Hilari Simmons

Week 7-Reimbursement Homework

Chapters 9 and 10

Check your understanding 9.1

1. Order entry is part of the Claims processing activities portion of the RC. This would be were each department needs to report/charge for services rendered. In which creates revenue.
2. RA's show the facilities what is covered/paid and what has been rejected. This is also were appeals and resubmissions are reviewed.
3. They are used so that you will have clean claims being submitted to all of your payers. This includes CCI edits which show you if codes match or meet medical necessity.
4. Charge Code=hospital

   Department Code=hospital

   Description= hospital

   HCPCS Code= nationally

   Revenue Code= nationally

   Charge= hospital
5. January 1st of every year.

Check your understanding 9.2

1. Used to measure performance improvement
2. Task of charge entry and late charges which are significant issues as the prescribed protocol for charge capture are not allowed.
3. Cost reduction, consistent performance, and coordinate strategic goals.
4. MCE- Medicare Code Editor
5. CC and MCC codes

Chapter 9 Review Quiz

1. Pre-claims submission activities. This task is important to the health of the revenue cycle because it is responsible for collecting complete and accurate patient information and educating the patient about financial responsibility for services and verifying data before costly procedures are done.
2. The CMS release of updates to codes and billing guidance, and performance of new services at the health care provided that require line items to be added to the system.
3. Reimbursement may be lost through claim denials, and compliance violations may occur.
4. By requiring all health care facilities to use standardized code sets on electronic claims that contain standardized formats, this changed the conventional submission of claims on paper forms.

5. Clinical documentation improvement (CDI) enhances medical data collection to maximize reimbursement revenue, and thus improve quality care in claims processing.
6. Provider contacts the patient to collect outstanding debt, the facility determines whether the claim can be corrected and resubmitted (if not, must be written off or adjustments made to patient's account), accounting personnel can also check for denied claims to determine whether corrected claims should be submitted to the insurer.
7. Key performance indicators (KPI) which represent areas that need to be improve are established by providers to define optimal performance for units of the facility.
8. Facility A could utilize root cause analysis (RCA to determine the root cause of the high denial rate there are several tools and techniques within RCA to uncover causes of problems, such as an event and causal factor analysis, change analysis, barrier analysis, and management oversight and risk three analysis.
9. Outdated CDM codes used on claims

   Data entry errors

   Inexperienced HIM coders

10. Hard coding is the use of the change description master to code repetitive services (codes assigned using CDM), whereas soft coding is when codes are manually assigned by HIM coders. The CDM has not made soft coding obsolete, because some situations will still require manual coding by HIM coders such as more complex visits and multiple diagnosis.

Check your understanding 10.1

1. Quality, performance, and payment
2. To err is human; building a safer health system, Crossing the Quality Chasm; A new health System for the 21s Century. Rewarding Provider Performance; Aligning Incentive in Medicare.
3. Bonuses, penalties, shared savings and shared risk.
4. Comprehensive Care, Patient-Centered Care, Coordinated Care, Accessible Services, and Quality & Safety.
5. #1; is one-sided and ACO's share in savings but not the loses. #2; is two-sided and ACO's share in both savings and losses.

Check your understanding 10.2

1. Hospital inpatient, hospital outpatient, and ASC.
2. Heart Failure, Acute MI, Pneumonia, COPD, total hip arthroplasty, total knee arthroplasty, and CABG surgery.
3. Safety domain, clinical care domain, efficiency & cost reduction domain, and patient & caregiver-centered experience of care domain.
4. Clinical quality care, communication & care coordination, patient & caregiver-centered experience, and patient safety.

5. Advanced alternative payment models (APM’S) and Merit-based incentive payment system (MIPS)

Chapter 10 Review Quiz

1. Quality, Performance and Payment
2. Wide spread movement toward quality and safety
   Pay-for-Performance (P4P) and value-based purchasing (VBP) emerge as a way to align payment incentives and quality
   These systems were created for the healthcare system as an incentive linked to payment, performance, and quality
3. Assignment of the cost of a patient's care in the outcomes of care to a specific individual provider or group of providers; allows our location of rewards or penalties (also known as assignment in Medicare)
4.
5. CMS allows a facility to maintain the full payment for services when it successfully participates in a quality-measure reporting program. In this type of program quality is not measured, the action of reporting data in proper format in the given time frame is what allows facilities to receive full payment. The CMS created the Measures Management System to monitor the development and implementation of high-caliber quality measures. Each program has its own set of measures that must be reported to CMS. Under the various quality reporting programs, quality data are reported for both Medicare and non-Medicare patients.
6. The Deficit Reduction Act of 2005.
7. X
8. HAC-POA: Hospital Acquired Conditions and Present on Admission Indicator Reporting Provision

   As required DRA, the Secretary of the United States (U.S.) Department of Health & Human Services was required to identify conditions that: "Are high cost or high volume or both?

   "Result in the assignment of a case to an MS-DRG that has a higher payment when present as a secondary diagnosis "

   Could reasonably have been prevented through the application of evidence-based guidelines

   HAC Reduction Program:

   Beginning in FY 2015, mandated by the Affordable Care Act, requires CMS to reduce hospital payments by 1 percent for hospitals that rank among the lowest-performing 25 percent with regard to HACs.

   Incentive for hospitals to reduce HACs - CMS website

   Requires the Secretary of the Department of Health and Human Services to adjust payments to hospitals that rank in the worst-performing quartile with respect to risk-adjusted HAC quality measures.

9. An Alternative Payment Model (APM) is a payment approach that offers incentive payments for providing high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
10. To be an advanced APM under the QPP, there are three criteria:

    Participants must use certified electronic health technology

    Payment for covered professional services must be based on quality measures comparable to those used in the quality performance category of the MIPS

    Participants must be a medical home model or participating APM entities must bear more than a nominal amount of financial risk for monetary losses.

    Track 1 does not assume downside risk (shared losses) if they do not lower growth in Medicare expenditures. Track 2 and 3 have two-sided risks and payment services are based on quality measures. Track 2 and 3 have all three criteria while track 1 does not.

Workbook

2. Understanding the Revenue Cycle Components (Level 2 – Understanding)

Complete the following table using information from the text. To complete the Tasks and Example Employee Positions categories, brainstorm functions and positions that you believe would be included in the RC Component.

RC Component	**Description**	**Tasks**	**Example Employee Positions**
Pre-Claims Submission	These are activities that are comprised of tasks and functions from pt. registration and case management.	Portion of the Revenue Cycle is responsible for collecting patient's information and the responsible parties' information for determining the appropriate financial class, for educating the patient about fiscal responsibility, collecting waivers, and for verifying all information prior to services.	When a Medicare patient arrives for admission into the Oncology unit for services, the admitting representative is responsible for collecting the patient's demographic data and Medicare beneficiary identifier.

Claims Processing	They are responsible for activities which include the capture of all billable services, claim generation, and claim corrections.	Every clinical area that provide services to a patient must report charges for the services that have been performed	When a provider sees a patient in the hospital, and after 15 min of care and decides to diagnose them with Ocular Melanoma. In which both the OM diagnosis and the 15 min of care translate into separate codes which are eventually submitted for reimbursement.
Accounts Receivable	Accounts Receivable department manages the amounts owed to a facility by patients who receive services but whose payments will be made after claims have been submitted and reimbursed by insurance at a later date by the patient, the guarantor, the third-party payer.	Once a claim is received by the TPP, the insurance processing of the claim begins, in addition to processing the claim for payment, the TPPs prepare an explanation of benefits that is delivered to the patient. After the claim is processed by the TPP, a remittance advice is electronically returned to the provider with an electronic form.	A patient has services provided at the hospital/facility. The next week the patient receives an EOB list of services provided and of what they cost. Then at the doctor's office they receive a Remittance Advice or EOP via TPP/clearing house and tells the doctor's office what was covered.
Claims Reconciliation and Collections	Healthcare facilities uses the EOP, MSN, and RA to reconcile their accounts.	This process allows facilities/hospitals to compare expected	A patient is treated for Ocular Melanoma receives a bill 2 weeks later for a

		reimbursement to the actual reimbursement provided by the TPP and the patient.	bunionectomy. The facility must review the ARs and to correct the claims error.

2. State Delivery Systems (Level 2 – Understanding)

The patient-centered medical home (PCMH) is a model of value-based purchasing (VBP) and pay-for-performance (P4P) systems. As stated in the textbook, PCMH initiatives are often organized by health plans, states, payers, providers, or multi-stakeholder groups. Several states have adopted policies and programs to advance PCMHs. Go to the web site of the National Academy for State Health Policy (NASHP) to learn about medical homes and other programs offered by state:

http://www.nashp.org/med-home-map.

On the State Delivery System and Payment Reform Map three categories of healthcare delivery models are discussed: Health Homes, Medical Homes, and Delivery System Reform Incentive Payment (DSRIP) programs. For each category, choose a state that is participating in the program. Answer the following questions based on the information provided about the models/programs offered in the state you selected. The information is provided on the left-hand side of the page.

A. Health Homes: Click on a state highlighted in blue. What is the activity this state? Include information about target population, eligible providers, and measurement and evaluation.

1. CMS has approved 6 HHSPA in Maine: 3 for the states BHHM, 2 for PCHHM, and 1 for OHHM.
2. Targeted Population is to include individuals with either one chronic condition or be at risk for a possible another. Two chronic conditions.
3. Eligible providers: they are required to be recognized as NCQA patient centered MH and have an EMR system that has 10 core regulations.
4. M&E: Improve chronic disease management, reduce inefficient healthcare spending, and ensure evidence-based prescribing.

B. Medical Homes: Click on a state highlighted in blue. What is the activity this state? Include information about qualification criteria, payments and supports, and metrics and outcomes. Indicate if the program is a multi-payer program.

1. Maine PCMH Pilot demonstrates a multi-payer. Which began January 2010.
2. 6 payers are participating in this Pilot:

Medicare fee for services

Anthem BC/BS

Aetna

HP

MCHO

Mainecare

3. CCT's receive PMPM payments in which supports practices by providing support and care coordination services to the most high risk/high cost patients in pilot. For example: Mainecare pays CCT's 129.50 PMPM for high risk/high cost patients who are referred from participating practices.
4. Multipayer program

C. DSRIP: Click on a state highlighted in blue. What is the activity this state? Include information about goals, eligible providers, types of projects, measurement and evaluation, payment and supports and overall status.

1. Oregon has a HTPP(Hospital Transformation Performance Program)
2. Goals are allowed DRG hospitals to earn incentives payments by meeting specific performance objectives. This concept allows to create a mutually beneficial system for both hospitals and CCO's by reducing costs while trying to improve quality.
3. HTPP is not a project based it is a standardized list of eleven performance measures that hospital must report.
4. Eligible providers are 28 urban DRG hospitals with the bed capacity of over 50 beds.
5. M/E is obtained in 2 overarching areas: hospital focused and hospital-CCO coordination focused.
6. All hospital is eligible to earn 500,000 by achieving at least 9 out of the 11 measures.
7. Program is still operational.