Lesson 11

Determining Payment

Step 1  Learning Objectives for Lesson 11

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Describe fee schedules and how they work.
  - Describe the usual, customary and reasonable method of payment and how it works.
  - Describe the Resource Based Relative Value System and how it works.
  - Differentiate between diagnosis related groups and ambulatory payment classifications, and explain how they are used to determine payment.

Step 2  Lesson Preview

Welcome to your second course in the healthcare document specialist program! Remember the career goal you set when you enrolled in this program? You are getting there! Think of how much you have learned in such a short time—medical insurance basics, terminology, ethics and medical records. By the end of this course, you will know the information necessary to fulfill the medical billing functions of your job. You will also begin learning about the fascinating human body—from how it is organized to various body systems (such as cardiovascular) to disease processes. Each lesson will bring you one step closer to your healthcare document specialist career goal!

Let’s start with a quick review of a topic you learned about in the first course—reimbursement. You’ll recall that reimbursement refers to the compensation or repayment for healthcare services. It is the process of paying a provider back for services he already performed or provided.

There are various forms of healthcare payment methods. We will discuss fee-for-service, usual, customary and reasonable and the Resource Based Relative Value System. Then we’ll look at the reimbursement methods used in a managed care system. We’ll compare and contrast diagnosis related groups and ambulatory payment classification payment systems.
Keep in mind, this lesson will help you understand terminology as it pertains to payments. As the healthcare document specialist, you will not determine the type of payment, create a fee schedule or calculate payment structures. The insurance company will determine the type of payment structure, the provider will agree to the type of payment structure and you will apply the payment structure to the service.

Ready to begin? Let’s go!

**Step 3  Fee-for-service**

- **Fee-for-service** is a method of charging where a provider bills for each encounter or service she rendered. In this traditional method of reimbursement, the patient can choose the physician, hospital or clinic, while the insurance reimburses for part of the fee according to the policy plan. The reimbursement amount is determined by a fee schedule.

A fee schedule is a predetermined dollar amount that the third-party payer allows for payment of a particular healthcare service. Some medical offices have more than one fee schedule for the same procedure (although some states prohibit this arrangement). Typically, fee schedules are affected by the participation of the doctor’s office in government programs and managed care.

The fee schedule must reflect whether a practice accepts Medicare or not. By law, the fees on the Medicare fee schedule cannot exceed those on the non-Medicare fee schedule. When a practice is involved in a managed care contract, such as an HMO or PPO, it can have many fee schedules. It can have one for each managed care insurance company it is involved with, including co-payments and allowable charges. Each managed care contract specifies what will be paid for each procedure. The practice might also have a non-managed care fee schedule and one for a government program such as Medicare or workers’ compensation.
Step 4 Usual, Customary and Reasonable

Usual, customary and reasonable (UCR) is the maximum amount the insurer will consider eligible for reimbursement under a health insurance plan. Usual indicates what a typical doctor normally charges for a service. Customary refers to the amount that most physicians in the community normally charge for a service. Reasonable is based on the appropriateness of the charge, considering all of the circumstances. Let’s look at an example of this method.

Tim has knee surgery, and the provider charges $1,000—the insurance company compares that fee to its UCR scale. If the UCR amount indicates a $900 limit for that particular procedure, then Tim may be responsible for the extra $100 depending on the agreement the physician has with the insurance company. Fees that exceed the UCR amount are disallowed by the carrier, which means these fees are not covered as a benefit.

In the 1970’s, Medicare used customary, prevailing and reasonable (CPR) rather than UCR. The prevailing charge reflects the average, or median, charge of a cross-section of providers in similar settings, such as practice or city size, for the same service. For the CPR, the “reasonable” charge, or the amount the physician would be paid, was the lowest of the actual charge, the customary charge or the prevailing charge. In 1988 it was recommended that the pay structure should be based on a relative value of the work needed to produce each service.

Step 5 Resource Based Relative Value System

While some insurance carriers use UCR, some have moved to RBRVS. In the Resource Based Relative Value System (RBRVS), several elements factor into the nationally uniform relative value. The calculation of the fee includes a geographic adjustment and conversion factor. The nationally uniform relative value is based on physician work, practice expense and malpractice expense.

The physician work component, which is the largest cost element, includes the physician’s time, mental effort, technical skill, judgment, stress and an amortization of the physician’s education. This value accounts for 52 percent of the total relative value for the service. CMS reviews this scale every five years.

The practice expense is the second element of the nationally uniform relative value; it represents the practice overhead and accounts for 44 percent of the total relative value.

Finally, the malpractice expense represents the cost of the malpractice insurance premium to provide the service or procedure. This accounts for four percent of the total relative value.
The calculation of the provider’s work, practice expense and malpractice expense gives you a unit of measurement assigned to the medical service based on the relative skill and time required to perform it, which is known as the **relative value unit**, or RVU.

The geographic adjustment is known as the **geographic practice cost index**, or GPCI. Consider that the cost for practice overhead and malpractice insurance in Los Angeles, California, would be more than that for Sheridan, Wyoming. The GPCI is multiplied by the RVU to show the cost element for each value in that specific geographical location.

A **conversion factor** is a numerical factor, or dollar amount, that you’ll use to convert the total RVUs into a payment amount to reimburse the provider. The conversion factor is updated annually. We will use 36.8729, as the conversion factor in this program.

You can log on to the CMS Web site at http://www.cms.gov/PhysicianFeeSched.com and locate PFS Relative Value Files. After you select the year, you can locate the nationally uniform relative value based on the **CPT** or **HCPCS**, as well as the GPCI, in Excel files.

Now, let’s take a look at the steps to determining the RBRVS.

**Steps to determine RBRVS:**
1. Determine the procedure code for the service. (You will learn how to do this in Course Four of your program.)
2. Using the http://www.cms.gov/... site, locate the RVU for the work, practice expense and malpractice.
3. Using the http://www.cms.gov/... site, locate the GPCI for the work, practice expense and malpractice based on location.
4. Multiply each RVU by each GPCI.
5. Add the three adjusted amounts (items 2, 3 and 4).
6. Multiply the total sum by the conversion factor.

Now, let’s put all of this information together to determine the RBRVS in the following scenario. Follow the steps to calculate the fee for the service.

Let’s walk through the steps for calculating the fee in Wyoming. When calculating the fee, you will not round the numbers.

1. Determine the procedure code for the service. We will use **99203** in this example.
2. Locate the RVU for the work, practice expense and malpractice.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>Practice RVU</th>
<th>Malpractice RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>2.43</td>
<td>1.61</td>
<td>0.71</td>
</tr>
</tbody>
</table>
3. Locate the GPCI for the work, practice expense and malpractice based on location.

<table>
<thead>
<tr>
<th>Location</th>
<th>Work GPCI</th>
<th>Practice GPCI</th>
<th>Malpractice GPCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles, CA</td>
<td>1.041</td>
<td>1.225</td>
<td>0.804</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1.00</td>
<td>0.921</td>
<td>0.889</td>
</tr>
</tbody>
</table>

4. Multiply each RVU by each GPCI.

- **Work** \(2.43 \times 1.00 = 2.43\)
- **Practice Expense** \(1.61 \times 0.921 = 1.48281\)
- **Malpractice** \(0.71 \times 0.889 = 0.63119\)

5. Add the three adjusted amounts.

\(2.43 + 1.48281 + 0.63119 = 4.544\)

6. Multiply the total sum by the conversion factor.

\(4.544 \times 36.8729 = \$167.55\)

Now, it's your turn to try it! Use the GPCI from Los Angeles, California to calculate the fee for the same procedure code. Did you come up with $187.05? If so, you're on the right track!

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### Step 6  Managed Care

- While private insurance carriers use fee schedules, UCR and RBRVS, in managed care, the third-party payer may use systems to control the costs of health care while still providing quality care. The two examples of this type of reimbursement are **capitation** and **global payment**.

**Capitation** occurs when the physician receives a set dollar amount determined by per member per month calculation to deliver medical services to a specified group of people. **Per member per month (PMPM)** is the amount of money paid each month for each individual enrolled in the health insurance plan. The provider will receive a lump-sum payment to provide services to a group of people. In capitation, the number of times the patient sees the physician or the level of service the physician provided does not reflect in the overall payment for the service. The provider will receive the same payment for seeing 10 of the 100 people in the group or 50 of the 100 people in the group. More services do not increase the payment, nor do fewer services decrease the payment. The payment is the same for seeing a patient with a common cold or one with congestive heart failure. There are no adjustments for the complexity or extent of the healthcare services.

Third-party payers implement systems to control healthcare costs.
With the **global payment method**, the third-party payer makes one combined payment to cover the services of multiple providers for a single episode of care. Similar to capitation, there is no additional payment for complexity or extent of the healthcare service. The global payment method differs in that it is not one lump-sum per member per month, but instead is based on the episode of care.

Ready to pause and review what you’ve learned? It’s time for a Practice Exercise.

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**Step 7  Practice Exercise 11-1**

- Select the best answer from the choices provided.

1. _____ refer to the pre-determined dollar amounts that third-party payers allow in healthcare services.
   a. Fee schedules  
   b. Actual charges  
   c. Prevailing charges  
   d. Relative value studies

2. The _____ reflects the average charge of a cross-section of doctors in similar settings for the same service.
   a. fee schedule  
   b. actual charge  
   c. prevailing charge  
   d. median charge

3. A(n) _____ fee is based on the appropriateness of the charge considering all the circumstances.
   a. usual  
   b. reasonable  
   c. customary  
   d. actual

4. In _____, geographic adjustments and conversion factors are used to calculate fees.
   a. the Resource Based Relative Value System (RBRVS)  
   b. usual, customary and reasonable lists  
   c. fee schedules  
   d. UCR systems
5. The fee that a doctor normally charges for a service is called the _____ fee.
   a. average
   b. usual
   c. customary
   d. actual charge

Step 8  Review Practice Exercise 11-1

☐ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 9  Diagnosis Related Groups

Diagnosis related groups (DRGs) were developed in the late 1970s by two Yale professors, John D. Thompson and Robert B. Fetter, to establish a way to classify patients in regard to their required treatment. The federal government subsequently implemented a diagnosis-specific prospective payment system (PPS) for inpatient hospital services called DRGs or diagnosis related groups. The original DRGs were intended to help with the utilization review system, as well as reimbursement and budget planning. Utilization review is a process in place to ensure that the care a patient receives is medically necessary, delivered in the most appropriate locations and follows general accepted medical standards. By 1983, DRGs were in widespread use, and Medicare reimbursed hospitals based on retrospective costs of inpatient services. This meant that for every Medicare beneficiary a hospital served, the hospital was reimbursed for the submitted costs for each patient’s services.

As the healthcare industry grew, the DRG also needed to evolve. Over time, with healthcare costs continually rising, the government refined the DRG system and developed an incentive for hospitals to manage their operations more cost effectively. Keep in mind that DRGs reimburse for facility use and resources, not provider fees.

How DRGs Work

DRGs provide a way to reimburse hospitals based on the average cost of treating patients with statistically similar conditions. The DRG rate is determined based on these factors:

- principal diagnosis
- patient’s age
- up to eight secondary diagnoses
- patient’s gender
- up to six procedures performed during the stay
- patient’s discharge status
Under the DRG system, payment is not made based on the cost of individual cases. Instead, each DRG has a set payment rate, and payment is made in one lump sum, based on an averaging process. Each DRG contains a range of costs and lengths of stay. A DRG’s weight represents the average of the resources necessary to care for cases in that DRG. The DRG payment calculation multiplies the facility rate times the DRG weight. Statistically, most cases incur costs close to the average. Obviously, some cases cost more and some less. Because medicine involves many variables, the DRG system has established outliers, which are cases that require patients to have additional time in the hospital, variations in treatments or other unusual circumstances.

Each case, regardless of the number of conditions treated or services provided, is assigned to one of the 497 DRGs. These 497 DRGs are classified into major diagnostic categories, usually based on a specific organ system of the body. Each major diagnostic category is divided into surgical or medical groups, and each DRG is further differentiated based on other case factors, including patient age or secondary diagnoses.

Let’s look at how DRGs work.

A look at how the DRG works, from admission to discharge:

1. A patient is admitted into the hospital as a Medicare patient. At this time, no DRG is assigned because the diagnosis is not available. (More tests or examinations may be necessary to establish an accurate diagnosis.)
2. The attending physician determines what is wrong and assigns a diagnosis to the patient.
3. The attending physician certifies the diagnosis and treatments.
4. The information from the registration is entered into the hospital computer.
5. The computer contains a program that searches the DRG system and assigns an appropriate DRG for the case, based on the patient’s demographics. This program sorts through all the information to find the DRG that allows for the highest payment to the hospital.
6. Now the patient has a DRG, and the hospital can then be reimbursed according to the DRG schedule. However, if the case becomes an outlier, the hospital can apply for additional payment.

If you are working as an independent healthcare document specialist, you do not need the computer program described above. Generally, the bills you submit will have any DRG already coded when you receive them. Hospitals use specialized DRG software, which enables the healthcare professionals to input diagnosis and procedure codes. The DRG software also provides the DRG category and reimbursement rate for the diagnosis and its associated procedures.
In a moment we’ll look at an example so you can see how DRGs work. DRGs are used for inpatient hospital care; therefore, the procedure codes listed are from Volume 3 of the *ICD-9-CM*. The diagnosis codes are from Volumes 1 and 2, which you’ll learn more about later in the program. Now, let’s look at the example.

A 28-year-old male was diagnosed with acute appendicitis with generalized peritonitis, and an appendectomy was performed.

**ICD-9-CM diagnosis code**

540.0 Acute appendicitis with generalized peritonitis

**ICD-9-CM procedure code**

47.09 Other appendectomy

When these codes are inserted into a DRG calculator, the following results are provided.
The results indicate this case is categorized into DRG 165 Appendectomy with Complicated Principal Diagnosis without CC (without complications) with an estimated Medicare reimbursement of $4,775.99. Remember that even though the calculator states “Medicare reimbursement,” other insurance carriers also use the DRG reimbursement amount. Also note that the reimbursement amount covers the facility use and resources necessary for the patient. It does not cover provider fees.

The DRG system is important to hospitals because it regulates the amount of money hospitals receive for services. The amount paid is based on national and regional averages. The reimbursements of virtually every hospital in the country are based on DRGs, regardless of insurance type. Medicare began using DRGs in hopes of keeping healthcare costs down.

The **DRG monitor** is a position that has become popular as more medical practices are reimbursed through DRGs. A **DRG monitor** is an individual who reviews current fee schedules and compares them to a current list of DRGs to make sure the fees are in line with the DRGs. This helps ensure maximum payment for the facility, as well as simplifying budget and cost planning because the medical practice knows that it will be paid a set amount for a certain diagnosis.

Now that you know a little bit about DRGs and how they work for inpatient claims, you may be wondering what kind of payment classification system is in use for outpatient claims. The answer to that is the ambulatory payment classification system.

### Step 10  Ambulatory Payment Classifications

Ambulatory payment classifications (APCs) work for outpatient coding like DRGs do for inpatient coding. The APC classification system was designed to specify the amount and type of resources used for each outpatient visit. Medicare requires the use of APCs on its claims, as do many other insurance companies. APCs, like DRGs, only cover healthcare facility fees, not the provider or other professional fees. APCs are used mainly in same-day surgery centers, emergency departments and clinics. They are not used for home visits, nursing homes or inpatient admissions.

APCs are based on procedures performed per visit, and a case can be assigned to several of the 346 APC groups, which is unlike DRGs, where only one DRG can be assigned per admission. Calculation of APC payment is quite complex, but to summarize, a lump payment is made to the facility based on the case’s assigned APC(s). This payment can include anesthesia, medications, supplies and operating and recovery room services.
Step 11  Working with DRGs and APCs

You’ve seen how DRGs and APCs work and how they are reviewed. But, how do you handle DRGs and APCs as a healthcare document specialist? If you are working for a provider, you will not use this reimbursement system. As you recall, DRGs apply to inpatient hospital services and APCs apply to facility charges. However, even though you may not work directly with DRGs or APCs, it’s important to understand the terminology as it relates to the healthcare system.

Let’s look at how APCs and DRGs differ.

<table>
<thead>
<tr>
<th><strong>Ambulatory Payment Classifications</strong></th>
<th><strong>Diagnosis Related Groups</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM diagnoses and CPT procedures</td>
<td>ICD-9-CM diagnoses and procedures, age, sex and discharge disposition</td>
</tr>
<tr>
<td>Classified by visit</td>
<td>Classified by an admission</td>
</tr>
<tr>
<td>Utilize the procedure as the initial variable in the classification process</td>
<td>Utilize the diagnosis in the classification process</td>
</tr>
<tr>
<td>Multiple APCs can be assigned per visit</td>
<td>Only one DRG is assigned per admission</td>
</tr>
</tbody>
</table>

Again, while payment calculations for APCs are complicated, APC classifications are generally assigned using specialized computer software that does all the work once codes are input.

Are you ready for your last Practice Exercise for this lesson? Let’s go!

Step 12  Practice Exercise 11-2

Select the best answer from the choices provided.

1. The objective of DRGs is to provide a way to reimburse _____.
   a. doctors’ fees based on what they normally charge
   b. hospitals based on the average cost of treating patients with similar conditions
   c. hospitals based on their highest charge for that condition
   d. the doctor based on the average cost of treating patients with similar conditions

2. DRG cases that require unusual circumstances like a patient staying longer in the hospital or needing a variation in treatment are _____.
   a. specialized cases
   b. peer review cases
   c. APCs
   d. outliers
3. The _____ system was designed to specify the amount and type of resources used for every outpatient visit.
   a. APC
   b. DRG
   c. DRG monitoring
   d. PPS

4. APCs are classified by _____, whereas DRGs are classified by _____.
   a. admission, visit
   b. major diagnostic categories, minor procedure groups
   c. visit, admission
   d. diagnoses, procedures

5. A case can be assigned to _____ DRG(s) and _____ APC(s).
   a. two, two
   b. one, two
   c. one, many
   d. many, one

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Step 13 Review Practice Exercise 11-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 14 Lesson Summary

As healthcare costs rise, more and more third-party payers are looking for ways to control and predict costs. Insurance companies and government programs use various ways to determine reimbursement. Usual, customary and reasonable is a standard that considers the usual fee a provider charges for services, the amount normally charged by most doctors in the community and the appropriateness of the charge considering the circumstances.
Diagnosis related groups are used in inpatient cases and represent one way to predict costs by establishing acceptable fees for entire diagnoses. From exam to treatment to follow-up, specific services are grouped together and paid as a single item. DRGs have changed medicine from a completely fee-for-service world to a world that also looks at the whole picture—a lump-sum tally. The DRG represents the lump sum.

Ambulatory payment classifications for outpatient facility services were designed to specify the amount and type of resources a patient uses for each outpatient visit. They are classified by visit and use only ICD-9-CM diagnoses and CPT procedures. Like DRGs, a lump sum payment is made to the facility based on the case’s assigned APC.

The DRG monitor reviews hospital stays, procedures and diagnostic tests. These groups work to check the DRG assignment and determine if treatments are acceptable for different diagnoses.

Let’s pause to review what you’ve learned and demonstrate your knowledge with the following Quiz.

☑️ **Step 15  Mail-in Quiz 8**

- Follow the steps to complete the Quiz.
  - a. Be sure you’ve mastered the instruction and the Practice Exercises that this Quiz covers.
  - b. **You have two options to get instant Quiz results:** It’s as easy as calling 1-877-599-5857 to have a representative enter your answers or log into www.at-homeprofessions.edu to take your Quiz online. Please be sure to fill in all of the information requested when submitting your Quiz online.
  - c. You may also mail or fax your Quiz. First, transfer your answers to the Scanner Answer Sheet included in this course. Use only blue or black ink on your Scanner Answer Sheet. **The Scanner Answer Sheet is the only sheet you need to mail or Fax to the school.** Please fill in all information requested on your Scanner Answer Sheet: your name, address, student ID number and program code.
  - d. **Regardless of how you submit your Quiz, you only need to submit it once.**
  - e. Good luck as you move one step closer to your career goals!
Mail-in Quiz 8

Select the best answer from the choices provided. Each item is worth 5 points.

1. **DRG stands for _____.**
   a. digital relations group
   b. diagnosis related group
   c. diagnostic retroactive guarantee
   d. diagnosis review group

2. **The initial goal of DRGs was to _____.**
   a. determine what doctors were charging for specific diagnoses
   b. classify each patient by the type of visit
   c. determine the average charges for procedures
   d. establish a classification system for patients and their required treatments

3. **DRGs are changing reimbursement from a(n) _____.**
   a. lump-sum fee system to a fee-for-service
   b. fee-for-service system to a lump-sum fee
   c. peer review system to a fee-for-service
   d. inpatient to an outpatient

4. **The DRGs are classified into _____.** based on a specific organ system of the body.
   a. outliers
   b. major diagnostic categories
   c. diagnostic related categories
   d. APCs

5. **____ are cases that require patients to have additional time in the hospital or variations in treatments.**
   a. DRGs
   b. APCs
   c. Outliers
   d. Variation cases
6. _____ is a factor considered when the DRG rate is determined.
   a. The principal diagnosis
   b. Secondary diagnosis
   c. The age and sex of the patient
   d. All of the above

7. APC is a payment system _____.
   a. based on procedures performed per visit
   b. for outpatient procedure codes
   c. that utilizes the procedure as the initial variable in the classification process
   d. all of the above

8. _____ are factors of the nationally uniform relative value.
   a. Malpractice expenses
   b. Usual, customary and reasonable standards
   c. Prevailing charges
   d. Actual charges

9. Charges that exceed the UCR scale of a policy are ____ by the carrier.
   a. allowed
   b. paid anyway
   c. disallowed
   d. always applied toward the deductible

10. A ____ is an individual who reviews current physicians’ fee schedules to make sure they are in line with DRGs.
    a. physician superintendent
    b. DRG monitor
    c. DRG administrator
    d. PRO president

11. A medical practice involved in a managed care contract, such as an HMO or PPO, _____.
    a. primarily uses the customary fee scale to determine payment
    b. may have several fee schedules
    c. is required to use the Resource Based Relative Value System (RBRVS)
    d. is managed by a DRG monitor
Match the descriptions with the corresponding classification system. Each item is worth 5 points.

12. _____ Used primarily in same day surgery centers, emergency departments or clinics  
   a. APC  
   b. DRG

13. _____ Uses only ICD-9-CM diagnoses and CPT procedures

14. _____ A case can be assigned to only one

15. _____ A case can be assigned to many

16. _____ Based on ICD-9-CM diagnoses and procedures, age, sex and discharge disposition

17. _____ Utilizes the procedure as the initial variable in the classification process

18. _____ Classified by an admission

19. _____ Developed by two Yale professors

20. _____ Utilizes the diagnosis as the initial variable in the classification process
Great start to Course Two!
You did very well with the reimbursement process.

Time to learn about anatomy!
The next lesson describes the human body, including how it works.

_Do not wait to receive the results of your Quiz before you move on._