# **PAYMENT INTEGRITY MODULE REVERSE KT DOCUMENT**

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Module 1 - **Introduction to US Healthcare**

**Intro to Healthcare**

**The Patient's Journey in Health Care**

A typical patient might experience a medical issue, such as:

* **Fractured ankle**
* **Pneumonia**
* **Other serious medical problems**

**Patient Payment Responsibilities**

Patients need to pay for their medical care. This starts with the following:

* **Health Care Provider**: Includes doctors, nurse practitioners, nurses, and other healthcare professionals in settings like hospitals or clinics.
* **Goods and Services Provided**:
  + **Goods**: Items like medications (e.g., painkillers), casts, or crutches that assist in recovery.
  + **Services**: Professional expertise, such as a radiologist conducting an X-ray.

**Handling Serious Medical Problems**

When patients encounter significant medical issues, the financial responsibilities can be overwhelming. This is where **insurance companies** play a crucial role by providing:

* **Risk Sharing**: A system where healthy individuals contribute to an insurance pool, protecting themselves against future, expensive medical needs.

**Insurance Premiums**

Patients contribute to their health care premiums, which helps insurance companies build a financial cushion. The resulting benefits include:

* **Lower Out-of-Pocket Costs**: Patients mainly pay co-pays or deductibles rather than the total cost of major treatments.

**The Role of Employers and Insurance**

**Employer Contributions**

In many cases, the relationship between employers and employees supports health care access:

* Employers often pay wages to employees in return for the goods and services they provide.
* Many employers contribute to employees' health insurance premiums, offering critical health benefits.

**Health Insurance as a Worker Benefit**

Health insurance is seen as a popular employee benefit, ensuring that the workforce remains healthy and productive.

| **Relationship Dynamics** | **Details** |
| --- | --- |
| **Employer Pays Wages** | Employees provide goods/services to their employers. |
| **Employer Pays Insurance Premiums** | Helps employees secure health coverage. |

**Government's Contribution to Health Care**

Individuals not only act as patients and workers but also as contributing citizens. **Taxes** play a vital role here, leading to government involvement in health care through programs like **Medicare and Medicaid**. Key points include:

* **Medicare**: Primarily caters to seniors.
* **Medicaid**: Supports low-income individuals and families.

**Government Functions**

The government assists with:

* **Tax Collections**: Funds raised from citizens contribute to public services.
* **Direct Payments**: Medicare and Medicaid often directly pay health care providers for patients' services.

**Major Forms of Access:**

1. **Employer-Sponsored Insurance**: Roughly **50%** of Americans receive health care through employer-sponsored plans.
2. **Government Programs**: Approximately **one-third** use government programs, split between Medicare and Medicaid.
3. **Direct Purchases**: A smaller percentage pays for their own insurance through private companies.
4. **Uninsured Individuals**: A significant segment, estimated at **47 to 60 million**, lack insurance and pay directly for medical care.

**Pie Chart Breakdown**

| **Access Method** | **Percentage** |
| --- | --- |
| **Employer-Sponsored Insurance** | ~50% |
| **Government Programs (Medicare/Medicaid)** | ~33% |
| **Direct Purchases** | Small sliver |
| **Uninsured** | 47 to 60 million |

It’s crucial to understand the implications surrounding these statistics, especially regarding financial vulnerability for those without insurance.

**Medicare**

**The Origins and Purpose of Medicare**

The creation of Medicare traces back to concerns held by early 20th-century leaders like Franklin Roosevelt and Harry Truman, who recognized that elderly and vulnerable individuals often lacked access to medical care. Here’s a breakdown of its historical context:

* **1965**: President Lyndon Johnson officially established the Medicare program, building upon the Social Security Act.
* **Target Groups**: Initially, Medicare aimed to assist:
  + **Elderly Individuals**: Primarily over the age of 65, who faced low incomes and high medical expenses.
  + **Disabled Individuals**: Those with limited income and high medical costs.

**Expansion Over Time**

Medicare continued evolving over the decades:

* **1970s**: Coverage was extended to patients with kidney failure, facilitating access to dialysis and other treatments.
* **2000s**: Individuals diagnosed with ALS (Lou Gehrig's disease) were included in Medicare coverage.

**Structure of Medicare: How it Works**

Medicare is divided into distinct parts, each with specific coverage areas:

1. **Medicare Part A**:
   * **Coverage**: Hospital insurance, covering expenses related to hospital stays, nursing care, and hospice services.
   * **Cost**: Beneficiaries must pay about a $1,000 deductible upon admission for the first 60 days.
   * **Funding**: Financed through a 2.9% payroll tax shared between employees and employers. Eligibility is contingent upon at least ten years of tax contributions.
2. **Medicare Part B**:
   * **Coverage**: Medical insurance for outpatient care, doctor visits, and preventive services.
   * **Cost**: Beneficiaries typically pay a monthly premium of approximately $100, along with deductibles and co-pays.
   * **Enrollment Requirement**: Unlike Part A, enrollment is optional and involves additional cost.
3. **Medicare Part C** (Medicare Advantage):
   * **Coverage**: An alternative to original Medicare (Parts A and B) through private insurance plans.
   * **Appeal**: Many prefer Part C as it often includes additional benefits like prescription drug coverage. About **25%** of Medicare expenses come from this part today.
4. **Medicare Part D**:
   * **Introduced in 2003**: This part adds a comprehensive prescription drug benefit.
   * **Funding Concerns**: It does not rely on a dedicated tax, adding to federal spending without a clear revenue source.

**The Financial Implications of Medicare**

Understanding Medicare's financial structure is crucial for grasping its impact on federal expenditures.

* **Annual Investment**: Medicare costs have been on a steady rise, placing a significant burden on the federal budget.
* **Historical Growth Trends**:
  + *Initial Growth*: Over the first few years, spending growth reached approximately **20%** annually.
  + *Stabilization Efforts*: Strategies like the prospective payment system emerged in the 1980s in attempts to regulate costs, albeit with mixed success.
* **Current Perspective**: Today, Medicare still incurs costs above the rate of inflation, despite various strategies implemented over the years to control expenses.

| **Year** | **Medicare Expense Growth** |
| --- | --- |
| 1960s | Nearly 20% annually |
| 1980s | Initial containment |
| 1990s | Renewed cost increase |
| 2000s | Stabilization efforts |
| Present | Still exceeding inflation |

**Challenges in Cost Management**

Controlling Medicare expenses has been an ongoing challenge due to:

* **Expanding Enrollment**: Increasing numbers of beneficiaries, due to the aging population.
* **Rising Healthcare Costs**: General increase in the costs of medical care.
* **Insurance Coverage Gaps**: Beneficiaries face co-pays and deductibles leading to substantial out-of-pocket expenses, which can accumulate to daunting figures.

**Medicaid**

Medicaid is a **joint federal and state program** aimed at providing healthcare coverage to the poor, including families with dependent children, the elderly, and individuals with disabilities. Understanding Medicaid requires knowing the following critical elements:

* **Target Population**: Medicaid is primarily designed for low-income individuals and families.
* **Federal and State Partnership**: Unlike Medicare, which is solely federally funded, Medicaid's costs are shared between federal and state governments - with each state utilizing its resources to expand coverage.

**Comparison with Medicare**

Although frequently confused, **Medicaid and Medicare** are distinct programs:

| **Criteria** | **Medicaid** | **Medicare** |
| --- | --- | --- |
| **Target Age** | Low-income individuals (of all ages) | Primarily for individuals over 65 |
| **Eligibility** | Means-tested (disability and poverty focus) | Universally available after age 65 |
| **Funding** | Shared funding (federal and state) | Fully funded by the federal government |
| **Coverage** | Varies by state; includes long-term care | General medical care and hospital services |

**Real-Life Examples**

To grasp Medicaid's importance, focusing on real-life scenarios can be particularly insightful:

1. **Young Family Scenario**:
   * A **25-year-old woman** with two young children relies on Medicaid to cover necessary medical check-ups.
   * She must prove her low-income status to qualify.
2. **Elderly Individual Scenario**:
   * A **70-year-old woman** has a long history of working, having paid Medicare taxes, enabling her access to Medicare for her healthcare needs.

Understanding the differences in care delivery for both examples reveals the challenges faced by low-income families needing Medicaid.

**Structure of Medicaid and Its Impact**

The structure of Medicaid significantly affects how individuals enroll and receive coverage. The partnership between federal and state governments creates variability in how states administer the program:

* **Funding Dynamics**: The federal government contributes at least **half of Medicaid costs**, with states covering the remaining costs.
* **Unequal Access**: The varying costs impact eligibility and access across states, resulting in considerable differences in who receives coverage.

**State Variability and Eligibility Criteria**

States vary widely in **eligibility criteria** for Medicaid, influenced by their fiscal policies and priorities. For instance:

* **New York**: Allows families to earn up to **400%** of the Federal Poverty Level (FPL) to qualify for Medicaid.
* **North Carolina**: Limited eligibility to **200%** of FPL, making it significantly tougher for families to qualify than in New York.

This disparity reflects state decisions regarding the prioritization of healthcare funding versus other budget allocations.

**Medicaid Expansion and the Affordable Care Act**

The **Affordable Care Act** (ACA) introduced substantial changes to Medicaid, creating **uniform eligibility standards**:

* **Eligibility**: Individuals making up to **133%** of the federal poverty line qualify, regardless of whether they have children.
* **Federal Support**: The ACA promised to cover **90-100%** of costs for newly eligible individuals, making expansion financially appealing to states.

| **Medicaid Expansion** | **States Accepting** | **States Rejecting** |
| --- | --- | --- |
| Enhanced federal funding | Access to wider coverage for low-income individuals | Limited access and unchanged eligibility criteria |

However, following a **Supreme Court decision**, states could not be compelled to accept expansion, leading to a split where some states opted in while others chose to maintain existing frameworks.

**Uninsured**

In the United States, a significant portion of the population lacks health insurance, creating a complex landscape of healthcare access and affordability. This summary delves into the characteristics, statistics, and implications of being uninsured, highlighting the complexities and challenges faced by this group.

**Understanding the Data**

* **Population Overview**: Approximately **300 million people** reside in the U.S. Half receive health insurance via their employer, while roughly one-third have government-sponsored insurance through programs like **Medicare** and **Medicaid**.

| **Source of Insurance** | **Percentage of Population** |
| --- | --- |
| Employer-Sponsored Insurance | ~50% |
| Government Insurance | ~33% |
| Self-Insured | Small Sliver |
| Uninsured | 47 to 60 million Americans |

1. **Employer-Sponsored Insurance**: Health coverage as a fringe benefit provided to employees.
2. **Government Insurance**: Includes programs like **Medicare** for individuals over 65 (or disabled) and **Medicaid** for children and low-income families.
3. **Self-Insured**: Some individuals purchase their insurance, often at high costs.

* **The Uninsured Population**: This segment lacks a stable payment source for healthcare, leading to financial burdens when seeking medical care. It is important to note that the uninsured can still visit doctors but face substantial bills upon doing so.

**Who Are the Uninsured?**

* **Estimates**: Understanding the number of uninsured individuals varies considerably, with estimates ranging from **47 million** to **60 million**.
* **Employment Factors**: Surprisingly, many uninsured individuals are employed, often by companies that do not offer healthcare benefits. Key points include:
  + Many have at least one full-time employed family member.
  + Employment changes can lead to shifts between insured and uninsured status.
* **Income Disparity**:
  + A significant portion, about **one-third**, earns below the federal poverty line, earning less than **$23,000** annually for a family of four.
  + Another third earns between **$23,000 to $60,000**, while the remaining portion earns above this range.

| **Income Level** | **Percentage of Uninsured** |
| --- | --- |
| Below Federal Poverty Line | ~33% |
| Between 1 and 2.5x Poverty Level | ~33% |
| Above 2.5x Poverty Level | Remaining Balance |

**Affordability of Health Insurance**

* The average annual health insurance cost for individuals is approximately **$6,000**, and around **$18,000** for families of four.
* Compare these figures to yearly household incomes, where many families cannot afford such premiums, leading to high rates of uninsured individuals.

**Burden of Being Uninsured**

* **Financial Strain**: The uninsured face exorbitant out-of-pocket costs due to the absence of negotiated rates provided by insurance companies.
* **High Medical Bills**: Hospital stays and medical treatments can amplify debt, which few families can handle, as they pay full "sticker prices" for healthcare

**Paying for Medicines: Copays and Deductibles**

**Types of Medications**

Medications can generally be divided into two categories based on how they are obtained and used:

1. **Over-the-Counter (OTC) Medications**
   * **Definition**: These are medicines available for purchase without a prescription.
   * **Examples**: Pain relievers and decongestants.
   * **Payment**: Generally paid out-of-pocket by the patient at the pharmacy.
   * **Experience**: Similar to purchasing any other consumer goods, the customer selects what they need and pays directly.
2. **Prescription Medications**
   * **Definition**: These are medications that require a doctor's authorization.
   * **Process**:
     + A patient experiencing more severe symptoms, such as a high fever or sore throat, may visit a doctor.
     + After diagnosis, the doctor writes a prescription, which is filled at a pharmacy.
   * **Payment**:
     + Typically not covered entirely by the patient; often involves insurance and some out-of-pocket contributions.

**Medication Usage Statistics**

The frequency of prescription medication use varies by age group:

* **Adults (ages 19–64)**: On average, they fill about **12 prescriptions per year**.
* **Seniors (65 and older)**: This number increases significantly, with an average of **28 prescriptions per year**.

Given these statistics, it becomes evident that prescriptions account for a substantial portion of healthcare needs and expenses.

**Financial Aspects of Medications**

When discussing how medications are financially managed, two key concepts arise:

| **Concept** | **Description** |
| --- | --- |
| **Co-Pay** | A fixed amount that a patient pays for medication while the insurance covers the remaining cost. For instance, for a $200 medication, the patient might pay around **$10**, while the insurance covers **$190**. |
| **Deductible** | The amount a patient needs to spend before the insurance begins to pay. For example, if a person pays **$400** out-of-pocket initially, the insurance then covers costs after surpassing this deductible. |

**Simplifying Complexities**

Many patients may find the payment system and medication procurement somewhat complex. However, understanding these terms helps demystify the purchasing process. Additionally, factors such as escalating medication prices have led to the development of insurance, which strives to support patients financially.

**Paying for Medicines: Tiering, Formularies, and Medicare Part D**

**The Complexity of Medication Payments**

Paying for medications involves multiple layers and options due to various factors:

* **Co-pays**: An upfront fee that patients pay for each medication.
* **Deductibles**: The amount patients must pay before insurance starts to cover costs.

For instance:

| **Payment Type** | **Example Cost** |
| --- | --- |
| Co-pay | $10 |
| Deductible | $400 |

**Why the Confusion?**

The fundamental question arises: *Why is paying for medications so complicated?*

* **Medication Forms**: Drugs can be available in various forms and can be differentiated into generic and brand names. For example:
  + **Furosemide** (the generic) is sold under the brand name **Lasix**.
  + **Brand vs. generic**: Both medications serve identical purposes but differ in pricing; generics are usually cheaper.

Patients are often tempted to choose the branded option without realizing the significant cost differences.

**Economic Perspective**

From an economic standpoint:

* Patients may prefer brand names; however, insurance companies encourage generic alternatives, influencing patients through:
  + **Reduced co-pays** for generics (e.g., $5 for the generic vs. $25 for the brand).
  + **Cost savings** for insurance companies can be substantial.

**Different Drug Classes**

Consider a scenario where two distinct medications, **Pill A** and **Pill B**, address hypertension through different mechanisms:

* **Pill A**: Cheap ($20), older, effective.
* **Pill B**: Expensive ($500), new, potentially less effective.

**Formulary Management**

To guide consumer choices, insurance companies maintain **formularies**, which categorize covered medications, steering patients toward cost-effective options while ensuring quality care.

* **Formulary drugs**: Covered with lower co-pays.
* **Non-formulary drugs**: Often excluded, leading to higher out-of-pocket expenses.

**Medicare's Role in Drug Payments**

With millions relying on Medicare, understanding its drug payment structure is crucial. Established by the **Medicare Modernization Act of 2003**, Medicare Part D created a crucial program for seniors:

* An average annual premium of **around $400**.
* Payment structures differ based on annual spending, categorized primarily into three areas:

| **Spending Tier** | **Patient Payment Responsibility** |
| --- | --- |
| $0 - $3,000 | 25% co-pay |
| $3,000 - $4,500 | Increased patient costs |
| $4,500+ | Higher government assistance |

**Challenges and Changes**

Notably, the **donut hole** presents a gap in coverage that patients experience when spending between $3,000 and $4,500 out-of-pocket. Although the Affordable Care Act aims to *close* this gap over time, complexities remain:

* **Medicare cannot negotiate drug prices**, potentially costing taxpayers billions.
* In contrast, the **Veterans Administration** can negotiate prices, showcasing a disparity in federal drug purchasing strategies.

**Medical Bill**

When a patient undergoes medical care, they eventually receive a **medical bill** containing a range of charges. These bills typically encompass several line items, including services, medications, and procedures performed during their hospital stay.

**Breakdown of a Medical Bill**

1. **Common Charges**:
   * **Medications**: Any pills or medications administered.
   * **Procedures**: X-rays or other diagnostic tools used.
   * **Nursing Care**: Regular assessments and monitoring by nurses.
   * **Accommodation**: Charges for the hospital bed used during their stay.
   * **Doctor Interactions**: Consultations from various specialists, such as an internist or a surgeon.
2. **Fee-for-Service System**:
   * Each service is assigned an individual price, leading to a cumulative total on the final bill.

**Payment Methods**

Payments for medical bills can be managed primarily in two ways: through **Medicare** or **private insurance**.

| **Payment Method** | **Overview** |
| --- | --- |
| **Medicare** | Provides a simplified billing process by bundling services into a **Diagnosis Related Group (DRG)**. Each medical issue, like back surgery, is assigned a set price (e.g., $3,000). |
| **Private Insurance** | Involves negotiations between insurers and hospitals, resulting in variable pricing based on contracts. A network of providers is often established, affecting patient choices. |

**Medicare Details**

* Medicare simplifies billing by categorizing hospital services into DRGs.
* **Part A** covers hospital services.
* **Part B** compensates for physician services based on relative value units (RVUs).

**Private Insurance Details**

* Involves **competitive negotiations** between insurers and healthcare providers.
* Prices can fluctuate greatly from one area to another based on local market dynamics.
* Private plans may offer **in-network** benefits for better pricing, while out-of-network services can lead to significant out-of-pocket costs for patients.

**The Challenge for Uninsured Patients**

Uninsured individuals face the most challenging scenario:

* They receive detailed bills with every service line itemized at **list prices**, which can be exceptionally high, leading to extreme financial burden.
* The absence of negotiated bundles like in Medicare or private insurance means they end up paying the **highest rates** for care.

**Healthcare costs**

A man's journey through the healthcare system begins with sudden severe symptoms leading him to seek medical assistance. Here's a breakdown of his experience:

1. **Initial Consultation**:
   * Patient visits a **primary care doctor**.
   * Symptoms indicate a possible case of **appendicitis**.
2. **Emergency Room Visit**:
   * A different physician conducts further tests, confirming the diagnosis.
   * Patient undergoes **surgery**.
3. **Rehabilitation**:
   * Post-surgery recovery includes an inpatient rehabilitation facility.
   * Follow-up consultation with the primary care doctor.

**Fragmented Billing System**

After treatment, the patient is faced with **multiple bills** from various providers:

| **Visit** | **Billing Encounter** |
| --- | --- |
| Primary Care Doctor | #1 |
| Emergency Room | #2 |
| Surgeon | #3 |
| Rehab Facility | #4 |
| Follow-up Visit | #5 |

* This fragmentation leads to six separate bills, revealing the **fee-for-service** model prevalent within the U.S. healthcare system. This model incentivizes providers to deliver more services without necessarily prioritizing patient outcomes.

**The Fee-for-Service Dilemma**

* The **fee-for-service** system allows providers to charge for every service rendered, often resulting in:
  + **Overuse of Services**: Providers have a financial incentive to deliver unnecessary tests or procedures.
  + **Costs Outstripping Value**: Billing is isolated; thus, care quality can be compromised in favor of high service volume.

As an analogy, consider a **contractor** performing a home renovation. The contractor charges based on quantity rather than the overall quality of the work. This model, inherently flawed, encourages unnecessary expenses while lacking accountability for service quality.

**Potential Solutions to Healthcare Costs**

Modifying the current fee-for-service system involves various strategies to create a more integrated approach to healthcare delivery:

1. **Pay-for-Performance (P4P)**:
   * Providers incentivized to enhance care quality.
   * Addresses issues like **hospital readmissions** through penalties.
2. **Episodic Care**:
   * A single comprehensive bill for a defined procedure (e.g., heart surgery).
   * Promotes teamwork among providers to ensure optimal care within a fixed budget.
3. **Global Care**:
   * A broader approach that encompasses ongoing treatment for specific chronic conditions.
   * Focus on long-term health rather than individual procedures.
4. **Full Capitation or Accountable Care**:
   * A population-based funding model, wherein a health organization receives a lump sum for all care within a certain time frame.
   * This strategy ensures ongoing care management, incentivizing providers to keep patients healthy and avoid costly hospitalizations.

**Private health insurance**

**Historical Context**

1. **Pre-1920s Origins**
   * Formation of a *membership model* by a group of doctors.
   * Patients paid a regular subscription fee for access to medical care, similar to a health club.
2. **1930s Developments**
   * An early attempt at *employer-sponsored insurance (ESI)* emerged in Dallas, Texas.
   * A school began providing health insurance for teachers at a cost of about $6, allowing for roughly 20 days in the hospital.
   * This model laid the groundwork for modern ESI systems.
3. **1940s Shift**
   * During **World War II**, businesses faced wage controls imposed by the government.
   * To attract employees, they began to offer *fringe benefits*, with health insurance becoming the most sought-after benefit.
   * The introduction of tax-free health insurance in a 1954 policy accelerated the adoption of employer-sponsored plans.

**The Explosion of Employer-Sponsored Insurance**

| **Year** | **Percentage of Workers with ESI** |
| --- | --- |
| 1940s | Low |
| 1960s | Approximately 75% |

* By the 1960s, about **75% of American workers** had employer-sponsored health insurance due to the combination of competitive benefits and favorable tax policies.

**Structure of Private Health Insurance**

**Types of Insurance Models**

1. **Fee-for-Service (FFS)**
   * *Indemnity plan* where patients can see various providers.
   * Providers send bills to insurers who pay for services rendered.

**Disadvantages of FFS:**

* + Encourages high health care costs because insurers pay whatever bills are submitted.
  + Leads to fragmented care as there’s no incentive for providers to communicate.
  + Increases cost-sharing over time, eventually reducing workers' wages.

1. **Managed Care**
   * Insurers form contracts with a network of doctors and hospitals to provide care at predetermined costs.

**Features of Managed Care:**

* + Sets limits on what providers can charge.
  + Implements disease management programs for chronic conditions.
  + May tiered co-pays based on the cost of providers to encourage visiting lower-cost doctors.

**Healthcare for the chronically ill**

Chronically ill patients face a challenging and complex healthcare landscape. This summary explores the various care pathways available to patients following significant medical events, such as a stroke, highlighting the roles of **post-acute care** and **long-term care** in the recovery process.

**Care Options for Patients with Serious Medical Conditions**

When a patient suffers from a major medical event, like a stroke, a range of care scenarios can unfold. Here are the **three main possibilities**:

1. **Best Case Scenario**
   * Hospitalization leads to full recovery.
   * The patient returns home, resuming normal life.
   * Insurance (e.g., Medicare) covers inpatient hospitalization.
2. **Partial Recovery Scenario**
   * The patient improves but is not ready to return home.
   * Transition to **Post-Acute Care Facilities** (PACs) is necessary.
     + **Inpatient Rehabilitation Facilities (IRFs)**:
       - Staffed with physical therapists.
       - Focus on regaining essential capabilities (e.g., walking, self-care).
     + **Skilled Nursing Facilities (SNFs)**:
       - Provide extra time and intensive nursing support post-surgery or illness.
       - Aim for patient recovery to return home.
     + **Home Health Agencies**:
       - Healthcare professionals visit the home for support.
       - Assist patients in achieving independence.
3. **Long-Term Care Scenario**
   * If recovery is inadequate, the patient may require **Long-Term Care (LTC)**.
   * **Distinct Characteristics of LTC**:
     + Typically involves extended stays (months to years).
     + Rehabilitation is less likely; the focus shifts to support and maintenance.
     + **Funding Considerations**:
       - Medicare does not pay for long-term care, leading to high out-of-pocket expenses.
       - Average annual costs can exceed **$80,000**, risking financial stability.

**Financial Implications of Care Options**

Understanding the cost dynamics is essential for patients and families:

| **Type of Care** | **Medicare Coverage** | **Estimated Annual Cost** |
| --- | --- | --- |
| Inpatient Hospitalization | Fully covered | Varies |
| Post-Acute Care (PACs) | Additional payment provided | $60 billion spend |
| Long-Term Care (LTC) | Not covered; out-of-pocket | > $80,000 |

Key points to consider:

* **Post-Acute Care**:
  + Accounts for **40%** of hospitalized Medicare patients transitioning to PACs.
  + Understandable rise due to Medicare incentives leading to **explosive growth** in PAC facilities.
* **Long-Term Care**:
  + Patients often face significant financial burdens.
  + Many families eventually apply for **Medicaid**, following personal bankruptcy from LTC expenses.

Module 2 - **Introduction to Payment Integrity**

**Adjudication**

Adjudication is the term used to describe the process that occurs between the submission of a claim by a healthcare provider—such as a doctor or hospital—and the payment made by the insurance company. The essential steps in this process are largely overlooked, leading to misunderstandings that can result in unnecessary costs and delays in care.

**Key Phases of Claims Adjudication**

1. **Claim Submission**
   * Initiated by healthcare providers.
   * Claims can involve various services related to patient care.
2. **Auto Adjudication**
   * Approximately 85% of claims are processed by software without human interaction.
   * This automation drastically reduces processing costs (around **$20 per claim** if handled manually).
3. **Mass Adjudication**
   * **Eligibility and Coverage:** Checks whether the services are eligible for coverage based on patient eligibility.
   * **Prior Authorization:** Assesses if necessary approvals are obtained.
4. **Claim Check**
   * **Coding Validation:** Proper checks are conducted against relevant codes like ICD-10, DRG, CPT, and HICS codes.
   * Determines **pay or deny** status.
5. **Secondary Audit**
   * **Timely Filing Requirements:** Ensures claims are submitted within specific time frames.
   * Additional coding checks and place-of-service validations.

**Problems with Auto Adjudication**

Despite its efficiency in processing claims, there are significant challenges associated with **auto adjudication**:

* **Outdated Software**: Most insurance companies still utilize legacy systems, some written in COBOL, a programming language from **1959**.
* **Skill Shortage**: There are fewer programmers proficient in COBOL, creating challenges in maintaining these systems.
* **Dollar Thresholds**: Many carriers set thresholds (e.g., **$10,000-$15,000**) where claims do not get manual review, allowing questionable claims to pass through.

**Example of a Procedural Failure**

A notable case from ProPublica highlighted a **$10,984 claim for a COVID-19 test**, essentially exposing the vast discrepancies between billed amounts and actual costs. The test, which was valued at **$6**, was fully reimbursed by the insurance company, raising concerns about oversight failures in the adjudication process.

**Fraud Prevention**

Quest Diagnostics demonstrates a proactive approach in screening claims internally to detect fraud, waste, and abuse. By leveraging detailed claims data, they effectively caught mistakes that traditional insurance carriers did not identify.

**Repricing**

**Claim repricing** is vital for ensuring that healthcare providers and insurance networks accurately invoice and receive payment for services rendered. This video serves as a follow-up to previous discussions surrounding claims adjudication, providing essential information for anyone involved in healthcare finance.

**Claim Repricing?**

Claim repricing involves applying **contract terms** to healthcare expenses incurred by patients. These terms are negotiated between hospitals or physician practices and insurance networks, impacting billed amounts from providers. The process of repricing includes the following steps:

1. **Claim Submission**: Originally, claims were filed on paper forms.
2. **Adjudication**: Claims are assessed for eligibility according to various criteria, including:
   * Service eligibility
   * Timeliness of filing
   * Covered services
3. **Repricing**: The billed charges are adjusted based on contractual agreements.

**Key Components of Repricing**

1. **Allowed Amount**: After repricing, the amount deemed acceptable is calculated, splitting responsibility between the patient and the insurance plan.
2. **Patient Responsibility**: Any deductible or copayment amount due from the patient.
3. **Plan Responsibility**: The portion covered by the insurance plan.

**Contractual Terms**

Understanding the complexity of **contract terms** is crucial. Some of the common terms include:

* **Case Rate**: A pred etermined amount paid for specific treatments.
* **Percent of Charge Discount**: A negotiated percentage reduction from billed charges.
* **Per Diem Rate**: A fixed daily reimbursement (e.g., $1,900 per day for hospitalization).
* **Carve Out**: Individual payments for specific medical procedures (e.g., pacemaker implantation).

Dr. Bricker has also provided a series of videos detailing these terms, which can serve as educational resources.

| **Term** | **Description** |
| --- | --- |
| Case Rate | Set fee for particular services |
| Percent of Charge Discount | Percentage off the billed amount |
| Per Diem | Daily reimbursement for hospitalization |
| Carve Out | Specific payments for designated procedures |

**Importance of Allowed Amounts**

The **allowed amount** represents the true cost of healthcare services, underpinning discussions around price transparency. For instance, if the allowed amount is $800 and a patient has a $1,000 deductible, they are responsible for the full $800, highlighting the need for clarity in disclosing these costs upfront.

**Billed Charges**: Billed charges often reflect inflated figures, as they derive from a **charge master**, a comprehensive list detailing service prices. This contributes to the notion of billed charges as fictional, often dubbed the **f-a-n-p** (fictional amount nobody pays).

**Introduction to Medical Coding and billing**

Medical coding and billing are specialized fields that require in-depth knowledge and sharp analytical skills. Medical coders translate clinical documentation into appropriate codes, while medical billers manage claims related to those codes. Understanding the intricate details of this profession is key for those exploring a career in medical billing and coding.

**Key Responsibilities**

**Medical Coder**

1. **Translation of Clinical Documentation**:
   * Utilizes specific manuals to translate patient diagnoses and procedures into **HIPAA-compliant codes**.
   * Codes for conditions like **flu**, **COVID-19**, and various allergies.
2. **Code Manuals**:
   * **ICD-10-CM**:
     + Focuses on diagnostic coding.
     + Provides codes for diseases such as flu, COVID-19, and allergic reactions.
   * **CPT Manual**:
     + Covers services and procedures (e.g., doctor visits, phlebotomy).
   * **HCPCS Manual**:
     + Contains codes for durable medical equipment, orthotics, and injectables.
3. **Claim Processing**:
   * Acts as an intermediary in the claims processing step which is performed post-coding.

**Medical Biller**

1. **Claims Follow-Up**:
   * Manages the status of claims to ensure timely payments.
   * Utilizes both phone and online methods to track claim statuses.
2. **Payment Posting**:
   * Posts payments received from **EOBs** (Explanation of Benefits) into the **EHR** (Electronic Health Record) system.
3. **Statement Generation and Reminders**:
   * Creates and sends statements to patients and follows up with reminders regarding outstanding balances.
4. **Denial Appeals**:
   * Advocates for reconsideration on denied claims, requiring detailed documentation to substantiate appeals.

**Coding Exercises Overview**

The practical aspect of medical coding can be enhanced using **ICD-10-CM coding exercises**. Here’s a closer look at some coding steps involving common conditions:

**Example Conditions and Codes**

| **Condition** | **Searching Term** | **Code** | **Description** |
| --- | --- | --- | --- |
| Influenza | Flu | **J11.1** | Influenza due to unidentified virus |
| Seasonal Allergies | Allergy | **J30.2** | Other seasonal allergic rhinitis |
| Common Cold | Cold | **J00** | Acute nasopharyngitis |
| Hypertension | High Blood Pressure | **I10** | Essential hypertension |
| Migraine | Migraine | **G43.909** | Migraine unspecified |

**Coding Steps**

1. **Alphabetic Index**:
   * Start by identifying the main term in clinical documentation.
   * Use the correct manual, such as ICD-10-CM, and locate the term alphabetically.
2. **Tabular Listing**:
   * Once the preliminary code is located, proceed to the **tabular list** to confirm specificity and any necessary additional coding.

Module 3 – **Client and Data Architecture**

**Key Stakeholders**

* **Members** (Patients)
* **Providers** (Healthcare facilities/doctors)
* **Payers** (Insurance companies like Humana, UHC, Aetna)

**2. Identification System**

* **Claim Number**: Typically valid for 1 year
* **Client Number**: Identified by codes (56, 57, 58)
* **Platform Code**: Uses designations like LV, EM
* **Eden UID Format**: 1234567LV~32 (standardized identifier)

**Insurance Types**

**1. Medicare**

* Federal program for:
  + People aged 65+
  + Disabled individuals
  + End-stage renal disease patients
* Requires 10 years of tax payment

**2. Medicaid**

* Combined federal and state program
* Serves low-income groups
* Provides additional coverage beyond Medicare (e.g., SNF, long-term care)

**3. Commercial Insurance**

**Payment Structures**

**1. Copay**

* Fixed payment amount
* Paid at time of service
* Higher copay correlates with lower premium
* Popular in high cost-of-living areas
* Common among senior citizens

**2. Coinsurance**

* Percentage-based payment
* Applies after deductible
* Billed after service provision
* Risk increases with service cost

**3. Deductible**

* Initial amount paid before insurance coverage begins
* Usually paired with coinsurance
* Contributes to out-of-pocket maximum
* Higher deductibles typically mean lower premiums

**Insurance Plan Types**

**1. Network-Based Plans**

* **HMO** (Health Maintenance Organization): Strict network
* **PPO** (Preferred Provider Organization): Flexible network choice
* **EPO** (Exclusive Provider Organization)
* **POS** (Point-of-Service): Hybrid of HMO and PPO

**Program Classifications**

**1. Inpatient (Bill Type 11\*)**

* DRG, SS, HBA programs
* 10 items (8 primary + 2 associated)

**2. Outpatient (Bill Type 13\*, 83\*, NULL)**

* CVIR, APC, Implants

**3. HomeHealth (Bill Type 32\*, 34\*)**

**Technical Infrastructure**

**1. Databases**

* SQL Server
* Hadoop ecosystem
  + Hive for programming
  + Ambari for UI
  + Minerva for queries
  + Zeppelin for multiple languages
* Tableau for visualization

**2. Key Tables**

* **Medclaimsummary**: Claim-level details
  + Includes claim numbers, client info, platform codes
  + Processed monthly (3rd Saturday)
* **Medclaim**: Line-level claim details
* **Member**: Patient information
* **Provider**: Healthcare facility/doctor details

**3. Processing Schedule**

* Prepay: Daily processing
* Postpay: Monthly processing
* HBA: Weekly processing

**Data Security**

* PHI (Personal Health Information) protection measures in place
* Secure identification systems
* Standardized data formats and processing procedures

Module 4 – **Programs**