reimbursement
9. Physicians are reimbursed based on fee schedules and capitation. Medicare publishes the Medicare Physician Fee Schedule (M P F S), updated annually.
10. Medicare uses a resource-based relative value scale (R B R V S) to establish reimbursement rates.
11. A relative value unit (R V U) identifies the amount of work and expense involved in providing a particular service.
12. Geographic costs are also factored into the calculation of R B R V S. This is called a *geographic practice cost index* (G P C I).
13. Annual *conversion factor* (C F) is used to calculate the fees.
14. Inpatient Hospital Reimbursement
15. Inpatient hospitals are reimbursed based on fee schedules; per diem payment (an all-inclusive flat charge per day); and prospective payment.
16. *Diagnosis-related groups* (D R G s) are the most common prospective payment system. *Hierarchical condition category* (H C C) coding further fine-tunes reimbursement.
17. Best-known D R G s are the Medicare severity-adjusted D R G s (M S-D R G s).
18. *Case-based payment* means that the rate is determined per case, or per inpatient admission.
19. *Cost outliers* are unusual cases in which the cost is above or below a standard threshold amount established for the D R G.
20. A *D R G grouper* is software that considers several clinical and demographic characteristics of a patient.
21. *Hierarchical condition category* coding (H C C) was developed to estimate future health risks and costs for Medicare Advantage and inpatients. The focus is to identify inpatients with chronic, high-cost illnesses, such as certain types of cancer.
22. Outpatient Hospital Reimbursement
23. C M S O P P S assigns individual services to an ambulatory payment classification (A P C) based on similar clinical characteristics and similar costs.
24. Private payers may adopt Medicare A P C s, modify them, establish their own, or pay based on individual C P T codes.
25. Reimbursement in other settings includes inpatient rehabilitation hospitals, ambulatory surgery centers, skilled nursing facilities, home health agencies, and others.

### Teaching Notes

#### Teaching Resource:

***Pearson’s Comprehensive Medical Coding: A Path To Success*, Chapter** **2**

#### PowerPoint Lecture Slides

#### In-Class Activities:

Discuss the extensive terminology and the acronyms associated with that terminology.

Discuss the role Medicare and C M S play in establishing fees and reimbursement.

Discuss how important reimbursement is in all medical settings.

#### Teaching Notes/Tips:

1. Show how a fee is established by multiplying the total R B R V S value for a C P T code by the annual conversion factor (C F). For example, a conversion factor of $35 means that an R B R V S value of 1.0 is worth $35 on the M P F S. A code with an R B R V S value of 0.5 would be worth $17.50. A code with an R B R V S value of 2.0 would be worth $70. A code with an R B R V S value of 10.0 would be worth $3,500. When Medicare adjusts prices each year, it publishes a new conversion factor that is applied to all C P T codes.
2. When discussing D R G groupers, be sure to mention the seen variables, including principal diagnosis, secondary diagnosis, surgical procedures, complications and comorbidities, age and gender, discharge status, and trim points. Show the students an example. (An example of a M S-D R G is D R G 375 Digestive Malignancy with Complication or Comorbidity. The M D C for this D R G is M D C 06 Diseases and Disorders of the Digestive System.)

#### Homework Assignment

Coding Practice Exercise 2.4, Reimbursement Methods, # 1-3

### Learning Objective 2.6:

Recognize the major healthcare claims formats.

#### Concepts for Lecture:

1. Providers must submit claims for services to payers to receive reimbursement. Specific formats or forms are required in each healthcare setting.
2. After completing registration information, a patient sees the physician and/or receives the treatments and procedures needed. The physician documents the patient’s problem in a progress note and may check off services and diagnoses on an encounter.
3. Physicians bill services on the C M S-1500 form. The electronic format for claims submission of physician services is the 837P.
4. The National Uniform Claim Committee (N U C C) provides specific guidelines for completion.
5. Items 1–13 are for patient and insured information.
6. Items 14–33 are for physician or supplier information.
7. Inpatient hospitals bill services on the U B-04, also known as the C M S-1450. The electronic format is the 837I. The National Uniform Billing Committee (N U B C) maintains and updates this form.
8. There are 81 form locators or boxes that must be completed. There are very specific rules that apply to each locator.
9. Instructions to complete the form are found on either [www.cms.gov](http://www.cms.gov/) or [www.nubc.org](http://www.nubc.org/).
10. The U B-04/837I is used to bill the facility portion of outpatient services and the C M S-1500 is used to bill for professional services.

### Teaching Notes

#### Teaching Resource:

***Pearson’s Comprehensive Medical Coding: A Path To Success*, Chapter** **2**

#### PowerPoint Lecture Slides

#### Figures:

Figure 2-3 Example of a completed C M S-1500 claim form.

Figure 2-4 Example of a completed U B-04 form (with annotations).

#### In-Class Activities:

Have the students complete a C M S-1500 form based on a patient’s encounter form.

As a group, have the students complete a U B-04 based on a patient’s hospital stay.

#### Teaching Notes/Tips:

1. Electronic standards specify exactly how data is to be submitted, so that payers’ computers can read the information submitted by providers and clearinghouses.
2. Discuss the “crosswalk” between the paper form and the electronic format.
3. Go to the website [www.nucc.org](http://www.nucc.org/).
4. Go to [www.nubc.org](http://www.nubc.org/).
5. Carefully review the codes and information that populate the locators on the form U B-04.

#### Homework Assignment:

Coding Practice Exercise 2.5, Healthcare Claims, #1-5

### Learning Objective 2.7:

Explain the federal compliance initiatives.

#### Concepts for Lecture:

1. In this era of electronic transmissions, it is much easier for payers to track patterns of billing, compare a physician’s fees with the average or norm, and target providers who deviate from the norm.
2. If the insurance company or Medicare detects a pattern of overpayments due to over coding or improper billing, it can conduct an audit.
3. *Fraud* is knowingly billing for services that were never given or billing for a service that has a higher reimbursement than the service actually provided.
4. *Abuse* is mistakenly accepting payment for items or services that should not be paid for by Medicare, due to improper coding and billing practices.
5. *Compliance* means following the rules established by multiple federal, state, and county government agencies.
6. The Office of the Inspector General is a division of D H H S which investigates fraud, abuse, and other noncompliance matters in the Medicare and Medicaid programs.
7. The federal False Claims Act imposes penalties on individuals and companies that defraud government programs.
8. Knowingly submitting a bill to a government healthcare program, such as Medicare, that contains incorrect codes is considered to be presenting a false claim for payment, because the provider is requesting payment for a service that was not provided.
9. Companies and organizations establish compliance programs to actively keep informed about regulations, educate employees, and make sure that everyone in the company is cooperating.
10. The Recovery Audit Contractor program uses independent contractors to identify improper Medicare payments to healthcare providers and suppliers made on claims of healthcare services provided to Medicare beneficiaries.
11. Hospitals, physicians, and other providers are using health information technology (H I T) advancements to streamline decades-old methods of capturing, storing, and using healthcare data.

### Teaching Notes

#### Teaching Resource:

***Pearson’s Comprehensive Medical Coding: A Path To Success*, Chapter** **2**

#### PowerPoint Lecture Slides

#### Figures:

1. Example of an encoder search screen

#### Teaching Notes/Tips:

1. When providers are overpaid, they are legally obligated to report the overpayment to Medicare, to refund the money, and possibly to pay interest on it.
2. Be careful to strike a balance between impressing on students the importance of compliance and raising anxiety unnecessarily. Information on fraud and abuse should not scare coders but make them aware of the importance of their role and the need for accuracy.
3. Discuss the three main forms of applications with which coders interface.
4. Show the students how an encoder works.
5. Show samples of Electronic Health Records screens.

#### In-Class Activities:

Discuss electronic health records and their benefits to the patient, to the healthcare facility, and to the payer.

#### Homework Assignment:

Coding Practice, Exercise 2.6, Federal Compliance, #1–3

Coding Practice, Exercise 2.7: Health Information Technology, #1–5

## CHAPTER 2 REVIEW

### Concepts for Lecture:

1. Third-party payers reimburse physicians and hospitals for 86% of all healthcare services in the United States. Coders need to understand the different types of third-party payers because each has separate, and sometimes conflicting, rules about coding and billing.
2. To fulfill their contractual obligations, payers may request information to verify whether the service is covered, including the site (location) of service; the medical need for and appropriateness of the diagnostic and therapeutic services provided; and that services billed on the claim are accurately coded based on the medical record.
3. Each step in the life cycle of an insurance claim must be completed in a timely and accurate manner in order for providers to receive correct payment for their services.
4. The methods vary by type of payer, the setting—such as physician office, outpatient hospital, or inpatient hospital—and the type of service.
5. Providers must submit claims for services to payers to receive reimbursement. Specific electronic formats or paper forms are required in each healthcare setting. Electronic standards specify exactly how data is to be submitted, so that payers’ computers can read the information submitted by providers and clearinghouses. The standard must be followed by health plans, healthcare clearinghouses, and certain healthcare providers when conducting electronic transactions.
6. When providers are overpaid, they are legally obligated to report the overpayment to Medicare, to refund the money, and possibly even to pay interest on it.
7. Proactive coders embrace new technology that increasingly uses computers to perform predictable, repetitive work, positioning themselves to accomplish more complex coding and data analysis tasks and thus adding value to an organization. Three H I T applications with which coders interface are encoders, E H R s, and computer-assisted coding (C A C).

### Teaching Notes

#### Teaching Resource:

***Pearson’s Comprehensive Medical Coding: A Path To Success*, Chapter** **2**

#### Homework Assignment:

Concept Quiz, Completion, #1–10

Concept Quiz, Multiple Choice, #1–10