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Outpatient Facility Reimbursement

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Outpatient Charge Levels

Today's outpatient care can be every bit as intense and expensive as an inpatient admission. In the 1980s it was vogue for group plans to offer 100 percent outpatient coverage as a cost saving measure since it was assumed anything done outpatient had to be less expensive than its inpatient counterpart. Now we know that isn't the case, especially if one has a charge-based outpatient reimbursement program. In the June issue of *Health Section News*, John Cookson documented the considerable variability of charge levels between hospitals and noted the significance of hospital charges to insurers and reinsurers.

An outpatient encounter doesn't necessarily mean a simple procedure followed by recovery at home. In many cases, an outpatient surgery may mean an overnight stay of up to 24 hours. There is a considerable amount of discretion on the part of the doctor and hospital as to whether an encounter is classified as inpatient or outpatient. Outpatients are routinely commingled with inpatients on the same floor. The patient may not even be aware that they were outpatient rather than inpatient.

Outpatient Reimbursement Methodologies

Outpatient reimbursement methodologies are generally composed of fees associated with HCSPCS codes and rules for packaging, code editing, billing and multiple procedure reimbursement. The following methods are widely employed by public and private payers for outpatient services:

- Ambulatory payment groupings (APGs)
- Ambulatory payment classifications (APCs)
- Medicare ambulatory surgery center (Medicare ASC)
- Discount on charges
- Commercial hybrid

APGs were developed by 3M under a HCFA (now CMS) contract. This was an attempt to duplicate the success of the Medicare's inpatient diagnosis related group (DRG) program on outpatient. Not surprisingly the underlying concept is the same. An encounter can be mapped to a single grouping, DRG (inpatient) or APG (outpatient), based on the diagnoses and procedure codes billed for the hospital encounter. The reimbursement for all the services provided during the encounter can be packaged into a single amount for that grouping. The user of the APG system can customize the degree of packaging. The user can set the program to consolidate all applicable APGs into one APG or allow multiple APGs for one encounter. Medicare never adopted APGs, but many commercial payers adopted APGs for reimbursement.

APCs were introduced by HCFA in August 2000. APCs are a modification of APGs. With a few exceptions, APCs are based solely on the procedure code rather than a combination of procedure and diagnoses. Similar procedures are mapped to one APC. Unlike APGs or DRGS, however, there can be and usually is more than one APC applicable per encounter. So there is less packaging in APCs than APGs.

Medicare ASC groupings are used by CMS to reimburse freestanding (non-hospital) surgery centers. There are only nine payment levels. The drawback to Medicare ASCs is that they only cover a limited number of surgical procedures. Many high-volume surgeries are not included. Further, the schedule does not contain any lab or radiology services.

Discount on charges is still a widely used method for reimbursing outpatient. Since hospital charges vary so much, one can't judge whether the reimbursement is fair by looking at the discount.

The final category I call commercial hybrid. These generally consist of some type of fee table, possibly based on one of the above methodologies. The degree of code editing and packaging varies widely. Comparing fee tables between commercial hybrid programs can be misleading if code editing and packaging are not considered. There is also a great deal of variation in the completeness of commercial hybrid programs. For example, an insurer may only have fees for high volume surgeries. Surgeries not on the fee schedule will be paid on a default discount.

Claim Example

The example below illustrates the reimbursement of a hospital claim based on the APC methodology. It is also useful to illustrate the difference between

packaging and code editing. By "packaging" I mean the rules for determining the reimbursable services on a correctly billed claim. Line 4 in the example is packaged. Under APCs, general pharmacy charges are packaged, and therefore are never reimbursed separately. In general, line items without a HCPCS do not receive separate payments. Code editing on the other hand is the process of reviewing a claim for consistency with existing coding standards and clinical logic. In this example, it isn't proper to bill a diagnostic laparoscopy 49320 and laparoscopic cholecystectomy (gallbladder removal) 47562, because surgical laparoscopy always includes diagnostic laparoscopy. Line 2 has a code editor rejection because it is a component procedure of line 1 and should not have been filed.

Summary of Methods and Trends In Contracting

The table below is a comparison of various reimbursement approaches to outpatient facility services. The methodologies are rated on a completeness, provider recognition and ease of modeling. Recognition and ease of modeling are important characteristics for provider acceptance. The fact that Medicare utilizes the APC method gives it credibility and means that providers have an understanding as to how it works and likely have the capability of modeling.

The SOA sponsored the "Provider Contracting Trends and Case Studies" seminar February 11 and 12 in Tempe, Arizona. Based on discussions at the seminar, many plans are considering changing their outpatient reimbursement in the near future.

Sample Outpatient Hospital Claim

Line Item	Rev Code	HCPCS	Description	Charge	APC Payment
1	360	47562	Laparoscopic Cholecystecomy	$2,000.00	$1,915.00
2	360	49320	Laparoscopy Diagnostic	$1,500.00	$0 Code Editor Rejection
3	730	93005	ECG	$ 30.00	$17.82
4	250	-	General Pharmacy	_ $3,530	Packaged 1932.82

Method	Completeness	Provider Recognition	Degree of Packaging	Ease of Modeling For Provider
Discount on Charges	Excellent	Excellent	None	Easy
Medicare ASC	Poor	Good	Moderate	Moderate
Schedule APG	Excellent	Fair	High	Difficult
Medicare APC	Good	Excellent	Moderate	Easy
Schedule Commercial Hybrid	Varies	Poor	Varies	Varies

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Those paying a discount on charges or Medicare ASC schedules are looking at an APC- or APG-based system. Many plans that have been on an APG-based system are looking to move to APCs based on provider dissatisfaction with the current program. There was overwhelming consensus the fixed fee-based systems were preferable to paying a discount on charge.

Impact On Trend

The choice of outpatient reimbursement methodology will have a large impact on cost per unit trend. An important issue is the amount of reimbursement that is based on billed charges. As mentioned above, many reimbursement programs with fixed fees have a default discount percent for items not on the schedule. Some programs may also have specific line items paid at a discount, such as implantable devices. For budgeting purposes, it's important to identify separately the component of trend associated with the negotiated change in fees and provider charges.

Component	Percent of Reimbursement	Trend
Negotiated Fees	80%	2%
Discounted Charges	20%	10%
Total	100%	4%

Monitoring, Modeling and Benchmarking

Regardless of the reimbursement methodology employed, it is critical to be able to compare costs between facilities. Simply looking at the discount obtained is useless since hospital charges vary. Benchmarking each facility's current reimbursement versus a standard program can help identify opportunities for enhanced contracting. In order to benchmark, it is necessary to be able to model reimbursement on a standard reimbursement program such as APCs. Consulting firms can run data through the APC pricing programs for a comparison of overall reimbursement to Medicare. It is important to monitor hospital reimbursement through benchmarking on a regular basis. To illustrate, suppose an insurer has a three-year discount on charge contract with hospital XYZ. In year one the insurer determined through modeling that the discount on charge program was 150 percent of the standard benchmark. In year two, hospital XYZ raises charges 50 percent. By modeling versus the standard benchmark, the insurer realizes that hospital XYZ is now 225 percent of the standard. The insurer contacts the hospitals and asks for a larger discount.

Codes Associated With Hospital Outpatient Claims

In order to work with hospital claims, one has to understand the various codes found on the standard UB92 hospital claim form. These codes are:

- Revenue Codes
- HCPCS
- ICD-9 Diagnoses
- ICD-9 Procedure

Revenue codes describe the hospital department billing for the line item. Each line item on a UB92 has a revenue code. In the claim example above revenue code 360 means "Hospital Room Services." HCPCS stands for health care procedure coding system and describes the specific service or item provided. HCPCS encompasses the CPT coding. There are three levels of HCPCS codes:

Level I CPT codes – CPT or current procedural terminology is the major portion of HCPCS. CPT is maintained by the American Medical Association.

Level II National Codes – CPT has a limited selection of codes that describe injections, materials and supplies. Level II HCPCS codes are alphanumeric codes that describe injections, materials, supplies and services. Note that level II and level I service will overlap.

Level III Local Codes – These codes vary by local Medicare carrier.

ICD-9 stands for International Classification of Diseases Version 9. ICD-9 diagnosis codes are

integral to the APG assignment. They are used in a limited fashion to determine the APC grouping for payment of observation rooms. Medicare's outpatient code editor will validate the HCPCS/ICD9 diagnoses code combination. For example, a line item with a HCPCS code indicating an open-heart surgery will be denied if the ICD-9 code indicates a diagnosis of a common cold.

The ICD-9 procedure code is not used in the APC or APG assignment; however, it is used in conjunction with the ICD-9 diagnosis code in the assignment of the DRG. It may interest the reader that much of the world uses ICD-10. If the United States ever moves to ICD-10, the effort to convert claims systems will be extraordinary.

Summary

There are a variety of hospital outpatient reimbursement programs in existence. The method of reimbursement will impact cost per unit trends. In order to dig into hospital claims an understanding of the coding found on hospital claims is needed. Careful monitoring of reimbursement through benchmarking will alert an insurer to changes in provider charging patterns and help identify areas for provider contracting focus.

Related Web sites

http://cms.hhs.gov/hcprofessionals/payment.asp—This site provides information on Medicare payment systems.

www.ingenixonline.com—This site provides an exhaustive list of reference books on payment methodologies and coding.

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