CHAPTER 7

REIMBURSEMENT

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CHAPTER OUTLINE

VOCABULARY

admission denial
ambulatory payment classifications (APCs)
billing
capitation
case management
case mix
case mix index (CMI)
charge capture
Chargemaster
charges
claim
coding compliance plan
continued stay denial
co-insurance
copay
deductible
Diagnosis Related Groups (DRGs)
discharge planning
discounted fee for service
encounter form
entitlement programs
fee for service
fee schedule
fiscal intermediaries
flexible benefit account
guarantor
group plan
group practice model HMO
grouper
health maintenance organization (HMO)
indemnity insurance
independent practice association (IPA) model HMO
insurance
insurer
local coverage determination (LCD)
Major Diagnostic Categories (MDCs)
managed care
maximization
Medicare administrative contractor (MAC)
Medicare Code Editor (MCE)
modifier
National Center for Health Statistics (NCHS)
national coverage determination (NCD)
network
Outpatient Prospective Payment System (OPPS)
optimization
outlier payment
patient financial services
patient assessment instrument (PAI)
payer
preferred provider organization (PPO)
premium
principal diagnosis
principal procedure
prospective payment system (PPS)
Prospective Payment System (PPS) blended rate
provider number
Quality Improvement Organization (QIO)
Recovery Audit Contractor (RAC)
Resident Assessment Instrument (RAI)
reimbursement
relative weight (RW)
reliability
resource-based relative value system (RBRVS)
Resource Utilization Group (RUG)
revenue code
Revenue Cycle Management (RCM)
resource intensity
risk
self-pay
staff model HMO
superbill
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
third party payer
Title XIX of the Social Security Act
Title XVIII of the Social Security Act
TRICARE
usual and customary fees (UCFs)
utilization review (UR)
validity
working MS-DRG
wraparound policies

CHAPTER OBJECTIVES

By the end of this chapter, the student should be able to:

1. List and describe the types of health insurance.
2. List and describe the major reimbursement methodologies.
3. Describe different prospective payment systems and the settings in which they are used.
4. Identify and explain the major components of the UB-04 (CMS-1450).
5. Identify and explain the major components of the CMS-1500.
6. Explain the role of the coder in reimbursement and data quality.
7. Describe the revenue cycle and the role of coding in the revenue cycle process.

Patients and providers were, historically, the two main parties involved in a health care relationship. Patients were free to seek whatever services they were able to afford, and providers could charge whatever the market would bear. This one-on-one relationship has been split into a multiparty, complex system. The following section explores this system.

PAYING FOR HEALTH CARE

payer The individual or organization that is primarily responsible for the reimbursement for a particular health care service. Usually refers to the insurance company or third party.

Medicare Federally funded health care insurance plan for older adults and for certain categories of chronically ill patients.

Medicaid A federally mandated, state-funded program providing access to health care for the poor and the medically indigent.

reimbursement The amount of money that the health care facility receives from the party responsible for paying the bill.

The party (person or organization) from whom the provider is expecting payment for services rendered (reimbursement) is called the **payer**. The payer is frequently an insurance company. It may also be a government agency, such as Medicare or Medicaid. The term **reimbursement** is something of a misnomer. It is generally used today to refer to the payment provided to a physician or other health care provider in exchange for services rendered. With respect to reimbursement in health care, one of following two reimbursement scenarios typically occurs:

1. A patient pays a health care provider directly for services rendered and then that patient requests reimbursement from the insurance company (the insurer).
2. The health care provider renders services and requests reimbursement (bills) for those services directly from the insurer (the payer).

In a hospital setting, for example, a hospital provides services and supplies to a patient, thus incurring costs, under the assumption that it will be reimbursed for these costs after the patient has been discharged. The payer is billed at a later date. Insurance plans today do not typically require a patient to reimburse a hospital and then submit a **claim** to the insurance company for reimbursement. Patients without some form of third party payment relationship are called **self-pay** patients and are billed directly for services rendered.

claim The application to an insurance company for reimbursement.

self-pay A method of payment for health care services in which the patient pays the provider directly, without the involvement of a third party payer (e.g., insurance).

TYPES OF REIMBURSEMENT

Reimbursement takes many different forms. In the past, it was not uncommon for a physician to be "paid in kind." For example, a physician might have made a house call to treat a patient and then received chickens as compensation. These types of bartering arrangements were mutually acceptable to both physician and patient. Reimbursement today is generally monetary, especially for hospitalization services, but in many parts of the world and in the United States, bartering for health care services is common and acceptable.

insurer The party that assumes the risk of paying some or all of the cost of providing health care services in return for the payment of a premium by or on behalf of the insured.

third party payer An entity that pays a provider for part or all of a patient's health care services; often the patient's insurance company.

Historically, a physician did not necessarily receive the payment that he or she charged but rather the payment that the patient thought the physician's services were worth. In the early twentieth century, this practice changed to paying what the physician charged. More recently, the amount of compensation given to the physician or health care provider is decided not by the patient or physician but by the third party payer. **Third party payers** have assumed the risk that a particular group of patients will require health care services and therefore incur the cost of paying for the services. In the following discussion, reimbursement is categorized according to the control that the health care provider exerts over the fees that are charged.

Insurance

Insurance is a contract between two parties in which one party assumes the risk of loss on behalf of the other party in return for some, usually monetary, compensation. The **insurer** receives a premium payment, often on a monthly basis, and in return it pays for some of all of the cost of health services.

insurance A contract between two parties in which one party assumes the risk of loss on behalf of the other party in return for some, usually monetary, compensation.
insurer The party that assumes the risk of paying some or all of the cost of providing health care services in return for the payment of a premium by or on behalf of the insured.

History

Insurance companies have existed for centuries. Notably, Lloyds of London insured cargoes on merchant ships, which were frequently subject to loss from piracy, inclement weather, and other catastrophes. The beginnings of insurance in health care date only to the mid-nineteenth century, when companies insured railroad and paddleboat employees in the event of catastrophic injury or death. A lump sum was paid to an employee or employee's family after such an event.

The origins of modern health care insurance, as we know it today in the United States, begin during the Great Depression in the 1930s. A decline in health care industry income prompted the development of hospital-based insurance plans. For a payment of a small sum, a hospital guaranteed a specific number of days of hospital care at no additional charge. The most successful of these plans was developed at Baylor University by Justin Ford Kimball (Sultz, Young, 2006; Blue Cross, 2011)—Baylor's plan eventually became the model for what we know today as Blue Cross Plans. Table 7-1 contains definitions of several terms that are useful during any discussion of health insurance.

In the early days of the industry, health care insurance was paid for by the recipient, sometimes through the employer, union, or other organization. In the original Baylor University scheme, teachers paid $0.50 a month, which entitled them to 21 days of hospital care should they need it (Sultz, Young, 2006). The insurance company became a third party payer in the relationship between the provider and patient.

Many patients have more than one payer. The primary payer is billed first for payment. A secondary payer is approached for any amount that the primary payer did not remit, and so on. For example, patients who are covered by Medicare may have supplemental or secondary insurance with a different payer. The physician first sends the bill to Medicare. Any amount that Medicare does not pay is then billed to the secondary payer.

Ultimately, the patient is financially responsible for payment of services that he or she has received. Depending on the type of insurance, the patient may have automatic responsibilities, such as *copays*, *co-insurance*, or *deductibles*. A **copay** is a fixed amount that a patient remits at the time of service. Copays typically vary according to the service rendered. For example, a copay may be $20 for a physician visit and $100 for an emergency department visit. **Co-insurance** is the percentage of the payment for which the patient is responsible. The payer may have 80% responsibility for the payment, and the patient 20%. A **deductible** is a fixed amount of patient responsibility that must be incurred before the third party payer is responsible. For example, if the patient has a $500 deductible, then the patient must spend $500 for health care services first. After $500 is expended, the third party payer will begin to reimburse for services rendered. In all cases, payment by third party payers depends on the contractual relationship between the third party and the patient. Third party payers will reimburse only for services that are covered in that contract.

copay A fixed amount paid by the patient at the time of service.
co-insurance A type of third party payer arrangement in which an individual is responsible for a percentage of the amount owed to the provider.
deductible A specified dollar amount for which the patient is personally responsible before the payer reimburses for any claims.

Go To This data is typically collected at registration, which is discussed in greater detail in Chapter 4.

If the patient is a dependent, a person other than the patient may be ultimately responsible for the bill. The person who is ultimately responsible for paying the bill is called the **guarantor**. For example, if a child goes to the physician's office for treatment, the child, as patient, cannot be held responsible for the invoice. Therefore the parent or legal guardian is responsible for payment and is the guarantor. Figure 2-6 lists financial data required by a health care provider.

After World War II, employers began offering their employees certain benefits, including health insurance. Benefits packages became useful in enabling employers to hire and retain employees. Employees benefited because they did not need to spend money on benefits, and employers benefited because health insurance benefits were a relatively inexpensive way to attract quality employees. Insurance companies benefited from an

guarantor The individual or organization that promises to pay for the rendered health care services after all other sources (such as insurance) are exhausted.
financial data Elements that describe the payer. For example, the name, address, and telephone number of the patient's insurance company, as well as the group and member numbers that the company has assigned to the patient.

premium Periodic payment to an insurance company made by the patient for coverage (an insurance policy).

TABLE 7-1

TERMINOLOGY COMMON TO HEALTH INSURANCE POLICIES

TERM	DESCRIPTION
Benefit	The payment for specific health care services, or the health care services that are provided from an insurance policy or a managed care organization
Beneficiary	One who receives benefits from an insurance policy or a managed care program, or one who is eligible to receive such benefits
Benefit period	A period of time during which benefits are available for covered services, and which varies among payers and policies
Claim	The application to an insurance company for reimbursement of services rendered
Copayment (copay)	A fixed amount paid by the patient (or the subscriber to insurance policy) at the time of the health care service
Coverage	The health conditions, diagnostic procedures, and therapeutic treatments for which the insurance policy will pay
Deductible	A specified dollar amount for which the patient is personally responsible before the payer reimburses for any claims
Exclusions	Medical conditions or risks not covered by an insurance policy; preexisting conditions and experimental therapy are common exclusions to standard policies
Fiscal intermediary	An entity that administers the claims and reimbursements for a funding agency (i.e., an insurer or payer)
Insurance	A contract (policy) made with an insurer to assume the risk of paying some or all of the cost of providing health care services in return for the payment of a premium by or on behalf of the insured
Out-of-pocket costs	Costs not covered by an insurer, which are in turn paid by the patient directly to the provider
Payer	The individual or organization that is primarily responsible for the reimbursement for a particular health care service. Usually refers to the insurance company or third party
Premium	Periodic payments to an insurance company made by the patient for coverage under a policy
Preexisting condition	A medical condition identified as having occurred before a patient obtained coverage within a health insurance plan
Reimbursement	The amount of money that the health care facility receives from the party responsible for paying the bill
Rider	An adjustment to a policy that increases or decreases coverage and benefits, corresponding in an increase or decrease in the cost to the insured
Policy	Written contract detailing the coverage, benefits, exclusions, premiums, copays, deductibles, and other terms of the health plan
Subscriber	A person who purchases insurance
Third party payer	An entity that pays a provider for part or all of a patient's health care services; often the patient's insurance company

increased client base. However, this thrust a fourth party into the provider/patient relationship: the employer.

Originally, the focus of insurance was on the coverage of services at the health care provider's fee. If the provider raised the fee, the insurance company raised its premiums to cover these fees. As health care costs increased, premiums also increased dramatically, becoming too expensive for many employers to pay in full. Currently, many employers pay only a part of the premiums, with employees bearing the rest of the expense.

Assumption of Risk

risk The potential exposure to loss, financial expenditure, or other undesirable events; used to determine potential reimbursement of health care services.

Health care providers render services for which they expect to be fairly compensated. Patients need these services, but their high cost is largely unaffordable. Insurance companies are willing to assume the **risk** of having to pay for expensive services, but they cannot spend more than they earn in premiums. To avoid this, insurance companies try to balance their risk by insuring a large number of patients, many of whom will likely not need health care services at all. This assumption of risk is the foundation of the concept of insurance.

Insurance companies negotiate contracts with both the patient (usually via the employer) and the provider. Each party would like to minimize its financial loss. The provider wants to minimize the chances of receiving less payment for services than it costs to provide the services. The insurance company wants to minimize the potential loss of paying out more

for health care than it receives in premiums. The patient wants to minimize the cost of health care. Each party negotiates contracts and attempts to minimize its risks by taking all potential treatment costs and circumstances into consideration.

Insurance companies serve the public by assuming the risk of financial loss. Automobile owners probably have auto insurance. They pay periodic premiums to the auto insurance company, which in turn covers all or part of the costs incurred in an accident. The auto insurance company, although assuming the risk of financial loss in the event of an accident, is gambling that its customers will not have one. In fact, it goes to great lengths to predict the likelihood of accidents in certain populations, geographical areas, and types of vehicles. If one pays $1000 per year in auto insurance premiums for 40 years and never has an accident, then the insurance company keeps the $40,000 (plus interest) accumulated over the life of the policy. If the auto insurance company insures a very large number of drivers, in theory and under normal circumstances, only a small percentage of them will ever have a costly accident. In some states, auto insurance companies are permitted to choose which drivers they wish to insure. Obviously, they would prefer to choose drivers with good driving records and no history of accidents. In other states, insurers may not pick and choose and must offer insurance to anyone who applies for it. This requirement raises the risk that the insurer will be required to pay for the costs of accidents and resultant settlements, in turn raising the cost of auto insurance for all, unless the premiums of the high-risk drivers are increased significantly to compensate.

Health insurance works in a similar way. In a system in which employers provide most private insurance plans, health insurers have fewer ways to limit their exposure to "high-risk" patients. Nevertheless, this model remains attractive to health insurers: they want to cover large numbers of individuals so that the cost of very expensive care is offset by premiums collected from many others requiring less expensive care. The health insurer wants to cover large numbers of individuals so that the risk that someone will require expensive medical care is offset by the large numbers of individuals who require less expensive care (Figure 7-1).

When the employer pays the cost (premium) of the health care insurance, it is the employer who negotiates what will be covered. Although there are some federal mandates regarding what must be covered and under what circumstances, in general it is the employer's decision—generally based on what the employer can afford to pay in premiums for the group. **Group plans**, such as those negotiated through employers, consist of pools of potential patients (in this case, employees) whose risk can be averaged by the third party payer.

group plan A pool of covered individuals that averages the risk for a third party payer, used to leverage lower premiums for the group as a whole.

payer The individual or organization that is primarily responsible for the reimbursement for a particular health care service. Usually refers to the insurance company or third party.

HIT-bit

RISK: THE BIG PICTURE

Risk is the danger that an activity will lead to an undesired outcome. In health care, risk applies to the patient, the physician, and the insurance company. The physician risks making an error in either the diagnosis or the treatment of the patient (obviously, this also presents a risk to the patient). There is also the risk that the physician will not be paid for the services rendered. The patient faces the risk that the cost of health care will be greater than the patient can bear, which would lead to excessive debt. For the payer, the risk is that claims for payment and administrative costs will exceed the premiums received. The payer may raise premiums to compensate; however, in so doing, the payer may lose subscribers. Overall, the financial risks and rewards in the health care industry are a delicate balancing act.

In an environment of rising health care costs, increases in payments to providers trigger increases in premiums to the insured. But the insertion of the employer into the patient/provider relationship has at least two effects: loss of control over the choice of individuals insured and loss of total freedom to raise premiums. The insurer is pressured to accept all applicants, reducing the insurer's ability to control risk. If one individual cancels a policy,

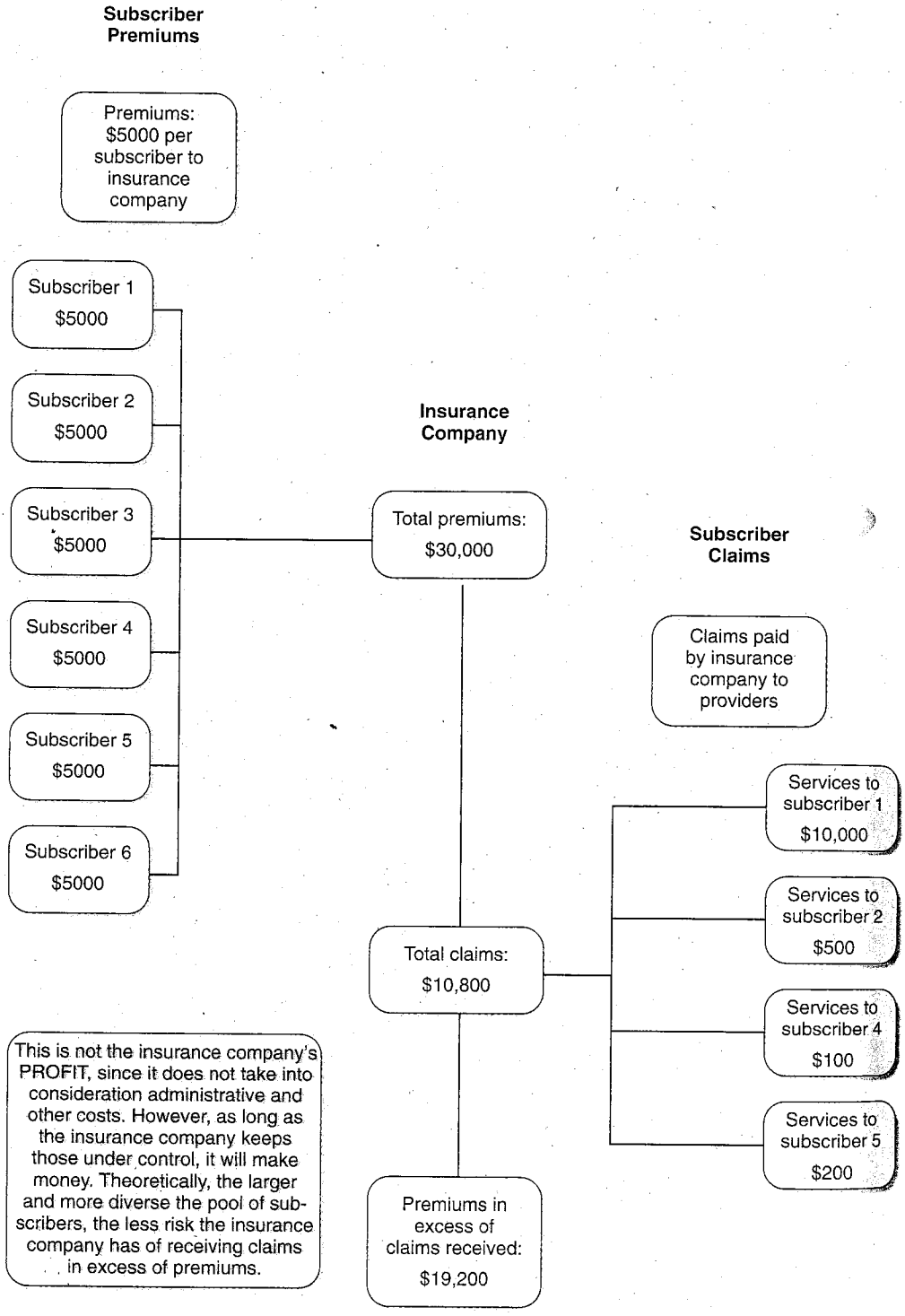


Figure 7-1 How insurance companies reduce risk.

the financial impact is far less dramatic than if an employer cancels a *group policy*. In this way, an employer can pressure the health insurer to keep premiums low so as not to lose the employer's account.

reimbursement The amount of money that the health care facility receives from the party responsible for paying the bill.

Types of Health Insurance

There are many different insurance plans, with an almost endless variety of benefits and reimbursement rules. Plans may set dollar-amount limits or usage limits on the benefits

used in a certain amount of time. Nevertheless, plans fall into one of two basic categories: indemnity and managed care. Managed care plans are further divided into two major types: preferred provider organizations (PPOs) and health maintenance organizations (HMOs). The major features of these plans are discussed later in this chapter. The plans differ in the relationships among the physician, patient, and insurer and affect the way patients access care.

Indemnity

A typical insurance arrangement requires the patient to pay the physician or other health care provider and then submit the bills to the insurance company for reimbursement. Under the terms of the insurance contract is a list of services for which the insurance company agrees to pay, called the covered services. If the patient receives a covered service, then the insurance company reimburses the patient. Some insurance companies pay 100% of the cost of certain covered services and a lower percentage of the cost of other covered services. This type of insurance, called **indemnity insurance**, was the predominant type of health insurance for many years, and patients generally paid the premiums. Indemnity insurance plans still exist, but managed care plans have become more prevalent.

indemnity insurance Assumption of the payment for all or part of certain, specified services. Characterized by out-of-pocket deductibles and caps on total covered payments.

An important feature of indemnity insurance is the deductible. A deductible is the amount for which the patient is personally responsible before any insurance benefits are paid. If a patient incurs medical expenses of $5000, and her policy includes a deductible of $300, she pays the first $300 out-of-pocket (from her personal funds). The insurer then pays the portion of the remaining $4700 covered by the policy. After that, the patient is responsible for any amount not covered by her policy.

deductible A specified dollar amount for which the patient is personally responsible before the payer reimburses for any claims.

out-of-pocket Payment from personal funds.

Depending on the insurance company plan, a deductible could apply for every encounter, every visit, or every hospitalization, or it could be applied on an annual basis. If the insurance plan covers a whole family, the deductible could be per person or per family. One effect of the deductible is that routine health care costs often do not exceed the deductible amount. In these instances, the insurance company ultimately covers and pays for only unusual or extraordinary expenses. Conversely, indemnity contracts often specify limits for certain covered services. If the benefit limit is $3000 for physician office visits and the patient's care (after the deductible) is $4000, then the patient is responsible for the additional $1000.

encounter A patient's health care experience; a unit of measure for the volume of ambulatory care services provided.

Indemnity insurance plans led to an increase in the amount of money spent on health care. In a simple physician-patient relationship, the patient bears the cost of the care and therefore has some influence on the fees. Individuals may choose not to go to the physician in the first place because they feel the fee is too high and they cannot afford it, or they might be able to afford only some services. But because indemnity insurance plans, even with the deductible, reduce the out-of-pocket expense to the patient, they increase the likelihood that the services of the provider will be used regardless of the fees. Consequently, the number of people using health care services has increased. In addition, if the insurance company reimburses for services without reviewing the need for those services, then physicians have no incentive to be conservative in their diagnostic and treatment plans. The costs have risen still further with advances in diagnostic and therapeutic technologies, many of which are extremely costly in their initial phases. As these technologies become more widely used, the cost of providing health care increases.

plan of treatment The diagnostic, therapeutic, or palliative measures that are taken to investigate or treat the patient's condition or disease.

In addition to the technology-driven expenses, health care costs have risen because a small portion of the health care community provided an excessive number of services to their patients. Two radiographs may have been taken when one would have sufficed, or computed tomography or magnetic resonance imaging was used when a simple radiograph would have been sufficient to achieve the same diagnostic goal. Often it is not entirely the provider's fault when these excesses occur. Some patients may feel entitled to the newest technologies even if they are not necessary, and so they pressure their physicians into ordering them. The physician may not want to lose the patient's business or to be subjected to a lawsuit for failure to use all available diagnostic means.

To meet the rising costs of health care, insurance companies raised health care premiums. Eventually, some employers could no longer afford to offer health insurance as a benefit. Many employers began shifting the cost of insurance to the employees. Other

premiums Periodic payments to an insurance company made by the patient for coverage (an insurance policy).

employers solved the escalating premium problem by hiring more part-time employees, who were not eligible for benefits. Still other employers hired outside contractors to perform noncritical functions.

With costs rising, health insurance companies had to find ways to control their expenses. Certain steps, such as imposing higher deductibles and strictly limiting the number and types of covered services, could help lower their costs. However, insurance becomes less attractive under these circumstances, and insurance companies want to remain in business. The insurance industry responded to these circumstances and factors, opening the door to the concept of managed care plans.

Managed Care

managed care A type of insurer (payer) focused on reducing health care costs, controlling expensive care, and improving the quality of patient care provided.

payer The individual or organization that is primarily responsible for the reimbursement for a particular health care service. Usually refers to the insurance company or third party.

reimbursement The amount of money that the health care facility receives from the party responsible for paying the bill.

diagnosis The name of the patient's condition or illness; or the reason for the health care encounter.

The term **managed care**, in general, refers to the control that an insurance company or other payer exerts over the reimbursement process and over the patient's choices in selecting a health care provider.

In the pure physician-patient relationship, the patient uses the physician of his or her choice. The patient arrives at the office with a medical concern, and the physician determines a diagnosis and develops a treatment plan. The patient agrees (or declines) to undergo the treatment plan, the physician bills the patient, and the patient pays the physician.

Under managed care, the insurer (payer) and the health care provider have a contractual arrangement with each other. The providers participate in a particular managed care plan, which means that they are under contract with the managed care plan insurer to provide services to the insurer's patients. Managed care patients are referred to, depending on the insurer, as members, enrollees, or covered lives. The primary insured member is the subscriber, with those covered under the subscriber's policy referred to as dependents or additional insured. The insurer's patients must choose their providers from those participating in the managed care plan. The scope of services paid for is determined by the insurer's contract with the subscriber (or the subscriber's employer or group manager). Decisions about the medical necessity of specific services are made by the managed care organization. For example, a physician may write an order for a blood test to determine whether the patient has a vitamin D deficiency. The managed care organization may have determined that it will pay for vitamin D blood tests only if the patient is known or suspected to have a bone loss condition, such as osteopenia or osteoporosis.

HIT-bit

THE INSURANCE CONTRACT

An insurance contract is essentially the promise to pay for certain health care costs incurred by the subscriber in return for the payment of a premium to the insurer by either the subscriber or another party. When the subscriber contracts directly with the insurer, the premium is not usually negotiable. However, when the subscriber is a member of a larger group, such as that provided by an employer, both the premium and the services for which the insurer will pay may be subject to negotiation.

Insurance companies (particularly managed care organizations) also negotiate with each provider to determine the services that apply to that provider, how much the insurer is willing to pay for those services, and under what circumstances the provider may render those services. Providers apply to be included in insurers' lists of in-plan providers. Because subscribers are encouraged to choose providers from those lists, being on multiple lists is theoretically a good business decision for providers. However, if insurers reduce payments and restrict services, providers may decide to avoid these payer relationships entirely. In fact, physicians may elect not to accept insurance at all, requiring patients to file cumbersome claims for reimbursement with their insurers.

In a managed care scenario, the patient goes to the primary care physician (PCP), whom the patient has chosen from a list of participating physicians. The physician diagnoses and treats the patient according to the guidelines from the managed care plan. The patient may pay the physician a small copay. The physician bills the managed care insurer directly for the visit. The managed care insurer may refuse to pay the physician if the physician does not obtain preapproval or authorization for some treatments, such as hospitalization. If the patient sees a physician outside the plan, the patient may not be covered at all and may have to pay the physician himself or herself. In many instances, the patient cannot go to a specialist directly but must visit the PCP first. After examination and discussion with the patient, the PCP must justify the necessity for the involvement of a specialist and must refer the patient to a specialist participating in the plan.

primary care physician (PCP) In insurance, the physician who has been designated by the insured to deliver routine care to the insured and to evaluate the need for referral to a specialist, if applicable. Colloquial use is synonymous with "family doctor."

copay A fixed amount paid by the patient at the time of service.

Managed care organizations seek to reduce costs by controlling as much of the health care delivery system as possible. The underlying rationale for managed care is to reduce overall costs by eliminating unnecessary tests, procedures, visits, and hospitalizations through financial incentives if the plan is followed and financial penalties or sanctions if the plan is not followed. A major controversy in this strategy lies in the definition of what constitutes unnecessary health care and who makes this determination. Traditionally, physicians have determined the care that they provide to patients, whereas managed care has shifted that determination somewhat to the insurer. To emphasize: The managed care organization does not dictate what care will be rendered; it dictates what care it will pay for. It is the prohibitive cost of care that drives a patient to elect only that care for which third party payment is available.

It should be noted that managed care plans employ physicians who assist in making determinations. For example, many managed care insurers did not consider preventive care to be necessary and would not pay for it. It was only through years of study, investigation, and trial and error that they discovered that preventive care was one of the best ways to reduce health care costs. This fact is particularly salient with regard to obstetrical care. The costs of treating a pregnant woman through prenatal testing, education, and regular examinations, with the goal of delivering a healthy newborn, are significantly less than those of treating a newborn or new mother with complications that could have been prevented or treated earlier at less cost. The same holds true for dental care. Theoretically, if teeth are examined and cleaned routinely, expensive fillings and root canal treatments will not be needed because the dentist will help detect and treat those problems early.

Individuals who change jobs are often forced to find new health care providers if their previous physicians are not included in the new insurer's plan. The same may be true if the employer changes insurers. Patients who live at the outskirts of a plan's primary service area may be required to travel unacceptably long distances to receive covered health care services.

Physicians may feel a loss of control in the treatment process. They are sometimes frustrated by the emphasis on medical practice standards, what some call "cookbook medicine," and resistance to what they may see as individualized, alternative approaches of care. Managed care organizations focus heavily on statistical analysis of treatment outcomes and scrutinize physicians whose practices appear to vary significantly from the norm. Managed care has forced physicians to become more aware of and active in managing their own resources by employing reimbursement methods other than fee for service that shift some financial risk to the physician.

outcome the result of a patient's treatment.

fee for service The exchange of monies, goods, or services for professional services rendered at a specific rate, typically determined by the provider and associated with specific activities (such as a physical examination).

Despite controversy and criticism, managed care has become an important presence in the health care arena. Managed care takes a number of different forms, and there are many variations in the relationship among managed care organizations and physicians and other health care providers who deliver their services. At the heart of managed care is the idea that the insurer can gain better control over cost of health care by delivering the services directly. The U.S. Congress supported this concept with the Health Maintenance Organization Act of 1973, which encouraged the development of **health maintenance organizations (HMOs)** and mandated certain employers to offer employees an HMO option for health care delivery.

health maintenance organization (HMO) Managed care organization characterized by the ownership or employer control over the health care providers.

network A group of providers serving the members of a managed care organization; the payer will generally not cover health care services from providers outside the network.

staff model HMO An HMO in which the organization owns the facilities, employs the physicians, and provides essentially all health care services.

group practice model HMO An HMO that contracts with a group or network of physicians and facilities to provide health care services.

independent practice association (IPA) model HMO An HMO that contracts with individual physicians, portions of whose practices are devoted to the HMO.

preferred provider organization (PPO) A managed care organization that contracts with a network of health care providers to render services to its members.

primary care physician (PCP) In insurance, the physician who has been designated by the insured to deliver routine care to the insured and to evaluate the need for referral to a specialist, if applicable. Colloquial use is synonymous with "family doctor."

claim The application to an insurance company for reimbursement.

flexible benefit account A savings account in which health care and certain child-care costs can be set aside and paid using pretax funds.

Health Maintenance Organizations

An HMO is a managed care organization that has ownership or employer control over the health care provider. Essentially, the HMO is the insurer (payer) and the provider. Members must use the HMO for all services, and the HMO will generally not pay for out-of-plan (also called out of **network**) services without prior approval. In some plans, approval to obtain health care services outside the plan is granted only in emergency situations.

In the **staff model HMO**, the organization owns the facilities, employs the physicians, and provides essentially all health care services. In a **group practice model HMO**, the organization contracts with a group or a network of physicians and facilities to provide health care services. Finally, in an **independent practice association (IPA) model HMO**, the HMO contracts with individual physicians, portions of whose practices are devoted to the HMO. Regardless of the HMO model, an HMO generally does not reimburse for services provided by providers who are not in the HMO's network.

Preferred Provider Organizations

A **preferred provider organization (PPO)** is another managed care approach in which the organization contracts with a network of health care providers who agree to certain reimbursement rates. It is from this network that patients are encouraged to choose their primary care physician and any specialists. If a patient chooses a provider who is not in the network, the PPO reimburses in the same manner as an indemnity insurer: for specified services, with specific dollar amounts or percentage limits, and after any deductible is paid by the insured.

A PPO is a hybrid plan that gives patients the option of choosing physicians outside the plan without totally forfeiting benefits. In addition, PPOs may offer patients a certain degree of freedom to self-refer to specialists. For example, some plans allow patients to visit gynecologists and vision specialists directly, without referral from the PCP.

Self-Insurance

Although not specifically a type of insurance, self-insurance (or self-funded insurance) is an alternative to purchasing an insurance policy. The term *self-insurance* should not be confused with patients who "self-pay" or those who have no insurance or coverage plan at all. Self-insurance is really a savings plan in which an individual or employer puts aside funds to cover health care costs. In this way, the individual or company assumes the financial risk associated with health care. Because the assumption of risk rests with the company or the individual, this is not so much a type of insurance as it is an alternative to shifting the risk to an insurer.

An employer may choose to self-insure for all health care benefits, or it may self-insure to provide specific benefits that its primary insurance plan does not cover. For example, an insurance plan may cover preventive care, hospital and physician services, and diagnostic tests. However, it may not cover vision or dental care. The employer may designate to each employee a certain dollar amount with which the employee may then be reimbursed for these other services. Ordinarily, if the annual dollar amount is not spent, it is lost to the employee. Because the issue of confidentiality is so important, employers may choose to contract with an insurer to process health care claims, even if the employer self-insures.

Individuals may self-insure by saving money on a regular basis through their employer. These savings are designated for health care expenses. One formal plan that enables individuals to save in this manner is a **flexible benefit account** (or medical savings account). A flexible benefit account provides the individual with a savings account, usually through payroll deduction, into which a set amount determined by the employee can be deposited routinely. These funds can then be drawn on to pay out-of-pocket health care and some child-care expenses. The advantage to a flexible benefit account is that the funds are withdrawn from the individual's salary on a pretax basis, thereby reducing the individual's income tax liability. The disadvantage is that nondisbursed funds are forfeited at the end of the year. Table 7-2 summarizes the four types of insurance that have been discussed.

TABLE 7-2

SUMMARY OF HEALTH INSURANCE RELATIONSHIPS

INSURANCE	MAJOR FEATURES
Indemnity	Employer maintains group policy with insurer, thereby spreading the risk among many. Employer may pay all or part of the premium. Employer sets policy as to classification of eligible employees and collects employee share of premium, if any.
HMO (health maintenance organization)	Providers are limited to those in the plan. Patient pays small copayment. Covered services must be medically necessary. Providers tend to be employees of the HMO or to have exclusive contracts with HMO. Primary care physician acts as gatekeeper, evaluating the need for specialized care and providing referrals.
PPO (preferred provider organization)	Combination of HMO and indemnity features. Providers are independent contractors.
Self-insurance	Employer may reserve funds to cover projected medical expenses. Covered employees may contribute to fund. Insured sets aside pretax dollars to cover specific medical expenses, such as vision care. Unused funds are lost.

Clinical Oversight

In Chapter 1, a collaborative process of patient care involving the physicians, nurses, and other allied health professionals was described. This patient care plan is more than just a series of instructions or recommendations for an individual patient. Clinicians typically follow established patterns of care that are based on experience, successful outcomes, and research. The formal description of these patterns of care is the clinical pathway. Each discipline has a specific clinical pathway that describes the appropriate steps to take, given a specific diagnosis or a specific set of signs and symptoms and based on the answers to critical questions. For example, a patient with high blood glucose (hyperglycemia) must be tested to determine whether the patient is diabetic. If the patient is diabetic, further studies will identify whether the condition is insulin dependent or not. The physician will prescribe the appropriate medications and other regimens on the basis of that determination. Nursing staff will assess the patient's level of understanding of his or her condition and take the appropriate steps to educate the patient and possibly the family. Figure 7-2 illustrates a clinical pathway.

patient care plan The formal directions for treatment of the patient, which involves many different individuals, including the patient.

outcome The result of a patient's treatment.

clinical pathway A predetermined standard of treatment for a particular disease, diagnosis, or procedure designed to facilitate the patient's progress through the health care encounter.

Case Management

The responsibility for patient care rests with the provider, but often multiple providers, and possibly multiple facilities, are involved in a patient's care. From the payer's perspective, **case management** is necessary to coordinate the approval of and adherence to the care plan. From the provider's perspective, case managers are necessary to facilitate the continuity of care. Thus a patient may have multiple case managers working from different perspectives, all helping to ensure that the patient is cared for appropriately and efficiently.

case management The coordination of the patient's care and services, including reimbursement considerations.

continuity of care The coordination among caregivers to provide, efficiently and effectively, the broad range of health care services required by a patient during an illness or for an entire lifetime. May also refer to the coordination of care provided among caregivers/services within a health care organization.

Utilization Review

Understanding clinical pathways and payer issues enables a facility to evaluate patient care, control the use of facility resources, and measure the performance of individual clinical staff. In a hospital, the **utilization review (UR)** department works closely with all health care disciplines involved in caring for a patient who has been admitted. UR

utilization review (UR) The process of evaluating medical interventions against established criteria, on the basis of the patient's known or tentative diagnosis. Evaluation may take place before, during, or after the episode of care for different purposes.

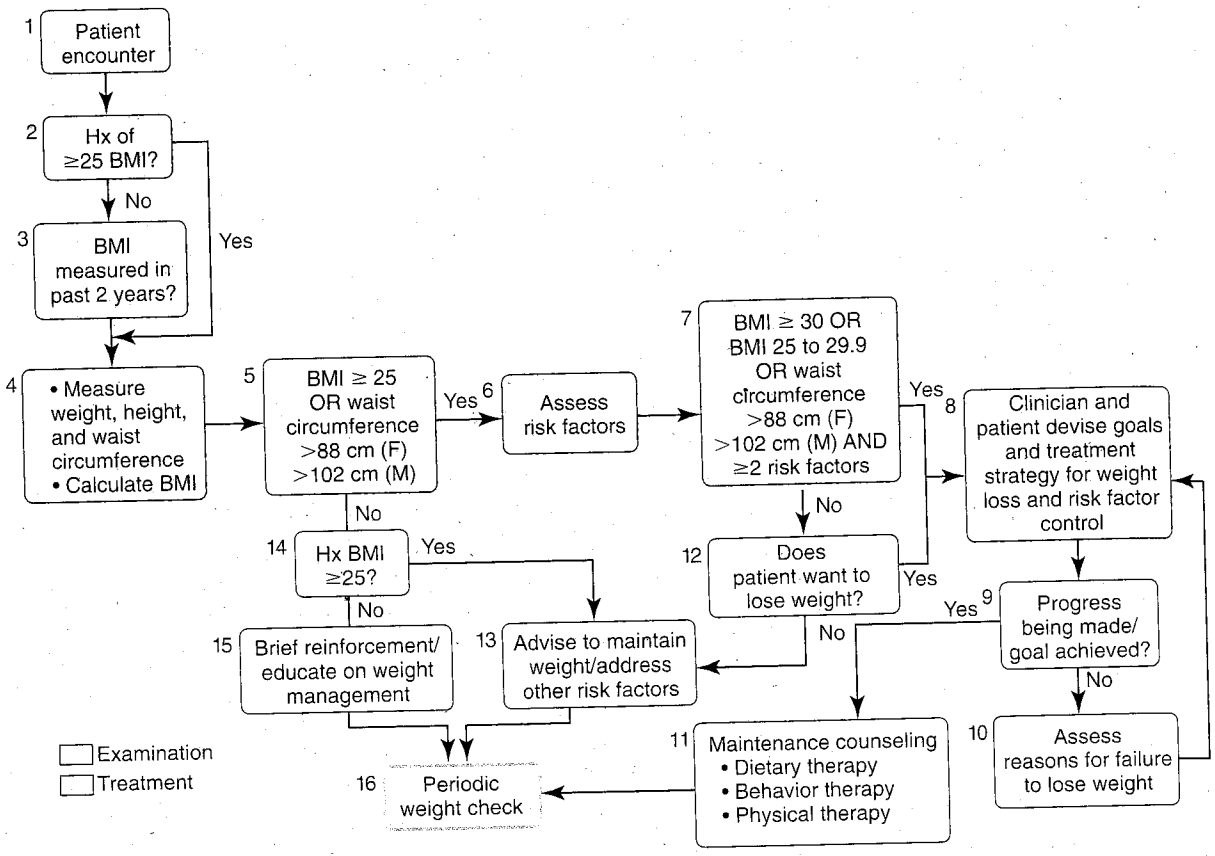


Figure 7-2 Clinical pathway for obesity. (From National Institutes of Health, National Heart, Lung, and Blood Institute in cooperation with The National Institute of Diabetes and digestive and Kidney Diseases: "Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults": The evidence report. NIH Publication No. 98-4083. http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf. Published September 1998.)

intensity of service In utilization review, a type of criteria, consisting primarily of monitoring and diagnostic assessments, that must be met in order to qualify a patient for inpatient admission.

discharge planning The multidisciplinary, coordinated effort to ensure that a patient is discharged to the appropriate level of care and with the appropriate support.

UR utilization review

admission denial Occurs when the payer or its designee (such as utilization review staff) will not reimburse the facility for treatment of the patient because the admission was deemed unnecessary.

staff members (also known as case management personnel) are responsible, with physician oversight, for performing an admission review that covers the appropriateness of the admission itself, certifying the level of care for an admission (e.g., acute, skilled nursing), monitoring the *intensity of services* provided, and ensuring that a patient's length of stay is appropriate for that level of care. UR staff members may have daily contact with a patient's insurance company during the patient's admission to verify that the correct level of care payment will be received for the anticipated length of stay. UR staff may also make provisions for aftercare once the patient is discharged; this is called **discharge planning**.

For example, suppose a patient with Type 1 diabetes mellitus is admitted because the patient performed a self-check at home and could not control his blood glucose level even while taking the prescribed amounts of daily insulin. UR staff members will be notified that the patient has been admitted, and they will perform an admission review. This admission review entails an evaluation of the patient's medical record, including physician orders and any test results. In some cases, the admission will be deemed unnecessary. The admission might be unnecessary if the patient's blood glucose levels were all normal on admission. At that point, UR staff members would not certify the admission for reimbursement; this is called an **admission denial**.

If UR staff members deem the admission necessary, they will certify the admission. UR staff may contact the patient's insurer, verify the diagnosis of uncontrolled Type 1 diabetes mellitus, and determine that the anticipated length of stay for that diagnosis is 2 to 3 days. The insurer agrees to reimburse the hospital for 3 days of acute care as certified by UR staff. During the hospitalization, UR staff members will discuss the aftercare, or discharge

plan, with the attending physician. In this case, perhaps more home health care services are warranted. On the third day, the patient is expected to be discharged. If the patient is not discharged on day 3, members of the UR staff must review documentation and discuss the case further with the physician to justify additional hospitalization. If the additional days are not justified by the documentation in the health record, the additional days may not be reimbursed by the insurer; this is called a **continued stay denial**. In these instances, the patient will be notified that he or she no longer needs to be in the hospital, that the insurer will not reimburse the hospital for any additional costs, and that the patient is responsible for all further costs. When a continued stay denial occurs, the physician is also notified. The physician will either concur with the continued stay denial and discharge the patient or provide documentation justifying the additional care.

attending physician The physician who is primarily responsible for coordinating the care of the patient in the hospital; it is usually the physician who ordered the patient's admission to the hospital.

home health care Health care services rendered in the patient's home.

health record Also called *medical record*. It contains all of the data collected for an individual patient.

continued stay denial Similar to admission denial; however, it is the additional payment for the length of stay that is not approved rather than the entire admission.

EXERCISE 7-1

Insurance

1. Each type of reimbursement has unique characteristics and a different approach to risk. Compare and contrast the four types of reimbursement, identifying the financial risk to the parties involved.
2. Health care insurance involves the assumption of the risk of financial loss by a party other than the patient. Describe how insurance companies can afford to assume such risk.
3. The text discussed three different types of health insurance. List them, and describe how they are different.

Entitlements

Although the United States does not have universal health care (i.e., government-subsidized health care for all citizens), the various levels of government do serve as the largest payer for health care services. Because eligibility for certain government-sponsored programs is automatic, being based on age, condition, or employment, they are called **entitlement programs** rather than insurance.

entitlement programs In health care, government-sponsored programs that pay for certain services on the basis of an individual's age, condition, employment status, or other circumstances.

Federal Coverage for Specific Populations

The U.S. government has historically allocated funds for the benefits of specific populations. In the case of health care, target populations of chronically ill or indigent patients have received low-cost or free health care. Until the 1960s, funding was not entirely predictable and health care providers were often required to provide a certain amount of charity care. In addition, large groups of individuals with limited incomes were not eligible for federal assistance. The federal government took the plunge in the mid-1960s with the enactment of legislation that made it the largest single payer in the health care industry: *Title XVIII* and *Title XIX of the Social Security Act*, which established the Medicare and Medicaid programs.

In addition to Medicare and Medicaid, the federal government administers **TRICARE** (formerly called CHAMPUS), which provides health benefits for military personnel, their families, and military retirees. The federal government provides health services to veterans through the Veterans Health Administration (VHA). The Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) was created in 1973 to provide health services for spouses and children of certain deceased or disabled veterans. TRICARE, VHA, and CHAMPVA are service benefits, not insurance, and are included here to illustrate the extent of the federal government's financial involvement in health care. (See the TRICARE and CHAMPVA Web sites for additional information.) Table 7-3 provides a summary of this involvement.

Medicare Federally funded health care insurance plan for older adults and for certain categories of chronically ill patients.

Medicaid A federally mandated, state-funded program providing access to health care for the poor and the medically indigent.

TRICARE A U.S. program of health benefits for military personnel, their families, and military retirees, formerly called *CHAMPUS*.

TRICARE on the Web: www.tricare.mil

CHAMPVA on the Web: http://www.va.gov/hac/forbeneficiaries/champva/champva.asp

TABLE 7-3
SUMMARY OF FEDERAL INVOLVEMENT IN HEALTH CARE

ACRONYM	DESCRIPTION	COVERED LIVES
Medicare	Title XVIII of the Social Security Act (1965)	Older adult, disabled, renal dialysis, and transplant patients Part A: inpatient services Part B: outpatient services and physician claims Part C: managed care option Part D: prescription drug benefit
Medicaid	Title XIX of the Social Security Act (1965)	Low-income patients
TRICARE	Medical services for members of the armed services, their spouses, and their families	Administered by the Department of Defense and applying to members of the Army, Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration
VHA	Veterans Health Administration	Health services for veterans
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)	Programs administered by the U.S. Department of Veterans Affairs (Health Administration Center) for veterans and their families
IHS	Indian Health Service	Provides, or assists in providing and organizing, health care services to American Indians and Alaskan Natives

The Indian Health Services (IHS) provides care for American Indians and Alaska Natives. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 564 federally recognized tribes in 35 states (Indian Health Services, 2012).

Title XVIII of the Social Security Act Amendment to the Social Security Act that established Medicare.

inpatient An individual who is admitted to a hospital with the intention of staying overnight.

ambulatory surgery Surgery performed on an outpatient basis; the patient returns home after the surgery is performed. Also called *same-day surgery.*

claim The application to an insurance company for reimbursement of services rendered.

Medicare administrative contractor (MAC) Regional, private contractor who processes reimbursement claims for CMS.

Medicare

Title XVIII of the Social Security Act established the Medicare program in 1965. Originally enacted to provide funding for health care for older adults, Medicare has grown to include individuals with certain disabilities or with end-stage renal disease requiring dialysis or kidney transplantation. Medicare represents more than 50% of the income of some health care providers. Medicare is an extremely important driving force in the insurance industry because many insurance companies follow Medicare's lead in adopting reimbursement strategies. For example, if Medicare decides that a particular surgical procedure will be reimbursed only if is it performed in the inpatient setting (as opposed to ambulatory surgery), other insurance companies may choose to enforce the same rule.

The Medicare program, although funded by the federal government and administered by the Centers for Medicare and Medicaid Services (CMS), does not process its own claims reimbursements. Reimbursements are processed by **Medicare administrative contractors (MACs)** located in different regions throughout the country.

HIT bit

ANCILLARY AND PHYSICIAN BILLING

Not all diagnostic testing and other services are billable by the health care facility. For example, a facility may not have a magnetic resonance imaging (MRI) machine. If this is the case, the patient is transported to the MRI provider, who bills either the payer or the original facility separately for both the diagnostic procedure and its interpretation, depending on the reimbursement method and payer. Additionally, unless the physician is an employee of the hospital, physicians bill separately for their services.

Medicare coverage applies in four categories: Parts A, B, C, and D. Part A covers inpatient hospital services and some other services, such as hospice. Part B covers physician claims and outpatient services. Part C is a voluntary managed care option. Part D, implemented in 2006, is a prescription drug program.

Because there are limits to Medicare coverage, many beneficiaries choose to purchase additional insurance; such plans, called **wraparound policies** (supplemental policies), are aimed at absorbing costs not reimbursed by Medicare. Many end-of-life hospital stays generate costs in the hundreds of thousands of dollars. Therefore wraparound policies can help preserve estates and save surviving spouses from financial ruin. Medicare may also be the secondary payer for enrollees who are still employed and covered primarily by the employer's insurance plan.

Medicare beneficiaries also may enroll in a Medicare HMO program, called Medicare+Choice. Different HMOs have contracted with the federal government under the Medicare+Choice program to provide health services to these beneficiaries.

hospice Palliative health care services rendered to the terminally ill, their families, and their friends.

outpatient A patient whose health care services are intended to be delivered within 1 calendar day or, in some cases, a 24-hour period.

wraparound policy Insurance policies that supplement Medicare coverage. Also called *secondary insurance.*

HMO health maintenance organization

Medicaid

In 1965, Congress enacted **Title XIX of the Social Security Act**, which created a formal system of providing funding for health care for low-income populations. Also administered by CMS, Medicaid, which is sometimes also called "Medical Assistance," is a shared federal and state program designed to shift resources from higher-income to lower-income individuals. Funds are allocated according to the average income of the residents of the state. Unlike Medicare, which reimburses through **fiscal intermediaries**, Medicaid reimbursement is handled directly by each individual state. The reimbursement guidelines vary from state to state. Some states have contracted with insurers to offer HMO plans to Medicaid beneficiaries.

Eligibility for Medicaid is determined by the individual states on the basis of the state's income criteria. The federal government mandates that the following services be included in each state's program: hospital and physician services, diagnostic services, home health, nursing home, preventive care, family planning, pregnancy care, and child care (see the CMS Web site for more information: http://www.cms.hhs.gov).

Title XIX of the Social Security Act Amendment to the Social Security Act that established Medicaid.

Medicaid A federally mandated, state-funded program providing access to health care for the poor and the medically indigent.

fiscal intermediaries Organizations that administer the claims and reimbursements for the funding agency. Medicare uses fiscal intermediaries to process its claims and reimbursements.

CMS Centers for Medicare and Medicaid Services

Tax Equity and Fiscal Responsibility Act of 1982

With the federal government's entry into the reimbursement arena, more citizens had access to health care services than ever before. The use of health care services rose accordingly, in turn driving health care costs upward at an alarming rate. Improved access for older adults meant better care and therefore longer life expectancy, which further increased costs. Thus cost containment became a critical issue. In the early 1970s, Professional Standards Review Organizations (PSROs) were established. PSROs conducted local peer reviews of Medicare and Medicaid cases for the purpose of ensuring that only medically necessary services were being rendered and appropriately reimbursed. Under the Peer Review Improvement Act of 1982, PSROs were replaced by Peer Review Organizations (PROs) through a federal law called the **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**. TEFRA included a broad array of provisions, many of which had nothing to do with health care. For example, TEFRA raised taxes by eliminating previous tax cuts. In 2002, PROs were replaced by (or, more accurately, renamed) Quality Improvement Organizations (QIOs). Many HIM professionals are employed in QIOs because certain specialized skills, such as data analysis and coding expertise, are necessary to support various federal initiatives delegated to QIOs. TEFRA's impact on health care included a modification of Medicare reimbursement for inpatient care to include a **case mix** adjustment based on diagnosis related groups (DRGs). In 1983, Medicare adopted the *Prospective Payment System (PPS)*, which uses the DRG classification system as the basis of its reimbursement methodology. **Prospective payment systems (PPS)** are discussed at length later in the chapter, but in the broadest terms, they operate on the assumption that patients with the same diagnoses will require roughly the same level of care, therefore consuming roughly the same resources and incurring roughly the same costs. Of course, the focus of treatment, patient length of stay, and the individuals involved in the care plan differ from setting to setting. Because

Go To More information about QIOs can be found in Chapter 11 and on the CMS Web site, with links to local QIOs.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) A federal law with wide-reaching provisions, one of which was the establishment of Medicare PPS.

case mix Statistical distribution of patients according to their utilization of resources. Also refers to the grouping of patients by clinical department or other meaningful distribution, such as health insurance type.

prospective payment system (PPS) A system used by payers, primarily CMS, for reimbursing acute care facilities on the basis of statistical analysis of health care data.

QOI Quality Improvement Organizations

DRGs diagnosis related groups

prospective reimbursement systems are based on just these types of factors, different systems were developed for each health care setting.

Paying for health care is an ever-changing subject. HIM professionals must be aware of new developments that pertain to their practice and keep abreast of general reimbursement issues.

EXERCISE 7-2

Government Influence on Reimbursement

1. What is the difference between Medicare and Medicaid?
2. What is the difference between the VHA and TRICARE?
3. Who benefits from the Indian Health Services?
4. Explain the impact of TEFRA on health care.

REIMBURSEMENT METHODOLOGIES

This section provides a general discussion of how reimbursement is accomplished in the health care industry, who is involved in the reimbursement process, what methodologies are used to calculate reimbursement, and how HIM professionals are involved in the process. One of the most visible roles that HIM professionals play in health care today involves the reimbursement process (e.g., as coding professionals or clinical data managers).

coding The assignment of alphanumerical values to a word, phrase, or other nonnumerical expression. In health care, coding is the assignment of alphanumerical values to diagnosis and procedure descriptions.

FEE FOR SERVICE

As previously mentioned, a physician or other health care provider does not necessarily need to receive money as compensation. Perhaps chickens, bread, or other food is acceptable under certain circumstances. In other circumstances, services might be bartered (e.g., "You treat my pneumonia, and I will take care of your plumbing."). This is known as an *exchange of services,* or *reciprocal services.* The parties involved decide the value of each service (e.g., how many hours of plumbing would be equal in value to how many hours of physician treatment). However, monetary compensation is the generally accepted reimbursement method in the United States.

fee for service The exchange of monies, goods, or services for professional services rendered at a specific rate, typically determined by the provider and associated with specific activities (such as a physical examination).

charges Fees or costs for services rendered.

Fee for service is the term assigned to the payment for services rendered by a physician, health care provider, or facility. It is sometimes referred to as "pay as you go" because this is how many patients without any insurance pay for treatments. The patient is essentially "buying" services or supplies. For example, a patient goes to, or "visits," the physician's office because of a runny nose. The physician examines the patient and determines that the patient is allergic to a house pet. This service, which comprises an office visit and examination, is billed at $100. This $100 is the "fee." Suppose this same patient also needs an allergy shot, and this shot has a fee of $20. In this case, the total fee for the visit is $120. As this example shows, fees correspond to the services rendered, "fee for service." Health care provider fees are also called **charges**. Note that costs and charges are different. Cost is what the health care provider expended in the process of rendering services. Costs include time, supplies, and expenses such as rent and utilities. Charges are the fees that are billed for the services. The term "cost" is often used to refer to the overall expenditures for health care, but the narrow definition is used for this discussion.

usual and customary fees Referring to health care provider fees, the rates established by an insurance company on the basis of the regional charges for the particular services.

payer The individual or organization that is primarily responsible for the reimbursement for a particular health care service. Usually refers to the insurance company or third party.

Comparing the fees charged by physicians in a particular state or geographical area, one finds that the fees for services are similar. Ignoring the very high and very low fees, one would be able to determine the **usual and customary fees (UCFs)** charged by physicians in that area. To determine usual and customary fees, it is necessary to compare not only the services but also the specialties of the physicians providing the services. The term *usual and customary fees* commonly appears in the language of insurance contracts because this is the fee that third party payers are willing to reimburse for services. For example, a physician may decide to charge $100 for an office visit, but the insurer will reimburse only $80, if $80 is the usual and customary fee for that specialty in that area.

DISCOUNTED FEE FOR SERVICE

Within this category of reimbursement are other negotiated fees. In a typical **discounted fee for service** arrangement, the third party payer (in this case, the insurer) negotiates a payment that is less than the provider's normal rate. For example, the provider may charge $100 for a service. The insurer assumes that the volume of patients added to the provider's business would warrant a 10% discount from the normal rate. Therefore the payment for the service would be $90.

Some insurers reimburse at flat rates, known as per diem (daily) rates, for service. A per diem rate is basically a flat fee, negotiated in advance, that an insurer will pay for each day of hospitalization. For inpatient health care providers or facilities, per diem rates may represent a significant discount from the actual accumulated fees for each service performed, but again, the provider or facility benefits by gaining that payer's business. Per diem rates are most commonly negotiated with providers who serve a limited patient population, such as providers of rehabilitation services.

discounted fee for service The exchange of cash for professional services rendered, at a rate less than the normal fee for the service.

PROSPECTIVE PAYMENT

Prospective payment is a method of determining the payment to a health care provider on the basis of predetermined factors, not on individual costs for services. Numerous insurers and government agencies use prospective payment systems for reimbursement, most notably the Medicare Prospective Payment System (PPS), which is discussed in detail later in this chapter. PPSs are based on the statistical analysis of large quantities of historical health care data for the purpose of evaluating the resources used to treat specific diagnoses and effect certain treatments. On the basis of this evaluation, it has been determined that certain diagnoses and procedures consume sufficiently similar resources, such that reimbursement to the facility for all patients with such diagnoses and undergoing such procedures should be the same. For this purpose, resources are measured in both costs and days. Essentially, the provider receives a payment that represents the historical average cost of treating patients with that particular combination of diagnoses and procedures.

For example, suppose a review of 10,000 uncomplicated appendectomies reveals that the patients were hospitalized for an average of 2 days. The statistical average charge for these hospitalizations, based on the 10,000 uncomplicated appendectomy cases, is $5000. An insurer who uses a prospective payment system to reimburse a facility will pay that facility $5000, regardless of how long a given patient who received an uncomplicated appendectomy was actually hospitalized or what the actual charges were. If the charges for that hospitalization were actually $4500, the facility would still receive $5000. If the charges for that hospitalization were actually $5500, the facility would still receive $5000. The use of the term "prospective" in this type of reimbursement system means that both the facility and the insurer know, in advance, how much each type of case will be reimbursed.

From the payer's perspective, prospective payment can be an extremely effective budgeting tool. Utilization trends can be followed, types of cases can be analyzed in groups, and reimbursement costs can be better controlled through rate setting for each type of case. From the perspective of the provider or facility, there is greater motivation to keep costs under tight control. If there are inefficiencies within the facilities or among physicians, facilities may lose income. However, critics of PPSs, including some physicians, maintain that prospective payment focuses only on the financial aspects of treating a patient and does not take into consideration individual, case-by-case clinical management.

prospective payment Any of several reimbursement methods that pay an amount predetermined by the payer on the basis of the diagnosis, procedures, and other factors (depending on setting) rather than actual, current resources expended by the provider.

diagnosis The name of the patient's condition or illness, or the reason for the health care encounter.

procedure A process that describes how to comply with a policy. Also, a medical or surgical treatment. Also refers to the processing steps in an administrative function.

CAPITATION

Another type of payment is capitation. **Capitation** requires payment to a health care provider regardless of whether the patient is seen or how frequently the patient is seen during

capitation A uniform reimbursement to a health care provider based on the number of patients contractually in the physician's care, regardless of diagnoses or services rendered.

primary care physician (PCP) The physician who has been designated by the insured to deliver routine care to the insured and to evaluate the need for referral to a specialist, if applicable.

a given period. For example, a physician might receive $10 a month for each patient under an insurance plan whose patients choose him or her as their primary care physician. If 100 patients choose this physician as their primary care physician, the physician receives $1000 a month for those patients—even if no one comes in for a visit. If all 100 patients are seen in one month, the physician still receives $1000. Generally, however, the more patients who choose this physician under a capitation plan, the greater the odds that that physician will receive adequate overall payment for his or her services, especially if that group of patients is relatively healthy and does not make many office visits. The insurer will still benefit if it is less expensive to pay a known monthly capitation fee rather than reimburse an unpredictable amount of money to the physician each month (Figure 7-3).

COMPARISON OF REIMBURSEMENT METHODS

Table 7-4 summarizes the four methods of reimbursement previously discussed: fee for service, discounted fee for service, prospective payment, and capitation. To distinguish among these methods, remember the previous example of the patient's visit to the doctor's office for an allergy shot. Say the charge for that visit, under fee-for-service reimbursement, is $100. Under discounted fee-for-service reimbursement, a contract may be negotiated for payment based on a discount of 10% of the fee for service; therefore the charge for the same visit would still be $100, but the reimbursement would be $90. The $10 difference is a contractual allowance, enabling the provider to keep track of the discount for accounting purposes. Under a PPS, the insurance company may reimburse the physician $85 on the

TABLE 7-4

COMPARISON OF REIMBURSEMENT METHODS

METHOD*	DESCRIPTION
Fee for service	Payment for services rendered
Discounted fee for service	Payment for services rendered but at a rate lower than the usual fee for a service
Prospective payment	Payment of a flat rate on the basis of diagnoses, procedures, or a combination of the two
Capitation	Payment of a regular, flat rate to the provider regardless of whether services are rendered

*There are numerous variations on these methods, and exceptions to a normal method of payment are made under certain circumstances. For example, under prospective payment, additional compensation can sometimes be obtained if it is medically necessary for the patient to be hospitalized far in excess of the average length of stay for the diagnosis or procedure.

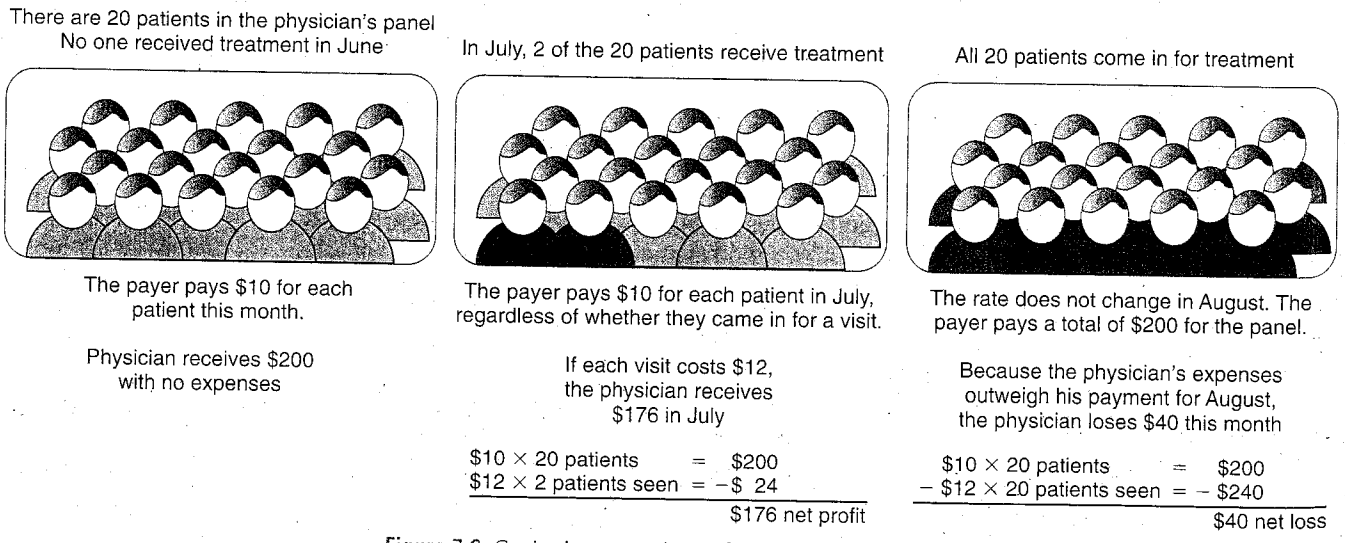


Figure 7-3 Capitation scenarios with a pool of 20 patients.

basis of a statistical analysis of costs associated with office visits for allergy shots. Under capitation reimbursement, the insurance company would not pay the physician anything for a particular visit, paying instead $10 each month for that patient. The total reimbursement for that patient under capitation amounts to $120 annually: a financial advantage to the provider if the patient visits once or not at all, but a disadvantage if the patient visits more than once.

These methods vary widely, and exceptions to a normal method of payment are made under certain circumstances. For example, under PPS, additional reimbursement can sometimes be obtained if it is medically necessary for the patient to be hospitalized far in excess of the average length of stay for the medical service.

EXERCISE 7-3

Reimbursement

1. The payer had an agreement with the physician to pay the usual and customary fee less 10%. This is an example of _____.
2. What incentive do physicians have to operate under each of the four methods of reimbursement discussed?

Use the following scenario to answer Questions 3 and 4:

The 82-year-old patient came to the physician's office for a routine physical examination. He gave the receptionist two cards proving his primary, government-funded insurance plan, which pays for most of the bill, and an additional private plan that covers the remaining charges.

3. The patient's primary insurance is most likely _____.
4. The patient's secondary insurance is called _____.
5. The physician charged the patient $75 for the office visit. The patient paid the physician $5, and the patient's insurance company paid the physician $70. This method of reimbursement is called _____.
6. The physician charged the patient $75 for the office visit. The patient paid the physician $5, and the patient's insurance company paid the physician $70. The patient's portion of the payment is called _____.

Match the definition on the left with the health insurance terminology on the right.

____ 1.	Amount of cost that the beneficiary must incur before the insurance will assume liability for the remaining cost	A. Beneficiary
____ 2.	Contractor that manages the health care claims	B. Benefit
____ 3.	One who is eligible to receive or is receiving benefits from an insurance policy or a managed care program	C. Claim
____ 4.	Party who is financially responsible for reimbursement of health care costs	D. Deductible
____ 5.	Payer's payment for specific health care services or, in managed care, the health care services that will be provided or for which the provider will be paid	E. Fiscal intermediary
____ 6.	Payment by a third party to a provider of health care	F. Payer
____ 7.	Request for payment by the insured or the provider for services covered	G. Reimbursement

PROSPECTIVE PAYMENT SYSTEMS

Prospective Payment Systems (PPSs), as they apply to inpatient acute care, are based on diagnosis related groups (DRGs). Medicare inpatients under PPS are grouped, and hospitals reimbursed, through the use of the MS-DRG grouper. The MS-DRG grouper is a DRG grouper that incorporates a patient's medical severity (MS) into its assignments and reimbursement calculation. The MS-DRG grouper is one of several DRG **groupers.** For example, the AP-DRG grouper is a grouper used by some payers other than Medicare. "AP" stands for All Payer. In general, DRGs classify, or group, patients by common type according to diagnosis, treatments, and resource intensity. The statistical foundation of DRGs is based on the assumption that the same diagnosis requires the same type of care

Prospective Payment System (PPS) A system used by payers, primarily CMS, for reimbursing acute care facilities on the basis of the statistical analysis of health care data.

diagnosis related groups (DRGs) A collection of health care descriptions organized into statistically similar categories.

grouper The software used to derive the DRG from the ICD-10-CM diagnoses and procedures.

resource intensity (RI) A weight of the resources used for the care of an inpatient in an acute care setting that result in a successful discharge.

for all patients. The term **resource intensity (RI)** generally refers to demands and costs associated with treating specific types of patients: how much it costs to treat a particular disease or condition, depending on what types of resources that type of patient consumes and in some instances factoring in the age and gender of the patient. For example, if a patient is being treated in the hospital for congestive heart failure and nothing else, then that patient will probably consume the same amount of resources, have the same procedures performed, require the same number of consultations, and have the same intensity of nursing care as any other patient coming into the hospital with the same diagnosis, barring complications. Statistically, on the basis of review of hundreds of thousands of records, this assumption proves to be true, allowing for the classification of the patient's stay into a DRG assignment.

DRG diagnosis related group
PPS prospective payment system

Classifying types of patients into DRGs and predicting their expected resource consumption provide the basis for assigning monetary amounts for each MS-DRG in Medicare PPS. For example, even though a normal newborn and a patient scheduled for a cholecystectomy (gallbladder removal) may both stay in the hospital for 3 days, the normal newborn will not consume as much in the way of resources as a patient who required use of the operating room and postoperative care. Both patients, having different diagnoses and treatments, would be assigned to two different MS-DRGs, with the amount reimbursed for the newborn's hospitalization less than the amount reimbursed for the patient who had gallbladder surgery.

History of Diagnosis Related Groups and Impact on Health Information Management and the Coding Function

case mix Statistical distribution of patients according to their utilization of resources. Also refers to the grouping of patients by clinical department or other meaningful distribution, such as health insurance type.
Medicare Federally funded health care insurance plan for older adults and for certain categories of chronically ill patients.

Currently, the DRG system is known as a "patient classification scheme, which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital" (Diagnosis Related Groups Definitions Manual, 1989). It also serves as a basis for hospital reimbursement by Medicare and certain other payers. However, DRG classifications were originally developed by Yale University in the 1960s as a tool to ensure quality of care and appropriate utilization. DRG classifications were separate from reimbursement until the late 1970s, when the New Jersey Department of Health mandated use of the system for reimbursement. In New Jersey, DRG-based methodology reimbursement applied to all patients and all payer classifications; DRG reimbursement classifications were adopted with the goal of containing overall inpatient health care costs, which were rapidly increasing. Because the DRG classification system in New Jersey applied to all inpatients and payers, even self-pay patients, it has been referred to as an "all payer" prospective payment system. (This is a historical reference, as the New Jersey systems have since changed.)

HIT-bit

CASE MIX GROUPS

It should be noted that there are many grouper systems in use in the United States and, in fact, the world. In 1983, the Canadian Institute for Health Information developed case mix groups.

The prospective payment system does not apply to Canadian hospitals. Instead, hospitals in Canada operate under a global budget. Each hospital receives a sum of money according to its size and the types of services it provides. A large hospital that performs organ transplants, for example, would receive a higher monetary global budget than a small community hospital would.

Later in this chapter, you will read in greater detail how patients are classified in groups according to the DRG classification system, with coding being the main critical element. Without assigned codes for each patient, there cannot be a DRG assignment. Without a DRG assigned, a hospital cannot receive reimbursement. When the coding function became linked to reimbursement, coders and HIM personnel (e.g., medical records staff) made

enormous gains in importance and stature. There was a saying at the time that medical records professionals came "out of the basement and into the board room." For the first time ever, a national health care publication featured a medical records director on its cover, when it published a feature article about DRGs. With the advent of the DRG system, HIM professionals basked in the national health care spotlight and embraced their new leadership roles and responsibilities.

Again, the coding function had comparatively fewer pressures before the implementation of prospective payment systems and DRGs. Coders were focused on assigning codes for statistical purposes, such as analysis of resource utilization in the facility. The accuracy of codes, although important, was not so closely scrutinized, and coders were under less pressure to perform their tasks in a timely manner. Most hospital administrators would try to complete the previous month's cases no later than 2 weeks into the following month. Coding was considered just another function in a medical records department, perhaps on par with the analysis function. Coders were trained primarily by their employers, and some were credentialed as either registered record administrators (RRAs) or accredited record technicians (ARTs), which were the only two credentials offered at the time. People earning either credential did not specialize in coding but rather took one or two courses in coding. Today, coding has become a highly specialized and desirable profession in itself, with several credentials offered solely for coding by different organizations.

analysis The review of a record to evaluate its completeness, accuracy, or compliance with predetermined standards or other criteria.

With the evolution of coding and the coding profession, tremendous changes occurred in hospital computer systems. In the late 1970s, most medical records departments did not have computers or even access to their hospital computers. In some instances, DRG grouping was actually done by using a large paper manual that outlined the DRG grouper program. In most cases, however, coders dialed into a system off-site, entered codes and other data elements for each patient, and received a DRG assignment over the telephone connection. This was not even an Internet connection but rather a telephone modem connection to an off-site computer, originally the one at Yale University, where DRGs were developed. One advantage (possibly the only one) in grouping cases this way was that the coder truly understood the software program and could therefore provide feedback and suggestions. Because today all grouping is computerized, coders may not be as familiar with all of the nuances and elements of grouping. On the other hand, computerized grouping is certainly far more accurate than grouping with a paper manual. In any event, coders not only began to take greater responsibility for timely and accurate coding because of the DRG system but also learned more about information technology and health information. Eventually, computerization and the data collection activities required to support coding, DRG assignment, and reimbursement moved facilities closer to what will eventually become an electronic health record (EHR).

DRG diagnosis related group

electronic health record (EHR) A secure real-time, point-of-care, patient centric information resource for clinicians allowing access to patient information when and where needed and incorporating evidence-based decision support.

Overall, the impact of DRGs and the prospective payment system on health care was enormous. In addition to New Jersey, a number of states soon adopted prospective payment systems, or "all payer" systems, requiring all payers, including Medicare, to use DRGs as a reimbursement methodology for hospital inpatients. Because the prospective payment system was a completely new reimbursement model, its adoption had a dramatic financial impact on facilities during the initial years. Patients were also affected because lengths of stay were gradually decreased. Before the adoption of prospective payment systems, there were no financial incentives to reduce a patient's length of stay. For example, it was once common for a new mother and baby to stay in the hospital for a week; today it would be unusual for a healthy mother and baby to stay more than 2 or 3 days.

prospective payment system (PPS) A system used by payers, primarily CMS, for reimbursing acute care facilities on the basis of statistical analysis of health care data.

inpatient An individual who is admitted to a hospital with the intention of staying overnight.

Diagnosis Related Group Assignment

DRGs, including MS-DRGs, were initially developed with some basic characteristics in mind (Figure 7-4). Put in simple terms, modern DRG grouping software gathers certain demographic and clinical data from the patient abstract and uses those data to assign a three-digit code. It uses the patient's gender, diagnosis code(s), procedure codes(s), any hospital-acquired conditions, and discharge status to determine the appropriate group. Prior to the implementation of ICD-10-CM and PCS, MS-DRGs were derived from

demographic data Data elements that distinguish one patient from another, such as name, address, and birth date.

clinical data All of the medical data that have been recorded about the patient's stay or visit, including diagnoses and procedures.

abstract A summary of the patient record.

ICD-10-CM code set mandated by HIPAA for reporting diagnoses and reasons for healthcare encounters in all settings.

ICD-10-PCS classification system used in the U.S. for reporting procedures used in inpatient settings.

Characteristics	Explanation
"The patient characteristics used in the definition of the DRGs should be limited to information routinely collected on hospital abstract systems."	This information consists of the patient's principal diagnosis code, secondary diagnosis code or diagnoses codes, procedure code or codes, the patient's age, sex, and discharge status. In some DRG groupers, a newborn's birth weight must also be included.
"There should be a manageable number of DRGs which encompass all patients seen on an inpatient basis."	The point of this is so that meaningful comparative analyses of DRGs can be performed and patterns detected in case mix and costs.
"Each DRG should contain patients with a similar pattern of resource intensity."	Clinical coherence means that patients in a particular DRG share a common organ system or condition and/or procedures, and that typically a specific medical or surgical specialty would provide services to that patient. For example, one would expect a psychiatrist to treat all patients in DRGs created for mental diseases and disorders.
"Each DRG should contain patients who are similar from a clinical perspective (i.e., each class should be clinically coherent)."	This is so that a hospital can establish a relationship between their case mix and resource consumption.

Figure 7-4 Characteristics of DRGs. (From All patient refined diagnosis related groups [APR-DRGs], methodology overview, version 20.0. Wallingford, CT, 2003, 3M Health Information Systems.)

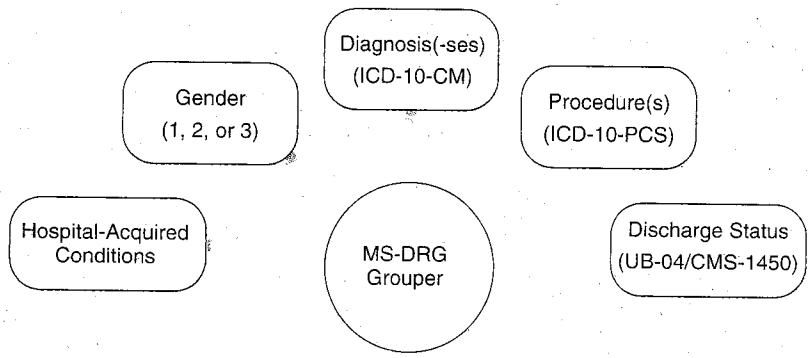


Figure 7-5 Data inputs for an MS-DRG grouping program.

Uniform Hospital Discharge Data Set (UHDDS) The mandated data set for hospital inpatients.
Uniform Bill (UB-04) The standardized form used by hospitals for inpatient and outpatient billing to CMS and other third party payers.

CMS Centers for Medicare and Medicaid Services

ICD-9-CM diagnosis (Volumes I and II) and procedure (Volume III) codes. Effective October 1, 2014, the MS-DRGs are based on ICD-10-CM and ICD-CM-PCS codes. The patient's gender is entered with a valid range of 1 to 3, in which 1 is male, 2 is female, and 3 is unknown. Discharge status is coded with use of Uniform Hospital Discharge Data Set (UHDDS) standards, as defined for the UB-04 by the The National Uniform Billing Committee (NUBC). Figure 7-5 illustrates the data elements of MS-DRG grouping.

DRG assignment can proceed once all of the necessary information is abstracted into the hospital's information system. Grouper software is used to assign each DRG. 3M Health Information Systems is the Grouper Contractor for CMS. Medicare patients under the Inpatient Prospective Payment System (IPPS) are grouped into MS-DRGs. Patients that self-pay or have other insurance may be grouped into a different DRG, such as the AP-DRG. Except for Medicare IPPS patients, the use of other DRG groupers may vary from state to state. Table 7-5 compares various DRG grouping systems.

TABLE 7-5

COMPARISON OF DIAGNOSIS RELATED GROUP GROUPERS FOR A SPECIFIC DIAGNOSIS, HEART FAILURE AND SHOCK, IN A 60-YEAR-OLD WOMAN

First Grouper		
Principal Diagnosis	Combined systolic and diastolic heart failure, acute on chronic	
Secondary Diagnoses	Pneumonia, not otherwise specified	
	Obstructive chronic bronchitis with acute exacerbation	
MS-DRG	291	HEART FAILURE & SHOCK W MCC
AP-DRG	544	CHF & CARDIAC ARRHYTHMIA W MAJOR CC
APR-DRG	194	HEART FAILURE
		2 Moderate Severity of Illness
		1 Minor Risk of Mortality
Second Grouper		
Principal Diagnosis	Combined systolic and diastolic heart failure, acute on chronic	
Secondary Diagnosis	Obstructive chronic bronchitis with acute exacerbation	
MS-DRG	292	HEART FAILURE & SHOCK W CC
AP-DRG	127	HEART FAILURE AND SHOCK
APR-DRG	194	HEART FAILURE
		2 Moderate Severity of Illness
		1 Minor Risk of Mortality
Third Grouper		
Principal Diagnosis	Combined systolic and diastolic heart failure, acute on chronic	
Secondary Diagnosis	No secondary diagnosis	
MS-DRG	293	HEART FAILURE & SHOCK W/O CC/MCC
AP-DRG	127	HEART FAILURE AND SHOCK
APR-DRG	194	HEART FAILURE
		1 Minor Severity of Illness
		1 Minor Risk of Mortality

CC, comorbidity or complication; CHF, congestive heart failure; DRG, diagnosis related group; MCC, major comorbidity or complication; w/o, without.

Grouping

The MS-DRG grouper software follows a process that resembles a flowchart, much like any flowchart created to track a process or procedure. This particular flowchart is referred to as a *decision tree diagram*. DRG grouper programs vary depending on the DRG system in use, but some generalizations may be made about the basic formats.

The process begins with examination of the **principal diagnosis** code. The principal diagnosis is defined in the UHDDS as the reason, after study, that the patient was admitted to the hospital. Codes must be currently valid and accepted as a principal diagnosis code by the **Medicare Code Editor (MCE)**. The MCE is essentially a list of codes that would not make sense if used as a principal diagnosis in an acute care facility. For example, many "Z codes" are on this list, such as ICD-10-CM code Z85.3, "history of breast cancer." The codes must also, when applicable, align with the sex of the patient. For example, a patient who is abstracted as male cannot then be assigned pregnancy codes.

If you examine an ICD-10-CM code book, you will see that the codes are divided into chapters or sections, primarily according to body system. In similar fashion, once the principal diagnosis code is accepted, the grouping process begins by assigning patients into basic sections, also primarily by body system, called **major diagnostic categories (MDCs)**. Whereas hundreds of DRGs exist, there are 25 MDCs in the Medicare MS-DRG grouper that resemble the chapters in ICD-10-CM, although not necessarily in the same order.

The MDCs are listed in Table 7-6. The complete list as well as the appendices can be seen on the CMS Web site: http://www.cms.gov/icd10manual/fullcode_cms/p0001.html.

principal diagnosis According to the UHDDS, the condition that, after study, is determined to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Medicare Code Editor (MCE) A part of grouping software that checks for valid codes in claims data.

acute care facility A health care facility in which patients have an average length of stay less than 30 days and that has an emergency department, operating suite, and clinical departments to handle a broad range of diagnoses and treatments.

UHDDS Uniform Hospital Discharge Data Set

major diagnostic categories (MDCs) Segments of the DRG assignment flowchart (grouper).

DRG diagnosis related group

TABLE 7-6

MAJOR DIAGNOSTIC CATEGORIES FOR MS-DRGs

MDC NUMBER	DESCRIPTION
1	Diseases & Disorders of the Nervous System
2	Diseases & Disorders of the Eye
3	Diseases & Disorders of the Ear Nose Mouth & Throat
4	Diseases & Disorders of the Respiratory System
5	Diseases & Disorders of the Circulatory System
6	Diseases & Disorders of the Digestive System
7	Diseases & Disorders of the Hepatobiliary System & Pancreas
8	Diseases & Disorders of the Musculoskeletal System & Conn Tissue
9	Diseases & Disorders of the Skin Subcutaneous Tissue & Breast
10	Endocrine Nutritional & Metabolic Diseases & Disorders
11	Diseases & Disorders of the Kidney & Urinary Tract
12	Diseases & Disorders of the Male Reproductive System
13	Diseases & Disorders of the Female Reproductive System
14	Pregnancy Childbirth & the Puerperium
15	Newborns & Other Neonates with Condtn Orig in Perinatal Period
16	Diseases & Disorders of Blood Blood Forming Organs Immunolog Disord
17	Myeloproliferative Diseases & Disorders Poorly Differentiated Neoplasm
18	Infectious & Parasitic Diseases Systemic or Unspecified Sites
19	Mental Diseases & Disorders
20	Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders
21	Injuries Poisonings & Toxic Effects of Drugs
22	Burns
23	Factors Influencing Hlth Stat & Other Contacts with Hlth Servcs
24	Multiple Significant Trauma
25	Human Immunodeficiency Virus Infections

From Centers for Medicare and Medicaid Services: MDC Description File. https://www.cms.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1247844&intNumPerPage=10. Published 2008. Accessed September 10, 2011.

Once the patient is assigned to an MDC, the grouper examines any procedure codes. Not all procedure codes are used for MS-DRG assignment. For example, codes for ultrasound examinations are diagnostic radiology and are essentially ignored during the grouping process. Procedure codes that are recognized and used for grouping are categorized as either OR (operating room) or Non-OR. An OR procedure code indicates that the patient has undergone a procedure requiring the use of an operating room: for example, a gastric bypass or open fracture reduction. Non-OR procedures include procedures or treatments such as paracentesis or nonexcisional débridements. Figure 7-6 shows an example of an MDC decision tree.

Most MDCs have two main sections, one for medical patients and one for surgical patients. The two sections are referred to as medical partitioning and surgical partitioning. Once a case is assigned to an MDC, the case is sorted or assigned to one of these main sections. Note that in Figure 7-6, the first question is whether the patient had an operation (OR procedure). If the answer is yes, then the correct MS-DRG is found in the surgical partitioning. If the answer is no, then the decision tree sends the user to the medical partitioning.

MDC major diagnostic category
CMS Centers for Medicare and Medicaid Services

MCE Medicare Code Editor

abstracting The recap of selected fields from a health record to create an informative summary. Also refers to the activity of identifying such fields and entering them into a computer system.

For cases sorted into the medical partition, the grouper looks for, depending on the MDC, the patient's age. The MCE detects instances in which a patient's age does not correspond with the principal or secondary coded diagnoses. For example, an 80-year-old woman with pregnancy codes would not pass the edit and would not be grouped until a correction was made in abstracting.

Next, depending on the MDC, the grouper will search the secondary diagnosis codes for a comorbidity or complication (CC) and major comorbidity or complication (MCC). The list of CCs and MCCs can be seen on the CMS Web site listed previously, in Appendix G, Diagnoses Defined as Complications or Comorbidities, and Appendix H, Diagnoses

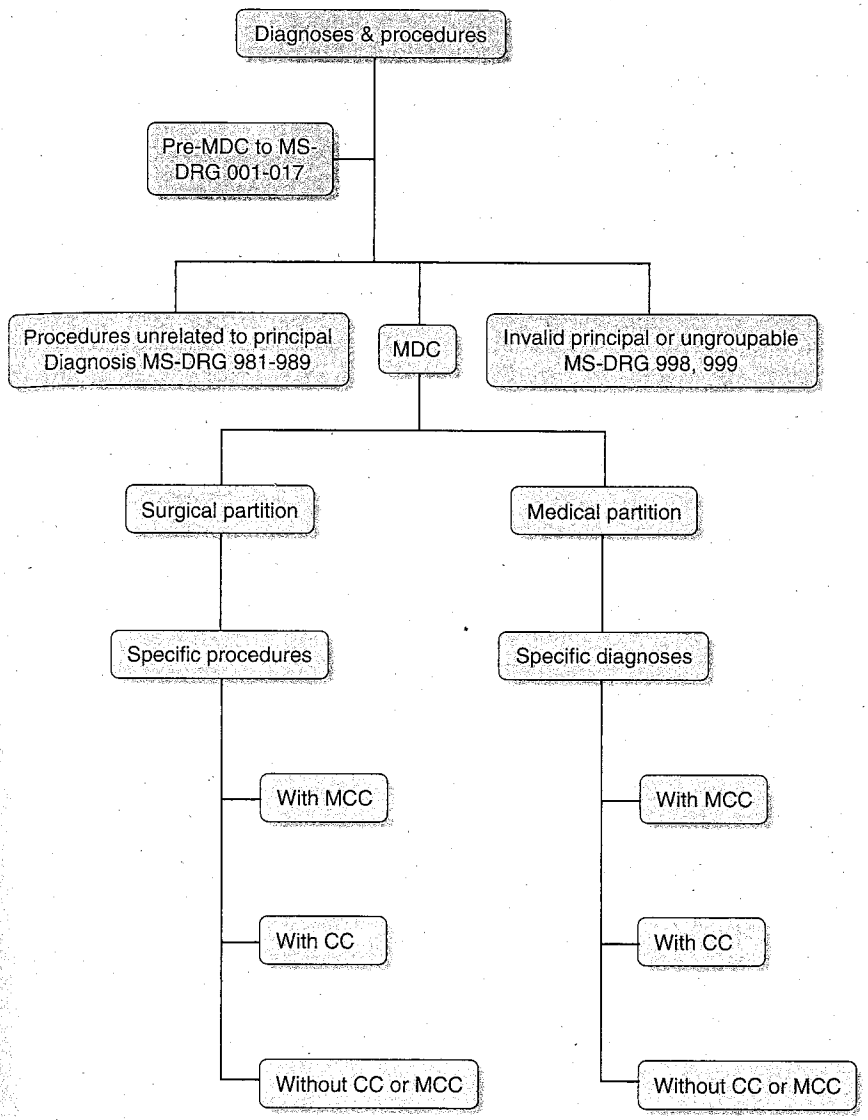


Figure 7-3 Overview of MS-DRG assignment logic. Adapted from Centers for Medicare and Medicaid Services: Acute Inpatient Prospective Payment System Fiscal Year 2013 Final Rule, Table 5. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html. Published 2012.

Defined as Major Complications or Comorbidities. Major comorbidity or complication (MCC) codes are complications or comorbidities of greater severity than CC codes. MCC codes, when applied in the MS-DRG calculation, "adjust" the DRG assignment and reimbursement to account for this greater severity.

A **comorbidity** is a condition that was present upon admission, whereas a **complication** is a condition that arose during the hospitalization. If a secondary diagnosis code, when matched with a certain principal diagnosis code, is statistically proved to extend a patient's length of stay by at least 1 day in 75% of cases, that secondary diagnosis is considered a CC in combination with that principal diagnosis. For example, suppose a patient has a principal diagnosis of pneumonia (J18.9) and also has hyponatremia (E87.1). It has been statistically demonstrated that 75% of patients with pneumonia and a secondary diagnosis of hyponatremia must remain in the hospital at least 1 day longer than patients with pneumonia alone. Therefore E87.1 is considered an applicable CC code when J18.9 is the principal diagnosis code.

The list of CC and MCC codes are reviewed and revised each year by CMS and published in the *Federal Register* and on the CMS Web site previously listed, usually at the same time as any DRG revisions.

CC comorbidity or complication
MCC major comorbidity or complication

comorbidity A condition that affects the patient's care and/or length of stay and exists at the same time as the principal diagnosis.
complication A condition that arises during hospitalization, or as a result of the health care encounter.
principal diagnosis According to the UHDDS, the condition that, after study, is determined to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
Federal Register The publication of the proceedings of the United States Congress.

Not all CC codes appearing in the CC or MCC list apply in all instances. Certain CC codes are not considered CCs with certain principal diagnoses codes because the secondary diagnosis code is a condition that has been determined to not significantly affect length of stay or treatment. A list of all CC codes and MCC codes can be seen in Appendix C (of the *Federal Register* publication), Complications or Comorbidities Exclusion List. Each CC or MCC code listed is followed by a code or codes that, when assigned as principal diagnoses, exclude that CC or MCC from affecting MS-DRG assignment. For example, I09.81, rheumatic heart failure, is a CC. If I09.81 is assigned as a secondary diagnosis code with a principal diagnosis of I50.1 Left Ventricular failure, it will not "count" as a CC because I09.81 is on the CC exclusion list for code I50.1.

CC comorbidity or complication
MCC major comorbidity or complication

CC and MCC codes are important to MS-DRG assignment because the presence of a CC or MCC code can determine the final MS-DRG assigned. The final stage in the MDC tree diagram is frequently a choice between an MS-DRG with a CC and an MS-DRG without a CC, or a MS-DRG with an MCC or without an MCC. For example, MS-DRG 290 is "Acute and subacute endocarditis w/o (without) CC/MCC," MS-DRG 289 is "Acute and subacute endocarditis w (with) CC," and MS-DRG 288 is "Acute and subacute endocarditis with MCC." The MS-DRG with the CC is reimbursed at a higher rate than the MS-DRG without the CC. The MS-DRG with the MCC is reimbursed at a higher rate than the MS-DRG with the CC. Multiple CC or MCC codes do not have any impact because only one CC or MCC code is needed for the case to be assigned to the MS-DRG with the higher rate of reimbursement.

MDC major diagnostic category

Cases assigned to the surgical partitioning section of an MDC essentially follow the same format for MS-DRG assignment as those in the medical partitioning section but must account for instances in which more than one procedure performed (from the OR or Non-OR List) on the same patient during the same admission. Only one MS-DRG is assigned for each admission, even if multiple procedures are performed. In these cases, the grouper reviews all of the procedure codes assigned and identifies the single procedure that required the most resource intensity. Each surgical partition is sequenced according to a surgical hierarchy. When multiple procedures have been performed, the procedure code that is highest in the surgical hierarchy is selected by the grouper for MS-DRG assignment. On the MDC tree diagram, the surgical hierarchy lists procedures in descending order, with the procedure requiring the greatest resource intensity at the top. For example, assume that a patient in MDC 8 ("Diseases and disorders of the musculoskeletal system and connective tissue") undergoes a total hip replacement. This case would group to MS-DRG 470, "Major joint replacement or reattachment of lower extremity w/o MCC." In another case, a patient undergoes a shoulder arthroscopy. That case would group to MS-DRG 512, "Shoulder, forearm or shoulder procedure excluding major joint procedure w/o/ CC/MCC." Now, suppose that a patient who was admitted for and underwent total hip replacement later complained of severe shoulder pain and was returned to the OR during the same admission for a shoulder arthroscopy. The MS-DRG for this admission would be MS-DRG 470, because a total hip replacement is higher on the surgical hierarchy than a shoulder arthroscopy. The arthroscopy has no influence on MS-DRG assignment in this case because it is superseded by the total hip replacement in resource intensity. When abstracting a case, even if the arthroscopy was listed first as **principal procedure**, the grouper would still select the total hip replacement for MS-DRG assignment. This is a major difference from cases in the medical partition, in which the principal diagnosis selected by the coder is used for MS-DRG assignment.

resource intensity A weight of the resources used for the care of an inpatient in an acute care setting that result in a successful discharge.
abstracting The recap of selected fields from a health record to create an informative summary. Also refers to the activity of identifying such fields and entering them into a computer system.
principal procedure According to the UHDDS, the procedure that was performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes or necessary to take care of a complication. If two procedures appear to meet this definition, then the one most related to the principal diagnosis should be selected as the principal procedure.
grouper The software used to derive the DRG from the ICD-10-CM diagnoses and procedures.

Exceptions to the program format described in the preceding paragraphs include organ transplantation cases and patients who have had a tracheostomy and a certain diagnosis. These cases are not assigned to an MDC first but rather directly assigned to each respective MS-DRG. Examples of these MS-DRGs include MS-DRG 002, "Heart transplant or implant of heart assist system," and DRG 013, "Tracheostomy for face, mouth, and neck diagnosis." As of fiscal year (FY) 2011, there were 11 DRGs grouped into these "Pre-MDCs."

There are other exceptions in which a case is grouped directly to a MS-DRG without first being assigned to an MDC. Unusual, unpredictable, or unique circumstances occasionally occur during hospitalization, making such cases exceptions to the usual rules of MS-DRG assignment. These exceptions are categorized into the following MS-DRGs:

major diagnostic categories (MDCs) Segments of the DRG assignment flowchart (grouper).

DRG 981, "Extensive OR procedure unrelated to principal diagnosis w MCC," DRG 982, "Extensive OR procedure unrelated to principal diagnosis w CC," and DRG 983, "Extensive OR procedure unrelated to principal diagnosis w/o CC/MCC": An example would be a patient admitted for a myocardial infarction. During her hospitalization, a breast lump is noticed, the patient is found to have breast cancer, and a mastectomy is performed. The myocardial infarction as principal diagnosis is not associated with or related to the mastectomy, so the case is grouped to DRG 983.

DRG 998, "Principal diagnosis invalid as discharge diagnosis": A code, such as Z93.8, "Colostomy status," was submitted as principal diagnosis for an inpatient admission.

DRG 984, "Prostatic OR procedure unrelated to principal diagnosis w MCC," DRG 985, "Prostatic OR procedure unrelated to principal diagnosis w CC," and DRG 986, "Prostatic OR procedure unrelated to principal diagnosis w/o CC/MCC": An example would be a patient who was admitted for exacerbation of chronic obstructive pulmonary disease and underwent a transurethral prostatectomy. This case would group to DRG 986.

DRG 987, "Non-extensive OR procedure unrelated to principal diagnosis w MCC," DRG 988, "Non-extensive OR procedure unrelated to principal diagnosis w CC," and DRG 989, "Non-extensive OR procedure unrelated to principal diagnosis w/o CC/MCC": These DRGs are similar to DRGs 981 to 983, except that the procedure is, as it states, non-extensive. An example would be if the previously mentioned patient with a myocardial infarction had a breast biopsy instead of a mastectomy. The myocardial infarction as principal diagnosis is not associated with or related to the breast biopsy, and the breast biopsy is a non-extensive procedure, unlike the mastectomy, so the case is grouped to DRG 989.

A complete list of DRGs and related information is published yearly, in late summer, as a Final Rule in the *Federal Register* on the CMS Web site in conjunction with ICD-10-CM/PCS updates, effective each October 1.

Understanding how DRGs are assigned helps coders to properly sequence their code assignments and focus on the correct principal diagnosis. Box 7-1 summarizes the steps in DRG assignment.

Diagnosis Related Group (MS-DRG) Reimbursement Calculation

Medicare reimbursements for MS-DRGs are based on two components: the national numerical value or **relative weight (RW)** of each MS-DRG and each hospital's **Prospective Payment System (PPS) blended rate.** The blended rate consists of the hospital-specific rate, which is based on historical financial data provided annually to CMS by the hospital, and additional factors such as regional labor costs and graduate medical education. The blended rate is expressed in a dollar amount specific to each hospital. All hospitals are reimbursed on the basis of the same national RW for each MS-DRG multiplied by the

relative weight (RW) A number assigned yearly by CMS that is applied to each DRG and used to calculate reimbursement. This number represents the comparative difference in the use of resources by patients in each DRG.

Prospective Payment System (PPS) blended rate A weighted component of MS-DRG assignment that consists of the hospital-specific rate and additional factors such as regional labor costs and graduate medical education.

BOX 7-1 ASSIGNMENT OF THE DRG

Most cases in various grouper programs follow the following format:

- Search for clinical procedures: transplants, ventilators, and tracheotomies, and group immediately to the appropriate DRG, if detected.
- The principal diagnosis code assigns a case to MDC.
- The grouper reviews all diagnoses and procedure codes and then assigns the case to either the medical or surgical portion of the MDC.
- The grouper, using the Medicare code edits, makes sure that the principal diagnosis code is appropriate for an inpatient admission.
- The grouper, using the Medicare code edits, makes sure that the patient's age and sex are appropriate for the diagnoses and procedures assigned.
- The grouper may further process the case according to the patient's age.
- The grouper reviews all secondary diagnoses codes for the presence of a comorbidity or complication.
- If the case is surgical the grouper reviews all procedure code assigned and bases the DRG selection on the procedure code highest in the surgical hierarchy.

DRG, diagnosis related group; MDC, major diagnostic category.

individual hospital's blended rate. For example, suppose MS-DRG 999 (fictional) has a national RW of 3.0000. Hospital A has a blended rate of $5000, and hospital B has a blended rate of $4500. Hospital A will receive $15,000 for each case in MS-DRG 999 (3.0000 × $5000). Hospital B will receive $13,500 for each case in MS-DRG 999 (3.0000 × $4500).

outlier payment An unusually high payment within a given case mix group.

There are variations to this basic calculation for cases incurring extraordinarily high costs. These cases may qualify for **outlier payment.** "To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of the case must exceed payments in order to qualify for outliers)" (Centers for Medicare and Medicaid Services, 2005). Several calculations to determine outlier payments depend on the hospital's specific operating and capital cost factors.

RW relative weight

The fact that each MS-DRG has its own RW used to calculate reimbursement makes the importance of correctly assigning codes for each case to group into the correct DRG apparent. For example, suppose that you are a coder at Hospital A. Your fictional MS-DRG 924 has an RW of 3.0000. MS-DRG 924 happens to be a pair MS-DRG (i.e., there is another similar MS-DRG, MS-DRG 925, that resembles MS-DRG 924 except MS-DRG 925 denotes that a CC code is present). Suppose MS-DRG 925 has an RW of 4.0000. If you do not correctly code and do not include the CC code for MS-DRG assignment, the case would group to MS-DRG 924. If the CC code were included, the case would group to MS-DRG 925. In this example, the absence or presence of the CC code would have the following effect on reimbursement with Hospital A's blended rate of $5000:

MS-DRG 925 "With CC" RW: 4.0000 × $5000 = $20,000 reimbursement
MS-DRG 924 "Without CC" RW: 3.0000 × $5000 = $15,000 reimbursement

principal diagnosis According to the UHDDS, the condition which, after study, is determined to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Consider how the MS-DRG grouper assigns cases to a MS-DRG and the great importance of assigning the correct principal diagnosis. If the incorrect principal diagnosis is assigned, it is highly likely that the MS-DRG will also be incorrect. The resultant incorrect MS-DRG assignment may be reimbursed at either a higher or lower rate than the correct MS-DRG assignment would have been. In either case, the hospital will not receive the appropriate reimbursement. When such errors in MS-DRG assignment are found, the hospital must rebill or reconcile the reimbursement amount with Medicare and other affected providers. In addition, the hospital's statistics will be negatively affected if cases are not correctly assigned. One important statistic is the hospital's *case mix index (CMI).*

Case Mix Index

case mix index (CMI) The arithmetic average (mean) of the relative DRG weights of all health care cases in a given period.

A hospital's **case mix index (CMI)** is a number derived by adding the RWs of all of the actual MS-DRG cases and then dividing by the total number of cases discharged in a given period.

A hospital uses the CMI to monitor its performance: the higher the number, the greater the reimbursement received. Fluctuations in CMI indicate incorrect coding, changes in patient populations, changes in physician practices and personnel, or other conditions.

For example, Hospital A discharged 54 patients in January. Each of the 54 MS-DRG RWs is added together, with a combined total of 43.9675. To calculate its CMI for January, Hospital A divides 43.9675 by 54; the CMI for January is 0.81421. Hospital A then decides to do a 6-month comparison and calculates its CMI for June. In June, 47 patients were discharged with a combined RW of 41.5482. The CMI for June is calculated by dividing 41.5484 by 47; the CMI for June is 0.88400. Hospital A must decide whether the difference in the CMI from January to June is significant enough to warrant further investigation. In this example, the CMI was higher in June than January, so the hospital received more reimbursement on average per patient in June.

provider number The number assigned to a participating facility by Medicare for identification purposes.

The CMI for all hospitals is published yearly by CMS on its Web site in the Public Use Files. Each hospital has its own unique **provider number** that can be referenced on a chart. The chart notes the total number of Medicare cases discharged in the previous fiscal year (FY) and the CMI for that FY. The federal FY begins October 1 and ends September 30. The chart is useful in that hospitals can use it as a reference to compare their CMIs with those of other hospitals that have a similar number of cases. The provider number must be known in order to identify a specific hospital. For example, an employee at Hospital A checks the chart and goes to the hospital's provider number, 000099. The chart shows that Hospital A had 808 Medicare cases discharged in the previous FY and that Hospital A had

a CMI of 1.023784 for that period. Next, the Hospital A employee checks the chart for hospitals that had a similar number of discharges and sees that provider number 000054 had 812 cases and a CMI of 2.371271, significantly higher than that of Hospital A. The employee reviews the chart again and in each instance notes that the CMI for similar providers is higher than the CMI for Hospital A. Hospital A administrators may elect to perform an internal investigation, such as a coding audit.

CMI case mix index

The Coder's Role in Diagnosis Related Group (MS-DRG) Assignment

The coder must be able to properly apply current coding rules and coding conventions to each case. Although this section focuses on the Medicare PPS system, all cases, regardless of payer, should be coded with equal care, even if payment is not affected, if a hospital's statistics are to be accurate and useful. As previously emphasized, complete and accurate coding is necessary to generate data and statistics beyond MS-DRGs and other DRG grouper assignments.

It is unethical and fraudulent to deliberately code a case incorrectly so that it may be placed into a MS-DRG with a higher reimbursement rate. This practice is sometimes referred to as "upcoding," maximizing, or "DRG creep." Some coding software includes prompts that alert the coder that a case would group to a higher-paying MS-DRG if a CC or MCC were added or if a different principal diagnosis were assigned. The coder may wish to review the medical record to search for a CC or MCC or confirm that there is no CC or MCC. Under no circumstances should the coder simply add a CC or MCC without confirming that the CC or MCC is documented in the medical record. Likewise, the principal diagnosis code should not be changed unless an error was made in the original assignment. The coding software prompts are intended to assist the coder in ensuring proper coding and sequencing; this process is sometimes referred to as optimizing. The prompts should never be interpreted as directives to code or sequence a certain way simply to obtain higher reimbursement when no supporting documentation exists.

maximization The process of determining the highest possible DRG payment.
optimization The process of determining the most accurate DRG payment.

CC comorbidity or complication
MCC major comorbidity or complication

In all cases, without exception, coding and sequencing must be supported by documentation in the medical record. To code otherwise is considered fraudulent by the federal government under the Civil False Claims Act and may subject the hospital to considerable monetary penalties if a pattern of fraud and abuse is demonstrated.

Go To Refer to Chapter 6, Figure 6-1.

Under the auspices of the U.S. Department of Health and Human Service's Office of the Inspector General (OIG), the federal government released Compliance Program Guidance for Hospitals, which addresses coding issues. Coders should be familiar with this publication as well as their own hospital's compliance program. The OIG publishes a Work Plan every year that includes coding projects focused on particular MS-DRGs and patterns of MS-DRG assignment.

Usually, medical records are coded and MS-DRGs are assigned after the patient is discharged. The hospital cannot submit a claim for reimbursement until after the patient is discharged. To minimize the time between discharge and claims submission, some facilities perform coding concurrently—that is, while the patient is still in the hospital. The coder may review the medical record when the patient is admitted and every day or every other day thereafter until discharge. Temporary codes are assigned as well as a temporary MS-DRG. This concurrently assigned MS-DRG is often referred to as a **working MS-DRG**. The coder has the opportunity to question the physician about documentation and potentially facilitate coding and MS-DRG assignment accuracy; these efforts may shorten the time between discharge and claims submission. Coding concurrently does present some disadvantages, however. More coding staff may be needed, and some necessary information, such as pathology reports, may not yet be available. In effect, concurrent coding may be a duplication of effort since the post-discharge coding must still take place.

discharged The status of a patient after leaving the care of the facility.
claim The application to an insurance company for reimbursement of services rendered.
working DRG The concurrent DRG. The DRG that reflects the patient's current diagnosis and procedures while still an inpatient.

One way to obtain both the advantages of concurrent coding and the resolution of physician queries prior to discharge is through a Clinical Documentation Improvement (CDI) program. In a CDI program, improving the quality of the physician documentation is the primary goal. Developing a working MS-DRG is important; however, the entire chart is not coded. A CDI program can be an effective and efficient way to ensure that the documentation accurately reflects the patient's severity of illness as well as the medical decision making involved in directing the care of the patient. This effort can support both case

CDI clinical documentation improvement

severity of illness (SI) In utilization review, a type of criteria, based on the patient's condition, that is used to screen patients for the appropriate care setting.

management, ensuring the documentation of the medical necessity of the inpatient stay, and postdischarge coding, obtaining the highest degree of specificity in the documentation. CDI specialists are usually nurses who have been trained to code or experienced coders with extensive clinical knowledge.

Ambulatory Payment Classification

outpatient A patient whose health care services are intended to be delivered within 1 calendar day or, in some cases, a 24-hour period.

capitation A uniform reimbursement to a health care provider based on the number of patients contractually in the physician's care, regardless of diagnoses or services rendered.

CMS Centers for Medicare and Medicaid Services

HCFA Health Care Financing Administration

Outpatient Prospective Payment System (OPPS) A Medicare prospective payment system (PPS) used to determine the amount of reimbursement for outpatient services.

ambulatory payment classifications (APCs) A prospective payment system for ambulatory care based on medically necessary services.

Healthcare Common Procedure Coding System (HCPCS) A coding system, of which CPT-4 is level one, used for drugs, equipment, supplies, and other auxiliary health care services rendered.

Current Procedural Terminology (CPT) A nomenclature and coding system developed and maintained by the American Medical Association to facilitate billing for physicians and other services.

claim The application to an insurance company for reimbursement.

APC ambulatory payment classification

As is true for inpatient services, the costs for outpatient, or ambulatory, services has risen. In addition, many patient care services have shifted from inpatient to outpatient settings, thus increasing the amount of reimbursement from outpatient/ambulatory services. In ambulatory health care, a number of different reimbursement methodologies apply; fee for service and discounted fee for service are most commonly used. A number of insurers are participating in capitation as well.

In the 1990s, the federal government was spending billions of dollars on outpatient services using a cost-based system. In an attempt to cut or at least control the costs of these services and as part of the Balanced Budget Act of 1997, Congress mandated that CMS (at that time the HCFA) develop a PPS for Medicare outpatient services, referred to as the **Outpatient Prospective Payment System (OPPS)**. Just as DRGs are used for reimbursement for Medicare inpatient services under PPS, the OPPS uses **ambulatory payment classifications (APCs)** to reimburse for Medicare outpatient services. Originally, this system was called ambulatory payment groups (APGs), but the HCFA changed the name when it modified APGs in 1998. The OPPS and APCs were implemented for services provided on or after August 1, 2000. The Final Rule for implementation and subsequent updates can be found on the CMS Web site and in the *Federal Register* (Medicare, 2000). APCs are updated annually to include additions, deletions, and modifications. Updates occur each calendar year (CY).

The APC system uses HCPCS/CPT procedure, service, or item codes to group patients. ICD-10-CM codes are used not for grouping but to indicate the medical necessity of the procedure, service, or item provided. For example, if a claim were submitted for reimbursement of an electrocardiogram, there should be a logical corresponding cardiac ICD-10-CM code that indicates the reason that the electrocardiogram was performed. ICD-10-PCS (procedure) codes are not used in OPPS and the APC system, although they are sometimes assigned.

Under the APC classification system, patients are grouped on the basis of clinical similarities and similar costs or resource consumption. There are approximately 2000 APCs, a figure subject to change depending on the yearly modifications. APCs are categorized as follows:

- Significant procedures, therapies, or services
- Medical visits
- Ancillary tests and procedures
- Partial hospitalization
- Drugs and biologicals
- Devices

Consideration of these categories makes it easier to envision how one outpatient visit can result in the assignment of multiple APCs. That more than one APC can be assigned per visit is a major difference between APCs and MS-DRGs, in which only one MS-DRG is assigned per inpatient hospitalization. For example, suppose a man is found unconscious on the sidewalk and brought to the hospital's emergency department by the police. The emergency department physician performs a workup, discovers that the patient is in a diabetic coma, and gives him insulin to bring his glucose level under control. In addition, the emergency physician notes that the patient injured his arm after falling on the sidewalk and orders a radiograph to rule out a fracture. In such a scenario, there will be an APC for the emergency visit, an APC for the administration of the drug insulin, and an APC for the radiograph. Each APC has its own payment. The facility is reimbursed in an amount equal to all three APCs added together or, in some instances, receives a reduced or discounted payment for one of the services. For example, if a patient requires the use of a minor surgery suite for multiple procedures, the patient probably uses fewer resources

overall than if the procedures were performed separately at different times. Therefore a reduced payment is warranted. By the same logic, if a procedure is terminated or discontinued, the payment is reduced or discounted, depending on whether anesthesia was started.

Final payment for APCs is based on a complex set of edits and payment rules that include, for example, HCPCS/CPT codes, code modifiers, and revenue codes. The coder is usually responsible only for assigning the HCPCS/CPT codes and modifiers, and the other billing elements are the responsibility of other departments where charges have been incurred.

A code **modifier** is a two-digit number added to a HCPCS/CPT code that provides additional information regarding the procedure or service performed. A modifier may be used, for example, to indicate a right, left, or bilateral body part; a specific appendage; extent of anesthesia; limited or reduced services; and other situations or circumstances. A **revenue code** is a three-digit code that denotes the department in which a procedure, service, or supply item was provided. Revenue codes are in the **Chargemaster**, which is discussed later in this chapter. Some modifiers are classified as "pricer modifiers"; others are considered "informational" or "statistical" modifiers.

On the basis of the HCPCS/CPT code or codes, each APC is assigned a payment status indicator (SI) that determines reimbursement under OPPS. For example, SI T indicates "significant procedure, multiple-procedure reduction applies." SI V indicates "clinic or emergency department visit," and SI X indicates "ancillary service." The entire list of APCs and each SI can be found on the CMS Web site along with the RW for each APC, each payment rate, national unadjusted copayment, and minimum unadjusted copayment. CPT/HCPCS codes and APCs are updated each CY; therefore it is important to note any changes because reimbursements may be affected.

modifier A two-digit addition to a CPT or HCPCS code that provides additional information about the service or procedure performed.

revenue code A Chargemaster code required for Medicare billing.

Chargemaster The database that contains the detailed description of charges related to all potential services rendered to a patient.

RW relative weight

Payment Denials and Claims Rejections

Coding professionals in various settings, from ambulatory hospital settings to physician offices, are frequently involved in responding to payment denials or claims rejections. As noted in this brief overview of APCs, the system undergoes changes yearly and is complicated on several levels, from coding to billing. When claims are submitted through the Medicare Administrative Contractors (MACs), the claims are subjected to a number of edits that include the outpatient code editor (OCE) and National Correct Coding Initiative (NCCI) edits. The OCE and NCCI edits flag coding errors in the claims. Until the errors are corrected, the claim is rejected and reimbursement is denied for that claim.

Avoidance of payment denials or claims rejections is of paramount concern because income is adversely affected. One way to avoid these rejections is to understand the reasons for the rejections. Each MAC uses a **local coverage determination (LCD)** definition to determine if a service is covered for payment. These LCDs are derived from the CMS (Medicare) **national coverage determination (NCD)**. The NCD is a general discussion of the service and what it is useful in determining. The LCD lists the specific diagnosis codes that justify the medical necessity of the service. The LCD is available to providers, usually on the MAC's Web site. The LCD is extremely useful in that the policy defines covered services and details concerning exactly what diagnosis codes are needed for a service, procedure, or item to be deemed medically necessary. Coders familiar with the LCD, as well as the OCE and NCCI edits, can be proactive in avoiding payment denials and claims rejections.

For example, general medical examination is not sufficient justification for Medicare to pay for a blood test for vitamin D deficiency. Osteoporosis and osteopenia, on the other hand, will justify the vitamin D test. A provider who is performing the laboratory test upon physician's order must query the physician to determine the reason for the test. If the diagnosis does not meet the LCD requirement for performing the test, then the provider must obtain a signed Advance Beneficiary Notice (ABN) from the patient. Completion of the ABN obligates the patient to pay for the test if Medicare does not. It is important to note that there is no prohibition on performing the test itself. If the physician feels the test is necessary and the patient is willing to pay for it, then the provider can certainly perform it.

Medicare Administrative Contractor (MAC) Regional, private contractor who processes reimbursement claims for CMS.

local coverage determination (LCD) A list of diagnostic codes used by Medicare contractors to determine medical necessity.

national coverage determination (NCD) A process using evidence-based medicine to determine whether Medicare will cover an item or service on the basis of medical necessity.

OCE outpatient code editor

NCCI National Correct Coding Initiative

OPPS Outpatient Prospective Payment System
LCD local coverage determination
MAC Medicare Administrative Contractor

CMS Centers for Medicare and Medicaid Services
CC comorbidity or complication

per diem Each day, daily. Usually refers to all-inclusive payments for inpatient services.

patient assessment instrument (PAI) A tool used to identify patients with greater needs and for the treatment of whom the long-term care or skilled nursing facility will receive higher reimbursement.
comorbidity A condition that affects the patient's care and/or length of stay and exists at the same time as the principal diagnosis.

etiology The cause or source of the patient's condition or disease.
Uniform Bill (UB-04) The standardized form used by hospitals for inpatient and outpatient billing to CMS and other third party payers.
principal diagnosis According to the UHDDS, the condition that, after study, is determined to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

OCE and NCCI details can be found on the CMS Web site in the Medicare section under OPPS. LCDs are issued by the regional MACs and are described in detail on the MACs' Web sites.

Additional Prospective Payment Systems

Inpatient Psychiatric Facility Prospective Payment System

CMS recognized that providing services for psychiatric patients is unique and not readily comparable to providing services for medical or surgical patients. The psychiatric setting is often more difficult to manage in terms of resources and length of stay. The Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) was designed to address these issues beginning January 1, 2005. The major change concerning reimbursement is that under IPF PPS, payment is made on a per diem rate based on a federal rate. The federal rate is based on various factors and adjustments. There are two levels of adjustments: patient level and facility level. The patient level includes length of stay and patient age, and the facility level includes the geographical location of the facility and whether the facility is a teaching hospital.

IPF PPS will be based on ICD-10-CM coding, and, as was the case under MS-DRGs, all of the coding rules will apply. A difference that coders will notice is that CC codes play a larger role than in the psychiatric MS-DRGs in the PPS MS-DRG system. The addition of these CC codes under IPF PPS will cause a case to fall into additional adjustment categories. It is important for psychiatrists to fully document all secondary diagnoses, including all medical diagnoses, in addition to psychiatric diagnoses.

Inpatient Rehabilitation Facility Prospective Payment System

The Balanced Budget Act of 1997 also required CMS to establish a PPS for Inpatient Rehabilitation Facilities (IRF PPS). The Final Rule for IRF PPS was published in the *Federal Register* on August 1, 2000, and became effective January 1, 2002. IRF PPS replaced a cost-based payment system. IRF PPS reimburses on a per-discharge basis addresses both the costs of inpatient rehabilitation services as well as the unique needs of each patient that a facility admits. A comprehensive **patient assessment instrument (PAI)**, called the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), is used to assess each patient with the intent that patients with greater needs will be identified and that the facility will receive higher payment for these individuals. IRF-PAI includes sections on, for example, bowel continence, impairments, infections, and pressure ulcers. Two sections of IRF-PAI require the use of ICD-10-CM codes. Patients are grouped into case mix groups (CMGs). Each CMG has four possible weights; the final weight is determined by the patient's comorbidities.

Unique to IRF PPS is that two types of coding practice are applied: one type for IRF-PAI and one type for billing. IRF PPS requires coding of the etiology diagnoses, essentially the same diagnoses that would have been coded in the acute setting even though the patient is no longer receiving acute care. For reporting purposes on the Uniform Bill (UB-04), standard coding rules and conventions are applied. For example, suppose a patient admitted to the hospital was diagnosed with type 1 diabetes mellitus with severe peripheral angiopathy and gangrene and had to have his leg amputated. The ICD-10-CM diagnosis code assigned for the inpatient stay is E10.52, Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene. After the amputation, the patient was transferred to an inpatient rehabilitation facility to learn how to use an artificial leg. The same code, E10.52, would be used for IRF-PAI, but a rehabilitation code, code Z47.81, Encounter for orthopedic aftercare following surgical amputation, would be reported as the principal diagnosis on the UB-04.

Long-term Care Hospital Prospective Payment System

The Long-term Care Prospective Payment System (LTCH-PPS) became effective for cost reporting periods beginning on or after October 1, 2002. Medicare regulations define long-term care hospitals as hospitals that have an average inpatient length of stay greater than 25 days. Patients in long-term care hospitals have multiple acute and chronic complex

conditions and may need, for example, comprehensive rehabilitation services, respiratory therapy, cancer treatment, and pain management. LTCH-PPS is based on DRGs, but these DRGs are modified to reflect patient acuity and the greater costs involved in treating the complex conditions of these patients, which require longer lengths of stay. This modification is accomplished through the identification of a **Resource Utilization Group (RUG)** category. A Minimum Data Set (MDS), which includes the MS-DRG, is completed for the patient at various intervals during the stay. MDS 3.0 is included in Appendix C of this text book. The data are entered into a grouper that determines the RUG.

Home Health Prospective Payment System

The Home Health Prospective Payment System (HH PPS) applies to reimbursement for services rendered by home health care providers. Payments are in units, each unit being a 60-day episode, and are distributed to the provider in two split payments. The case mix system used is called Home Health Resources Groups (HHRGs), and the level of the HHRGs determines the payment. A comprehensive patient assessment tool, OASIS (Outcomes and Assessment Information Set), is used with ICD-10-CM codes to group these patients into HHRGs.

Skilled Nursing Facility Prospective Payment System and Resource Utilization Groups

RUGs are the basis for payment for skilled nursing facility (SNF) services for Medicare patients. RUGs are currently in their fourth version and referred to as RUG-IV. Unlike DRGs and APCs, RUGs are not a retrospective reimbursement system for an entire stay or visit. Reimbursement based on RUGs is a daily, or per diem, rate based on the admission assessment of the patient. A review of data sets may help in a discussion of this concept.

As discussed in Chapters 2, 4, and 5, specific data sets are abstracted and reported retrospectively for both ambulatory and hospital care: the UACDS and the UHDDS, respectively. In long-term care, the Minimum Data Set (MDS) is collected as part of the **Resident Assessment Instrument (RAI).** The MDS, currently in version 3.0, contains far more data than the UHDDS or the UACDS. It includes the patient's cognitive and medical condition as well as his or her ability to perform self-care and other activities of daily living. Assessment therefore is performed at the beginning of the patient's stay, not at the end. Reimbursement is then based on the patient's care needs, consisting of 1 of 44 groups within seven broad categories: rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavioral problems, and reduced physical function. Although there are other RUG systems in existence, Medicare reimbursement is determined using the RUG-IV system.

In most SNF settings, much of the information collected has been under the domain of the nursing department. Nursing staff members usually collect and record the MDS data, largely composed of diagnostic statements and including the ICD-10-CM codes associated with the patient's medical condition. This is not to imply that health information professionals are incapable of performing this task.

PPSs continue to evolve and expand into various patient settings, primarily as a result of legislation and instruction from Congress. Although these PPSs are initiated and developed for reimbursing services for Medicare patients, other payers and insurers often use or modify these systems for their patients as well. To code accurately and in compliance with regulations, all coding professionals should be aware of what PPSs apply, and to whom, in the setting in which they are employed. Table 7-7 contains a summary of the previously discussed PPSs.

Resource-Based Relative Value System

The **resource-based relative value system (RBRVS)** is the basis of reimbursement to physicians for services rendered to Medicare patients. Because the reimbursement is for physician services, the location where services were provided can be the physician's office, a hospital, or a nursing home—essentially anywhere that a patient can be treated. Physicians submit claims for reimbursement using HCPCS/CPT codes. Each HCPCS/CPT code has

DRG diagnosis related group

Resource Utilization Groups (RUGs) These constitute a prospective payment system for long-term care. Current Medicare application is a per diem rate based on the RUG III grouper.

Minimum Data Set (MDS) The detailed data collected about patients receiving long-term care. It is collected several times, and it forms the basis for the Resource Utilization Group.

home health care Health care services rendered in the patient's home; or an agency that provides such services.

Outcome and Assessment Information Set (OASIS) Data set most associated with home health care. This data set monitors patient care by identifying markers over the course of patient care.

Skilled nursing facility (SNF) A long-term care facility providing a range of nursing and other health care services to patients who require continuous care, typically those with a chronic illness.

Resident Assessment Instrument (RAI) A data set collected by skilled nursing facilities (SNFs) that includes elements of MDS 3.0, along with information on patient statuses and conditions in the facility.

UHDDS Uniform Hospital Discharge Data Set

UACDS Uniform Ambulatory Care Data Set

SNF skilled nursing facility

PPS prospective payment system

resource-based relative value system (RBRVS) The system used to determine reimbursements to physicians for the treatment of Medicare patients.

Healthcare Common Procedure Coding System (HCPCS) A coding system, of which CPT-4 is level one, used for drugs, equipment, supplies, and other auxiliary health care services rendered.

Current Procedural Terminology (CPT) A nomenclature and coding system developed and maintained by the American Medical Association to facilitate billing for physicians and other services.

TABLE 7-7

SUMMARY OF PROSPECTIVE PAYMENTS SYSTEMS (PPSs)

SYSTEM	SETTING	CODE SYSTEM	BASIS OF REIMBURSEMENT
MS-DRG (medical severity–diagnosis related group)	Short-stay facility, inpatient acute care, Medicare patient	ICD-10-CM diagnosis and ICD-10-PCS procedure codes	Diagnoses and procedures Single MS-DRG assignment Retrospective
APC (ambulatory payment classification)	Ambulatory care, outpatient services, emergency departments	CPT-4 HCPCS ICD-10-CM diagnosis codes	Procedures Diagnoses used for validation May have multiple APCs Retrospective
Inpatient Psychiatric Facility (IPF) PPS	Inpatient psychiatric	ICD-10-CM	Per diem and federal rate
Inpatient Rehabilitation Facility (IRF) PPS	Inpatient rehabilitation facilities	ICD-10-CM	Per discharge Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Case mix groups
Long-term Care Hospital (LTCH) PPS	Hospitals with average length of stay >25 days	ICD-10-CM	DRGs Patient acuity
Home Health care (HH) PPS	Home health care providers	ICD-10-CM	Home Health Resources Groups (HHRGs) Payment units Oasis
Resource Utilization Group, version 4 (RUG-IV)	Medicare Skilled nursing facility services	ICD-10-CM	Per diem rate Not retrospective Minimum data set data

fee schedule The list of charges that a physician expects to be paid for services rendered. Also, a list of the amounts a payer will remit for certain services.

three relative value units (RVUs). Each RVU corresponds to the complexity of the service provided, the consumption of resources incurred by the service provided, and the relation of the service provided in comparison with other services provided. Physicians receive reimbursement on the basis of a national Medicare physician **fee schedule** that is adjusted according to the physician's geographical location. Physicians located in different areas of the United States receive varying reimbursement amounts for identical services because Medicare recognizes that operating costs vary by location.

EXERCISE 7-4

Prospective Payment System

1. If patients are grouped into the same MS-DRG, it is because they have what three criteria in common?
2. What is meant by the term "resource intensity"?
3. Describe how a case is assigned to a major diagnostic category (MDC).
4. After assignment of the MDC, what occurs next in the grouping process?
5. What patient attributes are important to grouper assignment?
6. What is a CC code, and why is it significant?
7. What is the difference between a comorbidity and a complication?
8. What is a MCC code, and why is it significant?
9. What does the Medicare Code Editor do?
10. Describe two types of coding errors that may affect MS-DRG assignment.
11. What coding classification or nomenclature system is used to indicate medical necessity?
12. What is a modifier, and for what is it used?

BILLING

To be reimbursed for services rendered to a patient, a facility must alert the payer that payment is due. This is accomplished by filing a claim with the patient's health insurance carrier, which is also called **billing**. In an acute care facility, the billing function is performed in a department that is often called patient accounting or patient financial services.

Coding and billing are key components of the *revenue cycle management* process. **Revenue cycle management (RCM)** is composed of all the activities that connect the services being rendered to a patient with the provider's reimbursement for those services.

billing The process of submitting health insurance claims or rendering invoices.

acute care facility A health care facility in which patients have an average length of stay less than 30 days and that has an emergency department, operating suite, and clinical departments to handle a broad range of diagnoses and treatments.

revenue cycle management (RCM) All the activities that connect the services being rendered to a patient with the provider's reimbursement for those services.

PATIENT FINANCIAL SERVICES

The **patient financial services** department is responsible for ensuring that accurate claims are sent for each patient's account, that they are sent in the correct format to the correct payers, and that the facility receives the correct reimbursement. A patient's bill includes a compilation of charges for items used and services rendered. Each patient is assigned an account number for items received and services rendered during a particular visit or stay. The account number, unlike the patient's medical record number, changes for each encounter. In this way, charges can be accurately assigned, or "posted," to each specific encounter so that the bill reflects the charges for each individual account. For example, a patient may visit a hospital three times in one month: once as an inpatient, then as a clinic patient, and later as an emergency department patient. The hospital does not combine all three visits into one monthly bill. Instead, a different account number is assigned for each encounter, and a separate bill is sent for each account that reflects the charges incurred for each individual visit. A bill that is produced and sent is called a "dropped," or final, bill. A bill that has been dropped is pending payment. Once the dropped bill has been paid, the account is closed to any further activity.

patient financial services The department in a health care facility that is responsible for submitting bills or claims for reimbursement. Also called *patient accounts* or *patient accounting*.

encounter A patient's health care experience; a unit of measure for the volume of ambulatory care services provided.

To use an acute care inpatient as an example, three key steps must happen in order to produce and drop a bill: (1) The patient's charges must be entered into, or posted to, the account; (2) the patient must have been discharged so that the account reflects the charges accumulated for the patient's entire length of stay; and (3) the medical record must be coded. Whether or not payers use MS-DRGs or another DRG grouper as a method of reimbursement, they still want to see the ICD-10-CM and ICD-10-PCS codes related to the clinical stay, and these codes must appear on the UB-04, a billing form discussed later in this chapter. It is through the coding of the diagnoses and procedures that the payer often gets the first impression of what actually should have happened in terms of services rendered.

charges Fees or costs for services rendered.

grouper The software used to derive the DRG from the ICD-10-CM diagnoses and procedures.

Uniform Bill (UB-04) The standardized form used by hospitals for inpatient and outpatient billing to CMS and other third party payers.

Beginning at discharge and until a final bill is dropped, hospitals monitor the accounts that have not been billed. This list of undropped bills is called by a variety of names, including the *unbilled list* or the *DNFB* ("discharged, no final bill" or "discharged, not final billed"). Regardless of the name used, this list of delayed payments can add up to millions of dollars. Because the delays are partially due to the fact that coding has not occurred on some of the accounts, the HIM department proactively and aggressively monitors the DNFB on a regular basis. Management of the coding function and the DNFB is often complex, with many factors contributing to uncoded medical records that then result in unbilled accounts. Because the patient accounting and HIM departments both have the same goal of reducing or eliminating unnecessary unbilled accounts, the departments ideally assist each other in reducing the factors contributing to payment delays.

DNFB "discharged, no final bill"

MASTER CHARGE DESCRIPTION MASTER

Whether a facility is reimbursed using PPS or another system, a variety of procedures must be in place to ensure the accurate accumulation of charges and the accurate

PPS prospective payment system

TABLE 7-8

SAMPLE FIELDS IN A CHARGE DESCRIPTION MASTER

FIELD	DESCRIPTION
General ledger code	Internal code used by the facility's accounting department to track revenue and expenses
CPT/HCPCS code	Billing code for transmission to the insurer
Cost basis	The cost of the item to the facility
Charge	The amount that the facility charges for the item or service
Description	Definition or description of the item or service
Date	Date of the most recent update of the aforementioned fields for the item or service

coding The assignment of alphanumerical values to a word, phrase, or other nonnumerical expression. In health care, coding is the assignment of alphanumerical values to diagnosis and procedure descriptions.

clinical data All of the medical data that have been recorded about the patient's stay or visit, including diagnoses and procedures.

fee schedule The list of charges that a physician expects to be paid for services rendered. Also, a list of the amounts a payer will remit for certain services.

coding of the clinical data. Charges are the facility's individual fees, or the dollar amount for items or services provided to a patient and owed to the facility. Each item or service is assigned a charge, which is usually reviewed and adjusted or changed annually. Charges may be set on the basis of fee schedules or contractual arrangements with certain payers or may be determined internally through the use of the facility's cost-accounting system. The actual charges are not always equal to the amount that the payer reimburses a facility; the payment received depends on contractual agreements and may be discounted accordingly, as discussed earlier in this chapter. A facility compares its charges with actual reimbursements to determine the impact of contractual arrangements and whether they allow the facility to operate profitably (i.e., earn more money than it spends).

The report of the data fields that contain a facility's charges or costs for services and items is called a Chargemaster. Other terms that are sometimes used include Charge Data Master and Charge Description Master (CDM). Table 7-8 illustrates key data fields that usually appear in a Chargemaster. The Chargemaster must be updated regularly so that fees and costs are accurate. Because HCPCS/CPT codes are included in the Chargemaster, these codes must also be updated when changes or revisions occur. All the services that a facility provides, from adhesive bandages to intravenous drips and room and board, must appear on the Chargemaster, or they cannot be billed. Coding professionals often initiate or assist in making the updates to the CDM and informing departments about changes.

Chargemaster The database that contains the detailed description of charges related to all potential services rendered to a patient.

CHARGE CAPTURE

charge capture The systematic collection of specific charges for services rendered to a patient.

As previously discussed, charges must be posted to a patient's account in order for proper billing to occur. This process is called **charge capture**.

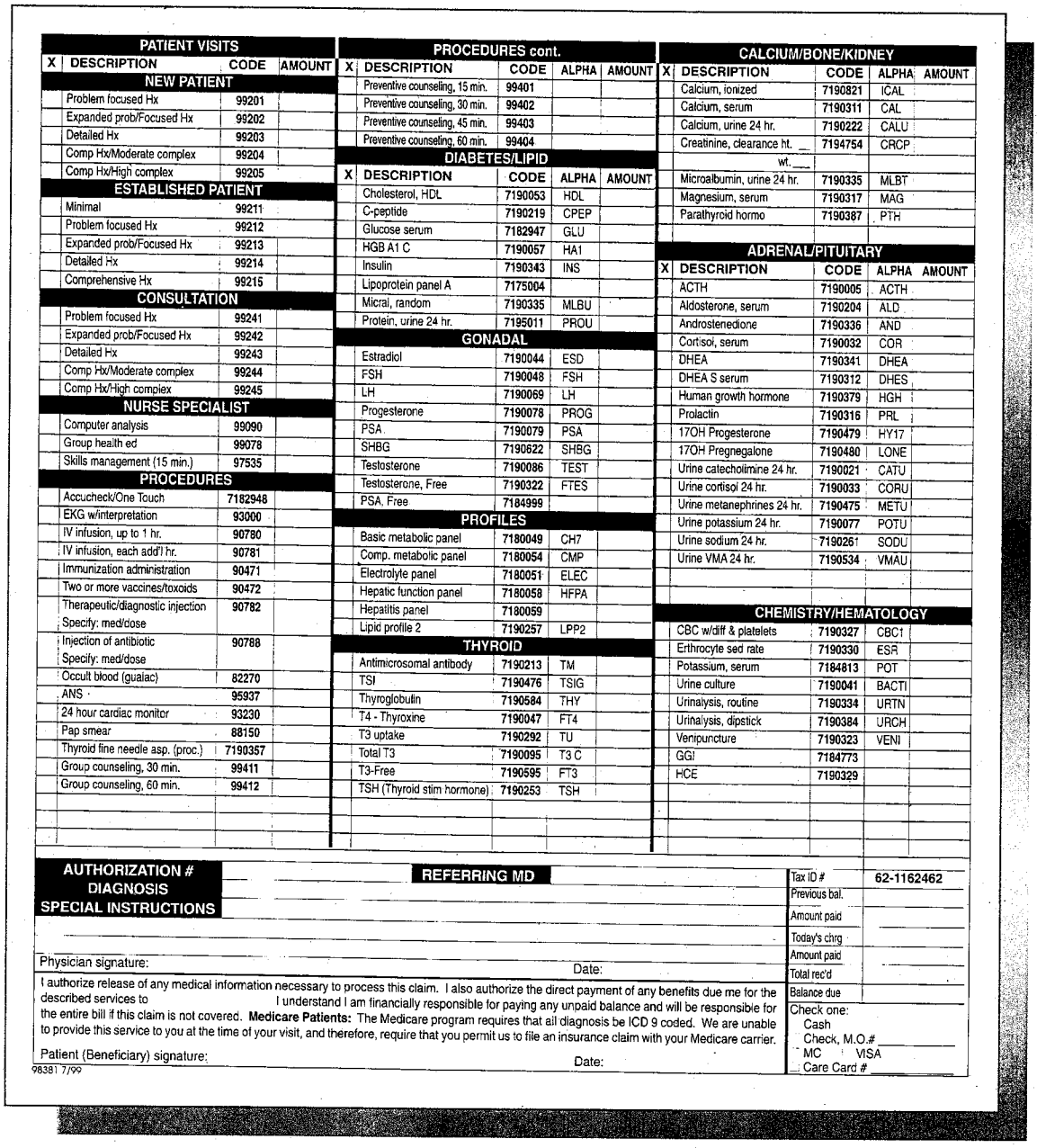
In an inpatient hospital setting, charges are usually posted to the patient's account electronically, using order-entry software, each time a service or item is provided. If the hospital does not use order-entry software or does not use the software for all types of charges, these charges still must be captured on a paper form called a charge ticket. All charge tickets must be forwarded to the accounting or billing department at the end of each business day and manually posted to the correct account. As one can imagine, manual charge capture is extremely laborious and vulnerable to human error.

Depending on factors such as length of stay, each account may have hundreds of posted charges. Most facilities allow time between discharge and submission of the bill so that all charges can be posted. This period, called the bill-hold period, usually ranges from 1 to 5 days after discharge, perhaps longer for outpatient or ambulatory services. In smaller facilities, posting delays may occur because of reduced staff on weekends. Charges posted after the final bill drops are considered late charges. Because late charges must be submitted separately and some insurers do not pay late charges at all or only after a certain time, it is essential that charges be posted no later than the end of the bill-hold period.

encounter form A data collection device that facilitates the accurate capture of ambulatory care diagnoses and services.

superbill An ambulatory care encounter form on which potential diagnoses and procedures are preprinted for easy check-off at the point of care.

In an ambulatory setting, charges are often captured, by service, on an **encounter form**, or **superbill**. An encounter form may be in electronic format or a single sheet of paper, sometimes double-sided, that contains a list of the most common patient complaints, diagnoses, procedures, and services provided by the facility. The paper form must be



PATIENT VISITS			
X	DESCRIPTION	CODE	AMOUNT
NEW PATIENT			
	Problem focused Hx	99201	
	Expanded prob/Focused Hx	99202	
	Detailed Hx	99203	
	Comp Hx/Moderate complex	99204	
	Comp Hx/High complex	99205	
ESTABLISHED PATIENT			
	Minimal	99211	
	Problem focused Hx	99212	
	Expanded prob/Focused Hx	99213	
	Detailed Hx	99214	
	Comprehensive Hx	99215	
CONSULTATION			
	Problem focused Hx	99241	
	Expanded prob/Focused Hx	99242	
	Detailed Hx	99243	
	Comp Hx/Moderate complex	99244	
	Comp Hx/High complex	99245	
NURSE SPECIALIST			
	Computer analysis	99090	
	Group health ed	99078	
	Skills management (15 min.)	97535	
PROCEDURES			
	Accucheck/One Touch	7182948	
	EKG w/interpretation	93000	
	IV infusion, up to 1 hr.	90780	
	IV infusion, each add'l hr.	90781	
	Immunization administration	90471	
	Two or more vaccines/toxoids	90472	
	Therapeutic/diagnostic injection Specify: med/dose	90782	
	Injection of antibiotic Specify: med/dose	90788	
	Occult blood (gualac)	82270	
	ANS	95937	
	24 hour cardiac monitor	93230	
	Pap smear	88150	
	Thyroid fine needle asp. (proc.)	7190357	
	Group counseling, 30 min.	99411	
	Group counseling, 60 min.	99412	

PROCEDURES cont.				
X	DESCRIPTION	CODE	ALPHA	AMOUNT
	Preventive counseling, 15 min.	99401		
	Preventive counseling, 30 min.	99402		
	Preventive counseling, 45 min.	99403		
	Preventive counseling, 60 min.	99404		
DIABETES/LIPID				
X	DESCRIPTION	CODE	ALPHA	AMOUNT
	Cholesterol, HDL	7190053	HDL	
	C-peptide	7190219	CPEP	
	Glucose serum	7182947	GLU	
	HGB A1 C	7190057	HA1	
	Insulin	7190343	INS	
	Lipoprotein panel A	7175004		
	Micral, random	7190335	MLBU	
	Protein, urine 24 hr.	7195011	PROU	
GONADAL				
	Estradiol	7190044	ESD	
	FSH	7190048	FSH	
	LH	7190069	LH	
	Progesterone	7190078	PROG	
	PSA	7190079	PSA	
	SHBG	7190622	SHBG	
	Testosterone	7190086	TEST	
	Testosterone, Free	7190322	FTES	
	PSA, Free	7184999		
PROFILES				
	Basic metabolic panel	7180049	CH7	
	Comp. metabolic panel	7180054	CMP	
	Electrolyte panel	7180051	ELEC	
	Hepatic function panel	7180058	HFPA	
	Hepatitis panel	7180059		
	Lipid profile 2	7190257	LPP2	
THYROID				
	Antimicrosomal antibody	7190213	TM	
	TSI	7190476	TSIG	
	Thyroglobulin	7190584	THY	
	T4 - Thyroxine	7190047	FT4	
	T3 uptake	7190292	TU	
	Total T3	7190095	T3 C	
	T3-Free	7190595	FT3	
	TSH (Thyroid stim hormone)	7190253	TSH	

CALCIUM/BONE/KIDNEY			
X	DESCRIPTION	CODE	ALPHA AMOUNT
	Calcium, ionized	7190821	ICAL
	Calcium, serum	7190311	CAL
	Calcium, urine 24 hr.	7190222	CALU
	Creatinine, clearance ht. ___ wt. ___	7194754	CRCP
	Microalbumin, urine 24 hr.	7190335	MLBT
	Magnesium, serum	7190317	MAG
	Parathyroid hormo	7190387	PTH
ADRENAL/PITUITARY			
X	DESCRIPTION	CODE	ALPHA AMOUNT
	ACTH	7190005	ACTH
	Aldosterone, serum	7190204	ALD
	Androstenedione	7190336	AND
	Cortisol, serum	7190032	COR
	DHEA	7190341	DHEA
	DHEA S serum	7190312	DHES
	Human growth hormone	7190379	HGH
	Prolactin	7190316	PRL
	17OH Progesterone	7190479	HY17
	17OH Pregnegalone	7190480	LONE
	Urine catecholimine 24 hr.	7190021	CATU
	Urine cortisol 24 hr.	7190033	CORU
	Urine metanephrines 24 hr.	7190475	METU
	Urine potassium 24 hr.	7190077	POTU
	Urine sodium 24 hr.	7190261	SODU
	Urine VMA 24 hr.	7190534	VMAU
CHEMISTRY/HEMATOLOGY			
	CBC w/diff & platelets	7190327	CBC1
	Erthrocyte sed rate	7190330	ESR
	Potassium, serum	7184813	POT
	Urine culture	7190041	BACTI
	Urinalysis, routine	7190334	URTN
	Urinalysis, dipstick	7190384	URCH
	Venipuncture	7190323	VENI
	GGI	7184773	
	HCE	7190329	

AUTHORIZATION #
DIAGNOSIS
SPECIAL INSTRUCTIONS

REFERRING MD

Physician signature: Date:

I authorize release of any medical information necessary to process this claim. I also authorize the direct payment of any benefits due me for the described services to I understand I am financially responsible for paying any unpaid balance and will be responsible for the entire bill if this claim is not covered. **Medicare Patients:** The Medicare program requires that all diagnosis be ICD 9 coded. We are unable to provide this service to you at the time of your visit, and therefore, require that you permit us to file an insurance claim with your Medicare carrier.

Patient (Beneficiary) signature: Date:

98381 7/99

Tax ID #	62-1162462
Previous bal.	
Amount paid	
Today's chrg	
Amount paid	
Total rec'd	
Balance due	

Check one:
Cash
Check, M.O.# ___
MC VISA
Care Card # ___

Figure 7-7 Ambulatory care encounter form/superbill. (From Abdelhak M, Grostick A, Hanken MA, Jacobs H: Health information: management of a strategic resource, ed 2, Philadelphia, 2001, Saunders, p 244. CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.)

transferred into an electronic billing format in order to submit the claim electronically. Some insurers provide their own encounter forms. A comprehensive encounter form includes ICD-10-CM diagnoses codes and HCPCS procedure codes. Encounter forms facilitate communication between the physician or other health care provider and the administrative personnel who are responsible for coding and billing. Because it is not the encounter form but the health record that supports the reimbursement claim, care must be taken to ensure that the health record indicates all services provided. Figure 7-7 is an example of an encounter form (superbill).

In a physician's office, the process of obtaining reimbursement may rest with the administrative personnel (e.g., the medical secretary, medical assistant, or practice manager). The role of these employees is to determine which services were provided for which patient and

Healthcare Common Procedure Coding System (HCPCS) A CMS coding system, of which CPT is level one, used for physician services, drugs, equipment, supplies, and other auxiliary health care services rendered.

claim The application to an insurance company for reimbursement.

which insurer or insurers should receive a bill and to ensure that all services provided are billed correctly.

In some situations, such as in a solo practitioner's office, the physician may file the claims directly to the insurer for payment. Because the insurance industry is so complex and there are many different types of payers, all with their own rules, many physicians rely on billing services to perform the administrative tasks of charge capture and billing. Performing all of these tasks is critical to accurate and timely reimbursement.

NUBC National Uniform Billing Committee
AHA American Hospital Association
UB Uniform Bill

The National Uniform Billing Committee (NUBC) is responsible for developing and implementing a single billing form and standard data set to be used nationwide by providers/hospitals and payers/insurers for handling inpatient health care claims. The NUBC comprises representatives from all the major provider and payer organizations, including the American Hospital Association (AHA) and Medicare, the public health sector, and electronic standards development organizations.

Uniform Bill (UB-04) The standardized form used by hospitals for inpatient and outpatient billing to CMS and other third party payers.

The first standard Uniform Bill appeared in 1982 and was referred to as the UB-82. Representatives from across the country were surveyed to seek improvements on the UB-82, and the UB-92 was the result of their efforts. At this time claims are submitted electronically using the UB-04, also known as the Form CMS-1450. Although the UB was originally used for claims reimbursement only, the NUBC has recognized that it contains a wealth of data that can be used for additional purposes. The data captured on the UB are now also used by health researchers to gauge the delivery of health care services to patients and to set future policy.

UHDDS Uniform Hospital Discharge Data Set

Figure 7-8 shows a UB-04 form. Notice that the Uniform Bill itself is composed of the UHDDS demographic and financial data elements as well as many additional data fields that are useful for communication between the provider and the payer. Coding professionals should be aware that fields on the UB-04 form include the admitting diagnosis code, distinct fields for the patient's reason for visit, and expanded diagnosis and procedure fields to accommodate ICD-10-CM and ICD-10-PCS codes (American Hospital Association, 2010). The UB-04 is the paper representation of the electronic 837I billing file.

UHDDS definitions allow standardized reporting of specific data elements collected by all acute care short-term hospitals. These data elements and their definitions can be found in the July 31, 1985, *Federal Register* (Health Information Policy Council, 1985). Figure 7-9 illustrates the data elements of the UHDDS and their relationship to the fields of the UB-04. The following section summarizes the UHDDS.

Federal Register The publication of the proceedings of the United States Congress.

Person/Enrollment Data:

1. *Personal/unique identifier:*
   The patient's full name and medical record number or other unique identifier. Although some advocate for the use of the Social Security Number in this field, there are strong arguments against it
2. *Date of birth:*
   The year, month, and day of the patient's birth
3. *Gender:*
   Male, female, or unknown/not stated
4. *Race and ethnicity:*
   Race: American Indian/Eskimo/Aleut; Asian or Pacific Islander; Black; White; Other; Unknown/not stated
   Ethnicity: Hispanic Origin; Other; Unknown/not stated
5. *Residence:*
   Full address and ZIP code of the patient's usual residence

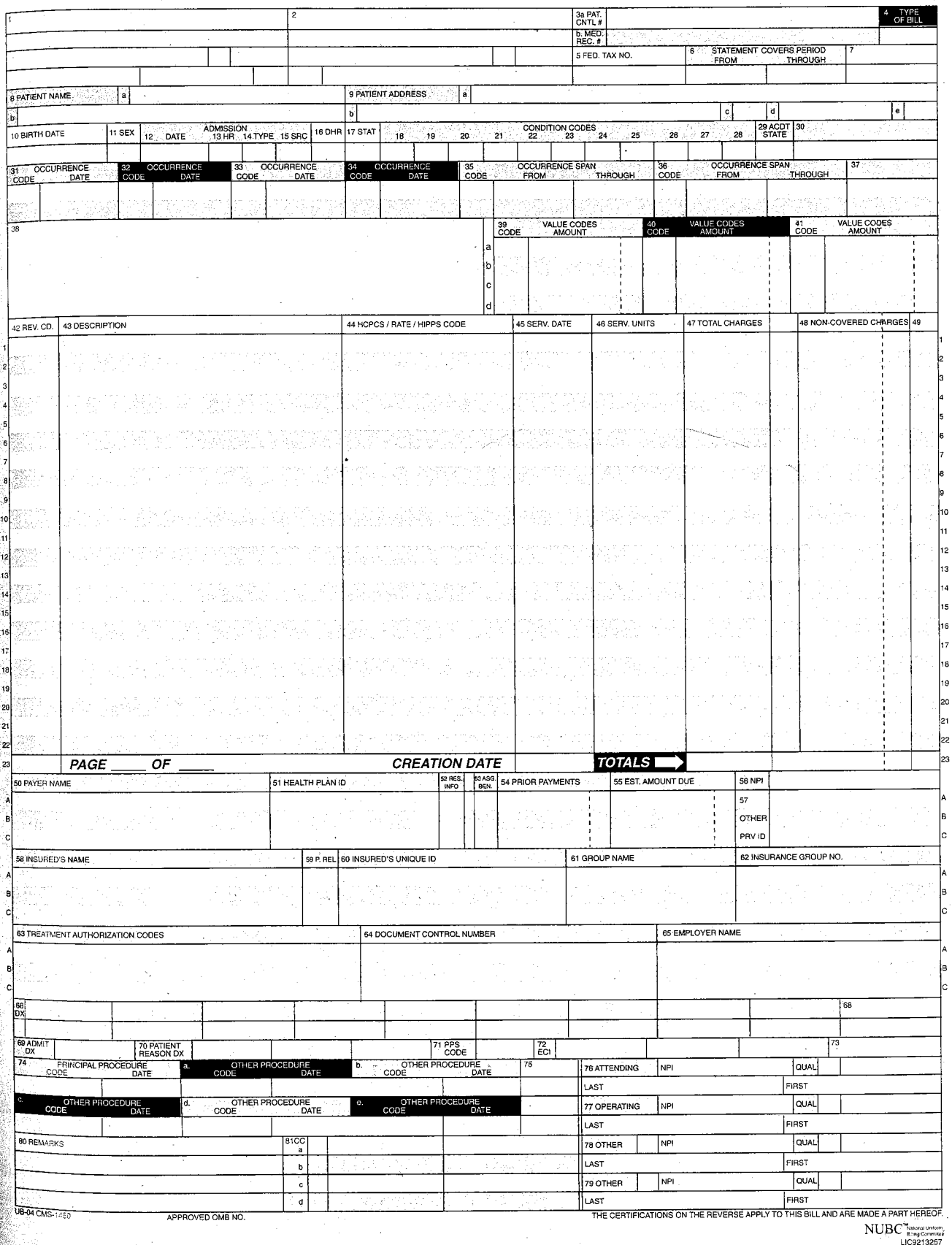
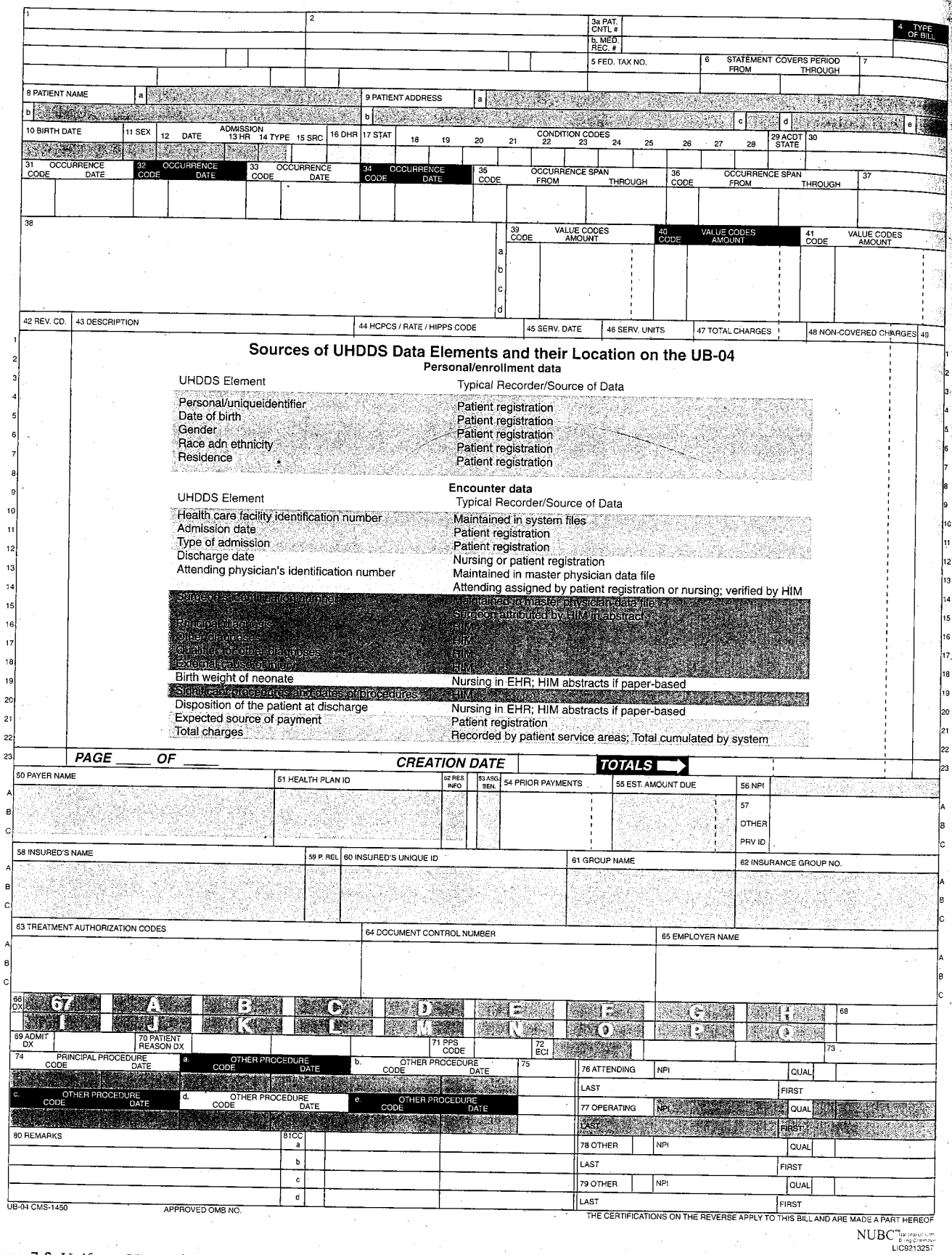


Figure 7-8 UB-04.



Sources of UHDDS Data Elements and their Location on the UB-04

Personal/enrollment data

UHDDS Element	Typical Recorder/Source of Data
Personal/uniqueidentifier	Patient registration
Date of birth	Patient registration
Gender	Patient registration
Race adn ethnicity	Patient registration
Residence	Patient registration

Encounter data

UHDDS Element	Typical Recorder/Source of Data
Health care facility identification number	Maintained in system files
Admission date	Patient registration
Type of admission	Patient registration
Discharge date	Nursing or patient registration
Attending physician's identification number	Maintained in master physician data file Attending assigned by patient registration or nursing; verified by HIM
Surgeon's identification number	Maintained in master physician data file Surgeon attributed by HIM in abstract
Principal diagnosis	HIM
Other diagnoses	HIM
Qualifier of other diagnoses	HIM
External cause of injury	HIM
Birth weight of neonate	Nursing in EHR; HIM abstracts if paper-based
Significant procedures and dates of procedures	HIM
Disposition of the patient at discharge	Nursing in EHR; HIM abstracts if paper-based
Expected source of payment	Patient registration
Total charges	Recorded by patient service areas; Total cumulated by system

Figure 7-9 Uniform Hospital Discharge Data Set (UHDDS) data elements on the UB-04 and their sources. EHR, electronic health record; HIM, health information management (department).

Encounter Data:

6. *Health care facility identification number:*
   Identification number of the facility that treated the patient
7. *Admission date:*
   The year, month, and day of admission for the current episode of care
8. *Type of admission:*
   Was the admission expected or unexpected?
9. *Discharge date:*
   The year, month, and day of discharge for the current episode of care
10. *Attending physician's identification number:*
    The unique national identification number assigned to the clinician of record at discharge who is responsible for the discharge summary
11. *Surgeon's identification number:*
    The unique national identification number assigned to the clinician who performed the principal procedure
12. *Principal diagnosis:*
    The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital (ICD-10-CM code)
13. *Other diagnoses:*
    All conditions that coexist at the time of admission, or develop subsequently, that affect the treatment received, the length of stay, or both (also an ICD-10-CM code)
14. *Qualifier for other diagnoses:*
    For each other diagnosis, was the onset prior to admission? (Yes or No)
15. *External cause-of-injury code:*
    The cause of an injury, poisoning, or adverse effect that has been recorded as the principal or other diagnosis (also an ICD-10-CM code)
16. *Birth weight of neonate:*
    If the patient is a newborn, the actual birth weight in grams is reported
17. *Principal procedure and date of procedure:*
    The procedure that was performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If more than one procedure qualifies, the one most closely related to the principal diagnosis should be selected (ICD-10-PCS code)
18. *Other procedure(s) and the date(s) of the procedure(s):*
    All other procedures that qualify (see 17)
19. *Disposition of the patient at discharge (see examples):*
    Discharged alive:
    - Discharged to home or self care (routine discharge)
    - Discharged/transferred to another short-term general hospital for inpatient care
    - Discharged/transferred to skilled nursing facility (SNF)
    - Discharged/transferred to an intermediate care facility (ICF)
    - Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
    - Home under care of organized home health service organization
    - Home under care of a Home IV (home intravenous therapy) provider
    - Left against medical advice or discontinued care

    Expired
    Status not stated
20. *Expected source of payment:*
    - Primary source of payment. The primary source is expected to be responsible for the largest percentage of the patient's current bill
    - Secondary sources of payment

    Categories of source of payment are as follows:
    - Self-pay
    - Workers' compensation
    - Medicare

- Medicaid
- Maternal and child health
- Other government payments
- Blue Cross
- Insurance companies
- No charge (free, charity, special research, or teaching)
- Other
- Unknown/not stated

22. *Total charges:*
    All charges for procedures and services rendered to the patient during a hospitalization or encounter

CMS-1500

The CMS-1500 form is the paper data collection form used for transmittal of billing information for ambulatory/outpatient claims and physician's office claims. The CMS-1500 form has fewer fields that the UB-04 but it contains much of the same information. Figure 7-10 shows a CMS-1500 form. The CMS-1500 is the paper representation of the 837P electronic billing file.

CLAIMS REJECTIONS

payer The individual or organization that is primarily responsible for the reimbursement for a particular health care service. Usually refers to the insurance company or third party.

local coverage determination (LCD) A list of diagnostic codes used by Medicare contractors to determine medical necessity.

Medicare Federally funded health care insurance plan for older adults and for certain categories of chronically ill patients.

ED emergency department

Optimally, the facility or provider has recorded all of the required billing data accurately, and the claim drops to the payer without human intervention. However, the potential for human error requires that all claims be reviewed prior to being submitted to the payer. The provider, or provider's billing service, will examine the claims for errors such as missing fields, LCD errors, and invalid data. Claims that are rejected must be corrected prior to resubmission.

An example of a claim rejection is the failure to combine an outpatient account with an inpatient visit that occurs within 3 days prior to the inpatient visit. Consider a patient who is treated for congestive heart failure in the emergency department and is admitted to that hospital 2 days later—also for congestive heart failure. Because the admission is within 3 days, Medicare will not pay separately for the emergency department visit. All diagnostic testing and all related therapeutic services must be combined into the inpatient visit. It is the responsibility of the hospital to support the rationale for not combining therapeutic visits. An example of therapeutic services that might not be combined is an ED visit for a broken leg, which would likely not be combined with a subsequent unrelated inpatient visit for pneumonia (CMS Three Day Payment Window, 2012).

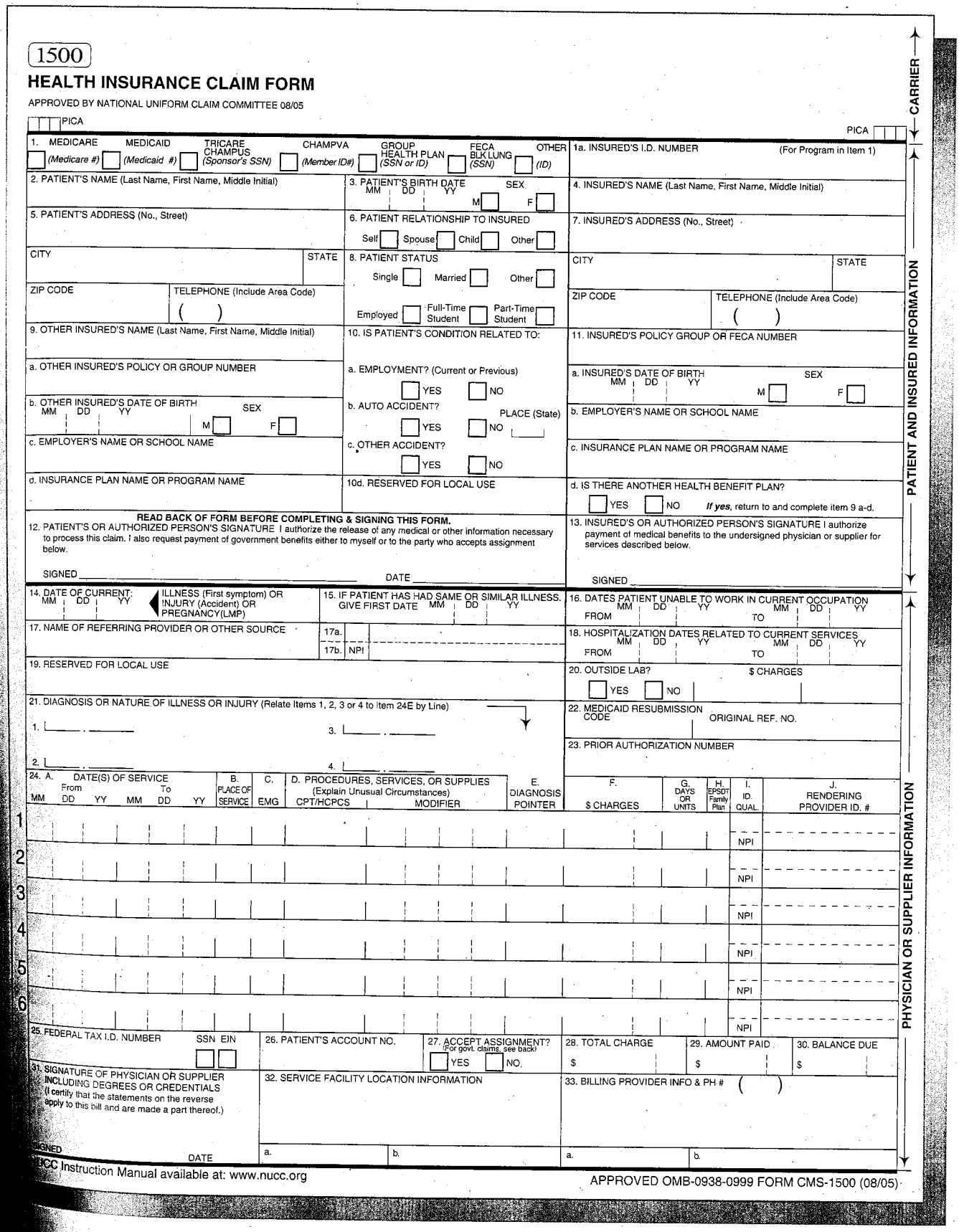
CLAIMS DENIALS

claim The application to an insurance company for reimbursement of services rendered.

ABN advance beneficiary notice

Once the claim is submitted, there is an additional layer of review by the payer. The payer may refuse to pay the claim for a variety of reasons; examples are services not covered by the patient's insurance plan, service overlaps another provider's bill, codes submitted on the bill do not match the preauthorized services, lack of medical necessity for the services provided, and untimely filing.

Some errors, such as untimely filing and lack of medical necessity, cannot be corrected. Such claims will be adjusted to a zero balance and the provider will receive no payment for the services. If the provider has obtained an ABN or waiver from the patient in advance of the services, the patient may be billed for the services directly. In some cases, the provider may file an appeal with the payer to challenge the payer's denial. There may also be the opportunity for the patient to appeal.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 7-10 CMS-1500 health insurance claim form.

HIM health information management

There is a great deal of pressure on both HIM professionals and billing professionals to submit claims that will be paid. Great care must be taken to ensure that only accurate, verifiable, and valid data are submitted on claims. If a claim is denied for codes submitted that do not match the preauthorized services, the case could be sent to a coding supervisor for review. Perhaps the case was coded incorrectly. If the coder made an error, the case can be recoded, re-abstracted, and rebilled. However, in some cases the codes provided to the payer at preregistration are NOT the codes for the services that were ultimately provided. For example, an ambulatory surgery case may have been preauthorized for a dilation & curettage without indicating that intrasurgical decision making could result in a hysterectomy. If the hysterectomy is performed and that is what the coder entered, then the case cannot be recoded, because there was no coding error.

ambulatory surgery Surgery performed on an outpatient basis; the patient returns home after the surgery is performed. Also called *same-day surgery.*

revenue cycle The groups of processes that identify, record, and report the financial transactions that result from the facility's clinical relationship with a patient.

Coding and billing processes may take place without error and yet the provider has one major step left in the revenue cycle process: follow-up and collections. Medicare and most major commercial payers remit payment on a relatively predictable schedule. However, some payers delay reimbursement as long as possible. When patients are responsible for all or part of the payment, further delays may ensue. Providers must be diligent in following up and seeking payment for services so that cash is received as timely as possible.

EXERCISE 7-5

Billing

1. What are some possible reasons that a bill has not been dropped?
2. What management tool is used to track unbilled accounts?
3. How would someone use the tool described in Question 2?
4. The charges or costs for a vaccination are listed in a facility's _____.
5. For the vaccination charge to appear on a patient's bill, how does the charge get to the patient's account?
6. In an ambulatory setting, an encounter form is often used for charge capture. Name three items that would be on an encounter form.

In any discussion of the various reimbursement methodologies, the importance of accurate ICD-10-CM, ICD-10-PCS and HCPCS/CPT-4 coding cannot be overstated. Because the codes determine the payment and facilitate the claim, the accuracy and timeliness of the coding function are critical.

postdischarge processing The procedures designed to prepare a health record for retention.
charge capture The systematic collection of specific charges for services rendered to a patient.
assembly The reorganization of a paper record into a standard order.
analysis The review of a record to evaluate its completeness, accuracy, or compliance with predetermined standards or other criteria.

Coding Quality

The timeliness and completeness of the postdischarge processing of a record are important. In addition to charge capture, all pertinent medical record data must have been collected for correct assignment of codes, and the processing cycle must facilitate efficient, timely coding. For example, if a paper-based medical record must be assembled and analyzed before it is given to a coder, and if the assembly and analysis sections are 5 or 6 days behind the current discharge date, then medical records may not be coded until 7 days after the discharge date. Even factoring in the bill-hold period, a week is a long time for a facility to go without dropping a bill for a patient's stay. Facilities sometimes choose to code the record before it is assembled or analyzed so that the bill may be dropped more quickly.

Although this sequence expedites payment, it can also lead to coding errors if the medical record is incomplete because missing elements are not clearly identified or if important reports are misplaced in the wrong sections of the record.

The issues surrounding a paper-based medical record will generally be eliminated with the electronic health record (EHR). The EHR will permit access to patient information immediately upon its entry. Information cannot be "lost" once it is entered into the EHR. Coders may access the EHR at any point after patient admission and after discharge. In addition, computer-assisted coding (CAC) programs embedded in the EHR may facilitate the coding process in terms of speed and accuracy.

electronic health record (EHR) A secure real-time, point-of-care, patient centric information resource for clinicians allowing access to patient information when and where needed and incorporating evidence-based decision support.

CAC computer-assisted coding

Coding must be reliable and valid, both individually and collectively within a facility or group. A coder or group of coders is said to demonstrate **reliability** when codes are consistently assigned for similar or identical cases. **Validity** of coding refers to the degree of accuracy of the codes assigned.

reliability A characteristic of quality exhibited when codes are consistently assigned by one or more coders for similar or identical cases.

validity The data quality characteristic of a recorded observation falling within a predetermined size or range of values.

Regulatory Issues

Effective each October, an updated version of the "ICD-10-CM Official Guidelines for Coding and Reporting" is issued by CMS and the **National Center for Health Statistics (NCHS)** and approved by the Cooperating Parties for the ICD-10-CM. The Cooperating Parties for ICD-10-CM are the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. The "Official Guidelines for Coding and Reporting" can be found in its entirety at http://www.cdc.gov/nchs/data/icd10/icdguide.pdf. Adherence to these guidelines is required under HIPAA (see Chapter 12). The following statement is made in the Guidelines regarding coding, provider documentation, and incomplete medical records: "The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of coding guidelines is a difficult, if not impossible, task."

National Center for Health Statistics (NCHS) A member of the Cooperating Parties. Sponsored by the Centers for Disease Control, a health care agency that reports on current public health care concerns.

Cooperating Parties The four organizations responsible for maintaining the ICD-10-CM: CMS, NCHS, AHA, and AHIMA.

Accurate coding is necessary for **optimization** of reimbursement, particularly in a PPS, and is best achieved through coding from a complete medical record. Optimization occurs when the coding results in the MS-DRG that most accurately represents the facility's utilization of resources, on the basis of the diagnoses and procedures, and is completely substantiated by documentation. **Maximization,** on the other hand, is simply assigning and sequencing codes to obtain the highest-paying MS-DRG. Optimization is highly desirable; maximization is illegal and unethical. Patterns of maximization could be considered abuse. Patterns of maximization that intentionally result in excessive payments to the provider are considered fraud. Under the U.S. government's National Correct Coding Initiative (NCCI), as well as fraud and abuse audits, patterns of maximization, if proved, can result in the criminal prosecution of facility administrators as well as individual complicit employees.

optimization The process of determining the most accurate DRG payment.

Prospective Payment System (PPS) A system used by payers, primarily CMS, for reimbursing acute care facilities on the basis of statistical analysis of health care data.

maximization The process of determining the highest possible DRG payment.

Coding Compliance

A comprehensive coding compliance plan is an important part of a facility's corporate compliance plan. The coding compliance plan should include regular internal audits and audits performed by objective external reviewers who have no vested interest in the facility's profit margin. Coding audits performed by payers are not necessarily useful in determining coding accuracy because their overall goal is to find only those coding errors that adversely affect the payer. In any type of audit, however, results should be shared and discussed with the coding staff.

coding compliance plan The development, implementation, and enforcement of policies and procedures to ensure that coding standards are met.

Go To See Chapter 12 for more information on compliance.

There are two fundamentally different approaches to coding audits: general reviews of all records of all payer types to identify potential problems and targeted reviews of known or potential problem areas. In general reviews, records are selected by a statistical method or by any method that captures a representative sample of records. All coders, all record types, and all payers should be included in a general review. The audit results can be used to determine coding error rates by coder or more generally.

DRG diagnosis related group
OIG Office of the Inspector General

Quality Improvement Organization (QIO) An organization that contracts with payers, specifically Medicare and Medicaid, to review care and reimbursement issues.
Recovery Audit Contractors (RACs) Entities contracting with CMS that audit providers, using DRG assignment and other data to identify overpayments and underpayments.

CMS Centers for Medicare and Medicaid Services

Targeted reviews may be aimed at specific coders, codes, DRGs, MS-DRGs, or other factors or elements of coding. For example, the OIG develops a list of so-called targeted MS-DRGs, which are MS-DRGs that have a history of aberrant coding (i.e., inaccurate coding leading to Medicare overpayments). **Quality Improvement Organizations (QIOs)** monitor and assess facility data and may perform reviews of cases assigned to these targeted MS-DRGs. **Recovery Audit Contractors (RACs)** are another group that reviews cases on behalf of CMS. RACs request records on the basis of targeted cases, including the DRG assignment as well as medical necessity. RACs review all providers, including physicians, durable medical equipment providers, and hospitals. Regardless of audit findings, coding error rates are not applicable to targeted reviews because such audits are not based on a random selection.

Throughout this chapter, the importance of the coding function and reimbursement has been emphasized. The essence of being a professional coder entails training and development, continuous education, knowledge and application of current rules, regulations, and guidelines, and ethical conduct, in spite of daily challenges and pressures. Performing the coding function well makes the professional coder a valuable member of the health care team.

EXERCISE 7-6

Impact of Coding

1. Why is the timing of postdischarge processing important to a coder?
2. What is a coding compliance plan?
3. Explain the difference between optimization and maximization.
4. Compare and contrast two different approaches to high-quality coding audits.

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CHAPTER ACTIVITIES

CHAPTER SUMMARY

One of the key uses for coded data is reimbursement. Medicare prospective payment systems arose out of cost-control measures and are based on code systems originally designed for other purposes. Inpatient hospitals are reimbursed using Medical Severity–Diagnosis Related Groups (MS-DRGs). Medicare outpatient services are reimbursed under Ambulatory Patient Classifications (APCs). Additional Prospective Payment Systems include Inpatient Psychiatric Facility Prospective Payment System (IPF PPS), Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), Long-Term Care Hospital Prospective Payment System (LTCH-PPS), Home Health Prospective Payment System (HH PPS), Skilled Nursing Facility Prospective Payment System (SNF PPS), and Resource Utilization Groups (RUGs).

Billing in a hospital is generally the responsibility of the patient accounts department. Charges are posted to the patient's account on the basis of data maintained in the facility's Chargemaster, or Charge Description Master. Hospital-based services are submitted for payment using a Uniform Bill, currently UB-04. Outpatient services are billed using the CMS-1500 form. Because of the importance of the coded data in correct billing and collections, health information professionals must maintain a strong working relationship with the patient accounts professionals.

Coders are an integral part of maintaining the quality of a facility's coded clinical data, ensuring compliance with regulatory mandates, and facilitating optimal reimbursement.

REVIEW QUESTIONS

1. What are the financial risks in health care delivery for providers, third party payers, and patients?
2. List, compare, and contrast four reimbursement methodologies.
3. Compare and contrast indemnity health insurance plans with managed care plans.
4. Describe government involvement in health insurance.
5. Discuss the impact of the prospective payment system on the coding function.
6. List three prospective payment systems, and describe how reimbursement is obtained in each.
7. Discuss the significance of a hospital's case mix index and reasons that it should be monitored.
8. What are the major differences between MS-DRGs and ambulatory patient classifications (APCs)?
9. Discuss the relationship between the HIM department and the patient accounts department with regard to unbilled accounts in an acute care hospital.
10. Provide an example of how incorrect inpatient coding would financially affect a hospital.
11. Distinguish between the UB-04 and the CMS-1500.
12. Describe how charges are captured in an inpatient setting, and compare this process with charge capture in an ambulatory setting.
13. Describe and discuss an example of an unethical coding practice.
14. What is the difference between optimization and maximization?
15. Name two types of coding audits. When would you use each?