Cost-Based, Charge-Based, and Contractual Payment Systems

Duane C. Abbey

CRC Press
Taylor & Francis Group
A PRODUCTIVITY PRESS BOOK

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Boca Raton London New York

CRC Press is an imprint of the
Taylor & Francis Group, an **informa** business
A PRODUCTIVITY PRESS BOOK

CRC Press
Taylor & Francis Group
6000 Broken Sound Parkway NW, Suite 300
Boca Raton, FL 33487-2742

Version Date: 20120723

International Standard Book Number-13: 978-1-4398-7300-7 (eBook - PDF)

Dedication

This text is dedicated to all of you who have struggled with understanding the explanation of benefits (EOBs) from your insurance company that was sent to you after receiving healthcare services. In some cases, you may be reviewing EOBs for family members and loved ones. These EOBs seem almost unfathomable relative to the way in which claims are paid, or not, for healthcare services.

While this is the fourth text in a series of books devoted to healthcare payment systems, we have really just scratched the surface of a complex and continuously evolving area. Most of the concepts discussed can be grasped by interested laypersons as well as those professionals involved in the healthcare services industry. I invite interested readers to be patient with themselves. You may have to read and then reread certain sections to grasp the concepts presented. Small case studies are used in this text as they were in the preceding three texts. These are used to assist in explaining and illustrating certain issues. My objective is not only to explain; it is to explicate.

I wish to acknowledge the many students who have attended my workshops over the years. We have discussed numerous, intricate topics and attempted to develop policies and operating procedures when guidance from Medicare and other private payers is less than precise. Compliance issues have always loomed large in our discussions, particularly the possibility of inadvertently receiving overpayments for services.

For all our readers, enjoy the technicalities. For healthcare payment, everything seems to be in the fine print.

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Preface

This is the fourth in a series of four books devoted to healthcare payment systems. I address several fee-for-service payment systems and discuss capitation in this book. References are made to the other three books from time to time in our discussions; here are their titles:

- *Healthcare Payment Systems: An Introduction*
- *Fee Schedule Payment System*
- *Prospective Payment Systems*

As feasible, a similar approach and style has been maintained for all four books.

Healthcare payment processes are often quite complicated. At times, there can even be political controversy concerning their use and the payment mechanisms that are included. Discussion surrounding various types of healthcare payment processes can become quite confusing unless there is uniformity in terminology and definitions. Unfortunately, you must sometimes glean the meaning of terminology from the context of the discussion. Also, healthcare payment and associated delivery system discussions involve hundreds of acronyms. An acronym listing has been provided to assist in wading through this alphabet soup.

Because healthcare payment is a statutory issue for the Medicare program and often a contractual issue for private third-party payers, great care must be taken to understand the terminology and the many acronyms that are used in this area. In some cases, healthcare providers file claims to third-party payers with whom the healthcare provider has no relationship. While there should be full payment for the charges made, often the unknown third-party payers will pay on the basis of a predetermined system, including various fee schedules, prospective payment, or other payment systems. Even when there is a contractual relationship, terminology specific to a given third-party payer may seem unorthodox. Always be prepared to ask exactly what certain terms mean.

Many of the adjudication discussions surrounding cost-based and charge-based payment can become quite technical. For example, the Medicare program uses several cost-based payment systems for certain types of healthcare providers. With the Medicare program, there are tens of thousands of pages of rules, regulations, bulletins, transmittals, and other documents that are issued. Thus, as a way to make reading of such materials a little more friendly, the term *small case studies* is used to illustrate various concepts as we discuss them.

Private third-party payers often use contractual payment processes. These are called *managed care contracts,* although our main emphasis is with the payment processes more than with the healthcare management processes. The complexity in the use of contracts lies within the contracts themselves. While these contracts are supposedly negotiated, the contracts tend to be written by

the payers and thus incorporate terms and features that are generally advantageous to the payer. Again, small case studies illustrate some of the concepts typically found in contracts. Note that with contracts, the contract itself may be very brief with the actual coding, billing, and reimbursement features being contained in associated companion manuals or links to web sites.

This text has been prepared to address various complexities by iterating certain concepts. This means that we address a concept or topic at a high conceptual level and then revisit the same or perhaps a similar topic and drill down with more detail. Due to the extreme complexities of most payment systems, we are only able to address many topics at a detailed conceptual level. For this text, our goal is to understand many of the features and the way in which payment systems function. When these systems are in use to actually reimburse healthcare providers, they are dynamic and are constantly changing and evolving.

The level of detail provided concerning cost-based, charge-based, and contractual payment arrangements has been balanced with the number of conceptual features that are presented. To fully discuss any of the many issues addressed would take a separate book. For instance, Chapter 5 briefly addresses capitated healthcare payment. To really discuss capitated payment systems, a rather large volume would be needed. The intent is to provide a framework to understand and analyze the characteristics of the payment systems discussed in this text. Thus, the intended level is that of a detailed conceptual discussion. The concepts can then be applied to a wide variety of specific circumstances.

Comments on Terminology and Notation

Acronyms abound in healthcare for coding, billing, and reimbursement. As much as possible, when acronyms are first used in a chapter, the meaning is provided. However, you may find times when you need to go to the acronym listing to verify the meanings. We are at a point where there are sometimes *second-order* acronyms. These are acronyms that can be used in different ways. For instance, the acronym *MAC* can refer to monitored anesthesia care or Medicare administrative contractor.

Special notes are provided throughout the text. These notes convey additional information that is an adjunct to the specific discussion. Almost any rule, regulation, or approach to payment will have exceptions and unusual idiosyncrasies. When possible, further references are provided. Also, alerts are made to topics subject to current change. If healthcare payment systems have any one feature in common, it is that they are in a constant state of change.

Modifiers are indicated in quotations with a leading hyphen, such as "-LT," *Left*. The description of the modifier is indicated in italics. This notation is used to indicate that the modifier is used as a suffix that is appended to a CPT® (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) code. This notation really follows from the paper claims. Today, for the most part, modifiers represent data elements that go into a specific location in the electronic format. Thus, the leading hyphen is for human reading purposes, not for actual claims-filing purposes.

Generally, the *Medicare program* is referred to, as opposed to CMS (Centers for Medicare and Medicaid Services). CMS is the administrator for the Medicare program. Thus, various rules, regulations, directives, transmittals, and the like all emanate from CMS. Thus, these various rules and regulations govern the Medicare program and the payment system arrangements that we discuss in this book, at least those applicable to Medicare.

I also use abbreviated descriptions for CPT and HCPCS codes as well as for the various modifiers. For the full descriptions of codes and modifiers, this can become lengthy; see the respective CPT or HCPCS manual.

Case Study Approach

A series of simple case studies or scenarios is used throughout this book to illustrate the concepts presented. For the most part, these case studies are in the context of a fictitious community, namely, Anywhere, USA. The hospital involved is the Apex Medical Center. When a clinic is needed, the Acme Medical Clinic is used. Anywhere, USA, also has a skilled nursing facility, home health agency, hospice, and other types of healthcare providers. The Maximus Insurance Company is also located in Anywhere, USA.

The individuals who present for various services include:

- Sarah: Feisty lady who has been 87 years old for the last 5 years. While she is actually a nonagenarian, Sarah's most endearing characteristic is her speed walker, which has a horn, headlight, and racing wheels. She is also tired of signing forms, so she has had a signature stamp fabricated that hangs from the handle on her walker.
- Sam: Sarah's cousin, who is an octogenarian, semiretired rancher. He also works part time at the local hardware store.
- Susan: Sarah's daughter, who teaches school.
- Sydney and Stephen: Both are elderly Medicare beneficiaries who have a number of chronic health conditions.

While there are other residents who may be used in THE case studies, these are the main characters. Keep in mind that this is a fictitious community that exists only in our imaginations. Also, when necessary for a given case study, the specific circumstances involving a healthcare provider may be altered. For instance, the Apex Medical Center may be an acute care hospital for a given case study and then changed to be a critical access hospital for another case study.

Anywhere, USA, is also home to a regional insurance company, Maximus Insurance Company, which provides health and accident insurance for individuals and companies. As with all third-party payers for healthcare services, Maximus must determine how to pay for healthcare services. We will join in some of their efforts and thoughts relative to different contractual payment systems.

The use of case studies is intended to make the study of sometimes-technical material a little more tractable and enjoyable. Note that for a given case study there may be many issues involved even though these are very short in nature and often without appropriately specific detail. Watch for notes that indicate there may be some hidden issues that are not a part of our immediate discussions.

Medicare Orientation

Several Medicare cost-based payment systems are discussed in this book. Information about these payment systems is publicly available and generally extensive. Specific information about private third-party payer utilization of cost-based, charge-based, and contractual payment is not as readily available. Also, contractual payment systems are highly variable and may involve unusual features. As a result, both Medicare payment approaches are discussed along with myriad charge-based and contractual payment systems. Private third-party payers often adopt modified forms of the different Medicare payment systems. In some sense, the Medicare program leads the way in breaking new ground for innovative healthcare payment processes.

For healthcare providers and patients alike, the way in which private third-party payer payment systems work can be mysterious and sometimes frustrating. The bottom line for payment

systems outside the Medicare program is that variability is the norm. This is the reason why, in this series of four books, we tend to start with the Medicare payment systems and then work toward how private payers adapt and use the different payment processes that have been developed by Medicare.

References

References to specific resources are provided on a limited basis. Some of the topics addressed are present in the Medicare program in one form or another. The *Federal Register* update process involves proposed rule changes followed by final rule changes. Other references are to the CMS manuals, *Federal Registers,* or the *Code of Federal Regulations*. The CMS manual system is updated through various transmittals. In some cases, extremely important guidance is made at very informal levels. For instance, there are significant policy statements from CMS through their Question and Answer (Q&A) website (https://questions.cms.gov/). Note that if you are creating policies and associated procedures based on informal guidance, be certain to save a copy of the document or website. Informal guidance can suddenly disappear. Changes to the CMS manuals have to go through a more formal process using the transmittals. Thus, there is official notice of the changes so that when changes are made, everyone knows what is being changed and when.

Note: Even with the transmittal process for updating the Medicare manuals, there are times when complete paragraphs are removed from a manual, but this may not be reflected in the changes indicated in a given transmittal.

While references to non-Medicare, that is, private, third-party payers would certainly be wonderful, most of these resources depend on very specific implementations and guidance that is provided through contractual relationships. The specific guidance for coding, billing, and associated payment may be adjunct to the actual contract. There are often companion manuals and guidance for providers through the Internet or secure intranets.

Note also that you must constantly update yourself on any given implementation or instantiation of a given payment arrangement. For healthcare payment, change is constant. Thus, this text is oriented toward understanding overall systems and implementation parameters for various types of payment systems. Specific details of exactly how a claim should be developed and then adjudicated must be supplied by the specific third-party payer, and this includes the Medicare program as well. There are always gaps in guidance, so questions are always appropriate.

As you read and study the materials in this text, you will probably want to access a number of different resources cited. Here is a list of specific resources and an Internet address for each. These are the general resources. You may need to delve further into a particular manual or book to find specific information and concepts referenced.

1. Social Security Act (SSA): http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. You will need to know which section to reference specific issues. For example, §1861(s)(2)(A) addresses payment to physicians, including "incident-to" language and noncoverage for self-administrable drugs.
2. *Code of Federal Regulations* (*CFR*): http://www.nara.gov. You will need to know the specific citation, such as 42 CFR §413.65 for the provider-based rule.

3. *Federal Register*: http://www.archives.gov/. You will need to know the date or the formal legal citation, such as 74 FR 60315, which refers to page 60315 (and following) of the November 20, 2009, *Federal Register* and discusses physician supervision requirements.
4. CMS Manual System: CMS has a series of very large manuals that provide all of the rules and regulations. Go to https://www.cms.gov/manuals/iom/list.asp to start. You will need to know which manual, such as Publication 100-04, *Medicare Claims Processing Manual* (MCPM), and then the chapter and section number within a given manual.
5. CMS Transmittals: CMS uses frequently issued transmittals to update their manual system. Go to https://www.cms.gov/transmittals/. You will need to know the number of the transmittal and the manual to which it applies. Typically, if you have the number and date, you will be able to find the correct transmittal.
6. CPT Manual: This is published annually by the American Medical Association. Go to http://www.ama-assn.org/ to obtain more information.
7. HCPCS Manual: The HCPCS code set is published by CMS and is available at https://www.cms.gov/medhcpcsgeninfo/. This code set is also republished by different healthcare publishing companies. Note that this code set is updated quarterly.
8. AHA Coding Clinic® for *ICD-10*: Official guidance from the American Hospital Association on *ICD-10* (*International Classification of Diseases, Tenth Revision*). See http://www.ahacentraloffice.com/.
9. AHA Coding Clinic for HCPCS: Official guidance from the American Hospital Association on HCPCS coding. See http://www.ahacentraloffice.com/.
10. UB-04 Data Specifications Manual: See the National Uniform Billing Committee at http://www.nubc.org.
11. 1500 Health Insurance Claim Form Reference Instruction Manual: See the National Uniform Claims Committee at http://www.nucc.org.
12. SNF (Skilled Nursing Facility) PPS: The SNF PPS is RUGs. Go to http://www.cms.gov/snfpps/ for additional information.
13. Home Health Agency (HHA) PPS: Information on the HHA PPS can be found at https://www.cms.gov/HomeHealthPPS/.
14. Long-Term Care Hospitals (LTCHs): The LTCH MS-DRGs represent a modification to MS-DRGs (Medicare Severity Diagnosis Related Groups) for long-term care hospitals. See http://www.cms.gov/longtermcarehospitalpps/.
15. Inpatient Rehabilitation Facilities (IRFs): Information for the IRF PPS can be found at http://www.cms.gov/InpatientRehabFacPPS/.
16. Inpatient Psychiatric Facilities (IPFs): Further information concerning the IPF-PPS can be found at http://www.cms.gov/InpatientPsychFacilPPS/.
17. Hospice: See https://www.cms.gov/Hospice/ for additional information.
18. Pricer Information for all Medicare PPSs: See http://www.cms.gov/PCPricer/.
19. MedPAC (Medicare Payment Advisory Commission): See http://www.medpac.gov.
20. Medicare Physician Fee Schedule (MPFS): Go to https://www.cms.gov/PhysicianFeeSched/ to download the large MS Excel spreadsheet that constitutes the MPFS.
21. Medicare Provider-Supplier Enrollment and CMS-855 Forms: Go to https://www.cms.gov/MedicareProviderSupEnroll for information and the five different forms.
22. Medicare HPSA (health personnel shortage area) and PSA (physician scarcity area): Go to https://www.cms.gov/hpsapsaphysicianbonuses/ for additional information.
23. Clinical Laboratory Fee Schedule (CLFS): Go to https://www.cms.gov/ClinicalLabFeeSched/.
24. Ambulance Fee Schedule (AFS): Go to https://www.cms.gov/AmbulanceFeeSchedule/.

25. Medicare Secondary Payer (MSP): Go to https://www.cms.gov/MedicareSecondaryPayerand You/.
26. National Correct Coding Initiative (NCCI) Coding Policy Manual: Go to https://www.cms.gov/NationalCorrectCodInitEd/. In this book, specific references may be to chapter and page numbers along with the version of the policy manual that is referenced.
27. Critical Access Hospitals (CAHs): See https://www.cms.gov/center/cah.asp. For Method II billing, the hospital bills the professional component for physicians and practitioners on the hospital facility component on the UB-04 claim form.

While the information in the *CFR* is official, this information is often rather cryptic. More detail can be found in the CMS manual system. The two manuals that are most often referenced relative to payment systems are

- The *Medicare Claims Processing Manual* (MCPM), Publication 100-04, and
- The *Medicare Benefit Policy Manual* (MBPM), Publication 100-02.

For instance, Chapter 3 of MCPM is devoted to inpatient hospital billing. These manuals are updated through rather frequent transmittals, sometimes called *change requests* (CRs). The transmittals are sometimes only a few pages long; in other cases, they can comprise a hundred pages or more.

References to the *Federal Register* and the *Code of Federal Regulations* may also be provided. Generally, the date and page number for the *Federal Register* will be provided along with a notation like 76 FR 42914. This is Volume 76, page 42914, which was issued on July 19, 2011, and addresses proposed rules for the MS-DRG Pre-Admission Window. A reference like 42 CFR §413.65 refers to Title 42 of the *CFR* and then Section 413.65. This is the provider-based rule (PBR). For the *CFR*, there are also volume, chapter, and part indicators, but the section numbers appear most commonly.

For the Medicare program, there are tens of thousands of pages of manuals, *Federal Register* entries, and less-formal guidance that Medicare refers to as *subregulatory*. Technically, *subregulatory* refers to guidance that appears below the *CFR* level. The *CFR* actually has the force and effect of law and is the equivalent, at the federal level, to state administrative law.

For private third-party payers, specific information about their payment systems is not nearly as readily available. Your healthcare provider may enter into contractual arrangements with a private third-party payer and thus come under several different payment systems for various types of healthcare services. The information on billing, claims adjudication, and payment will probably not be in the contract itself. Most likely, there will be companion manuals that go along with the contract. Also, these payment arrangements tend to be individualized to the needs of the payer. Specific information on these payment arrangements, using various payment methodologies, is not always readily available.

Compliance

Throughout our discussions of various contractual payment systems, compliance issues will arise. This is also true for the cost-based and charge-based payment systems. While we will discuss cost-based payment under the Medicare program, issues surrounding the cost reporting process are subject to compliance concerns from the Medicare program. Cost reports involve statutory compliance.

For most of the other payment systems discussed in this text, compliance issues involve contractual compliance because generally there will be some sort of a contract in place. While contractual

compliance is less severe than statutory compliance, great care must be taken to meet any and all contractual obligations. The biggest difference with statutory compliance is that criminal prosecutions can result, whereas with contractual compliance, cases are normally in the civil courts, and often arbitration can resolve any issues that might arise.

In *Healthcare Payment Systems: An Introduction,* various compliance concerns are discussed. Compliance is inherent throughout the overall process of providing services, filling claims, and receiving payment. This process is referred to as the *revenue cycle*. Because we are interested in claims that are paid through some sort of payment system, the phrase *reimbursement cycle* is more appropriate. This implies that reimbursement is occurring based on a filed claim.

From a compliance perspective, what steps in the overall adjudication process could possibly yield any sort of compliance concerns? Here are the generalized steps in the reimbursement cycle:

- Covered Individual
- Covered Service or Item
- Ordered by a Physician or Qualified Practitioner
- Medically Necessary
- Provided by Qualified Facility or Healthcare Personnel
- Appropriate Written Documentation
- Billing Privileges
- Proper Claim Filed Timely

While each of these steps can create compliance concerns, even for contractual payment, the main area of concern is the proper development and timely filing of the claim for the services provided or items dispensed. For instance, while issues such as medical necessity or covered individual are important, the adjudication of claims should not even get to the point of calculating a payment unless these sorts of conditions are satisfied. The payment systems discussed in this text are highly varied, and there can be significant differences in third-party payer requirements for filing claims. A provider may find that even for the same services, two different payers may have different claims-filing requirements.

There are definitely instances when the healthcare provider may not properly code services and thus generate incorrect payment. This can occur for a number of reasons, not the least of which is that some claims-filing guidance can become confusing and complex. Today, the Medicare program uses a number of different audit and recovery programs, the latest of which is the Recovery Audit Contractor or RAC program. This is a recovery program with regional RACs paid a percentage of any incorrect payments, mainly overpayments, made by the Medicare program.

Note: See the *Medicare Recovery Audit Contractor Program: A Survival Guide for Healthcare Providers*, published by CRC Press (2010). This book is an adjunct to a more general compliance book for healthcare providers, *Compliance for Coding, Billing & Reimbursement: A Systematic Approach to Developing a Comprehensive Program,* also published by CRC Press (2008).

Contents and Approach

The first chapter is devoted to providing important background material concerning types of healthcare providers and associated organizations, along with a review of the main types of healthcare payment systems. Chapter 2 addresses healthcare costs and cost-based reimbursement systems.

This is the oldest of the payment systems. Cost-based reimbursement is still used by the Medicare program for critical access hospitals (CAHs) and RHCs (rural health clinics) and FQHCs (federally qualified health centers). At a very localized or micro level, cost-based reimbursement is used in almost all payment systems for special or expensive items on a pass-through basis.

Chapter 3 discusses healthcare charges and charge-based reimbursement. Healthcare costs and charges have become rather contentious issues over the last decade. Charge-based reimbursement and cost-based reimbursement are actually closely related, presuming that healthcare providers establish their charges based on their costs.

Contractual payment is generally a combination of several different types of payment processes or systems. Healthcare providers and payers often enter into contractual arrangements. Chapter 4 provides a discussion of some of the features and pitfalls with these contractual arrangements.

Chapter 5 discusses a very different type of payment system, namely, capitation. Capitated payment involves a healthcare payer making fixed payments in advance. The payments are often made on a per member per month arrangement, with payments on a per capita or per head basis. A significant paradigm change occurs with capitation in that the risk for excessive services is transferred from the payer to the healthcare provider.

The operational implementation of a healthcare payment system lies in the processing of claims and the determination of payment. Chapter 6 delves into some of the intricacies involved with adjudication of claims. The adjudication process often involves rather complicated logic structures that are programmed into the healthcare payers' claims-processing systems. Whenever there are complex logical constructs used to adjudicate claims, compliance becomes an issue. Payment system interfaces have been discussed throughout this series of texts. An additional payment system interface involves secondary payer issues. For Medicare, a separate effort in this area is the MSP or Medicare secondary payer program.

Chapter 7 briefly discusses where healthcare payment systems are headed in the future. This is a very dynamic area with constant change. Currently, there are very clear attempts to ensure the quality of healthcare while reducing overall costs on the part of healthcare payers.

An appendix is provided that outlines the various Medicare payment systems. References to the previous three books in this series are also provided.

Enjoy the Technicalities

This book addresses what most would consider as technical, convoluted, and boring. Granted, the *Federal Register* entries from CMS are not always scintillating, but make the process fun by looking for inconsistencies and obtuse and sometimes misleading language in the various rules and regulations. Also, reading contracts that establish contractual payment processes is not always that interesting until you realize that significant financial and medical care issues are at stake.

Watch for the definitions. Often, words are used and phrases are invented that are never really defined. Discussing any topic without having precise definitions is a misunderstanding waiting to happen. Also, watch for words like *clarification* and *restatement* as opposed to *changes* in rules and regulations.

Look for words like *believe*. What are people allowed to believe? Basically, anything! This word is often used when an individual does not know something for certain; the person simply thinks it is true or might be true. Is it not interesting how often this word appears in the *Federal Register*?

This book, and the other three books in this Healthcare Payment Systems series, is intended for anyone who is interested in learning more about the specific systems and processes that are

used to make (or not) payment for healthcare services. Thus, this text is for motivated laypersons along with those who are entering the healthcare field or find themselves in healthcare without a reasonable understanding of how healthcare payment systems actually work. The one most important guiding factor is that healthcare payment processes are constantly changing and evolving. This is a dynamic area. Be prepared to be surprised every day as changes occur.

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