

THIRD EDITION

Health Care Finance

**AND THE
MECHANICS OF
INSURANCE AND
REIMBURSEMENT**

Michael K. Harrington
MATS, MSHA, RHIA, CHP
Program Director
St. Joseph's College of Maine
Department of Health Administration
Standish, Maine



**JONES & BARTLETT
LEARNING**



World Headquarters
Jones & Bartlett Learning
25 Mall Road
Burlington, MA 01803
978-443-5000
info@jblearning.com
www.jblearning.com

Jones & Bartlett Learning books and products are available through most bookstores and online booksellers. To contact Jones & Bartlett Learning directly, call 800-832-0034, fax 978-443-8000, or visit our website, www.jblearning.com.

Substantial discounts on bulk quantities of Jones & Bartlett Learning publications are available to corporations, professional associations, and other qualified organizations. For details and specific discount information, contact the special sales department at Jones & Bartlett Learning via the above contact information or send an email to specialsales@jblearning.com.

Copyright © 2025 by Jones & Bartlett Learning, LLC, an Ascend Learning Company

All rights reserved. No part of the material protected by this copyright may be reproduced or utilized in any form, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system, without written permission from the copyright owner.

The content, statements, views, and opinions herein are the sole expression of the respective authors and not that of Jones & Bartlett Learning, LLC. Reference herein to any specific commercial product, process, or service by trade name, trademark, manufacturer, or otherwise does not constitute or imply its endorsement or recommendation by Jones & Bartlett Learning, LLC and such reference shall not be used for advertising or product endorsement purposes. All trademarks displayed are the trademarks of the parties noted herein. *Health Care Finance and the Mechanics of Insurance and Reimbursement, Third Edition* is an independent publication and has not been authorized, sponsored, or otherwise approved by the owners of the trademarks or service marks referenced in this product.

There may be images in this book that feature models; these models do not necessarily endorse, represent, or participate in the activities represented in the images. Any screenshots in this product are for educational and instructive purposes only. Any individuals and scenarios featured in the case studies throughout this product may be real or fictitious but are used for instructional purposes only.

This publication is designed to provide accurate and authoritative information in regard to the Subject Matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the service of a competent professional person should be sought.

26161-5

Production Credits

Vice President, Product Management: Marisa R. Urbano
Vice President, Content Strategy and Implementation:
Christine Emerton
Director, Product Management: Matthew Kane
Product Manager: Sophie Fleck Teague
Director, Content Management: Donna Gridley
Content Strategist: Tess Sackmann
Director, Project Management and Content Services:
Karen Scott
Manager, Project Management: Jackie Reynen
Project Manager: Jennifer Ridsen
Senior Digital Project Specialist: Angela Dooley

Senior Marketing Manager: Susanne Walker
Content Services Manager: Colleen Lamy
Product Fulfillment Manager: Wendy Kilborn
Composition: Straive
Project Management: Straive
Cover Design: Michael O'Donnell
Media Development Editor: Faith Brosnan
Rights & Permissions Manager: John Rusk
Rights Specialist: Robin Landry
Cover Image (Title Page, Part Opener, Chapter Opener):
© Vladitto/Shutterstock
Printing and Binding: Sheridan Books

Library of Congress Cataloging-in-Publication Data

Names: Harrington, Michael K., author.
Title: Health care finance and the mechanics of insurance and reimbursement
/ Michael K. Harrington.

Description: Third edition. | Burlington, Massachusetts : Jones & Bartlett Learning, [2024] | Includes bibliographical references and index.

Identifiers: LCCN 2023001127 | ISBN 9781284259292 (paperback)

Subjects: MESH: Insurance, Health, Reimbursement | Insurance Claim Reporting | Financial Management—methods | United States | BISAC: MEDICAL / Administration

Classification: LCC RA412.3 | NLM W 275 AA1 | DDC 368.38/200681—dc23/eng/20230508

LC record available at <https://lcn.loc.gov/2023001127>

6048

Printed in the United States of America

26 25 24 23 10 9 8 7 6 5 4 3 2 1

Dedication

This book is dedicated to the people in my life who, unfortunately, have passed away, but along their way in life, they provided me with insight, understanding, patience, love, and most importantly, the ability to know that what one receives in life must be shared with others, or the tremendous gift they gave me would be lost.

Vincent J. Harrington

Winifred Harrington

George E. Donahue

Marie Donahue

John E. Vaughan

Vincent Harrington, Jr.

Contents

Preface	xv
Acknowledgments	xix
Foreword	xxi
About the Author	xxiii

PART I

1

CHAPTER 1 Introduction to Healthcare Finance

3

Introduction	3
Accounting Authorities	4
Federal Accounting Standards Advisory Board ..	4
American Institute of Certified Public Accountants	5
International Accounting Standards Board	5
Public Company Accounting Oversight Board	5
Generally Accepted Accounting Principles	6
Securities and Exchange Commission	6
Internal Revenue Service	6
Centers for Medicare & Medicaid Services	7
Objectives for Financial Reporting	7
Usefulness of Financial Information	8
Recognition and Measurement in Financial Statements	9
Elements of Financial Statements	9
Financial Organizations	9
Sources of Financial Data	11
Transactions in a Healthcare Facility	11
Uses of Financial Data	11
Reimbursement	11
Cost Control	11
Planning and Forecasting	12

Conclusion	13
References	13

CHAPTER 2 Financial Management

15

Introduction	15
Financial Accounting	16
Differences Between Healthcare Financial Accounting and Other Organizations	16
Assets	18
Cash	18
Inventory	18
Accounts Receivable	18
Buildings	18
Equipment	18
Liabilities	19
Accounts Payable	19
Notes Payable	19
Net Assets and Equity	20
Revenue	20
Revenue Categories	20
Revenue Forecasting	21
Expenses	21
General Ledger	21
Journal Entry	22
Managerial Accounting	22
Definition of Costs	22
Direct Costs	22
Indirect Costs	22
Fixed Costs	22
Variable Costs	23
Semifixed Costs	23
Allocation of Overhead	24

Budgets	24
Fixed Budget	25
Flexible Budget	25
Activity-Based Budget	25
Zero-Based Budget	25
Budget Cycles	25
Budget Components	25
Budget Variances	26
Explanation of Variances	26
Capital Budgets	26
Financial Statements	26
Balance Sheet	26
Income Statement	28
Cost of Goods Sold and Gross Profit	28
Cash Flow Statement	29
Who Uses Financial Statements?	29
Accrual Accounting Method	30
Ratio Analysis	30
Current Ratio	30
Acid-Test Ratio	31
Debt Ratio	31
Conclusion	32
References	32

PART II

33

CHAPTER 3 Introduction to Claims Processing 35

Introduction	35
History of Reimbursement	36
Providers, Suppliers, and Claims	36
Providers Defined	36
Suppliers Defined	36
Types of Claims	37
Claims for Medicare Services Furnished to Patients Not Lawfully Present in the United States	38
Domestic Claims Processing Jurisdiction	38
Portable X-Ray and Other Portable Services	38
Ambulance Services	38
Laboratory Services	39
Railroad Retirement Beneficiary Carrier	43
Misdirected Claims to Carrier for Payment	43

Claims for Payment When Items/Services Are Part of PPS	43
Provider Charges to Beneficiaries	43
Charges to Hold a Bed During an SNF Absence	44
Patient Refunds	44
Provider Treatment to Beneficiaries	44
Assignment of Payment to Provider	44
Payment to Agent	45
Payment to Bank	45
Payment to Employer of a Physician	45
Payment Under Reciprocal Billing Arrangements	45
Carrier Claims: Mandatory Assignment	46
Showing Payment on CMS-1500 Claim Forms	46
Physicians' Charge for Missed Appointment	46
Timely Filing and Date Postmarked as Date of Filing	46
Physician Self-Referral Prohibition	46
Background	46
Financial Relationship	47
Regulations	47
Financial Liability Protections for Beneficiaries	47
Advance Beneficiary Notice	47
Requirements of the ABN	47
Capable Recipient	48
Authorized Representatives	48
Generic and Blanket ABNs	48
ABNs Used When a Patient Is Under Duress	48
Qualified Medicare Beneficiary Program	49
Common Working File	49
Appeals of Claims	51
Overview	51
General Guidelines	51
Required Elements of an Appeal Letter	51
Letter Format of an Appeal/Denial Letter Response to CMS	52
Establishing a Reading Level	52
Completing the Form CMS-1450 Data Set	52
Form Locators (FL) 1–15	52
Form Locators (FL) 16–30	52

Form Locators (FL) 31–42	53
Form Locators (FL) 43–65	53
Form Locators (FL) 66–81	54
Conclusion	54
References	55

CHAPTER 4 Government Payer Types 57

Introduction	57
The History of Medicare.	57
Medicare Part A	58
Coverage Under Medicare Part A	59
<i>Inpatient Hospital Coverage.</i>	59
<i>Skilled Nursing Facility</i>	60
<i>Home Health Care.</i>	60
<i>Hospice Care</i>	61
<i>Renal Dialysis Centers.</i>	63
Financing Medicare Part A	64
Medicare Part B	64
Financing Medicare Part B	64
Medicare Part C	64
Medicare Part D	65
Medigap Insurance	65
Medicaid	65
The History of Medicaid	65
Medicaid at the State Level	65
Scope of Medicaid Services	66
Duration and Payment for Medicaid Services	66
Medicare–Medicaid Relationship	66
Other Types of Coverage	67
Children’s Health Insurance Program	67
<i>Eligibility</i>	67
Programs of All-Inclusive Care for the Elderly	68
Temporary Assistance for Needy Families	68
TRICARE	68
TRICARE Prime	68
TRICARE Standard and Extra	68
TRICARE For Life	69
Civilian Health and Medical Program of the Department of Veterans Affairs	69
Worker’s Compensation	69
Indian Health Services	69
Conclusion	70
References	70

CHAPTER 5 Affordable Care Act and Other Healthcare Reform 73

Introduction	73
The Patient Protection and Affordable Care Act.	74
Title I: Quality, Affordable Health Care for All Americans	74
Title II: The Role of Public Programs.	75
Title III: Improving the Quality and Efficiency of Health Care	75
Title IV: Prevention of Chronic Disease and Improving Public Health	76
Title V: Health Care Workforce	76
Title VI: Transparency and Program Integrity	76
Title VII: Improving Access to Innovative Medical Therapies.	77
Title VIII: Community Living Assistance Services and Supports Act.	77
Title IX: Revenue Provisions	77
Title X: Reauthorization of the Indian Health Care Improvement Act	77
Time Line of the PPACA.	77
2010 New Consumer Protections	77
2011 Improving Quality	78
2012 Improving Quality and Lowering Costs	78
2013 Improving Quality and Lowering Costs	80
2014 New Consumer Protection.	80
2015 Improving Quality and Lowering Costs	80
Results of the Affordable Care Act After 12 Years	81
Overview	81
Accomplishments of the ACA	81
The Center for Consumer Information and Insurance Oversight	82
Health Insurance Marketplace	83
Cracking Down on Policy Cancellations	83
Doctor Choice and Out-of-Network Services	83
Policy Lifetime and Yearly Limitations	83
Rate Review and the 80/20 Rule	84
Filing an Appeal	84
Summary of Benefits and Coverage.	84
21st Century Cures Act	99
Overview	99
Information Blocking	100

Information Blocking Exceptions	100
The Mid-Build Requirement	100
Medicare Access and CHIP Reauthorization Act of 2015.	102
Merit-based Incentive Payment System. .	103
Conclusion	103
References	103

CHAPTER 6 Managed-Care Organizations and Non-Managed- Care Commercial Insurance105

Introduction	105
Health Maintenance Organizations	106
Group Model HMOs.	107
Independent Practice Associations	107
Network Model HMOs.	107
Staff Model HMOs	107
Preferred Provider Organizations	107
POS Plan	107
Exclusive Provider Organizations	108
Integrated Delivery Systems	108
Managed-Care Cost Controls	108
Medical Necessity	109
Utilization Review.	109
Primary Care Physician as a Gatekeeper . . .	109
Prior Authorization.	109
Case Management.	109
Prescription Management	110
Prescription Benefit Managers.	110
Contract Management and Financial Incentives	110
Episode-of-Care Payment Method	110
Capitation.	111
Global Payment	111
Financial Incentives	111
Contract Management.	111
National Committee for Quality Assurance.	112
Healthcare Effectiveness Data and Information Set	113
Medicare Managed Care	114
Non-Managed-Care Traditional Health Insurance	114
10 Essential Health Benefits	115

Out-of-Pocket Expenses	115
Coordinated Care Plan	116
Health Maintenance Organization.	116
Preferred Provider Organization	116
Exclusive Provider Organization.	116
Special Needs Plans	116
Senior Housing Facility Plans.	117
Medical Savings Account Plans	117
Private Fee-for-Service Plans.	117
Employer Group Health Plan	117
Religious Fraternal Benefit Plans	117
Conclusion	118
References	118

CHAPTER 7 Medicare Prospective Payment Systems . . . 119

Introduction	119
History of Prospective Payment Systems . .	120
Acute Care Prospective Payment System	120
Medicare Severity Diagnosis-Related Group Classification System.	121
Inpatient Hospital Payments Under PPS . . .	121
Disproportionate Share Adjustment	121
Indirect Medical Education.	122
Hospital Wage Index	122
High-Cost Outliers	123
Cost-to-Charge Ratios.	123
Calculation of Charges	123
Transfer Cases.	126
Billing of Transplant Services.	129
Kidney Transplant.	129
Heart Transplant.	130
Liver Transplant	130
Pancreas Transplants with Kidney Transplants.	130
Pancreas Transplants Alone.	131
Inpatient Rehabilitation Facility Prospective Payment System	131
Comorbidities.	132
IRF Qualifications.	132
Data Collection and Reporting	132
IRF PPS Payment Calculation	133

Inpatient Psychiatric Facility	
Prospective Payment System	133
IPF PPS Payment Structure	134
Budget Neutrality	134
Comorbidity Adjustment	134
Age Adjustment	134
Calculation of IPF PPS Payment.	135
Health Insurance Prospective	
Payment System.	135
Long-Term Care Hospitals PPS	136
Short-Stay Outliers	138
Interrupted Stays	138
High-Cost Outlier	139
Other Adjustments	139
Billing for LTCH Services	139
Conclusion	139
References	139

CHAPTER 8 Hospital Outpatient Prospective Payment System . . . 141

Introduction	141
Hospital Outpatient Prospective	
Payment System.	141
History	141
Payment Status Indicators.	142
Ambulatory Payment Classification Groups	142
Composite APCs.	143
Calculation of APC Payment Rates	143
Packaging.	144
Packaging Types Under the OPPOS	144
Discounting	144
Payment Adjustments.	144
OPPOS Coinsurance	145
Pass-Through Payments	145
New Technology.	146
Transitional Corridor Payments	146
Home Health Prospective	
Payment System.	146
History	146
Outcomes Assessment Information Set	147
Payment of Episodes.	147
Billing Process Under HH PPS	148
Submitting a Request for Anticipated	
Payment	148

Transfer Cases.	148
Discharge and Readmission	149
Partial Episode Payment	149
Low Utilization Payment.	149
Therapy Thresholds	150
Adjustment of Episode of Payment—	
Early and Late Episodes	150
Adjustment of Episode of Payment—	
Outlier Payments	150
Home Health Prospective Payment	
System Consolidated Billing	151
Responsibilities of Providers	151
Discharge Planning and Transfer Patients	151
Physician and Nonphysician Practitioners	152
Ambulatory Surgical Center	153
History	153
ASC Listing.	153
Conclusion	153
References	154

CHAPTER 9 Skilled Nursing Facility Prospective Payment System and Consolidated Billing . . 155

Introduction	155
Overview of Skilled Nursing Facility	
Prospective Payment System	155
History of the SNF PPS Model	155
Services Within the Scope of Care in an SNF	156
Consolidated Billing.	156
Facilities Subject to Consolidated Billing	158
Types of Services Subject to	
Consolidated Billing	158
Services Excluded from Skilled Nursing	
Facility Prospective Payment System	159
Physician's Services and Other Professional	
Services.	159
Other Excluded Services.	160
Patients with End-Stage Renal Disease	160
ESRD Services.	160
Hospice Care and Other Services	160
Ambulance Services	161
Screening and Preventive Services.	162
Billing Skilled Nursing Facility Prospective	
Payment System Services	162
HIPPS Rate Code	163

Rate Components for SNF PPS	163
Other Billing Practices	164
End of a Benefit Period	165
Other Billing Situations	165
The New Patient Driven Payment Model	166
PDPM History	166
PDPM Patient Classification	166
Interrupted Stay Policy	168
VPD Adjustment	169
AIDS Adjustments	170
Conclusion	170
References	171

PART III 173

CHAPTER 10 Coding for the Non-Health Information Management Professional175

Introduction	175
The Health Record	175
History of the Health Record	175
Making an Entry in the Health Record	176
Hybrid Medical Records	178
Formats of Medical Records	178
Record Retention	178
International Classification of Diseases History	179
<i>International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)</i>	179
<i>ICD Volumes and Code Format</i>	179
<i>ICD-9-CM Coding Guidelines</i>	180
<i>International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)</i>	180
<i>ICD-10-CM Guidelines</i>	181
<i>Conventions for the ICD-10-CM</i>	181
<i>General Coding Guidelines</i>	182
<i>Selection of a Principal Diagnosis</i>	182
<i>Admission from Observation Unit</i>	183
<i>Admission from Outpatient Surgery</i>	183
<i>Reporting Additional Diagnoses</i>	183
<i>Guidelines for Outpatient Services</i>	184
Healthcare Common Procedure Coding System	184

History of Healthcare Common Procedure Coding System	184
Structure of the HCPCS	184
Medicare National Correct Coding Initiative	186
Evaluation and Management	186
New Patient	186
Established Patient	186
Levels of E/M Services	186
Office or Other Outpatient Services (99201–99205)	187
Hospital Observation Services (99218–99226)	187
Hospital Inpatient Services (99221–99233)	187
Hospital Observation and Discharge Planning (99234–99239)	188
Office Consultations (99241–99245)	188
Inpatient Consultations (99251–99255)	188
Emergency Department (99281–99288)	189
Other Services Covered	189
Conclusion	189
References	190

CHAPTER 11 Revenue Cycle Management191

Introduction	191
Comprehensive and Integrated Approach	192
Components of the Revenue Cycle	192
Front-End Process	193
Insurance Verification	194
Prior Authorization and Precertification	194
Financial Counseling	195
Patient Pay at the Time of Service	195
Medical Necessity	196
System Tools	197
Middle Process	197
Case Management and Utilization Management	197
Charge Capture	198
Charge Description Master	199
Correct Coding Initiative	199
Clinical Documentation Improvement	199
Coding	200
Case-Mix Index	200
Back-End Process	200
Claims Processing	200

Payment Posting	201
Denial Management	201
Quality Measures for Improvement	201
Price Transparency	201
Price Transparency Background	201
Definition of a Hospital	203
Items and Services and Standard Charges	203
Format of Display of Consumer-Friendly Information	204
Price Estimator Tool	204
Selected Shoppable Services	204
Required Corresponding Data Elements	204
Federal and State Hospitals Deemed to Have Met the Requirements	208
General Rules	208
Location and Accessibility of Online Data	209
The No Surprises Act Part 1	209
The No Surprises Act Part 2	211
Conclusion	212
References	212

CHAPTER 12 Healthcare Fraud and Abuse 215

Introduction	215
Medicare Fraud	216
Medicare Abuse	216
CMS Fraud Prevention Initiative	217
Healthcare Fraud Prevention and Enforcement Action Team	217
Zone Program Integrity Contractors	218
National Benefit Integrity and Medicare Drug Integrity Contractor	218
Medicare Fraud and Abuse Laws	218
The Center for Program Integrity	218
Top 10 Ways Consumers Can Help Fight Medicare Fraud	219
False Claims Act	220
Criminal Health Care Fraud Statute	220
Anti-Kickback Statute	220
Physician Self-Referral Law (Stark Law)	220
Exclusion from Participation in Federal Healthcare Programs	220

Violation of OIG Exclusion by an Excluded Person	221
Determining If an Individual or Entity Is Excluded	222
Frequency of Screening and Which Individuals to Screen	223
Physician Self-Referral	224
Self-Referral Disclosure Protocol	224
Recovery Audit Contractor Origin and History	225
Goals of the Recovery Audit Contractor	226
The RAC Process from Review to Response	227
Long-Term Care Facilities	228
Overpayments	228
Underpayments	228
Appeals of RAC Determinations	228
Lessons Learned	229
Cost of Operating the RAC	230
Impact on Providers	230
Review of the RAC	232
Tools for the Healthcare Administrator	233
Physician Compliance Programs	233
Auditing and Monitoring	233
Establish Practice Standards	233
Specific Risk Areas	234
Conclusion	235
References	235

CHAPTER 13 Government Incentive Programs: Electronic Health Records and Meaningful Use 237

Introduction	237
Electronic Health Record	238
Introduction to the Electronic Health Record	238
Vision and Benefits of an EHR System	239
Components of the EHR	239
Registries	239
Point-of-Care Charting Systems	239
History of Meaningful Use	240
Introduction to Meaningful Use	240
Meaningful Use Eligible Professionals	240
Participation in Other CMS Programs	240

Incentive Payment Calculation and Time Frame	241
Maximum Incentive Payments	241
Meaningful Use, Stage 1	242
EP and Hospital Core Objectives, Stage 1	242
Menu Objectives for EPs, Stage 1	245
Menu Objectives for Hospitals, Stage 1	245
Core Set Clinical Quality Measure, Stage 1	246
Meaningful Use, Stage 2	246
EP Core Objectives, Stage 2	247
Menu Objectives, Stage 2	250
Clinical Quality Measures, Stage 2	251
Meaningful Use, Stage 3	251
Pay-for-Performance.	251
Introduction to Pay-for-Performance.	251
Characteristics of P4P.	251
Quality Measures	252
Stakeholders Using P4P	252
Private Sector Initiatives	253
Return on Investment Calculators.	253
Quality Indicators.	253
Hospital Value-Based Purchasing Program	253
Introduction	253
History	254
Goals of the Program	254
How VBP Works.	255
Quality Domains.	255
Participating Hospitals	257
Scoring of Hospital Performance.	257
VBP Program Periods	257
The Reward Process for Hospitals.	258
Public Reporting.	258
Hospital Consumer Assessment of Healthcare Providers and Systems	258
Survey Content.	259
What HCAHPS Measures	259
HCAHPS Public Reporting	260
Patient-Centered Medical Homes	260
Comprehensive Care.	260
Patient-Centered Care.	260
Coordinated Care	260
Accessible Services	261
Quality and Safety	261

Independence at Home Demonstration Project	261
Requirements for Participation	261
Eligible Beneficiaries for the Independence at Home Demonstration Program	262
Financial Incentives	262
Comprehensive Primary Care Plus	262
Performance-Based Incentive Payments	262
Attribution Methodologies	263
Look-Back Period	263
Eligible Primary Care Visits.	264
Risk Scores, Risk Tiers, and Related Payments.	264
Conclusion	265
References	265

CHAPTER 14 The Mechanics of Hierarchical Condition Categories from a CMS Perspective and Lessons Learned 267

Introduction	268
Reinsurance	268
Risk Adjustment History	269
Risk Adjustment Data Submission	270
Risk Adjustment Models Overview	270
Setting of Payments for the HCC Risk Adjustment Model	271
Risk Adjustment Models for CMS-HCC	273
Demographic Factors Influencing Risk Scores	274
Risk Adjustment with a Medicaid Factor.	275
Disease Hierarchy	275
Disease and Disabled Interactions.	275
End-Stage Renal Disease	276
Prescription Drug HCC	276
Adjustments	277
Comparison of the CMS-HCC Model with the CMS RxHCC Model	277
Frailty Adjustments	278
Normalization Factor	278
Medicare Advantage Coding Adjustment	278
The Payment Process for Risk Adjustments	278

Demographic Data Capture	278	HCC and the CMS 1500 Claim Form.	289
Diagnostic Data	279	Diagnosis/Conditions	289
Five Areas of Required Data Elements.	279	Lessons Learned	290
Unaccepted Sources of Data	279	Amputation or Absence Of	290
Identification of Acceptable Facilities	280	Body Mass Index	290
Identification of Physician Types.	280	Chronic Conditions	291
ICD-10-CM Coding for HCC	280	Condition Documented but Not Coded	292
The Purpose of HCC	280	Highest Level of Specificity.	292
General Principles of Medical Record		History	295
Documentation.	283	Major Organ Transplant	295
Key Components of an HCC EM Visit	283	Status Not Coded	295
History	283	Stroke	295
Chief Complaint.	283	Chronic Obstructive Pulmonary Disease.	296
History of Present Illness	284	Atrial Fibrillation	297
Review of Systems	284	Conclusion	297
Past Family and/or Social History	284	References	298
Documenting the Examination			
of the Patient	284	List of Acronyms 299	
Medical Decision-Making.	285	Glossary. 303	
The Mechanics of HCC	286	Index 319	
Documentation Tips.	287		
The Mechanics of HCC from a Coder's			
Perspective	288		



Preface

In our current healthcare delivery model, the healthcare administrator needs to be more adept in managing not only the financial end of the facility, such as appropriate debits, credits, ratios, and trial balances, but also the reimbursement end that is a feeder to these reports and transactions. As a matter of fact, the financial end has become more involved with, and reliant on, the reimbursement process unlike in years past. In addition, the overall profitability of the healthcare organization rests entirely on the administrator's shoulders and is tied to reimbursement and the quality of care provided to the patient. It is imperative that healthcare administrators know about all of these areas through the education process and that from their first job postgraduation, they must be aware of these complex reimbursement issues on day one of their employment and not wait until they can learn on the job.

In my years of teaching healthcare finance and healthcare reimbursement at the undergraduate and graduate levels, I looked at several healthcare finance books for the courses I taught, and they all focused on accounting and only touched on a few areas of reimbursement. However, with the rapidly changing environment where reimbursement is the driving force of healthcare facilities, we need to give faculty the tools necessary to educate their students and prepare them to make an impact in the field that they have chosen to pursue. The graduates who have received a robust and comprehensive education in healthcare finance, along with healthcare reimbursement, will be far more marketable as professionals than those without any formal education in healthcare reimbursement. It is more evident now than ever before that a healthcare facility is not only responsible for quality care but it is also fully responsible

for the profit or loss on any given patient stay. This responsibility comes from the integration of the revenue cycle into the daily management function of the healthcare administrator and that of the health information management professional. All departments are not only worried about their annual budget, but they are also concerned about driving quality, reducing costs, and improving access for the patients. This is happening because the focus on reimbursement is now the driving force in healthcare facilities; processes are integrated across the continuum of care, which makes everyone responsible for the financial success of the facility.

The current topics that a healthcare administrator has to deal with when it comes to reimbursement are the different types of payment arrangements, such as block payments, capitation, and managed care. Synonymous with reimbursement these days are diagnosis-related groups and prospective payment systems for acute, inpatient rehabilitation, skilled nursing facilities, home care, outpatient settings, and ambulatory surgical centers. As if the different payment types were not enough, the healthcare administrator has to deal with readmissions, and Case Mix Index and the Recovery Audit Contractors (RAC) who look for overpayments made to a facility.

What the Text Does for the Student

Health Care Finance and the Mechanics of Insurance and Reimbursement introduces reimbursement to healthcare administrators and gives them a comprehensive outlook on who the payers are in health care, the payment systems in health care,

basic coding instruction, revenue cycle management, what fraud and abuse are and how they can have a negative impact on your facility, some essential tools that can have a negative impact on a facility if they are not managed daily such as transfer cases and high cost outliers, and tomorrow's trends. Reimbursement has evolved from a process where hospitals and other healthcare providers were paid for what they did for the patient. This type of retrospective payment system, fee-for-service, is one of the leading causes for healthcare costs spiraling out of control in the 1970s and 1980s. Now, we have a prospective payment system for many of the types of care, such as Inpatient Prospective Payment System (IPPS) and Hospital Outpatient Prospective Payment System (HOPPS). These payment systems allow healthcare facilities to be in full control of their profit or loss on any given patient. Unless healthcare administrators have a solid foundation of finance and reimbursement, they will not have the necessary skill sets to manage effectively in today's environment.

Other healthcare finance books cover all of the basic functions of accounting, such as business transactions, general ledger, financial statements, depreciation, payroll, expenses, inventories, and interpretation of financial statements. *Health Care Finance and the Mechanics of Insurance and Reimbursement* will not only cover the basic financial accounting process, but it will also cover things like the interpretation of financial statements in the healthcare arena, which is crucial for healthcare administrators as they will need to manage their facilities with these financial statements. Understanding the different ways an insurance company can pay a facility will help healthcare administrators become more involved in the contract negotiation process and work toward a more favorable contract or better manage the population that is being served.

Along with this, the different types of insurance coverage will be addressed. This will include traditional insurance, managed care, HMOs, Medicaid, and Medicare. Understanding how these payers work is instrumental to healthcare administrators so that they can better manage

their contracts and reimbursement levels and enable their facilities to remain profitable. This text will help the healthcare manager to better understand managed care organizations, staff models, closed networks, exclusive provider organizations, and preferred provider organizations, just to name a few. Understanding managed care organizations and all of their unique characteristics is critical to the healthcare manager, so they can effectively plan budgets, negotiate contracts, and understand the projected utilization versus the actual utilization needed to break even or realize a profit while servicing the managed care organization's patients.

Health Care Finance and the Mechanics of Insurance and Reimbursement addresses not only the basic finance and accounting tools for the healthcare administrator but also the full picture of reimbursement, including charge description master (CDM) and revenue cycle management. The CDM is a tool that automatically manages up to 70% of the charges in a hospital. The CDM is managed by both the finance department and the health information management department. If this tool is not accurate, it is highly likely that the facility revenue will not be accurate. It can either be understated or overstated. If it is understated, then costs need to be cut or programs that are not profitable need to be eliminated. But without the CDM being accurate, some of the programs could be losing money or their revenue could be understated. With regard to overstating revenue, this usually generates a visit from your payers or the federal government (OIG or CMS) and can lead to charges of fraud, abuse, or both.

Revenue cycle management is not a new tool for the healthcare administrator, but a process that has evolved from a fragmented system of individual departments, each managing a single part of the revenue process of a system that has integrated all sections that handle the revenue process, into one function called the revenue cycle. The revenue for a healthcare facility has evolved from an accounting- and finance-driven area with cost reports to a revenue cycle process in which insurance companies and other payers reimburse the facility based on the services provided to the

patient. It is critical for the finance department and health information management to communicate on a daily basis to see about charts that are not coded yet, audits from payers, and Case Mix Index issues. If the healthcare administrator is not well versed in the revenue cycle, he or she stands to have a very short career in that healthcare facility.

Finally, the text addresses electronic medical records (EMRs). This is generally a costly project to undertake, but it is also another way to receive reimbursement from the government that can help to cover the expense of catching up to the electronic age. In *Health Care Finance and the Mechanics of Insurance and Reimbursement*, the basics of healthcare finance will be covered along with electronic health records (EHR) and meaningful use, which will assist the healthcare administrator to not only be up to speed with current topics but also be able to act on and implement the changes necessary to meet the standards set forth in the health reform bill under the Obama Administration.

Now, it was clear to me that if we provide access to the information that includes health care reimbursement to healthcare administration students, they will be better equipped to function in the healthcare environment today. This ever-changing environment has shifted from

the process-oriented environment of cost reporting to a fully integrated revenue cycle management-focused environment. I had to learn this process on my own, as did many of the current vice presidents of health care finance and vice presidents of revenue cycle management because it is not offered in many of the healthcare administration programs. However, there is one thing that none of us can forget. There is a patient in the middle of all of this, and we need to keep our facilities providing the highest quality care for the patient, and at the same time understand the revenue streams and remain profitable and be able to change with the times. This includes access, technology, reducing costs, and increasing the quality delivered to the patient. And, last but not least, we must be able to survive in an era of pay-for-performance, medical home models, value-based purchasing, price transparency, the No Surprises Act, the Payment Driven Payment Model (PDPM), and the 21st Century Cures Act where the healthcare administration student needs to be well versed in all future trends in health care. Bringing healthcare reimbursement to the forefront can have a significant impact in the education process of healthcare administration programs because, after 30 years of the same approach, I think it is time for a change.



Acknowledgments

I really do enjoy teaching and feel that everyone learns differently. I pride myself in taking the time to get to know all the students in the class and to make sure that I figure out how each one learns. This process is accomplished by timely and accurate communication in class through discussions, assignments, and emails. I find that my experience in the healthcare arena was started by someone who believed in me and mentored me through my early years. This person is my sister, Ruthann, and without her help, I would not be where I am today. So, with that said, I do what I do in the healthcare field and the classroom because I want to give back what was given to me.

Others who were of great help along the way were Dr. Twila Weiszbrod from St. Joseph's College of Maine, who was the program director for the Healthcare Administration Program. Twila was not only instrumental in supporting me with encouraging dialogue along the way, but she also provided me with her insight into the need for focusing more on reimbursement in

a healthcare administration program to support the current and future trends in the healthcare market. Her direction and insight were invaluable, and I can't thank her enough. And my sister Ruthann, who was instrumental in guiding me into health care through medical records as a teenager and ultimately to a teaching role that really opened my eyes to the issues that we face in health care. Her genuine belief in me and guidance helped me to become the person that I am today.

Most importantly, I acknowledge my wife Kathy and our daughter Michaela and our grandchildren Isabelle and Isaiah. The time spent away from the family to complete this book was significant, and without their support and understanding, none of this would be possible. So, I say thank you to Kathy and Michaela and Isabelle and Isaiah. And since the third edition is now complete, maybe this time we will stop eating out every night and start cooking again. Probably not as some things never change.



Foreword

A 40-year progressive career in healthcare accounting, finance, and revenue cycle may have qualified me as a subject-matter expert in one of the most complex ever-changing industries, the world of health care. Notwithstanding, it requires continuous learning and development in order to keep abreast of all that is new in the field of healthcare finance and reimbursement. For this reason, I continue to educate and learn by pursuing professional educational sessions and conferences as well as networking with local and national industry leaders. Serving as an adjunct professor allows me the opportunity to be with those that I will always concede are “smarter than I will ever be”: my students. My passion to serve as an educator and mentor is a result of my appreciation for those who have taken the time to develop and teach me over my long career. The author of this book has served as one of those that I hold in highest esteem. He is not only a professional colleague but a fellow high school and college peer, which has transcended into a lifetime friendship spanning five decades.

This third edition of *Health Care Finance and the Mechanics of Insurance and Reimbursement* continues all that was presented in the past editions but with continued refinement of the concepts and principles required for students to excel in their college careers. Educators requiring this book for their students will find subject matter with instructional ease, at the same time assisting the student with career preparation, informed decision-making, and a propensity for advancement. This book will become a “go-to” for the student with a current career in any healthcare setting, whether as a business person or clinician. This book will transfer from backpack to briefcase as a reference tool for consummate students pursuing their goals and aspirations in healthcare.

Guy J. Hoffman, MBA
December, 2022

Chief Revenue Officer, Hunterdon Health
Flemington, NJ

Adjunct Professor, Saint Joseph College of Maine



About the Author

Michael K. Harrington, MATS, MSHA, RHIA, CHP, has more than 30 years of experience in health care in areas such as health information management, managing homecare companies on a local and regional level, and consulting in the post-acute sector. He is a leading authority on healthcare reimbursement and revenue cycle management (RCM) and has extensive experience in implementing the RCM model in physicians' offices and other healthcare organizations outside of the acute-care setting.

After starting out in the healthcare field in a home care company as a coordinator, Harrington quickly advanced into managing home care companies that handled durable medical equipment, specialty home infusion, high-tech respiratory services, and specialty biologicals and repositioned these companies by using reimbursement and quality clinical care as the cornerstones to his success. In addition to managing home care companies, Harrington started to teach and was part of the adjunct faculty at Gwynedd Mercy College, Temple University, and St. Joseph's University in the Philadelphia area. His focus has always been in healthcare reimbursement when teaching, but he has instructed in other areas, such as healthcare

policy, healthcare ethics, healthcare delivery, computerized medical records, and healthcare law. In 2018, Harrington became the Program Director for the Health Administration Program Online at St. Joseph's College, where he is overseeing the Undergrad Health Administration, Master of Health Administration, Bachelor in Health Information Management, Long-Term Care, and Radiology Science programs. In addition, Harrington provides healthcare organizations with consulting services focused on healthcare reimbursement, specifically, revenue cycle management services in physicians' practices and other healthcare settings.

Harrington earned his bachelor's degree from LaSalle College and his master's degree from Independence University (formerly California College for Health Sciences). Harrington also earned his Registered Health Information Management (RHIA) credentials at Alabama State University. He is an active patient advocate and is a much sought-after speaker, on a global basis, in the areas of healthcare reimbursement, healthcare finance, and healthcare operations.

He can be reached at michaelharrington@sjcme.edu.

