Revenue-Cycle Management and Reimbursement: The Impact of Health Law and Health Reform on Providers

Timothy D Martin, Southern Methodist University
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REIMBURSEMENT: THE IMPACT
OF HEALTH LAW AND HEALTH
REFORM ON PROVIDERS
FEBRUARY 2011

Timothy D. Martin
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*Timothy D. Martin*

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* J.D., SMU Dedman School of Law, December 2010; LL.M. Candidate, SMU Dedman School of Law, May 2011, tmartin@smu.edu. CPT® 2010 Professional Edition. Copyright 2010. American Medical Association. All rights reserved. Used by permission. Mr. Martin formerly served as a founder and Chief System Architect for Innovative Managed Care Systems, LLC (now MedAssets, Inc.) and Chief Technical Officer of Claimshop, Inc. (also now MedAssets, Inc.). He thanks his long-suffering wife, Christi, for her patience and support, his mother, Korkye Purviance, for her tireless proofing and editing, and Professor Tom Mayo at SMU Dedman School of Law for his guidance and forbearance. Mr. Martin also thanks Greg Everett, Dale Kahlich, and Harriett Flowers for their invaluable contributions. This article is dedicated to the memory of Steve Baird: I have always been, and ever shall be, your friend.
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Abstract

Healthcare payment systems are complex and difficult to administer. Over the years, providers have developed a complex process, called revenue-cycle management, for administering their interactions with payers operating under various payment systems. The Patient Protection and Affordable Care Act of 2010 will have a significant impact on payment systems—as will other recent reform measures. This paper contains primers on revenue-cycle management, health insurance systems, medical claims, claim coding, electronic-data interchange (EDI), claims processing, and public and private reimbursement methods for hospitals and physicians. But its focus is on the impact recent healthcare reform initiatives have had and are likely to have on payment systems and providers’ legal rights and obligations.
I. Introduction

An act of parliament can do no wrong; though it may do several things, that look pretty odd.1

Concerns over the quality and cost of medical care, as well as concerns about who pays for it and how, date from at least the second millennium B.C.2 The ancient Code of Hammurabi even contains what may be the first physician fee schedule.3 Today, healthcare services generally cost far more than the two or three shekels defined by that dusty codicil.4 And the problems created by rising costs recently motivated Congress to take unprecedented action in a sweeping attempt to hold those costs down and improve access to health insurance.5 With the passage of healthcare reform, the Secretary of Health and Human Services (HHS), Kathleen Sebelius, must dramatically expand regulation in the healthcare arena; the new reform package mandates that “the Secretary shall . . .” (establish or promulgate rules) more than 3,000 times.6

The cost of healthcare delivery in the U.S. has long loomed over the nation’s economy like a seven-headed hydra. At the Great Depression’s outset in 1929, Baylor Hospital in Dallas, Texas began the nation’s first group insurance plan—now known as Blue Cross.7 The plan

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3 See HANDCOCK, supra note 2, at 34-35 (translating Codes of Law 215-23 that indicate the payment or penalty for certain services and outcomes).
4 Id.
7 James McGrath, Overcharging the Uninsured in Hospitals: Shifting a Greater Share of Uncompensated Medical Care Costs to the Federal Government, 26 QUINNIPIAC L. REV. 173, 180 (2007).
provided teachers (who were generally unable to pay for medical services) with coverage for
twenty-one days of hospitalization at a cost of $6 per year.8 Today, each person in the U.S.
spends, on average, more than $300,000 on healthcare over a lifetime.9 And healthcare costs in
the U.S. continue to rise—growing from 5% of gross domestic product (GDP) in 1960, to 13% in
2000, and to a projected 18% in 2010.10

As the cost of healthcare has increased, the complexity of delivery and insurance
mechanisms has increased exponentially.11 Along with increasing complexity faced by
healthcare providers in managing reimbursement comes increasing downward pressure on the
dollars they get paid.12

Healthcare providers depend on reimbursement from public and private insurers (and to a
lesser extent, patient payments) to stay afloat.13 To deal with decreases in payment and the ever-
increasing complexity of reimbursement rules, regulations, standards, and systems, healthcare
providers have instituted a process called revenue-cycle management (RCM).14 RCM comprises
“[a]ll administrative and clinical functions that contribute to the capture, management and

8 Id.
9 Bruce Campbell, Reflections in a Head Mirror: Controlling Healthcare Costs – 1929, FROEDTERN & THE
MEDICAL COLLEGE OF WISCONSIN (May 14, 2009), http://www.froedtern.com/HealthResources/ReadingRoom/HealthBlogs/Reflections/ControllingHealthcareCosts192
9.htm.
10 PRICEWATERHOUSECOOPERS’ HEALTH RESEARCH INSTITUTE, BEHIND THE NUMBERS—MEDICAL COST TRENDS
RESEARCH & QUALITY, FACT SHEET—HEALTH CARE COSTS 1 (2002), available at
11 William O. Cleverley, Foreword to the Second Edition of ANNE B. CASTO & ELIZABETH LAYMAN, PRINCIPLES OF
HEALTHCARE REIMBURSEMENT, at xi (2d ed. 2009); see also McGrath, supra note 7, at 180-82.
12 Ken Terry, Pressure to Cut What Doctors Get Paid is Mounting, and There’s Not Much to Stop It, CBS
INTERACTIVE BUSINESS NETWORK (June 2, 2010), http://www.bnet.com/blog/healthcare-business/pressure-to-cut-
13 See Samuel R. Maizel, Shane Passarelli, & George D. Pillari, The Financial Crisis Facing America’s Hospital
Industry: Part I, AM. BANKR. INST. J., Jan. 2009, at 56-57 (discussing the need for revenue cycle management in the
healthcare industry because of third-party payment complexity).
14 Id.; Robert J. Schneider, et al., Process-Centered Revenue-Cycle Management Optimizes Payment Process,
management/operations-quality-control/10619721-1.html.
collection of patient service revenue."\textsuperscript{15} 

Recent legal literature about reimbursement tends to focus on the global systemic issues providers face.\textsuperscript{16} But this paper also focuses on the nuts and bolts of provider reimbursement, how providers deal with it through RCM, and where it all is headed.

Understanding reimbursement and RCM requires some background about the history of health coverage and payment as well as a primer on the types of insurance available in the U.S. Part II of this article briefly discusses the progression from indemnity plans (reimbursing expenses as patients incur them) to managed-care plans (comprehensive services with incentives for patients to use plan providers) in the private sector.\textsuperscript{17} Part II also discusses the development of public payment systems from fee-for-service (FFS) models (payment for services rendered) to prospective-payment systems (PPS) (payment of a fixed amount for a given case).\textsuperscript{18} But at the core of RCM is the need for providers to file clean, accurate claims.\textsuperscript{19}

Creating medical claims involves a whole host of activities that captures information


\textsuperscript{16} See generally, e.g., Final FY 2011 IPPS Rule Includes 2.9% Reduction for Coding Changes, HEALTH LAWYERS WEEKLY, Aug. 6, 2010 (discussing overall reductions in Medicare inpatient payments to hospitals), available at http://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Pages/2010/August%202010/August%202006%202010/FinalFY2011IPPSRuleIncludes29ReductionForCodingChanges.aspx; Donald J. Palmisano, Jr., Eric Weatherford & Nancy L. Johnson, Dollars and Sense: Healthcare Reform, Cost Control, Reimbursements and Their Impact on Physicians and Hospitals, Online CLE Course, ABA Health Law Section (May 26, 2010) (discussing tort reform and Medicare market basket updates); Carol K. Lucas & Michelle A. Williams, The Rights of Nonparticipating Providers in a Managed Care World: Navigating the Minefields of Balance Billing and Reasonable and Customary Payments, 3 J. HEALTH & LIFE SCI. L. 132 (2009) (discussing balance billing and other aspects of payment to nonparticipating providers).

\textsuperscript{17} INTERDEPARTMENTAL COMM. ON EMPLOYMENT-BASED HEALTH INS. SURVEYS, DEFINITIONS OF HEALTH INSURANCE TERMS 3-4 (2002), available at http://www.bls.gov/ncs/ces/sp/healthterms.pdf; see also infra Part II (discussing the evolution of health insurance in the U.S.).

\textsuperscript{18} See Randall R. Bovbjerg, Charles C. Griffin & Caitlin E. Carroll, U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s, 21 J.L. MED & ETHICS 141, 141 (1993); infra Part II.

\textsuperscript{19} See Cleverley, supra note 11, at xii.
about medical treatment and puts it in a form that complies with a payer’s rules. Part III discusses these activities, which typically include scheduling, eligibility and authorization, registration and up-front collection, documentation, coding, grouping, claim scrubbing and editing, and claim rework.

A key activity of RCM, at least between providers and private payers, is negotiating contractual reimbursement rates. Part III briefly discusses the contract negotiation process—but a detailed discussion of reimbursement terms and procedures appears in Part IV.

To maximize payment, providers must submit claims in a timely fashion and in a way that is acceptable to insurers. Though the number of claims still printed and mailed is surprisingly large, that activity is increasingly accomplished through electronic transactions. Part III briefly discusses claim submission and Part IV elaborates further on paper claim forms and electronic transaction standards.

Another important step in RCM is managing and reacting to remittance advice—a notice that shows “final claim adjudication and payment information.” Once a provider submits a claim and receives remittance advice from a payer, the provider must manage write offs (sometimes called write downs), accounts receivable (A/R), denials, claim rework, claim

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20 See Schneider, supra note 14, at 63; CASTO & LAYMAN, supra note 11, at 207-08; infra Part III.
21 See generally Schneider, supra note 14, at 63; CASTO & LAYMAN, supra note 11, at 207-08; infra Part III.
23 Infra Part III-IV.
24 See e.g., Requirements for Covered Entities, 45 C.F.R. § 162.923(a) (2009); TEX. CIV. PRAC. & REM. CODE § 146.002 (West 2010).
25 Interview with Greg Everett, former Director of Reimbursement, Medical Center of Mesquite, in Plano, Tex. (July 14, 2010).
26 Infra Part III-IV.
resubmission, appeal, and cash collections. Part III discusses each of these activities and focuses on related trends such as up-front patient-liability calculation and payment, discounts for uninsured or underinsured patients, information technology, and the impact of health-information exchanges (HIEs).

Part III also discusses the nuts and bolts of submitting claims to payers in both paper and electronic form. Healthcare insurers in the U.S. handle more than five billion medical claims each year. And one of those claims’ most complex aspects is properly determining and recording diagnosis, procedure, and various other standard codes on the claim. Medical coding is complex enough that the American Health Information Management Association (AHIMA) offers various certifications for medical coding professionals. After laying a foundation for understanding the elements of a medical claim, Part III continues by outlining the various claim forms and transactions standards providers use to submit claims to payers, both public and private.

In the past, private expenditures have dominated healthcare’s financial landscape, but the Centers for Medicare & Medicaid Services (CMS) expects public spending to overtake private spending in 2011. According to some experts, the Patient Protection and Affordable Care Act (Affordable Care Act) will increase public insurance rolls by 16 million people in the coming

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29 Infra Part III.
30 Id.
34 Infra Part IV.
years, so this trend is likely to continue and reimbursement from public sources will assume increasing importance.36 Part IV examines the reimbursement methodologies for major public payment systems in detail.37 These major methodologies apply to hospital in-patient and out-patient as well as physician reimbursement. Payment for anesthesia, ambulance, skilled-nursing services, rehab, and psychological services employs similar reimbursement procedures but Part IV treats them with less detail.38

Private payment for healthcare services often uses variations on public payment methods.39 In addition to payment based on public payment methods, Part IV also discusses other private payment methods in detail.40 Finally, Part IV looks at trends in reimbursement, both public and private, and the effects of recent healthcare legislation on reimbursement.41

II. Insurance Plan and Payment System History

INSURANCE, n. An ingenious modern game of chance in which the player is permitted to enjoy the comfortable conviction that he is beating the man who keeps the table.42

The evolution of health insurance in the U.S. affected more than just payment for healthcare services; it also changed the way hospitals, insurance companies, and patients interact. This section tracks the changes in those relationships as they relate to the way providers and

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37 Infra Part IV.
38 Id.
40 Infra Part IV.
41 Id.
42 AMBROSE BIERCE, THE DEVIL’S DICTIONARY 72 (Online ed. 1993).
payers process and pay claims.

A. The Development of Indemnity Plans

After that first Blue Cross plan began in 1929, commercial insurers proceeded cautiously, insuring only about 100,000 people by 1938. Early insurance plans were indemnity plans that paid subscribers for the cost of medical services, but usually did not cover the entire hospital bill. The patient was responsible for the bill and filed a claim with the insurance company. That meant there was very little contact between the healthcare provider and the insurance company.

After World War II, employer-based group health insurance coverage surged. Wage and price controls prevented employers from using salaries to compete for employees, but the government allowed employers to offer health coverage packages as employment incentives. The favorable, nontaxable status of health benefits to both employers and employees further encouraged employer-sponsored health insurance.

In the 1960s, Congress modeled the Medicare payment system after private fee-for-service indemnity plans. Medicare was initially divided into two parts—Part A for hospital services and Part B for physician services—and covered Americans sixty-five and older. Congress later expanded the program to include persons receiving disability benefits from Social

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43 Bovbjerg, Griffin & Caitlin, supra note 18, at 143.
44 McGrath, supra note 7, at 180.
45 Id. at 180-81.
46 Id. at 181.
47 Bovbjerg, Griffin & Caitlin, supra note 18, at 145.
49 Id.
50 Provider Payment Lessons from Medicare History, HEALTHCARE LEADERSHIP COUNCIL,
51 REIMBURSEMENT METHODOLOGIES, supra note 39, at xxiii.
Security and those patients with end-stage renal disease.\textsuperscript{52}

Under Medicare, the government made payments directly to providers—a clear departure from earlier insurance systems.\textsuperscript{53} This created a whole new industry devoted to adjudicating claims and processing payments.\textsuperscript{54} Today, information technology companies compete for hundreds of millions of dollars worth of lucrative contracts with the federal government to adjudicate claims and process payments.\textsuperscript{55}

**B. Managed Care**\textsuperscript{56}

Even as fee-for-service indemnity plans evolved, a different kind of health plan also developed: Health Maintenance Organizations (HMOs).\textsuperscript{57} Professor Markovich noted that “[i]ndustrialist Henry J. Kaiser, working with Dr. Sidney Garfield, offered prepaid health care to the workers who built the Grand Coulee Dam in 1938,” so HMOs are really nothing new.\textsuperscript{58} An HMO is “an organization that combines the provision of health insurance and the delivery of health care services.”\textsuperscript{59} In a traditional HMO, the provider and payer are the same

\textsuperscript{52} Id.


\textsuperscript{56} “A system of comprehensive healthcare provided by a health-maintenance organization, a preferred-provider organization, or a similar group.” \textit{BLACK’S LAW DICTIONARY} 1045 (9th ed. 2009).

\textsuperscript{57} See MARTIN MARKOVICH, \textit{THE RISE OF HMOs} 2 (2003) (showing that HMOs began developing in the 1930s).

\textsuperscript{58} Id.

\textsuperscript{59} Id.
organization—a dramatic shift from third-party payment systems.\textsuperscript{60}

The medical profession initially resisted the idea of HMOs and the model’s early growth was very slow, but by the time Congress passed the Health Maintenance Organization Act of 1973 (HMO Act), the writing was on the wall.\textsuperscript{61} The HMO Act required employers with more than 25 employees to allow employees to choose an HMO-based health plan.\textsuperscript{62} Even so, HMO growth was already on the rise by then; Professor Markovich suggested that the Act may have hindered HMO growth as much as it helped it.\textsuperscript{63}

As HMO enrollment grew, the organization models they employed changed.\textsuperscript{64} Four main organizational models developed—along with different payment methods:

(i) \textit{staff model} HMOs, which directly employ physicians to provide healthcare services; (ii) \textit{group model} HMOs, which contract with an independent multi-specialty physician group; (iii) \textit{network model} HMOs, which contract with multiple groups on a non-exclusive basis; and (iv) \textit{individual practice association ("IPA") model} HMOs, which contract with an IPA that in turn contracts with individual healthcare providers.\textsuperscript{65}

Staff-model HMO doctors generally work for a salary and are an HMO’s full-time employees.\textsuperscript{66} IPA-model HMOs usually contract with doctors individually or in small groups on a \textit{capitated} basis.\textsuperscript{67} That means the HMO pays each doctor a monthly fee determined by the number of patients who select the doctor as their primary-care physician (PCP).\textsuperscript{68} It makes no

\textsuperscript{63} MARKOVICH, \textit{supra} note 57, at 98.
\textsuperscript{64} Id. at 28.
\textsuperscript{67} Id.
\textsuperscript{68} Id. This type of capitated agreement is also called a “per-member per-month,” or “PMPM” contract. \textit{E.g.}, TEX. DEP’T OF INS., HMO DEFINITIONS (2007), http://www.tdi.state.tx.us/hmo/profiles/defintns.html (last visited Dec. 22, 2010).
difference what kind or how much service the doctor provides. But in group-model HMOs, the
HMO contracts with a group practice and pays individual doctors a capitated rate based on the
number of patients that select any doctor in the group as their PCP.

Some IPA arrangements may preserve fee-for-service reimbursement and pay doctors
according to a fee schedule (a list of amounts keyed to the particular services a doctor
provides). These contracts may also include a risk-sharing agreement in which the HMO
withholds a portion of reimbursement in lieu of meeting certain cost targets.

A rarer, fifth form of HMOs has also emerged, called a “joint venture HMO,” where the
HMO contracts with a physician-hospital organization (PHO) or creates a tripartite agreement
between the HMO, a hospital, and the hospital’s staff physicians. It typically involves
capitated payment or a premium-sharing agreement.

While HMOs often employ doctors directly under the staff model, they usually contract
discounted rates with outside hospitals for in-patient and out-patient services. The promise of
steering the HMO’s patients to a hospital motivates the hospital to accede to reduced
reimbursement rates. Reimbursement terms found in HMO contracts with hospitals are

69 See U.S. Healthcare, 986 F.2d at 591 (noting that doctors who contract with IPA-model HMOs do not charge by
the visit).
70 Michele M. Garvin, Health Maintenance Organizations, in The Law of Health Care Finance and
Regulation 212 (Mark A. Hall, Mary Anne Bobinski & David Orentlicher eds., 2d ed. 2008).
71 Id.
72 Id.
73 See Gregg v. NYLCare Health Plans, Inc., No. CIV. 99-995-KI, 2000 WL 336553, at *1 (D. Or. Mar. 20, 2000);
Garvin, supra note 70, at 212-13; Scott B. Clay, Provider-Sponsored HMOs: Make, Buy, or Joint Venture?,
http://findarticles.com/p/articles/mi_m3257/is_n3_v51/ai_19300261/.
74 Garvin, supra note 70, at 213.
75 John E. Kralewski et al., Factors Related to the Provision of Hospital Discounts for HMO Inpatients, 27 Health
76 Id.

The distinctive feature of HMOs from a patient’s perspective is that they require patients to use only providers that belong to the HMO.\footnote{U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 591 (1st Cir. 1993).} The HMO may also employ certain HMO doctors “as ‘gatekeepers’ who direct the patients to specialists only when necessary and who monitor hospital stays.”\footnote{Id.}

A managed-care alternative to HMOs, preferred-provider organizations (PPOs), became very popular in the 1990s.\footnote{Milt Freudenheim, (Loosely) Managed Care Is in Demand; Provider Plans Zooming Over Restrictive H.M.O.’s, N.Y. TIMES, Sept. 29, 1998, at C1.} PPOs are very similar to HMOs in that they define a fixed universe of providers—but there are significant differences.\footnote{Id.} Patients may choose to see any doctor they want—even specialists—without prior approval from a gatekeeper.\footnote{Id.; MARIANNE F. FAZEN, MANAGED CARE DESK REFERENCE 207 (1994).} And PPOs offer patients financial incentives to choose providers that participate in the PPO network (in-network or par providers).\footnote{Freudenheim, supra note 80, at C1; FAZEN, supra note 82, at 207.} If a patient chooses a provider that does not participate in the network (out-of-network or non-par provider), the patient must usually pay higher copayments (fixed amounts due from the patient for each visit) or coinsurance (usually a percentage of billed charges).\footnote{Freudenheim, supra note 80, at C1; FAZEN, supra note 82, at 207.}

The traditional PPO model connects payers to providers using these patient incentives to encourage patients to use in-network providers.\footnote{Am. Ass’n of Preferred Provider Orgns., PPO Definition, http://www.aappo.org/index.cfm?pageid=11 (last visited Dec. 22, 2010).} PPOs come in two basic flavors: (1) risk PPOs—created and used by insurance carriers; and (2) non-risk PPOs—a collection of providers...
in a geographical area that leases or rents its network to payers. Figure 1 shows the basic PPO structure.

![Figure 1. Traditional PPO Structure.](image)

Point-of-service (POS) plans allow patients to choose whether to use an HMO, PPO, or fee-for-service arrangement at the time the service is needed. Like PPOs, POS plans offer patients financial incentives to use network providers.

Besides sometimes employing a gatekeeper or other incentives to encourage patients to use network providers, managed-care plans generally employ additional methods to control care. Most require that a patient or hospital get authorization (pre-authorization) for any

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86 Id.
87 *Infra*, Figure 1. Over time, this structure has become significantly more complex—Part III discusses that added complexity in detail. *Infra*, Part III(D)(iii)(g).
88 PPO Definition, *supra* note 85.
89 *Fazen, supra* note 82, at 207.
90 Id.
services the hospital intends to render; the provider must justify the service’s medical necessity.\(^92\)

There are generally other contractual procedures involving claim filing requirements; responsibility for determining if a patient has other coverage; whether the payer must make partial payment in lieu of any disputed amounts; the rules for a payer’s utilization review (determining whether the care given was medically necessary); and other constraints or restrictions.\(^93\)

A more controversial practice on which managed care plans rely is the use of usual and customary rates (UCR) in fee-for-service contracts.\(^94\) Managed care plans usually limit reimbursement to what the payer determines providers usually charge and what is customary to charge for a given service.\(^95\) But the UCR for a service can often be much less than what the provider charges, and the provider may bill the patient for the difference.\(^96\) Controversy over that practice recently resulted in a large settlement between Ingenix, a subsidiary of United Healthcare that maintained a UCR database payers used, and the state of New York, among others.\(^97\) In the settlement agreement, United agreed to fund an independent nonprofit effort to develop a more accurate UCR database.\(^98\)

The last twenty years have seen the introduction of prospective-payment systems—paying a predetermined amount for a particular medical condition—specifically in public

\(^{92}\) Id.
\(^{93}\) Id.
\(^{95}\) FAZEN, supra note 82, at 272.
\(^{96}\) Carroll, supra note 94.
\(^{98}\) Id.
coverage plans.\textsuperscript{99} Also, the healthcare industry has developed bundled-payment systems that, along the same lines, “make a single payment for all services related to a treatment or condition.”\textsuperscript{100} In recent years, both Medicare and some private systems have begun to incorporate a severity measurement into the payment system to compensate providers for more difficult cases.\textsuperscript{101}

In the late 1990s and early 2000s, Congress created Medicare Part C, which introduced managed-care coverage options into the Medicare system.\textsuperscript{102} Under the Balanced Budget Act of 1997, Medicare Part C, then called Medicare+Choice, allowed Medicare beneficiaries to choose plans that included HMOs, PPOs, fee-for-service arrangements, and medical savings accounts tied to plans with high deductibles.\textsuperscript{103} The Medicare Modernization Act of 2003 (MMA) modified Medicare Part C and changed the name to Medicare Advantage.\textsuperscript{104} It also added the prescription drug program—Medicare Part D.\textsuperscript{105} Private entities manage the plans under Medicare Parts C and D.\textsuperscript{106}

All these changes in the structure and organization of public and private coverage have far-reaching implications for RCM and reimbursement.\textsuperscript{107}

\begin{footnotes}
\item[99] See Fischer v. United States, 529 U.S. 667, 685 (2000) (citing 42 U.S.C. § 1395ww (2010)) (discussing Medicare’s change from reimbursing on the basis of reasonable cost to a fixed price based on the “patient’s diagnosis, age, and sex, among other things.”).
\item[101] Id.
\item[105] Id.
\item[106] Id.
\item[107] See infra Part IV (discussing the various Medicare payment systems).
\end{footnotes}
III. Revenue-Cycle Management

Organization doesn’t really accomplish anything. Plans don’t accomplish anything, either. Theories of management don’t much matter. Endeavors succeed or fail because of the people involved. Only by attracting the best people will you accomplish great deeds.\(^{108}\)

In the past, RCM activities in provider organizations were fragmented across departments with each department pursuing different methods and practices for managing claims, contracts, and revenue.\(^{109}\) Over time, however, many providers adopted a more integrated, process-centered, or multidisciplinary approach to RCM.\(^{110}\) Healthcare claims are the center of the RCM universe and providers engage in at least five major activities closely related to claims: (1) claim generation, (2) claim processing and submission, (3) contract management, (4) account management, and (5) claim reconciliation and collection.\(^{111}\) Revenue-cycle best-practice standards typically include monitoring and managing a number of performance benchmarks and standards for: (1) scheduling; (2) preregistration; (3) insurance verification and authorization; (4) patient financial counseling; (5) coding personnel performance; (6) charge maintenance; (7) billing and claim submission; (8) third-party and guarantor follow-up; (9) account posting; (10) denial management; (11) customer service; and (12) collection.\(^{112}\) Figure 2 shows the main steps and areas of activity in revenue-cycle management.\(^{113}\)

\(^{109}\) Casto & Layman, supra note 11, at 207; Schneider, supra note 14, at 63.
\(^{110}\) Casto & Layman, supra note 11, at 207; Schneider, supra note 14, at 63.
\(^{112}\) Hammer, supra note 28, at 48.
\(^{113}\) *Infra*, Figure 2.
A healthcare claim is “[a]n original/initial request for payment of services for a single client that consists of one or more line item. A claim can be submitted on paper or electronically.” But claims are really more than that because they also include demographic information about the patient and the provider, diagnosis and classification information, and information about the reasons for treatment. In 1975, the American Hospital Association (AHA), along with industry players, formed the National Uniform Billing Committee (NUBC) to create a standard hospital billing form that would simplify institutional (hospital) medical

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114 See generally Part III-IV (describing revenue-cycle steps and activities in detail).
116 See infra, APPENDIXES A-B (showing the standard billing forms).
billing—the Universal Billing Form (UB-04/CMS-1450).117 The Administrative Simplification Compliance Act (ASCA) of 2001 and its enabling regulation required that providers submit paper Medicare claims on standard forms and that electronic Medicare claim-submission standards be based on those forms.118 For non-institutional claims (generally physician claims), the National Uniform Claim Committee (NUCC) maintains the standard billing form—the CMS-1500 form.119 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided further authorization to these two organizations to develop standard forms, and private—not just public—payers have long since adopted them.120 While providers move most claims about electronically, rather than on paper, most computerized healthcare tools still present claim information to users using the classic claim forms.121 For that reason, a strong familiarity with those forms and the elements they contain is a must to understand revenue-cycle management and reimbursement.122

119 42 C.F.R. § 424.32(b); Nat’l Unif. Claim Comm., Who Are We?, http://www.nucc.org/ (last visited Dec. 22, 2010); see also infra APPENDIX B (showing an example CMS-1500 form).
121 Everett, supra note 25.
122 Infra, Figure 3.
Figure 3. Elements of a Healthcare Claim.\textsuperscript{123}

\textsuperscript{123} See generally Part III (describing the elements of healthcare claims in detail).
A. Pre-Claims Submission Activities

The revenue cycle actually starts when a provider signs a contract with a payer. After that, the focus shifts to producing claims. This subsection walks through the process of readying a claim for submission to a payer—a process that involves tasks such as scheduling and registration, verifying eligibility, getting authorization for services, collecting copayments or coinsurance, documenting charges, coding, grouping, scrubbing and editing claims, and pre-submission rework. Some of these tasks are called “front-end” billing activities, which are generally the responsibility of the office or facility that actually treats patients. The rest are called “back-end” billing activities—tasks a central-billing office usually performs. The first front-end billing activity, scheduling or registration, usually occurs (except in emergency cases) when a patient decides to seek treatment.

i. Scheduling and Registration

The revenue cycle continues when a patient, either as an individual or through a doctor (perhaps a gatekeeper for an HMO, a family practitioner, or a specialist), schedules a visit or service with the provider or presents for treatment. The complexity of scheduling and managing doctor appointments and hospital visits compels providers to turn to information technology to handle the scheduling task. There is a dizzying array of systems available to

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125 Id.; CASTO & LAYMAN, supra note 11, at 207; Schneider, supra note 14, at 63.
126 WALKER, LARCH & WOODSTOCK, supra note 124, at 4.
127 Id.
128 Id. at 1.
handle this and other RCM tasks, so choosing the right one can be very difficult.\(^ {130}\)

Scheduling is a critical RCM function for at least two reasons: It is the first opportunity to capture data—such as patient demographic data, the source of payment, diagnoses, and information about the patient’s condition; and, if handled well, it allows efficient management of clinical and technological resources.\(^ {131}\) In the late 1980s, a group of providers and vendors combined forces to create the Health Level 7 (HL7) protocol to allow disparate information systems within a provider’s organization to communicate using standard electronic transactions.\(^ {132}\)

Used primarily by hospitals, HL7-enabled systems allow a scheduling system to transmit information it takes in to a provider’s clinical and billing systems, making it very important to capture accurate information from the outset.\(^ {133}\) And good information at the beginning of the process became even more important when the Deficit Reduction Act (DRA) of 2005 required Medicare claims to contain a present-on-admission (POA) code for all discharges after October 1, 2007.\(^ {134}\) CMS uses the POA code to adjust reimbursement depending on whether the patient

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acquired certain conditions during treatment.\textsuperscript{135} If a provider fails to use the POA code properly on a claim, CMS will reject the claim causing, at best, substantial rework and, at worst, lost reimbursement.\textsuperscript{136}

Properly educating a patient about the patient’s financial responsibilities at this stage of the revenue cycle improves copayment and coinsurance collection and is an essential part of managing the revenue cycle.\textsuperscript{137} Starting data collection and education before a patient presents for treatment can short-circuit a number of problems and help the patient gain the proper expectations about financial responsibility.\textsuperscript{138} But to determine the patient’s likely portion of a bill at least requires that the provider find out whether patient is properly enrolled in a health plan and whether the plan will pay for the scheduled service.

ii. Eligibility and Authorization

Eligibility verification amounts to determining whether an insurance plan covers medical services a provider intends to render to a patient.\textsuperscript{139} “Eligibility verification defines who can render what care and under what circumstances.”\textsuperscript{140} In the past, providers usually called a patient’s insurer to capture eligibility information.\textsuperscript{141} Getting accurate eligibility information as early as possible in the revenue cycle, and doing it through web-based electronic-data-interchange (EDI) transactions, prevents rework and allows the patient to get better information.

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\textsuperscript{136} TRANSMITTAL 1240, supra note 134, at 2.
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\textsuperscript{137} Life Cycle Approach, supra note 131, at 5; CASTO & LAYMAN, supra note 11, at 207;
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\textsuperscript{138} WALKER, LARCH & WOODSTOCK, supra note 124, at 11.
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\textsuperscript{139} See FAZEN, supra note 82, at 84.
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\textsuperscript{140} Alan Bingham, Internet-Based Eligibility Verification Lowers Costs, Improves Payment Timeliness, HEALTHCARE FIN. MGMT., Feb. 2001, at 47, available at http://findarticles.com/p/articles/mi_m3257/is_2_55/ai_70657263/.
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\textsuperscript{141} Id.
\end{flushleft}
about financial responsibility in a far more convenient way than making a phone call. Also, using EDI reduces a provider’s cost of verifying eligibility by as much as an order of magnitude over doing it with a phone call.

Eligibility responses usually inform the provider about what amounts are due from the patient, so providers may attempt to collect those amounts up front. Like clearinghouse vendors, many insurance companies provide automated eligibility services. And CMS is currently testing an automated eligibility service called the HIPAA Eligibility Transaction System (HETS). Eligibility transactions usually take the form of American National Standards Institute (ANSI) X12 270 and 271 transactions—a standardized format used by almost every eligibility system and accepted by almost every patient accounting system.

Providers use the 270 transaction, also called the “Health Care Eligibility, Coverage, or Benefit Inquiry” transaction, to request information about eligibility. Payers use the 271 transaction, also called the “Health Care Eligibility, Coverage, or Benefit Information” transaction, to reply to the request. Figure 4 and Figure 5 show what 270 and 271 transactions look like.

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143 Bingham, supra note 140.
145 Id.; see also, e.g., UnitedHealth, Patient Personal Health Records, https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=552f4378103f6110VgnVCM2000008040dc0a (last visited Dec. 22, 2010).
147 E.g., id.; Passport Health Communications, OneSource Overview, http://www.passporthealth.com/Libraries/Product_PDFs/OneSource_Product_Overview.sflb.ashx (last visited Dec. 22, 2010); see also infra, Figures 2-3 (showing partial examples of 270 and 271 transactions).
149 Id.
150 Infra, Figures 2-3.
Authorization, a closely-related utilization-management process almost all health plans require, determines whether an insurer deems a particular service medically necessary, and therefore covered under the plan.153 Though many routine authorization requests may take only minutes, most plans still require authorization requests by phone or fax.154 And doctors are typically not fond of authorization procedures because they may change the doctor’s treatment.

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152 Id. at 2-10.
153 See Fazen, supra note 82, at 26.
plan. Failure to get prior authorization for services can result in a payer denying payment for resulting claims. And if the services authorized do not match the services actually rendered, the payer may refuse to pay.

If a private payer refuses to authorize services, patients must usually go through an appeal process defined the policy, the contract between the payer and the provider, or regulated by state or federal law. If a public payer refuses to authorize services, patients must first exhaust administrative remedies before turning to the courts. Once a provider gets authorization and admits or sees a patient for treatment, the provider must begin the process of carefully documenting charges accrued during the course of treatment.

iii. Documenting Charges

Capturing charges in a health-delivery setting is vital to RCM because properly documented charges form the basis of medical claims. A charge is a dollar amount a patient, or the patient’s insurer, owes to a provider for a service or article. Charge capture is the process of determining and reporting charges for services a provider performs. Inaccurate charge capture can result in nonsensical claims, such as a hip replacement seemingly performed without

155 Id.
156 See Kerry Vermillion et al., Innovations in Performance Management: In One Year, Baptist Health Care Significantly Reduced Operating Expenses, Improved Revenue Cycle Processes, and Increased Revenue by Aligning Leaders’ Goals With Financial Performance and Engaging Staff in Steps Toward Improvement, HEALTHCARE FIN. MGMT., May 2010, at 98, available at http://findarticles.com/p/articles/mi_m3257/is_5_64//ai_n54641865/ (discussing “denials for lack of authorization.”).
160 FAZEN, supra note 82, at 43.
161 CASTO & LAYMAN, supra note 11, at 207.
anesthesia or a procedure to implant a pacemaker without actually using a pacemaker.  

For providers, failing to capture charges accurately can result in claim denial or rejection, or worse, money simply left on the table (for instance, when a payer rejects or denies a claim, it at least creates a bit of a stir—but not so with some kinds of missing charges). And even though a provider may be able to remedy these issues by reworking and resubmitting claims, that solution has its own significant costs. Inaccurate charge capture may be the result of undertrained staff, use of disparate electronic systems, or archaic manual systems.  

Many charges attached to a bill or claim originate with the order-entry process. Order entry is the mechanism practitioners use to order tests, medications, and other services, and is most important in acute-care or ambulatory-surgical settings. Errors in order entry not only have a deleterious effect on payment, they can also cause adverse drug events (ADEs) or other serious errors that can harm patients.  

Many systems still employ error-prone handwritten notes or paper forms. In the last decade or so, the pressure to automate order entry—sometimes called computerized physician order entry (CPOE)—has intensified, but order-entry systems are costly and difficult to implement, sometimes because practitioners resist making the necessary changes to how they work. One healthcare information technology executive called automated order entry “the

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163 Id.
164 Id.
165 Id.
166 CASTO & LAYMAN, supra note 11, at 208.
167 Fern FitzHenry et al., Implementing Outpatient Order Entry to Support Medical Necessity using the Patient’s Electronic Past Medical History, PROC. AM. MED. INFORMATICS ASS’N SYMP. 250, 250 (2002).
168 COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 191 (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson eds. 2000) [hereinafter TO ERR IS HUMAN].
169 Id.; FitzHenry et al., supra note 167, at 250.
170 See, e.g., TO ERR IS HUMAN, supra note 168, at 192 (discussing the possible introduction of new errors using automated systems); COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM:
most difficult technology implementation [he could] think of in an acute care setting.”171 By
2007, only 15% of acute-care hospitals and 10% of ambulatory clinics had implemented
automated order-entry systems, though the Agency for Healthcare Research and Quality
(AHRQ) expected the number of adopters to increase by 50% annually in subsequent years.172
Regardless of the method providers use to record charges on a patient’s account, the heart of
capturing charges is the Charge Description Master (CDM) list.

The CDM, “or chargemaster, is a comprehensive listing of items that could be billed to a
patient, payer or healthcare provider.”173 The chargemaster is the underlying source for most
information on a claim, though claims do not contain the level of detail found in the
chargemaster.174 When practitioners or staff record charges using an order-entry process or
system, they enter or select a unique identifier from the chargemaster for each article or
service.175 Automated systems or billing personnel then post that identifier, along with certain
other codes—usually department, revenue, and procedure codes—to the patient’s account
record.176 That posting event also records a per-unit charge and a number of units on the
account.177 The unique identifier for each item is generally called a charge code.178 Table 1

had been implemented on a limited basis around the country) [hereinafter CROSSING THE QUALITY CHASM]; Marc
Kaufman, Medication Errors Harming Millions, Report Says. Extensive National Study Finds Widespread, Costly
Mistakes in Giving and Taking Medicine, THE WASHINGTON POST, July 21, 2006, at A08, available at
http://www.washingtonpost.com/wp-dyn/content/article/2006/07/20/AR2006072000754.html (discussing the costs
and difficulties in implementing automated order-entry systems).
171 David Classen, Chief Med. Officer, First Consulting Group, Leapfrog Computerized Physician Order Entry
(CPOE) and Electronic Health Record (EHR) Evaluation Tools, Webcast for Agency for Healthcare Research and
Quality Health Information Technology Web Teleconference Series 5 (Jan. 12, 2007), available at
(quoting John Glaser, VP and CIO, Partners Healthcare).
172 Id.
173 Charge Description Master (CDM), CEDARS-SINAI, http://www.cedars-sinai.edu/About-Us/Charge-Description-
[hereinafter Chargemasters].
175 Id.; CASTO & LAYMAN, supra note 11, at 208.
176 Chargemasters, supra note 174; CASTO & LAYMAN, supra note 11, at 208-09.
177 Chargemasters, supra note 174; CASTO & LAYMAN, supra note 11, at 208-09.
contains an example of what records in a chargemaster might look like.\footnote{CASTO & LAYMAN, supra note 11, at 209; see also infra, Table 1 (showing an example excerpt from a charge description master).}

<table>
<thead>
<tr>
<th>Dept. No.</th>
<th>Charge Code</th>
<th>Description</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>2000123</td>
<td>Nasal bone x-ray</td>
<td>0320</td>
<td>70160</td>
<td>613.00</td>
</tr>
<tr>
<td>22</td>
<td>2200269</td>
<td>Thyroid Sonogram</td>
<td>0402</td>
<td>76536</td>
<td>1,129.00</td>
</tr>
<tr>
<td>43</td>
<td>4300430</td>
<td>Surgery Assist</td>
<td>0360</td>
<td></td>
<td>914.00</td>
</tr>
<tr>
<td>79</td>
<td>7925738</td>
<td>Rabies vaccine-IM use</td>
<td>0250</td>
<td>90675</td>
<td>839.97</td>
</tr>
<tr>
<td>79</td>
<td>7901010</td>
<td>Albumin 5% saline</td>
<td>0250</td>
<td>P9045</td>
<td>248.82</td>
</tr>
</tbody>
</table>

\textbf{Table 1. Sample Extract from an Example Chargemaster.} \footnote{DAMERON HOSP. ASS’N, DAMERON HOSPITAL CHARGE MASTER – 2010 5, 9, 42, 123, 145 (2010), available at \url{http://www.dameronhospital.org/documents/DameronHospital2010Chargemastera.pdf}.}

The chargemaster links a number of elements essential to Medicare and private billing for hospital or ambulatory inpatient and outpatient services.\footnote{Infra Table 1.} The first of these elements is a \textit{revenue code}.\footnote{\textit{Id.}; CASTO & LAYMAN, supra note 11, at 208-09.} Revenue codes are “[c]odes that identify specific accommodation, ancillary service or unique calculations or arrangements.”\footnote{\textit{Id.}; NAT’L UNIF. BILLING COMM., OFFICIAL UB-04 DATA SPECIFICATIONS MANUAL 101 (2011) [hereinafter UB-04 SPECIFICATIONS].} Further, a revenue code is “[a] four-digit code number representing a specific accommodation, ancillary service, or billing calculation required for Medicare billing.”\footnote{Chargemasters, supra note 174.} The first three digits represent a particular category and the last digit, often denoted in the literature with an “x,” represents a subcategory.\footnote{UB-04 SPECIFICATIONS, supra note 183, at 101.} Table 2 shows a sample subset of revenue codes and their descriptions.\footnote{Infra, Table 2.}
<table>
<thead>
<tr>
<th>Rev. Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0110</td>
<td>Room &amp; Board – Private (Medical or General) - General classification</td>
</tr>
<tr>
<td>0120</td>
<td>Room &amp; Board - Semi-private Two Bed (Medical or General) - Oncology</td>
</tr>
<tr>
<td>0250</td>
<td>Pharmacy – General Classification</td>
</tr>
<tr>
<td>0320</td>
<td>Radiology – Diagnostic - General Classification</td>
</tr>
<tr>
<td>0360</td>
<td>Operating Room Services – General Classification</td>
</tr>
<tr>
<td>0450</td>
<td>Emergency Room – General Classification</td>
</tr>
<tr>
<td>0451</td>
<td>EMTALA Emergency Medical Screening Services</td>
</tr>
<tr>
<td>0452</td>
<td>ER Beyond EMTALA Screening</td>
</tr>
<tr>
<td>0456</td>
<td>Urgent Care</td>
</tr>
<tr>
<td>0459</td>
<td>Emergency room – other</td>
</tr>
</tbody>
</table>

**Table 2. A Sample of Revenue Codes and their Descriptions.**

For inpatient services, a provider may aggregate multiple services along with the number of units of service under a single revenue code line-item on a bill in UB-04 field 42. For outpatient services, the provider may aggregate multiple services under a single line-item with the number of units but must also provide a procedure code and a date of service. A special optional code, 0001, denotes the total charges for all revenue codes on the claim. If the provider renders services on different days under the same revenue code, the provider must break out those services and report them under different line-items. In any case, the provider must report revenue code line-items in ascending order by date along with the units and total charges for each date/revenue code combination, listing the 0001 line-item last.

188 UB-04 SPECIFICATIONS, supra note 183, at 102; see also infra, Figure 6 (showing aggregated line items on a UB-04 inpatient claim form).
189 UB-04 SPECIFICATIONS, supra note 183, at 102; see also infra, Figure 7 (showing aggregated line items on an out-patient UB-04 claim form).
190 UB-04 SPECIFICATIONS, supra note 183, at 102.
191 Id.
192 Id.; see also infra Figures 4-5 (showing examples of revenue-code line-items for inpatient and outpatient UB-04 claims).
The procedure-code element of revenue-code line-item reporting is also very important.

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194 *IBX UB-04*, supra note 193, at 3; CASTO & LAYMAN, supra note 11, at 208.
(a detailed discussion of procedure codes appears in Part III(A)(iv)).\textsuperscript{195} Because CMS updates the list of valid revenue and procedure codes at least once a year and issues guidance on a continual basis, diligent chargemaster maintenance is critical.\textsuperscript{196} Some facilities may employ a single person to maintain the chargemaster, but a wiser choice is to create a committee to oversee maintenance and account for the multiple hospital departments that contribute to it.\textsuperscript{197} Ineffective chargemaster maintenance can result in overcharging and overpayment or undercharging and underpayment.\textsuperscript{198} Worse still, poor chargemaster maintenance can result in claim rejection, denial, fines, and other penalties.\textsuperscript{199}

To create more transparency in hospital billing, at least thirty states have enacted, or are considering enacting, laws that require providers to make their chargemasters available to the public.\textsuperscript{200} To at least some degree, the Affordable Care Act renders these statutes moot because it requires each hospital in the U.S. to publish its chargemaster once a year.\textsuperscript{201} The object of requiring hospitals to publish chargemasters is to create transparency in hospital pricing; however, while some hospitals publish their charge codes linked to revenue codes and procedure codes, other hospitals sometimes leave out these links, which can make it difficult to compare

\textsuperscript{195} \textit{Infra}, Part III(A)(iv).

\textsuperscript{196} \textit{Chargemasters, supra} note 174; CASTO & LAYMAN, \textit{supra} note 11, at 208; \textit{see also, e.g.}, CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE CLAIMS PROCESSING MANUAL § 75.4 (2010), \textit{available at} http://www.cms.gov/manuals/downloads/clm104c25.pdf (describing the use of field 42 on the UB-04 form); CTRS. FOR MEDICARE & MEDICAID SERVS., PUB. 100-04 MEDICARE CLAIMS PROCESSING, TRANSMITTAL 1885 10 (2009), \textit{available at} http://www.cms.gov/transmittals/downloads/R1885CP.pdf (describing changes to revenue-code reporting for hospice care) [hereinafter TRANSMITTAL 1885].

\textsuperscript{197} \textit{Chargemasters, supra} note 174; CASTO & LAYMAN, \textit{supra} note 11, at 208.

\textsuperscript{198} \textit{Chargemasters, supra} note 174.

\textsuperscript{199} \textit{Id.}

\textsuperscript{200} \textit{E.g.}, ARIZ. REV. STAT. ANN. § 36-436(C) (West 2010); CAL. HEALTH & SAFETY CODE § 1339.51 (West 2010); TEX. HEALTH & SAFETY CODE ANN. § 324.101 (West 2010); \textit{see also} Nat’l Conf. of State Legislatures, \textit{State Legislation Relating to Transparency and Disclosure of Health and Hospital Charges}, April 6, 2009, http://www.ncsl.org/default.aspx?tabid=14512 (discussing various approaches to charge disclosure by the states).

hospital pricing.202 The issues surrounding chargemaster maintenance and keeping up with ever-changing code lists are just the beginning of one of RCM’s most complex aspects: coding medical claims.

iv. Coding Medical Claims

To get paid for healthcare services, a provider must somehow communicate the reasons for, circumstances surrounding, and exact nature of services to a payer.203 That communication takes the form of coded information.204 “In its simplest form, coding is the transformation of verbal descriptions into numbers.”205 It may also involve submitting claim attachments, which “are supplemental documents providing additional medical information to the claims processor that cannot be accommodated within the claim format.”206 Attachments may include “Certificates of Medical Necessity (CMNs), discharge summaries and operative reports.”207 But the coded information appearing on a claim form or within an electronic claim is still the most important component of reimbursement communication with a payer.208 And claims must comply with industry and government standards.209

The most critical codes that appear on inpatient, outpatient, and physician claims are

202 Interview with Robert Calloni, Charge Description Master Specialist, Dameron Hosp. Ass’n, in Stockton, Cal. (Jan. 25, 2011).
203 CASTO & LAYMAN, supra note 11, at 21; WALKER, LARCH & WOODSTOCK, supra note 124, at 4; ROBERT BONNEY & ROBERT SMITH, CONTRACTING IN A MANAGED CARE ENVIRONMENT—MARKET-BASED APPROACHES 34 (2002).
204 Medical Coding, supra note 32.
207 Id.
208 CASTO & LAYMAN, supra note 11, at 21.
209 UB-04 SPECIFICATIONS, supra note 183, at 4.
diagnosis codes and procedure codes—generally referred to as code sets. These describe in detail the medical reasons for treatment and the treatment itself. Other less important, but still necessary, codes appear on claims describing the claim’s purpose, circumstances surrounding the need for treatment, the outcome of treatment, and the like.

a. International Classification of Diseases

The most widely recognized diagnosis and procedure code set is the International Classification of Diseases (ICD). It has a long history dating from the 19th century or even before. Its roots trace back to 18th-century efforts to systematically classify diseases by François Bossier de Lacroix of Austria, William Cullen of Edinburgh, and others. Even before that, during The Great Plague beginning in 1665, the London Bills of Mortality published categorized death statistics.

The World Health Organization (WHO) and some dozen other international centers collaborate on developing and updating the ICD and release modifications once every decade or so (though the last update has taken more than 20 years to achieve widespread adoption).

HIPAA mandates that providers and payers in the U.S. use the ICD’s ninth revision—called

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211 Medical Coding, supra note 32.
212 See generally UB-04 SPECIFICATIONS, supra note 183 (describing bill-type codes, value codes, occurrence codes, discharge-status codes, and other codes that appear on hospital claims).
214 Id.
217 ICD History and Impact, supra note 213, at 1.
ICD-9—but U.S. healthcare entities have long used ICD codes.218 In a major change to the ICD-9 code set, the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) added clinical modifications to the IDC-9 diagnosis code set in 1979—now called ICD-9-CM.219 Department of Health and Human Services (HHS) regulations, authorized by HIPAA, require providers to use that version.220 The NCHS made the clinical modifications to the ICD-9 diagnosis code set to allow mortality, morbidity, and chronic condition tracking.221 CMS is responsible for disseminating the ICD-9-CM procedure code set’s U.S. variation.222 Together, the NCHS and CMS comprise the ICD-9-CM Coordination and Maintenance Committee, which is responsible for maintaining the ICD-9-CM code set in the United States.223

The AHA publishes the only official ICD-9-CM coding guidelines, known as the Coding Clinic for ICD-9-CM (Coding Clinic).224 The NCHS, the AHA, AHIMA, CMS, and the Editorial Advisory Board (EAB), which together form the Cooperating Parties, maintain the Coding Clinic.225 The guidelines include official coding advice on new technologies and newly identified diseases, improving quality, and coding changes.226 Coding professionals generally consider Coding Clinic an indispensable tool for education and operations in healthcare.

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219 § 162.1002(b)(1).
221 Id.
223 Id.
225 Id.
226 Id.
ICD-9-CM classifies diseases (Volumes 1 and 2) and “surgical, diagnostic, and therapeutic procedures” (Volume 3). While hospitals must use IDC-9-CM procedure codes only on inpatient claims, both hospitals and physicians must use ICD-9-CM diagnosis codes on both inpatient and outpatient claims. Diagnosis codes employ three, four, or five digits with the fourth and fifth digits describing subclassifications. If the code employs more than three digits, a decimal point generally appears after the third digit. When a diagnosis code is divided into subclassifications, providers must report those subclassifications to the most granular level of detail possible. “For example, Acute myocardial infarction, code 410, has a fourth digit that describes the infarction’s location (e.g., 410.2, Of inferolateral wall), and a fifth digit that identifies the episode of care.” In this example, if a provider does not specify the episode of care, it would report the diagnosis code 410.20. If the diagnosis refers to the first episode of care, the provider would report 410.21, and if the diagnosis refers to any subsequent episode of care, it would report 410.22. When actually reporting the diagnosis code on UB-04 forms for hospital claims or CMS-1500 forms for physician claims, providers may right-pad the

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229 UB-04 SPECIFICATIONS, supra note 183, at 12, 186.
230 ICD-9-CM OFFICIAL GUIDELINES, supra note 228, at 9.
231 Id.
232 Id.
233 Id.
235 Id.; see also infra, Table 3 (showing a sample of ICD-9-CM codes from each major group and demonstrating the use of subclassifications).
diagnosis code with zeros and leave out the decimal point.\textsuperscript{236}

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>032.0</td>
<td>Localized salmonella infection, unspecified</td>
</tr>
<tr>
<td>032.1</td>
<td>Salmonella meningitis</td>
</tr>
<tr>
<td>100.0</td>
<td>Primary tuberculous infection, unspecified</td>
</tr>
<tr>
<td>200</td>
<td>Bubonic plague</td>
</tr>
<tr>
<td>381.0</td>
<td>Staphylococcal septicemia, unspecified</td>
</tr>
<tr>
<td>410.00</td>
<td>Acute myocardial infarction of anterolateral wall, episode of care unspecified</td>
</tr>
<tr>
<td>410.01</td>
<td>Acute myocardial infarction of anterolateral wall, initial episode of care</td>
</tr>
<tr>
<td>410.02</td>
<td>Acute myocardial infarction of anterolateral wall, subsequent episode of care</td>
</tr>
<tr>
<td>410.12</td>
<td>Acute myocardial infarction of other anterior wall, subsequent episode of care</td>
</tr>
<tr>
<td>535.00</td>
<td>Acute gastritis, without mention of hemorrhage</td>
</tr>
<tr>
<td>535.01</td>
<td>Acute gastritis, with hemorrhage</td>
</tr>
<tr>
<td>611.72</td>
<td>Lump or mass in breast</td>
</tr>
<tr>
<td>611.79</td>
<td>Other signs and symptoms in breast</td>
</tr>
<tr>
<td>716.20</td>
<td>Allergic arthritis, site unspecified</td>
</tr>
<tr>
<td>716.21</td>
<td>Allergic arthritis, shoulder region</td>
</tr>
<tr>
<td>800.00</td>
<td>Closed fracture of vault of skull without mention of intracranial injury, unspecified state of consciousness</td>
</tr>
<tr>
<td>800.01</td>
<td>Closed fracture of vault of skull without mention of intracranial injury, with no loss of consciousness</td>
</tr>
<tr>
<td>800.02</td>
<td>Closed fracture of vault of skull without mention of intracranial injury, with brief [less than one hour] loss of consciousness</td>
</tr>
<tr>
<td>995.20</td>
<td>Unspecified adverse effect of unspecified drug, medicinal and biological substance</td>
</tr>
<tr>
<td>995.22</td>
<td>Unspecified adverse effect of anesthesia</td>
</tr>
<tr>
<td>V01.0</td>
<td>Contact with or exposure to cholera</td>
</tr>
<tr>
<td>V01.1</td>
<td>Contact with or exposure to tuberculosis</td>
</tr>
<tr>
<td>V49.71</td>
<td>Great toe amputation status</td>
</tr>
<tr>
<td>E843.0</td>
<td>Fall in, on, or from aircraft injuring occupant of spacecraft</td>
</tr>
<tr>
<td>E843.1</td>
<td>Fall in, on, or from aircraft injuring occupant of military aircraft, any</td>
</tr>
<tr>
<td>E843.2</td>
<td>Fall in, on, or from aircraft injuring crew of commercial aircraft (powered) in surface to surface transport</td>
</tr>
</tbody>
</table>

Table 3. Sample ICD-9-CM Codes Demonstrating Subclassification.\textsuperscript{237}

The ICD coding system’s main part comprises codes that begin with 001 through 999 to

\textsuperscript{236} UB-04 SPECIFICATIONS, supra note 183, at 186; infra, Figures 6-7.
\textsuperscript{237} See generally ICD-9-CM TABULAR DIAGNOSIS LIST, supra note 234 (containing IDC-9-CM diagnosis codes and short descriptions).
classify diseases and injuries. But there are also categories of ICD-9-CM codes that providers use for other purposes.

Figure 8. Example of ICD-9-CM Diagnosis Codes on a UB-04 Form.

Figure 9. Example of ICD-9-CM Diagnosis Code on a CMS-1500 Form.

Codes that begin with “V” indicate instances where a patient who is not ill seeks a prophylactic vaccination, wants to act as an organ donor, or has had a previous illness not directly related to a current condition. For example, if a person wants vaccination or treatment because of exposure to a communicable disease, a provider may assign the patient an appropriate ICD-9-CM vaccination code for cholera (V01.0), tuberculosis (V01.1), smallpox (V01.3), or

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238 ICD-9-CM TABULAR DIAGNOSIS LIST, supra note 234, at 700, 758.
239 Id.
242 ICD-9-CM TABULAR DIAGNOSIS LIST, supra note 234, at 700. The “V” codes are characterized as “Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01-V89).” Id.
other disease. And if a patient has some type of physical dysfunction and seeks treatment for a different condition, a provider may assign the patient an ICD-9-CM code for mechanical and motor problems with the head (V48.2), sensory problems with limbs (V49.3), amputation of the great toe (V49.71), or other physical dysfunction.

Codes that begin with “E” indicate the nature of “environmental events, circumstances, and conditions” that may have caused or contributed to an injury or poisoning. Providers assign “E” codes in addition to other diagnosis codes and only one “E” code may appear on a claim. For example, a provider would assign an “E” code to a person injured while ice dancing (E003.0), mountain climbing (E004.0), or vacuuming (E013.2), though the provider would also assign one or more other codes to describe the injury. The fourth digit of an “E” code generally describes an injured person’s situation. So E840.3 indicates that an aircraft accident injured a commercial passenger during takeoff or landing. And in a more outlandish coding rule application, E843.0 would indicate that someone or something fell in, on, or from an aircraft injuring the occupant of a spacecraft.

ICD-9-CM procedure codes are three or four digits with a decimal point between the second and third digit. Providers need not report them on hospital outpatient claims. As with diagnosis codes, the decimal point is implied and not reported on the UB-04 form. And similar to diagnosis codes, the numbers that appear after the decimal point in ICD-9-CM

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243 Id. at 701-02.
244 Id. at 728-29.
245 Id. at 758. The “E” codes are characterized as “Supplementary Classification of External Causes of Injury and Poisoning (E000-E999).” Id. Note also that the “E” codes are followed by three digits before the decimal point, unlike the “V” codes, which are followed by only two digits before the decimal point. Id.
246 Id.
247 Id. at 760-61, 764.
248 Id. at 781.
249 Id. at 782.
250 Id. at 782-83.
251 ICD-9-CM OFFICIAL GUIDELINES, supra note 228, at 10.
252 UB-04 SPECIFICATIONS, supra note 183, at 198.
253 Id.
procedure codes “provide greater detail.” For example, diagnosis code 14.2 is the destruction of a chorioretinal lesion, 14.21 is the destruction of a chorioretinal lesion by diathermy, and 14.24 is the destruction of a chorioretinal lesion by laser photoagulation.

<table>
<thead>
<tr>
<th>ICD-9-CM Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.10</td>
<td>Intracranial pressure monitoring</td>
</tr>
<tr>
<td>01.14</td>
<td>Open biopsy of brain</td>
</tr>
<tr>
<td>36.03</td>
<td>Open chest coronary artery angioplasty</td>
</tr>
<tr>
<td>36.07</td>
<td>Insertion of drug-eluting coronary stent(s)</td>
</tr>
<tr>
<td>72.51</td>
<td>Partial breech extraction with forceps to aftercoming head</td>
</tr>
<tr>
<td>73.51</td>
<td>Manual rotation of fetal head</td>
</tr>
<tr>
<td>88.71</td>
<td>Diagnostic ultrasound of head and neck</td>
</tr>
</tbody>
</table>

**Table 4. Sample ICD-9-CM Procedure Codes.**

The first two digits of ICD-9-CM procedure codes come from one of seventeen surgical categories. For example, procedure codes that begin with numbers between 01 and 05 represent operations on the nervous system, and procedure codes that begin with numbers between 72 and 75 are obstetrical procedures. A complete list of ICD-9-CM procedure categories appears in Table 5.

<table>
<thead>
<tr>
<th>ICD-9-CM Procedure Code Range</th>
<th>Procedure Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Procedures and interventions, not elsewhere classified</td>
</tr>
<tr>
<td>01-05</td>
<td>Operations on the nervous system</td>
</tr>
</tbody>
</table>

254 ICD-9-CM OFFICIAL GUIDELINES, supra note 228, at 10.
256 See generally ICD-9-CM TABULAR PROCEDURE LIST, supra note 255 (containing IDC-9-CM procedure codes and short descriptions).
258 Id.; ICD-9-CM TABULAR PROCEDURE LIST, supra note 255, at 11, 172.
259 Infra, Table 5.
<table>
<thead>
<tr>
<th>ICD-9-CM Procedure Code Range</th>
<th>Procedure Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>06-07</td>
<td>Operations on the endocrine system</td>
</tr>
<tr>
<td>08-16</td>
<td>Operations on the eye</td>
</tr>
<tr>
<td>18-20</td>
<td>Operations on the ear</td>
</tr>
<tr>
<td>21-29</td>
<td>Operations on the nose, mouth, and pharynx</td>
</tr>
<tr>
<td>30-34</td>
<td>Operations on the respiratory system</td>
</tr>
<tr>
<td>35-39</td>
<td>Operations on the cardiovascular system</td>
</tr>
<tr>
<td>40-41</td>
<td>Operations on the hemic and lymphatic system</td>
</tr>
<tr>
<td>42-54</td>
<td>Operations on the digestive system</td>
</tr>
<tr>
<td>55-59</td>
<td>Operations on the urinary system</td>
</tr>
<tr>
<td>60-64</td>
<td>Operations on the male genital organs</td>
</tr>
<tr>
<td>65-71</td>
<td>Operations on the female genital organs</td>
</tr>
<tr>
<td>72-75</td>
<td>Obstetrical procedures</td>
</tr>
<tr>
<td>76-84</td>
<td>Operations on the musculoskeletal system</td>
</tr>
<tr>
<td>85-86</td>
<td>Operations on the integumentary system</td>
</tr>
<tr>
<td>87-99</td>
<td>Miscellaneous diagnostic and therapeutic procedures</td>
</tr>
</tbody>
</table>

Table 5. ICD-9-CM Procedure Code Categories.\(^{260}\)

Keeping up with changes to ICD-9-CM code sets can be a considerable challenge for revenue-cycle managers. The ICD-9-CM Coordination and Maintenance Committee holds meetings every March and September and any interested parties may attend.\(^{261}\) CMS also accepts suggestions for changes to the code sets and, if accepted, those modifications become official at the beginning of October of the following year.\(^{262}\) Revenue-cycle managers should plug themselves into this process and keep abreast of changes to official ICD coding requirements by monitoring the CMS and NCHS websites. Software vendors can help manage some of this complexity by incorporating the continual stream of updates and changes into smart

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software coding systems. Some organizations have managed some costs and difficulties of coding operations by allowing coding staff to work from home. But the coding process is still cumbersome and it is about to become even more challenging.

Beginning October 1, 2013, providers must use the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) procedure codes. The conversion to ICD-10 has been long and arduous. Though there will be little change in the way practitioners document services, coding staff will have to deal with a new code set that is substantially different. Diagnosis codes under ICD-10-CM contain up to seven alpha-numeric characters; alpha characters are no longer limited to “E” and “V” codes (e.g., the diagnosis code for a thumb laceration under ICD-9-CM, 493.92, becomes either S61.011A or S61.012A under ICD-10-CM). To aid in conversion, CMS created General Equivalence Mappings (GEMs) to “ensure consistency in national data.” But preparing for the conversion is more difficult than simply mapping one code set to another. Among other things, it requires careful budgeting, heightened attention to accuracy and quality, additional staff training, and conversion of internal processes and information technology systems.

There are other, more intractable problems the conversion foists onto providers. First,

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263 Rogoski, supra note 227, at 14.
264 Id.
268 Id.
Despite CMS’s GEMs, there is not a one-to-one mapping of ICD-9 codes to ICD-10 codes.\footnote{Shadih N. Shah, The Looming Problem in Healthcare EDI: ICD-10 and HIPAA 5010 Migration, HEALTHCARE TECH. ONLINE (Oct. 29 2009), available at http://www.healthcaretechnologyonline.com/article.mvc/The-Looming-Problem-In-Healthcare-EDI-0001.} Second, the ICD-10 code set is ten times larger than the ICD-9 code set and therefore will create significant new demands on clinicians, coding personnel, and existing information-technology systems.\footnote{Id.} This increased complexity could also increase providers’ exposure to fraud under the False Claims Act because of the potential for mistakes leading to overbilling.\footnote{Rushing ICD-10 Implementation Would Likely Cause Improper and Fraudulent Medicare Payments to Soar, HEALTH INSURANCE LAW WEEKLY 19 (June 11, 2006).} Third, ICD-9 is deeply embedded in software and automated systems and conversion to ICD-10 will require significant upgrades and modifications to those systems.\footnote{Shah, supra note 271.} Fourth, the conversion to ICD-10 will involve significant changes to providers’ contracts with payers, fee-schedules, and internal provider forms such as coding documentation and superbills given to patients after a visit.\footnote{Am. Acad. of Dermatology Ass’n, ICD-10 and 5010 Standards Overview, http://www.aad.org/pm/hit/HITDashboard/icd10.html (last visited Feb. 3, 2010).} Fifth, ICD-10 conversion will affect providers’ adoption and implementation of electronic health record (EHR) technology (although it should improve standardization and enhance clinical information available in EHRs).\footnote{Karen Bell, Improving Health-Care Statistics through Electronic Medical Records and Health Information Exchange, NAT’L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL & PREVENTION, available at http://www.cdc.gov/nchs/data/nhcs/EMR_workshop_summary.pdf.} And sixth, difficulties in mapping ICD-9 codes to ICD-10 codes may hamper research and analysis using data collected over any time that spans the conversion date.\footnote{Letter from Joanne Conroy, Chief Health Care Officer, Assoc. of Am. Med. Colleges, to Michael O. Leavitt, Secretary, U.S. Dep’t of Health & Human Servs. (Oct. 21, 2008), available at https://www.aamc.org/download/80400/data/aamc_comment_letter_to_hhs_on_the_icd_10_and_5010_proposed_rules.pdf.} But the ICD code sets are not the only complex code sets that worry revenue-cycle managers.
**b. Healthcare Common Procedural Coding System**

The Healthcare Common Procedural Coding System (HCPCS—often pronounced “hick-picks”) is another standardized coding system that identifies medical services, procedures, supplies, and other articles used in treatment by physicians and other practitioners.\(^{278}\) HIPAA requires physicians and some other nonhospital providers to use HCPCS codes to report services.\(^{279}\) For institutional claims, HCPCS codes report procedures on outpatient claims, while ICD-9-CM codes report procedures on inpatient claims.\(^{280}\) HCPCS divides codes into two groups: HCPCS Level I and HCPCS Level II.\(^{281}\)

HCPCS Level I comprises the Current Procedural Terminology (CPT®-4) code set maintained by the American Medical Association (AMA) CPT Editorial Panel.\(^{282}\) The AMA created CPT in 1966 to help standardize terms and allow computerized service analysis.\(^{283}\) The Panel meets three times a year to discuss any issues or needs concerning the coding system.\(^{284}\) Early editions primarily addressed surgery, but the AMA has since expanded CPT to include medicine, radiology, laboratory, diagnostic, and therapeutic services and procedures.\(^{285}\) The CPT system further divides codes into three categories: Categories I, II, and III.\(^{286}\)

Category I codes are five-digit numeric codes divided still further into six main sections:
(1) anesthesia, (2) surgery, (3) radiology, (4) pathology and laboratory, (5) medicine, and (6) evaluation and management. Table 6 breaks down these sections by code range.

<table>
<thead>
<tr>
<th>CPT-4/HCPCS Procedure Code Range</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>00100 – 01999</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>10021 – 69990</td>
<td>Surgery</td>
</tr>
<tr>
<td>70010 – 79999</td>
<td>Radiology</td>
</tr>
<tr>
<td>80047 – 89398</td>
<td>Pathology and laboratory</td>
</tr>
<tr>
<td>90281 – 99607</td>
<td>Medicine</td>
</tr>
<tr>
<td>99201 – 99499</td>
<td>Evaluation and management</td>
</tr>
<tr>
<td>0001F – 7025F</td>
<td>Category II codes</td>
</tr>
<tr>
<td>0016T – 0233T</td>
<td>Category III codes</td>
</tr>
</tbody>
</table>

Table 6. CPT-4 Code Sections.

And the surgery section is divided into segments between CPT codes 10021 and 69990 related to 14 physiological areas. Table 7 breaks down these categories by code range.

<table>
<thead>
<tr>
<th>CPT-4 Category I Surgical Procedure Code Range</th>
<th>Physiological System or Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>10021 – 19499</td>
<td>Integumentary system</td>
</tr>
<tr>
<td>20000 – 29999</td>
<td>Musculoskeletal system</td>
</tr>
<tr>
<td>30000 – 32999</td>
<td>Respiratory system</td>
</tr>
<tr>
<td>33010 – 39599</td>
<td>Cardiovascular system</td>
</tr>
<tr>
<td>40490 – 49999</td>
<td>Digestive system</td>
</tr>
<tr>
<td>50010 – 53899</td>
<td>Urinary system</td>
</tr>
<tr>
<td>54000 – 55980</td>
<td>Male genital system</td>
</tr>
<tr>
<td>56405 – 58999</td>
<td>Female genital system</td>
</tr>
<tr>
<td>59000 – 59899</td>
<td>Maternity care and delivery</td>
</tr>
<tr>
<td>60001 – 60699</td>
<td>Endocrine system</td>
</tr>
<tr>
<td>61000 – 64999</td>
<td>Nervous system</td>
</tr>
</tbody>
</table>

287 LAURA SOUTHARD DURHAM, LIPPINCOTT WILLIAMS & WILKINS’ ADMINISTRATIVE MEDICAL ASSISTING 294 (2d ed. 2008).
288 Infra, Table 6.
290 CASTO & LAYMAN, supra note 11, at 24.
291 Infra, Table 7.
Category II CPT codes (alpha-numeric codes ending in “F”—0001F to 7025F) are designed to track provider performance, but providers are not required to use them. Still, they “decrease the need for record abstraction and chart review, thereby minimizing administrative burden on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care.” Providers and agencies often use these “F” codes to aid in quality improvement and patient safety programs. Category II codes are broken down into eight groups shown in Table 8.

<table>
<thead>
<tr>
<th>CPT-4 Category II Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001F – 0005F</td>
<td>Composite Measures</td>
</tr>
<tr>
<td>0500F – 0503F</td>
<td>Patient Management</td>
</tr>
<tr>
<td>1000F – 1008F</td>
<td>Patient History</td>
</tr>
<tr>
<td>2000F – 2004F</td>
<td>Physical Examination</td>
</tr>
<tr>
<td>3000F – 3002F</td>
<td>Diagnostic/Screening Processes or Results</td>
</tr>
<tr>
<td>4000F – 4018F</td>
<td>Therapeutic, Preventive or Other Interventions</td>
</tr>
<tr>
<td>5000F – xxxxx</td>
<td>Follow-up or Other Outcomes (no codes yet)</td>
</tr>
<tr>
<td>6000F – xxxxx</td>
<td>Patient Safety (no codes yet)</td>
</tr>
</tbody>
</table>

Table 8. CPT-4 Category II Code Segments.
“Category III CPT codes are a set of temporary codes for emerging technology, services, and procedures.”\textsuperscript{298} Like Category II codes, Category III codes are also alpha-numeric codes (in the range 0016T to 0233T) but each code ends in “T” instead of “F.”\textsuperscript{299} The AMA discards Category III codes after five years unless it creates a new Category I code for the corresponding procedures or services.\textsuperscript{300} To make the move from Category III to Category I, a number of providers in multiple locations must perform the service and the Food and Drug Administration (FDA) must approve it.\textsuperscript{301}

A list of the most common CPT-4 codes submitted to Medicare on claims in 2006 appears in Table 9.\textsuperscript{302}

<table>
<thead>
<tr>
<th>CPT-4 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36415</td>
<td>Collection of venous blood by venipuncture</td>
</tr>
<tr>
<td>85025</td>
<td>Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count</td>
</tr>
<tr>
<td>93005</td>
<td>Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report</td>
</tr>
<tr>
<td>80053</td>
<td>Comprehensive metabolic panel</td>
</tr>
<tr>
<td>80048</td>
<td>Basic metabolic panel</td>
</tr>
<tr>
<td>71020</td>
<td>Radiologic examination, chest, 2 views, frontal and lateral; (chest x-ray)</td>
</tr>
<tr>
<td>85610</td>
<td>Prothrombin time</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient</td>
</tr>
<tr>
<td>84484</td>
<td>Troponin, quantitative</td>
</tr>
</tbody>
</table>

\textsuperscript{298} CPT 2011, supra note 289, at 537; Am. Med. Ass’n, CPT\textsuperscript{®} Category III Codes: The First Ten Years, CPT\textsuperscript{®} ASSISTANT, May 2009, available at http://www.ama-assn.org/ama1/pub/upload/mm362/cat3-codes-first-10-yrs.pdf. \textsuperscript{299} CPT 2011, supra note 289, at 537; see also supra, Table 6 (describing the code range for Category III codes). \textsuperscript{300} CPT 2011, supra note 289, at 537. \textsuperscript{301} Id. \textsuperscript{302} Infra, Table 9.
<table>
<thead>
<tr>
<th>CPT-4 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>88305</td>
<td>Level IV – tissue exam by pathologist</td>
</tr>
</tbody>
</table>

Table 9. 2006 Medicare Most Common Procedures by Unit of Service.\(^{303}\)

The HCPCS Level II code set, developed in the 1980s, “is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS or DME) when used outside a physician’s office.”\(^{304}\) Unlike HCPCS Level I, which is maintained by the AMA, CMS maintains the HCPCS Level II coding system.\(^{305}\) Federal regulations require use of HCPCS Level II codes for medical supplies, orthotic and prosthetic devices, and durable medical equipment.\(^{306}\) Table 10 shows the various categories of Level II codes broken down by code range.\(^{307}\)

<table>
<thead>
<tr>
<th>HCPCS Level II Code Range</th>
<th>HCPCS Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0021 - A0999</td>
<td>Transportation Services Including Ambulance</td>
</tr>
<tr>
<td>A4000 - A8999</td>
<td>Medical and Surgical Supplies</td>
</tr>
<tr>
<td>A9000 - A9999</td>
<td>Administrative, Miscellaneous and Investigational</td>
</tr>
<tr>
<td>B4034 - B9999</td>
<td>Enteral and Parenteral Therapy</td>
</tr>
<tr>
<td>C1300 - C9800</td>
<td>Outpatient PPS</td>
</tr>
<tr>
<td>E0100 - E8002</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>G0001 - G9142</td>
<td>Procedures / Professional Services</td>
</tr>
<tr>
<td>H0001 - H2037</td>
<td>Alcohol and Drug Abuse Treatment</td>
</tr>
<tr>
<td>J0120 - J8999</td>
<td>Drugs Administered Other than Oral Method</td>
</tr>
<tr>
<td>J9000 - J9999</td>
<td>Chemotherapy Drugs</td>
</tr>
<tr>
<td>K0001 - K0899</td>
<td>Durable medical equipment</td>
</tr>
<tr>
<td>L0100 - L4398</td>
<td>Orthotic Procedures and services</td>
</tr>
</tbody>
</table>

---

\(^{303}\) CASTO & LAYMAN, supra note 11, at 25; see generally CPT 2011, supra note 289 (containing descriptions for CPT-4 codes).

\(^{304}\) CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) LEVEL II CODING PROCEDURES 1 (2010) [hereinafter LEVEL II CODING PROCEDURES].

\(^{305}\) Id.

\(^{306}\) Medical Data Code Sets, 45 C.F.R. § 162.1002(b)(3) (2010).

\(^{307}\) Infra, Table 10.
<table>
<thead>
<tr>
<th>HCPCS Level II Code Range</th>
<th>HCPCS Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>L5000 - L9900</td>
<td>Prosthetic Procedures</td>
</tr>
<tr>
<td>M0064 - M0302</td>
<td>Medical Services</td>
</tr>
<tr>
<td>P2028 - P9615</td>
<td>Pathology and Laboratory Services</td>
</tr>
<tr>
<td>Q0035 - Q9968</td>
<td>Temporary Codes</td>
</tr>
<tr>
<td>R0070 - R0076</td>
<td>Diagnostic Radiology Services</td>
</tr>
<tr>
<td>S0012 - S9999</td>
<td>Temporary National Codes (Non-Medicare)</td>
</tr>
<tr>
<td>T1000 - T5999</td>
<td>National Codes Established for State Medicaid Agencies</td>
</tr>
<tr>
<td>V2020 - V2799</td>
<td>Vision Services</td>
</tr>
<tr>
<td>V5008 - V5364</td>
<td>Hearing Services</td>
</tr>
</tbody>
</table>

**Table 10. HCPCS Level II Code Sections.**

HCPCS also includes two-character alpha-numeric codes called “payment modifiers.”

Modifiers sometimes accompany HCPCS codes on claims “to provide additional information regarding the service or item identified by the HCPCS code.” CMS is responsible for maintaining payment modifiers. Modifiers may convey information such as the professional (26) and technical (TC) components of a procedure, multiple surgeries (51), bilateral surgery (50), unusual services (22), and the like. A modifier might designate that an assistant surgeon performed a surgery (80) or that a qualified anesthesiologist administered anesthesia (AA). Or it may communicate something as mundane as whether a piece of durable medical equipment (DME) provided to a patient was new equipment (NU) or used equipment (UE). There are hundreds of modifiers—a list of a few more common ones appears in Table 11.

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310 LEVEL II CODING PROCEDURES, supra note 304, at 6.
312 Id.
313 LEVEL II CODING PROCEDURES, supra note 304, at 6.
314 See generally CPT 2011, supra note 289 (listing modifiers for use with all categories of CPT-4 codes); infra, Table 11.
<table>
<thead>
<tr>
<th>CPT/HCPCS Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Unusual Procedural Services</td>
</tr>
<tr>
<td>26</td>
<td>Professional Component.</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Procedure</td>
</tr>
<tr>
<td>51</td>
<td>Multiple Procedures</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon</td>
</tr>
<tr>
<td>99</td>
<td>Multiple modifiers</td>
</tr>
<tr>
<td>AA</td>
<td>Anesthesia performed by anesthesiologist</td>
</tr>
<tr>
<td>LT</td>
<td>Procedure performed on left side</td>
</tr>
<tr>
<td>RT</td>
<td>Procedure performed on right side</td>
</tr>
<tr>
<td>TG</td>
<td>Complex/high tech level of care</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
</tr>
</tbody>
</table>

Table 11. Some Commonly-Used HCPCS Modifiers.\(^{315}\)

On hospital claims, providers must append modifiers to the end of a HCPCS code in the revenue-code line on the UB-04 form.\(^{316}\) But the CMS-1500 form for professional (physician) claims has a designated space to report up to four modifiers per HCPCS code.\(^{317}\)

Figure 10. Example of HCPCS codes with Modifiers on a UB-04 form.\(^{318}\)


\(^{316}\) UB-04 SPECIFICATIONS, supra note 183, at 162; see also infra, Figure 10 (showing an example of HCPCS codes with modifiers on a UB-04 claim form).

\(^{317}\) NAT’L UNIF. CLAIM COMM., 1500 HEALTH INSURANCE CLAIM FORM REFERENCE INSTRUCTION MANUAL FOR FORM VERSION 08/05 36 (2008) [hereinafter CMS-1500 INSTRUCTIONS]; see also infra, Figure 11 (showing an example of a HCPCS code with a modifier on a CMS-1500 claim form).

The ICD-9 and HCPCS code sets represent the most voluminous and complex code sets with which revenue-cycle managers must concern themselves. And they are the most important discretionary portions of a claim. But there are still a few other code sets—very small by comparison—that can have a major impact on the revenue cycle.

c. Patient Discharge Status

The patient discharge status code appears only on hospital (UB-04) claims—Medicare requires it on those claims.\(^{320}\) The discharge status code can be important in both Medicare and private payment scenarios.\(^{321}\) This is because Medicare and some private payers consider certain discharges to be transfers—in some cases, the claims from the transferring facility and the receiving facility belong to the same episode of care for reimbursement purposes.\(^{322}\)

The discharge status code is a two-digit numeric “code indicating the disposition or discharge status of the patient at the end of service.”\(^{323}\) For example, a discharge status code of 01 indicates that a patient’s discharge was routine.\(^{324}\) But other discharge codes indicate that the

\(^{319}\) CMS-1500 INSTRUCTIONS, supra note 317, at 36.

\(^{320}\) UB-04 SPECIFICATIONS, supra note 183, at 41; see generally CMS-1500 INSTRUCTIONS, supra note 317.

\(^{321}\) UB-04 SPECIFICATIONS, supra note 183, at 41.

\(^{322}\) Id.; Discharges and Transfers, 42 C.F.R. § 412.4(b) (2009).

\(^{323}\) UB-04 SPECIFICATIONS, supra note 183, at 41.

\(^{324}\) Id. at 42.
patient left against medical advice (07) or was transferred to another facility, such as a skilled
nursing (03) or custodial care facility (04). In some cases, discharge codes indicate that the
patient died and they designate the death’s general circumstances such as whether the patient
died in the hospital (20) or at home (40). Determining the correct code “may often be
confusing” so the NUBC provides guidance in the form of a Frequently Asked Questions (FAQ)
document on its website and CMS provides other online guidance documents.

Coding the correct discharge status not only has implications related to reimbursement,
but if “the coder enters the wrong discharge status code, the billing department might get paid
incorrectly and be guilty of having sent a ‘false claim to the government.” At best, an
incorrectly recorded discharge code can result in resubmission, payment delay, or penalties.
Getting this part of coding correct depends on proper documentation practices in a hospital’s
case-management department and a high level of cooperation between that department and the
clinical-coding department.

d. Value Codes and Amounts

Value codes (and associated amounts) are a set of hospital-claim-only codes that relate to
amounts a provider charges or specific benefits available to a patient. “The codes are two

325 Id. at 42–43.
326 Id. at 43.
327 Id. at 41, 45–53; see generally, e.g., Ctrs. for Medicare & Medicaid Servs. Medicare Learning Network,
Clarification of Patient Discharge Status Codes and Hospital Transfer Policies, July 6, 2009,
328 Judy Sturgeon, Discharge Codes: Let’s Go Home . . . Or Maybe Not, 21 FOR THE RECORD 6 (2009), available at
329 Id.
330 Id.
331 UB-04 SPECIFICATIONS, supra note 183, at 84-87; MEDICARE CLAIMS PROCESSING MANUAL, supra note 196, at §
75.3.
alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00).**332 (This bland description belies the many purposes the value code serves.)333

For example, a provider may need to justify its semi-private room rate by recording value code 01 in the value-code field, and the value of its most common semi-private room rate in the amount field.334 Other uses for the value code and amount include listing the Medicare Part A or Part B coinsurance (codes 09 and 11) and amount, the total Medicare blood deductible (06) and amount, a patient’s liability for services that are not covered (31), and the amount a patient has already paid (FC).335 Another important code (05) indicates that a doctor’s charges were included in the amount billed on the claim, but the provider will still submit a second bill for the doctor’s charges.336

A provider may also use the amount field associated with a value code to report things other than dollar amounts. For example, providers must use the amount field to report the number of visits for therapy including physical therapy (50), occupational therapy (51), speech therapy (52), or cardiac rehabilitation (53).337 Other examples of nonmonetary values providers report in the amount field include newborn birth weight (54), arterial blood gas readings (58), and oxygen saturation readings (59).338

This broad range of uses for the value code amount shows at least one way in which data are sometimes shoe-horned into the UB-04 form.339 That type of practice increases the complexity and reduces the clarity of generating and evaluating claims and creates a very real

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**332** MEDICARE CLAIMS PROCESSING MANUAL, supra note 196, at § 75.3.
**333** See UB-04 SPECIFICATIONS, supra note 183, at 85-100 (showing varied uses for the value code amount field on the UB-04 form).
**334** Id. at 85.
**335** Id. at 85, 99.
**336** Id. at 85.
**337** Id. at 92.
**338** Id. at 93.
**339** See id. at 85-100 (showing varied uses for the value code amount field on the UB-04 form).
headache for revenue-cycle managers. The good news is that, unlike Medicare, most commercial payers do not require providers to report value codes—though that may be changing as a result of a trend among private payers to more closely emulate Medicare.  

*e. Condition and Occurrence Codes*

With places for up to 11 instances on the UB-04, *condition codes*—even more than value codes—represent a catch-all class of data that describes circumstances surrounding the treatment, coverage, or claim that may be relevant to reimbursement.  

Condition codes are two-character alpha-numeric indicators “used to identify conditions or events relating to [a] bill that may affect processing.”

For example, condition code 02 means that a patient alleged that employment circumstances or activities caused a medical condition.  

Code 05 means that a provider has filed a lien to recover money owed to a patient because of “legal action initiated by or on behalf of the patient.”  

Condition codes may indicate that the provider treated a hospice patient for a non-terminal condition (07), both the patient and the patient’s spouse are unemployed (09), the patient is homeless (17), the payer previously denied the bill but the provider wants to receive a denial notice from the payer (21), the patient is a student (codes 31-34), or the patient received dialysis in the hospital or at home (codes 71-74).  

There is even a range of codes that describe the reasons for performing an abortion: rape (AA), incest (AB), fetal genetic defect (AC), the mother’s life was endangered by the pregnancy (AD), the mother had a non-life-threatening

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340 Everett, supra note 25.
341 See UB-04 SPECIFICATIONS, supra note 183, at 54 (defining condition codes as “code(s) used to identify conditions or events relating to this bill that may affect processing.”).
342 Id.
343 Id.
344 Id.
345 Id. at 55-61.
condition (AE), the mother had a debilitating emotional or psychological condition (AF), social or economic reasons (AG), or the abortion was elective (AH). 346

The UB-04 also contains places for occurrence codes and occurrence-span codes. 347 These codes denote significant events that affect claim processing and payment. 348 Occurrence codes, two-digit codes in the range 01-69 and A0-LZ, denote events that occurred on a single date. 349 For example, occurrence code 01 indicates that the claim is for an accident-related injury for which there is medical coverage. 350 Occurrence code 11 indicates the date a patient first noted the onset of symptoms for an illness. 351 And code 18 records the date the patient retired (which could have a bearing on coordination of benefits).

Occurrence-span codes “identify occurrences that happened over a span of time.” 352 For instance, code 76 indicates a span of time when a patient was not covered by Medicare. 353 And code 77 indicates a span of time during which a provider is liable for the costs of the patient’s care. 354

f. National Provider Identifier

In past years, payers have had great difficulty in automating a process for identifying healthcare providers and linking claims to the appropriate reimbursement terms. This was primarily caused by relying on a provider’s name or address, which was often misspelled.

346 Id. at 62-63.
347 Id. at 70.
348 Id. at 71,78.
349 Id. at 70.
350 Id. at 72.
351 Id.
352 Id. at 78.
353 Id. at 80.
354 Id. at 80.
abbreviated, or used an unknown but legitimate variation of these data elements.\textsuperscript{355}

To solve this problem, facilitate electronic transactions, and to help prevent fraud and abuse, HIPAA required that CMS develop a unique identifier for providers.\textsuperscript{356} CMS then created a 10-digit numeric identifier, called the National Provider Identifier (NPI), unique to each provider that is a HIPAA covered entity.\textsuperscript{357} Providers must share their NPIs with other providers, healthcare plans, and clearinghouses.\textsuperscript{358} The NPI simplifies claim administration and makes it possible for healthcare entities to readily exchange electronic transactions.\textsuperscript{359} Providers must use their NPIs on both institutional and physician claims.\textsuperscript{360}

g. Type of Bill

The *type-of-bill indicator*, or *bill-type code*, is a four-digit numeric code that applies only to institutional claims.\textsuperscript{361} The bill-type code’s first digit is always zero and the second digit specifies the healthcare setting.\textsuperscript{362} The general classes of settings that bill type codes accommodate include hospitals (01xx); skilled nursing facilities (02xx); home health (03xx); religious healthcare institutions (04xx); intermediate care facilities (06xx); clinics (07xx); and hospice, ambulatory surgery centers, free-standing birthing centers, critical access hospitals, and residential facilities (08xx).\textsuperscript{363}

\textsuperscript{355} Interview with Dale Kahlich, former Chief Systems Architect, Innovative Managed Care Systems, in Dallas, Tex. (Sept. 9, 2010).
\textsuperscript{357} Standard Unique Health Identifier for Health Care Providers, 45 C.F.R. § 162.406 (2009).
\textsuperscript{360} UB-04 SPECIFICATIONS, supra note 183, at 175-76; CMS-1500 INSTRUCTIONS, supra note 317, at 26.
\textsuperscript{361} UB-04 SPECIFICATIONS, supra note 183, at 12.
\textsuperscript{362} Id. at 12-15.
\textsuperscript{363} Id at 14-15.
The bill-type code’s third digit states whether the claim is an inpatient or outpatient claim and, in the public-payment context, whether the claim is intended to bill for Medicare Part A or Part B services.\textsuperscript{364} For example, the bill type for a hospital inpatient claim for Part A would take the form 011x, a hospital inpatient claim for Part B only would take the form 012x, and a hospital outpatient claim would take the form 013x.

The bill type code’s fourth digit, the \textit{bill-frequency code}, is extremely important in determining reimbursement and represents “the frequency of the bill for the institutional and electronic professional claim.”\textsuperscript{365} The most common, and most important, bill-frequency codes represent the claim as an admit-through-discharge claim (bill-frequency code 1) that contains all the detail for the entire hospitalization; the first interim claim in a series of interim claims (bill-frequency code 2) that contains information about only the first part of treatment—perhaps at the first billing cycle’s end during treatment; the second and any subsequent interim claim (bill-frequency code 3) that may or may not replicate detail from the first interim claim; and the final interim claim (bill-frequency code 4) that also may or may not replicate detail from prior interim claims.\textsuperscript{366} Other bill frequency indicators may mean the claim is for late charges (bill-frequency code 5)—charges recorded after the provider submitted the admit-through-discharge or final interim claim); replacement of a prior claim (bill-frequency code 7); or cancellation of a prior claim (bill-frequency code 8).\textsuperscript{367}

So a provider submitting claims for a short inpatient visit might submit an admit-to-discharge claim using bill type 0111. But a long inpatient hospital visit might generate a first interim claim (0112), a second interim claim (0113), a third interim claim (0113), a final interim

\textsuperscript{364} \textit{Id.}
\textsuperscript{365} \textit{Id.} at 12, 17.
\textsuperscript{366} \textit{Id.}
\textsuperscript{367} \textit{Id.}
claim (0114), a claim containing late-arriving charges (0115), a replacement claim for the late-charge claim (0117), a cancellation of all previous claims (0118), and finally, another admit-to-discharge claim (0111).

For payers attempting to adjudicate claims and for revenue-cycle managers attempting to anticipate payment, the type and frequency of claims can create a confusing jumble of claims, revenue codes, procedure codes, and diagnosis codes.368 To sort all this out, some healthcare entities employ a process called “charge compiling,” which is a set of rules for screening and consolidating claims and the information they contain.369 To gain a basic understanding of this process, one must take a different view of what a combination of claims represents:

In trying to figure out what a ‘claim’ was, we kept encountering a hurdle created by a provider’s need to send a transaction to a payer as quickly as possible and the time lag before all the information came in. Rather than viewing a claim as a transaction, we began to view it as a collection of transactions. It’s really episodic in nature. And that’s not surprising because healthcare is filled with a continuum of episodes—from episodes of care to, in this case, a ‘billing episode.’

The clarity came when we were able to articulate that the proper definition of an episode, or encounter, required (1) one patient, (2) one medical entity (physician, nurse practitioner, or facility), and (3) one contiguous block of time.370

Because there is such a wide variety of differing implementations for handling charge compilation, consolidating the mishmash of institutional-claim transactions into a final, coherent claim represents a great challenge to claim adjudication and reconciliation.371 “We expended a tremendous amount of effort in charge compilation over the years and it was always a work in progress—never settled, never complete.”372 And with a move to episode-of-care reimbursement models that combine claims across providers, some aspects of charge compiling may become

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368 Kahlich, supra note 355.
369 Id.
370 Flowers, supra note 77.
371 Kahlich, supra note 355.
372 Id.
even more challenging.\textsuperscript{373}

v. Grouping

Title VI of the Social Security Amendments of 1983 amended the Social Security Act to create a prospective-payment system (PPS) for Medicare inpatient claims.\textsuperscript{374} And in 1997, Congress required Medicare to institute a prospective-payment system for outpatient claims.\textsuperscript{375} A prospective-payment system is one in which payment rates are fixed in advance and paid accordingly regardless of the actual cost of services.\textsuperscript{376} The prospective-payment system’s motivation is to give providers an incentive to control costs because they receive a fixed payment, even if the services cost less (or more) than the payment.\textsuperscript{377}

a. Diagnosis-Related Groups (DRGs) for Hospital Inpatient Claims

Title VI prescribed a system based on classification according to diagnosis-related groups (DRGs) and directed CMS to establish “a methodology for classifying specific hospital discharges within these groups.”\textsuperscript{378} Consequently, CMS, through its fiscal intermediaries or Medicare administrative contractors, assigns a single DRG to a claim based on “the patient’s age, sex, principal diagnosis . . ., secondary diagnoses, procedures performed, and discharge status.”\textsuperscript{379} CMS uses up to eight diagnoses (not including the principal diagnosis) and six
procedures to determine the DRG for a claim.\textsuperscript{380} Medicare originally employed a band of 467 DRGs, but by 2010, it had expanded that number to 738.\textsuperscript{381} The DRG is represented by a numeric code (four digits are reserved, but to date only three are used for Medicare).\textsuperscript{382}

DRGs were originally developed in the late 1960s at Yale University to relate a hospital’s case-mix (the types of patients the hospital treats) to the hospital’s costs.\textsuperscript{383} DRGs partition diagnostic areas into major diagnostic categories (MDCs).\textsuperscript{384} There are 25 MDCs that “correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty.”\textsuperscript{385} For example, MDC 5 represents circulatory system diseases and disorders and MDC 19 represents mental diseases and disorders.\textsuperscript{386} A list of MDCs appears in Table 12.\textsuperscript{387} Each MDC is further divided into surgical or medical DRGs to account for the fact that surgical procedures typically use more hospital resources.\textsuperscript{388} A few very resource-intensive cases are assigned a DRG based on the procedure alone without any consideration of diagnoses and other factors.\textsuperscript{389} These are called pre-major diagnostic categories (Pre-MDCs) and include major organ transplants.\textsuperscript{390} Some DRGs are further divided on the basis of age, diagnosis, or the presence of a complication or comorbidity.\textsuperscript{391} A comorbidity is an additional condition that

\textsuperscript{380} Revision to Hospital Inpatient Prospective Payment Systems—2007 FY Occupational Mix Adjustment to Wage Index; Implementation; Final Rule, 71 Fed. Reg. 47,870, 47,879 (Aug. 18, 2006).
\textsuperscript{382} UB-04 SPECIFICATIONS, supra note 183, at 195.
\textsuperscript{384} 71 Fed. Reg. at 47,879.
\textsuperscript{385} Id. at 47,879-80.
\textsuperscript{386} Id.
\textsuperscript{387} Id., Table 12.
\textsuperscript{388} 71 Fed. Reg. at 47,880.
\textsuperscript{389} Id.
\textsuperscript{390} Id.
\textsuperscript{391} Id.
exists when a hospital admits a patient and increases the illness’s severity.392

<table>
<thead>
<tr>
<th>MDC</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diseases and disorders of the nervous system.</td>
</tr>
<tr>
<td>2</td>
<td>Diseases and disorders of the eye.</td>
</tr>
<tr>
<td>3</td>
<td>Diseases and disorders of the ear, nose, mouth, and throat.</td>
</tr>
<tr>
<td>4</td>
<td>Diseases and disorders of the respiratory system.</td>
</tr>
<tr>
<td>5</td>
<td>Diseases and disorders of the circulatory system.</td>
</tr>
<tr>
<td>6</td>
<td>Diseases and disorders of the digestive system.</td>
</tr>
<tr>
<td>7</td>
<td>Diseases and disorders of the hepatobiliary system and pancreas.</td>
</tr>
<tr>
<td>8</td>
<td>Musculoskeletal system and connective tissue.</td>
</tr>
<tr>
<td>9</td>
<td>Diseases and disorders of the skin, subcutaneous tissue, and breast.</td>
</tr>
<tr>
<td>10</td>
<td>Endocrine, nutritional, and metabolic diseases and disorders.</td>
</tr>
<tr>
<td>11</td>
<td>Diseases and disorders of the kidney and urinary tract.</td>
</tr>
<tr>
<td>12</td>
<td>Diseases and disorders of the male reproductive system.</td>
</tr>
<tr>
<td>13</td>
<td>Diseases and disorders of the female reproductive system.</td>
</tr>
<tr>
<td>14</td>
<td>Pregnancy, childbirth, and the puerperium.</td>
</tr>
<tr>
<td>15</td>
<td>Newborns and other neonates with conditions originating in the perinatal period.</td>
</tr>
<tr>
<td>16</td>
<td>Diseases and disorders of the blood, blood-forming organs, and immunological disorders.</td>
</tr>
<tr>
<td>17</td>
<td>Myeloproliferative diseases and disorders and poorly differentiated neoplasms.</td>
</tr>
<tr>
<td>18</td>
<td>Infectious and parasitic diseases (systemic or unspecified sites).</td>
</tr>
<tr>
<td>19</td>
<td>Mental diseases and disorders.</td>
</tr>
<tr>
<td>20</td>
<td>Alcohol/drug use and alcohol/drug induced organic mental disorders.</td>
</tr>
<tr>
<td>21</td>
<td>Injuries, poisonings, and toxic effects of drugs.</td>
</tr>
<tr>
<td>22</td>
<td>Burns.</td>
</tr>
<tr>
<td>23</td>
<td>Factors influencing health status and other contacts with health services.</td>
</tr>
<tr>
<td>24</td>
<td>Multiple significant trauma.</td>
</tr>
<tr>
<td>25</td>
<td>Human immunodeficiency virus infections.</td>
</tr>
</tbody>
</table>

Table 12. Major Diagnostic Categories used to Classify Diagnosis-Related Groups.393

In 2007, CMS moved to a new DRG system called the Medicare-Severity DRG (MS-DRG) “to better recognize severity of illness.”394 The new system was designed to “adequately reimburse a facility for the more complex and resource intensive cases.”395 It takes both

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392 FAZEN, supra note 82, at 54.
393 71 Fed. Reg. at 47,879-80.
395 CASTO & LAYMAN, supra note 11, at 105.
complications and comorbidities (CCs) and major complications and comorbidities (MCCs) into account to determine the proper MS-DRG for a claim.\footnote{Dividing Proposed MS-DRGs on the Basis of the CCs and MCCs, 72 Fed. Reg. 24,680, 24,705 (May 3, 2007).} CMS publishes a list every fiscal year of diagnosis codes that it considers CCs and MCCs.\footnote{See Ctrs. for Medicare Medicaid Servs., FY 2011 IPPS Final Rule Home Page, http://www.cms.gov/AcuteInpatientPPS/IPPSS2011/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237948&intNumPerPage=10 (last visited Dec. 22, 2010) (hosting links to files comprising Tables 6G-6K that contain MCC and CC inclusion and exclusion lists).}

The process of determining the proper DRG for a claim is called “grouping” or “pricing” and is usually accomplished by software called a “grouper” or a “ pricer.”\footnote{E.g., Ctrs. for Medicare & Medicaid Servs., Inpatient PPS PC Pricer, http://www.cms.gov/PCPricer/Downloads/ZZWeb_INP10A10072.zip (last visited Dec. 22, 2010); DRGGroupers.com, DRG Assignment Software & Services, http://www.drggroupers.com/drgs.html (last visited Dec. 22, 2010); Innovative Resources for Payors, Groupers and Pricers, http://www.irp.com/solutions/groupers.html (last visited Dec. 22, 2010).} Grouping involves a four step process: (1) Pre-MDC assignment: If the claim has a procedure code on the Pre-MDC list, the grouper assigns the corresponding DRG to the claim and takes no further action; (2) MDC determination: The grouper determines the MDC based on the principle diagnosis; (3) Medical or surgical status: If a procedure is a qualifying operating room procedure (minor procedures and tests do not qualify), the grouper assigns a surgical status to the claim but otherwise assigns a medical status; (4) Refinement: The grouper evaluates MCCs, CCs, age, sex, medical or surgical status, and discharge status to make a final DRG assignment.\footnote{CASTO & LAYMAN, supra note 11, at 108-09.} Table 13 lists the more common MS-DRGs.\footnote{Infra, Table 13.}

<table>
<thead>
<tr>
<th>MS-DRG Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>193</td>
<td>Simple pneumonia &amp; pleurisy w MCC</td>
</tr>
<tr>
<td>194</td>
<td>Simple pneumonia &amp; pleurisy w CC</td>
</tr>
<tr>
<td>195</td>
<td>Simple pneumonia &amp; pleurisy w/o CC/MCC</td>
</tr>
<tr>
<td>246</td>
<td>Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents</td>
</tr>
<tr>
<td>247</td>
<td>Perc cardiovasc proc w drug-eluting stent w/o MCC</td>
</tr>
<tr>
<td>248</td>
<td>Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents</td>
</tr>
</tbody>
</table>
Table 13. Some Example MS-DRG Codes and Descriptions.\textsuperscript{401}

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>69</td>
<td>Perc cardiovasc proc w non-drug-eluting stent w/o MCC</td>
</tr>
<tr>
<td>249</td>
<td>Esophagitis, gastroent &amp; misc digest disorders w MCC</td>
</tr>
<tr>
<td>391</td>
<td>Esophagitis, gastroent &amp; misc digest disorders w/o MCC</td>
</tr>
<tr>
<td>392</td>
<td>Major joint replacement or reattachment of lower extremity w MCC</td>
</tr>
<tr>
<td>469</td>
<td>Major joint replacement or reattachment of lower extremity w/o MCC</td>
</tr>
<tr>
<td>470</td>
<td>Kidney &amp; urinary tract infections w MCC</td>
</tr>
<tr>
<td>689</td>
<td>Kidney &amp; urinary tract infections w/o MCC</td>
</tr>
<tr>
<td>690</td>
<td>Esophagitis, gastroent &amp; misc digest disorders w MCC</td>
</tr>
</tbody>
</table>

Table 14. Hospital-acquired conditions excluded from DRG grouping.\textsuperscript{405}

<table>
<thead>
<tr>
<th>Hospital-Acquired Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign object retained after surgery</td>
</tr>
<tr>
<td>Air embolism</td>
</tr>
<tr>
<td>Blood incompatibility</td>
</tr>
<tr>
<td>Stage III and IV pressure ulcers</td>
</tr>
<tr>
<td>Falls and trauma</td>
</tr>
<tr>
<td>Manifestations of poor glycemic control</td>
</tr>
<tr>
<td>Catheter-associated urinary tract infection</td>
</tr>
<tr>
<td>Surgical site infections</td>
</tr>
<tr>
<td>Deep vein thrombosis (DVT) or pulmonary embolism (PE)</td>
</tr>
</tbody>
</table>

For discharges on or after October 1, 2007, hospitals must report a present-on-admission (POA) indicator for each diagnosis code on a claim.\textsuperscript{402} If a particular diagnosis code’s POA indicator reports a hospital-acquired condition (HAC), CMS will not use that diagnosis to select a higher-paying DRG.\textsuperscript{403} Table 14 lists the categories of HACs that CMS will not use to select a higher-paying DRG.\textsuperscript{404}

\begin{itemize}
  \item [403] TRANSMITTAL 1240, supra note 134, at 2.
  \item [404] Infra, Table 14.
  \item [405] CTRS. FOR MEDICARE & MEDICAID SERVS., HOSPITAL-ACQUIRED CONDITIONS (PRESENT ON ADMISSION INDICATOR), https://www.cms.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage (last visited Dec. 22, 2010).
\end{itemize}
groupers and pricers are usually more suitable for integration into existing hospital information systems. This is important not only because providers can use groupers and pricers to check their own work and the work of Medicare contractors handling their claims, but also because private contracts often base certain reimbursement terms on a percentage of Medicare reimbursement. And because DRG and MS-DRG payment methods usually apply only to geriatric patients, government and private industry groups developed DRG payment system derivatives to accommodate many patient demographics.

The National Association of Children’s Hospital and Related Institutions (NACHRI) created the first important DRG variation, called Pediatric Modified Diagnosis-Related Groups (PM-DRGs), in the mid 1980s to classify pediatric and neonatal patients. Working with the 3M™ Health Information Systems (3M HIS) group in 1987, the New York Department of Health incorporated the PM-DRG system, along with classifications for patients with Human Immunodeficiency Virus (HIV) infections and other conditions, into another DRG variation called All Patient Diagnosis-Related Groups (AP-DRGs). Many state agencies and private payers have used AP-DRGs in prospective-payment systems for non-Medicare inpatients.

While the DRG and AP-DRG systems focused on classifying patients according to hospital resource usage, demand in the healthcare sector for a broader classification system

407 Id.
408 Id.
411 Muldoon, supra note 407, at 303.
grew. The 3M HIS team continued its research and developed the All Patient Refined Diagnosis-Related Group (APR-DRG) system. The APR-DRG system accounts for three additional factors: (1) severity of illness—“the extent of physiologic decompensation or organ system loss of function”; (2) risk of mortality—“the likelihood of dying”; and (3) resource intensity—“the relative volume and types of diagnostic, therapeutic, and bed services used in the management of a particular disease.” Hundreds of hospitals, payers, and state agencies use the APR-DRG system not only for payment systems, but also for quality and reporting purposes. As with the DRG system, a hospital may incorporate third party grouper software into its workflow (and may even be contractually required to produce a DRG or variation on its claims).

b. Ambulatory Payment Classifications (APCs) for Hospital Outpatient Claims

The Balanced Budget Act of 1997 required Medicare to institute a prospective-payment system for outpatient claims beginning in 1999. In September of 1998, CMS proposed an Ambulatory-Payment Classification (APC) system comprising “346 groups of services that are

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412 APR DRG Classification System, supra note 410, at 23.
413 Id.
414 Id.
415 Muldoon, supra note 407, at 304; AGENCY FOR HEALTHCARE RESEARCH & QUALITY, AHRQ QUALITY INDICATORS—UNDERSTANDING THE 3M™ ALL PATIENT REFINED DRGS (APR DRGs) 1, http://www.qualityindicators.ahrq.gov/%5Cdownloads%5Clistserv%5CUnderstanding%20the%203M%20APR-DRG.pdf (last visited Dec. 22, 2010).
covered under the hospital outpatient PPS.”

The types of services belonging to APC groups include “surgical procedures; radiology, including radiation therapy; clinic visits; emergency department visits; diagnostic services and other diagnostic tests; partial hospitalization for the mentally ill; surgical pathology; cancer chemotherapy.” CMS developed the APC system in conjunction with 3M HIS and defined the APC groupings in terms of HCPCS Level I and Level II codes.

To discourage upcoding (submitting a bill for a more expensive service when reporting a less expensive service is more appropriate), APCs combine like services (and ultimately they pay an amount based on the median costs of the services in the combination). APCs embody the concepts of packaging and bundling. CMS has defined packaged services as those services “that are recognized as contributing to the cost of the services in an APC, but that [CMS does] not pay for separately.” In its final rule issued in 2008, CMS defined bundling as grouping “services that are typically performed together during a single clinical encounter and that result in the provision of a complete service.” The APCs resulting from bundling are referred to as composite APCs.

APCs are four-digit codes that “provide a single payment for a comprehensive diagnostic and/or treatment service that is defined . . . as a service typically reported with multiple HCPCS

\[^{418}\text{Hospital Outpatient Prospective Payment System, 63 Fed. Reg. 47,552, 47,560 (Sept. 8, 1998) (codified at 42 C.F.R. pts. 409 et al.).}\]
\[^{419}\text{Id.}\]
\[^{420}\text{Id. at 47,561.}\]
\[^{421}\text{Id. at 47,562.}\]
\[^{422}\text{CASTO & LAYMAN, supra note 11, at 177.}\]
\[^{423}\text{Id. at 47,563.}\]
\[^{424}\text{Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates, 73 Fed. Reg. 68,502, 68,550 (Nov. 18, 2008).}\]
\[^{425}\text{Id.}\]
codes.” For example, APC 8000 (cardiac electrophysiologic evaluation and ablation) must have “[a]t least one unit of CPT code 93619 or 93620 and at least one unit of CPT code 93650, 93651 or 93652 on the same date of service.” And APC 8001 (low dose rate prostate brachytherapy) comprises “[o]ne or more units of CPT codes 55875 and 77778 on the same date of service.”

Though providers do not report APCs directly on either the UB-04 or CMS-1500 claim forms, it is still important for providers to perform pre-submission APC grouping to allow revenue-cycle managers to review “revenue, cost, use of services, and identification of areas where efficiency or improvement is needed.” But even after a provider gathers all the data for a claim, more work must be done to prepare the claim for submission to a payer.

vi. Claim Editing, Scrubbing, and Pre-Submission Rework

A key to effective RCM is to submit clean claims to payers and prevent errors from propagating. Most providers perform a series of quality checks just before submitting claims for payment and make necessary changes, or edits. Typically, a provider checks a claim to ensure that its coding staff has coded supplies and services correctly, there are no missing codes, staff appropriately documented medical necessity, and the data on the claim complies with local,
national, or payer-specific rules. When there are problems or questions, this quality check may necessarily involve the medical staff, such as a nurse auditor or other clinician.

In addition, providers should verify demographic and insurance information such as current eligibility for coverage, membership number, policy number, provider number, referring-physician name, subscriber name, dependent name, admission date, discharge date, and the like. Finally, providers should check the consistency of data elements for things such as sex conflicts (a male patient would be unlikely to receive an obstetrical procedure), and age conflicts (a 72-year-old is unlikely to spend time in the neonatal intensive care unit).

The claims editing process can be daunting, expensive, and largely ineffective—denial rates as high as 40% are common. There can be many levels of coding compliance to contend with, including (1) private payer guidelines; (2) local coverage determinations (coverage decisions made by a Medicare fiscal intermediary); (3) national coverage determinations (“a national policy statement granting, limiting, or excluding Medicare coverage for a specific medical item or service”); (4) official coding guidelines; (5) regular coding and payment system updates; (6) Office of Inspector General (OIG) Workplan targeted audits and

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432 *Improving Cash Flow*, supra note 162, at S1.
437 See generally Yale Med. Group, supra note 434, at 1-6 (describing local rules).
440 See generally, e.g., CPT 2011, supra note 289 (describing the proper use of CPT codes).
evaluations;\textsuperscript{441} and (7) the National Correct Coding Initiative (NCCI).\textsuperscript{442} The NCCI is probably the most prominent, and perhaps the simplest, standard for claim editing and its rules are generally referred to as \textit{correct-coding initiative edits} (CCI edits).\textsuperscript{443}

"CMS developed the NCCI to prevent inappropriate payment of services that should not be reported together."\textsuperscript{444} The main components of CCI edits are two tables of procedure codes: (1) the Column One/Column Two Correct Coding Edit Table, and (2) the Mutually Exclusive Edit Table.\textsuperscript{445} Both tables contain HCPCS/CPT codes that should not appear on the same claim for the same date of service.\textsuperscript{446} For example, providers should never report CPT code 70120 (radiologic examination, mastoids; less than three views per side) with CPT code 70130 (radiologic examination, mastoids; complete, minimum of three views per side).\textsuperscript{447}

An additional set of rules embodied by CCI edits includes Medically Unlikely Edits (MUEs).\textsuperscript{448} "An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service."\textsuperscript{449} For example, CPT code 80048 (basic metabolic panel) must not appear with more than two units of service on the same date of service.\textsuperscript{450} Interestingly, though CMS

\textsuperscript{445} Id.
\textsuperscript{446} Id.
\textsuperscript{447} Id. at I-20.
\textsuperscript{448} Id. at I-29.
\textsuperscript{449} Id.
publishes most MUEs, “some MUE values are not published and . . . should not be published in
oral or written form by any party that acquires one or more of them.”451 This proscription,
however, does not prevent a provider from noting denials due to undocumented MUEs and
adding that information to its own proprietary knowledge base.

To help manage this complexity, fifty to sixty percent of providers have implemented
automated claims editing software solutions called *scrubbers* or *code editors*.452 CMS makes
both inpatient and outpatient code editors (from 3M HIS) available for purchase or download.453
But the integrated outpatient code editor CMS provides has limited functionality; it can process
only one claim at a time and is limited to 450 line items.454 This has created a robust market for
third-party scrubbers.455

These third-party claims scrubbers offer a range of functionality that may include: (1) full
billing-system integration; (2) basic demographic scrubbing (e.g., checking that a social security
number is nine digits and is not just a series of repeating digits); (3) procedure and diagnosis
code scrubbing (e.g., identifying code mismatches based on Medicare, CCI edits, or payer-
specific rules); or (4) intelligent scrubbing (e.g., using advanced algorithms and feedback loops
from previously denied claims to identify potential problems—especially helpful with
undocumented MUEs); and (5) timely updates.456

When a provider’s automated scrubber finds a problem with a claim, the scrubber repairs
the claim or puts its submission on hold until coding or clinical staff reviews it and makes

451 NCCI POLICY MANUAL, supra note 444, at I-32.
452 Rhodes, supra note 431, at 62.
454 CTRS. FOR MEDICARE & MEDICAID SERVS., *OUTPATIENT CODE EDITOR (OCE)—OCE BACKGROUND*,
455 E.g., HEALTHTEC SOFTWARE, INC., CLAIMS SCRUBBER, http://www.healthtec-software.com/claims.htm (last
22, 2010).
456 *Don’t Leave Money on the Table*, supra note 430.
necessary corrections. This process can dramatically reduce claim denial and it can have significant side benefits as well—providing feedback to coding staff so they can eliminate errors before they reach the claim scrubber. Employing a claim scrubber not only increases the number of claims a payer accepts upon first submission, it can improve cash flow by reducing overall time to payment—even for claims that fail the scrubber’s first run. Once a provider has properly scrubbed and edited a claim, the pre-claim submission process is complete and the claim is ready to submit to a payer.

B. Claim Submission

So far, this paper has discussed claims mostly in terms of standard UB-04/CMS-1450 and CMS-1500 claim forms. In the past, providers typically printed and mailed paper claims to payers on these forms (or their predecessors), but over the last 25 years that process has given way to electronic-data interchange (EDI) as a means to submit claims to payers. “EDI is the electronic exchange of standardized business documents between what are known as ‘trading partners.’” Because EDI is now so pervasive, this section discusses claim submission primarily in terms of EDI, examining its origins, the evolution of its application in the healthcare field, the current mandated system of standard electronic transaction formats, and the difficulties

457 Dorothy Hattan, Developing the Coder’s Role in Revenue Cycle Management, AHIMA’S 77TH NATIONAL CONVENTION AND EXHIBIT PROCEEDINGS (2005), available at http://library.ahima.org/xpedio/idcplg?IdcService=GET_HIGHLIGHT_INFO&QueryText=%28%22claim+scrubber%22%29%3Cand%3E%28xPublishSite%3Csubstring%3E%60BoK%60%29&SortField=xPubDate&SortOrder=Desc&dDocName=bok3_005641&HighlightType=HtmlHighlight&dWebExtension=hcsp; Improving Cash Flow, supra note 162, at S1.
458 Improving Cash Flow, supra note 162, at S1.
459 Id.
460 E.g., supra Part III(A), infra APPENDICES A-B.
providers face with it today.

i. A Brief History of EDI in Healthcare

The modern history of EDI began during the Berlin airlift after World War II. U.S. Air Force Colonel Ed Guilbert used telex transmissions to help manage the supply flights that landed in West Berlin every three minutes. The ocean, motor, and rail shipping industries as well as the grocery, energy, and retail industries have long since adopted EDI to increase efficiency and reduce costs. But healthcare entities traditionally resisted national standard transaction sets because multiple systems would be affected, compliance costs were prohibitive, payers often had their own complex and incompatible proprietary rules in place, and use of local procedure code sets would have to be shelved for national standard code sets.

In the 1980s, the Health Care Financing Administration (now CMS), defined the UB-92 (the predecessor to the UB-04) Institutional Electronic Media Claims (EMC) format for hospital claims and the Professional EMC National Standard Format (NSF) for physician claims. These were fixed-length formats—each line contained a certain number of characters; data fields appeared at specified locations within each line. The industry never fully accepted these formats, and most trading partners—including Medicare fiscal intermediaries—created unique proprietary variations to satisfy contractual or local rules. So the industry was still without

463 STEVE BASS, LISA MILLER & BRYAN NYLIN, HIPAA COMPLIANCE SOLUTIONS 4 (2002).
464 Id.
465 Id. at 25.
466 Id. at 29.
469 Id.
any real national electronic-claims-transaction standards.

Figure 12. Sample National Standard Format (NSF) Transaction.\(^{470}\)

The electronic standards in use today were a decade in the making.\(^{471}\) The Workgroup for Electronic Data Interchange (WEDI), comprising government and industry leaders and established in 1991, worked with ANSI’s insurance subcommittee (X12N) to develop the ANSI Accredited Standards Committee (ASC) X12 family of healthcare EDI standards.\(^{472}\) WEDI and ANSI designated Washington Publishing Company as the authorized source for standards documents.\(^{473}\) Before HIPAA mandated the current standards, the most widely-accepted standard in the industry was the ANSI X12 ASC version 3051, released in 1996.\(^{474}\) The 3051 version became popular because of its direct correspondence to the paper forms and its ease of

\(^{470}\) i-Plexus Solutions, *Sample NSF*, http://www.iplexus.net/plexus/GettingStarted/SampleNSF.htm (last visited Dec. 22, 2010). Note that the display’s right side is truncated to fit on the page.


\(^{472}\) *Id.*


CMS finally adopted a later ANSI version under HIPAA in 2003.\textsuperscript{476}

ii. HIPAA Mandates National EDI Standards for Healthcare

In 1996, HIPAA required the HHS Secretary to create standard EDI transactions for (1) health claims, (2) health claims attachments, (3) healthcare payment and remittance advice, and (5) health claim status, among other things.\textsuperscript{477} Subsequent regulations require health plans, clearinghouses, and providers that submit EDI transactions to comply with standard transaction specifications; notably, the regulations excluded providers from this requirement.\textsuperscript{478} Though the regulation still allows providers to submit claims on paper or in other electronic formats—and implementing the standards can be difficult and costly—the reasons to adopt the standards are compelling and include reduced claim-management costs, decreased complexity in complying with multiple claim formats and standards, and more automation of traditionally manual tasks.\textsuperscript{479}

For the period between 2003 and 2009, CMS adopted the ANSI ASC X12N 837, version 4010A1, standards for professional (physician) and institutional (hospital) claims.\textsuperscript{480} For the period beginning in 2009, version 5010 is the new CMS standard.\textsuperscript{481} The professional standard (ASC X12N/005010X222) is often referred to as the 837P and the institutional standard (ASC X12N/005010X223) is often referred to as the 837I.\textsuperscript{482} The 837 format comprises looping

\textsuperscript{475} Everett, supra note 25.
\textsuperscript{476} Standards for Health Care Claims or Equivalent Encounter Information Transaction, 45 C.F.R. § 162.1102(a)(3)-(4) (2009).
\textsuperscript{478} Applicability, 45 C.F.R. § 160.102(a) (2009).
\textsuperscript{479} BASS, supra note 463, at 34.
\textsuperscript{480} Id.
\textsuperscript{482} Professional (837), supra note 481, at i; Institutional (837), supra note 481, at i.
structures containing labels, segments, hierarchical levels, and data elements. Unlike its predecessor, NSF, the 837 uses variable-length data fields marked with contextually significant identifiers. For a number of reasons, the healthcare industry did not greet the new standards with much enthusiasm.

iii. Problems with the Transaction Standards

Because trading partners were having difficulty implementing the new standard, Congress delayed, for a year, the original transaction standard compliance deadline of October 16, 2002. Some health-information professionals pointed out that the new standards (1) lacked the clarity of earlier standards such as HL7; (2) failed to closely track the standard claim forms (e.g., UB-04 and CMS-1500) in some cases; and (3) were difficult to implement because

Figure 13. Sample Institutional 837 Claim.

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483 INSTITUTIONAL (837), supra note 481, at 26-27.
484 Id. at 27; see also infra, Figure 13 (showing a sample 837 institutional claim).
485 INSTITUTIONAL (837), supra note 481, at 494.
of inscrutable internal conditional logic.\footnote{Everett, \textit{supra} note 25; BASS, \textit{supra} note 463, at 31.}

For example, the CMS-1500 form contains fields for the patient employer’s name.\footnote{CMS-1500 \textsc{Instructions}, \textit{supra} note 317, at 17.} But while the 837P contains a data segment for the employer identification number, there is no data segment for the employer’s name.\footnote{\textsc{Professional} (837), \textit{supra} note 481, at 94.} To make matters worse, early adopters found it tedious and difficult to reach agreement with trading partners on the meaning of some detailed specifications.\footnote{\textit{See} Everett, \textit{supra} note 25 (discussing use of “the Jamie output”—a complex proprietary electronic claim transmission format used by only one clearinghouse and one of its clients to circumvent having to implement the new transaction standards).} Nonetheless, CMS went forward with the October 16, 2003 compliance deadline.\footnote{Standards for Health Care Claims or Equivalent Encounter Information Transaction, 45 C.F.R. § 162.1102(a) (2009).}


Because HIPAA does not require providers to implement the transaction standards, providers who are unwilling or unable to convert their paper-claim output to the new electronic standards often avoid large up-front conversion costs by employing third-party vendors to convert and transmit their paper claims in electronic form.\footnote{Everett, \textit{supra} note 25.} The process generally involves
what some call a “poor man’s EDI”: the provider prints UB-04 or CMS-1500 claim images to a Portable Document Format (PDF) file and transmits the file to a third-party conversion vendor via e-mail, File Transfer Protocol (FTP), or other method.\textsuperscript{495} The vendor converts the claim images into standard EDI transactions and then sends the claims to the appropriate payer or to a clearinghouse for further routing to a payer or Medicare carrier, fiscal intermediary, or administrative contractor.\textsuperscript{496} Providers using more sophisticated practice-management or billing systems can bypass the conversion step and send HIPAA-compliant transactions directly to payers or clearinghouses for further routing.\textsuperscript{497}

iv. Claim Routing, Rejection, Pendency, and Status

Many payers offer mechanisms to providers for submitting claims directly.\textsuperscript{498} Those mechanisms may include the ability to send multiple electronic claims in one file or stream (in “batches”) by various methods; or the ability to use direct data entry screens hosted on a payer’s website to rekey claims one at a time.\textsuperscript{499} While payers may offer these services at no charge, some industry players recommend using a clearinghouse.\textsuperscript{500} Sending batches containing multiple claims directly from a practice-management or hospital-information system to a clearinghouse is far more efficient than reentering claims one at a time. But there are more than 3,000 payers in the U.S., and hooking up directly with even a small percentage of them could be

\textsuperscript{495} Id.
\textsuperscript{496} Id.
\textsuperscript{497} Id.
\textsuperscript{499} CMS ELECTRONIC HEALTH CARE CLAIMS, supra note 498.
\textsuperscript{500} Beaver Creek Software, supra note 467.
a daunting task. Each payer generally has unique submission requirements and certification procedures that force a provider to modify or update its system.

A clearinghouse usually offers established, working payer connections to providers. A clearinghouse usually offers established, working payer connections to providers. So if a provider uses a clearinghouse, the provider must go through a testing and certification procedure with only one trading partner. Clearinghouses also typically offer additional claim scrubbing, formatting, and conversion services to providers.

One drawback is that clearinghouses charge a monthly, yearly, or per-transaction fee for what many payers provide at no cost. And some payers have, in the past, made exclusive arrangements with a particular clearinghouse that could limit a provider’s clearinghouse choices or force it to use more than one clearinghouse vendor. But after the advent of HIPAA transaction standards, “smaller stealth clearinghouses began to gain momentum by luring away the small providers with better service.” Concurrently, many “providers and payers cut their relationships with large players and learned how to get better service at reduced prices through smaller, nimble regional clearinghouses, which could offer parallel services with lower prices and higher quality.” Because printing and mailing claims costs almost twice as much as sending electronic transactions, the cost of a clearinghouse is easier for health executives to

502 Beaver Creek Software, supra note 467.
503 MPM Soft, supra note 501, at 2; see also emdeon, Payer List, https://access.emdeon.com/PayerLists/ (last visited Dec. 22, 2010) (showing connections to more than 1,000 payers).
504 See MPM Soft, supra note 501, at 2 (asking why a provider might need a clearinghouse); Beaver Creek Software, supra note 467 (asking why a provider might use a clearinghouse).
505 MPM Soft, supra note 501, at 2-3; Beaver Creek Software, supra note 467.
506 Beaver Creek Software, supra note 467.
508 Id.
509 Id.
There are numerous issues revenue-cycle managers must keep in mind when sending electronic claims. First, a clearinghouse or payer may reject an entire batch of claims because a single formatting error causes the batch to violate the HIPAA transaction standards. This situation can result from a technical glitch in either the sender’s or the receiver’s transaction-processing system, thus causing significant delay in payment for a large number of claims.

Second, the provider may have correctly formatted a batch of claims, but the payer may “pend” many claims in the batch—forcing the provider to take further action to get the payer to adjudicate the claims. A clearinghouse or payer may pend a claim because it (1) contains incomplete or incorrect information; (2) is a duplicate of a previously submitted claim; (3) contains invalid or incorrectly formatted data; (4) represents services that are not covered; (5) represents out-of-network or non-par services; (6) is sent to a secondary payer, thus requiring coordination of benefits; (7) represents services that still need coverage determination; or (8) is pended for some other reason.

And third, a provider must be able to properly track claim status and take appropriate action when an unusual event such as rejection or pendency occurs. CMS has adopted the ANSI X12 276 and 277 transaction sets for requesting and receiving claim status information, respectively. Like the 837, a provider may send batches of 276 requests in a single file, and a payer may send multiple 277 responses in a single file.
The 276 and 277 transactions contain data segments that help providers and payers identify the relevant claims using such information as “the payer’s claim number, dates of service, claim amount, type of bill, patient control number,” and the like.\footnote{Id. at 7.} While the status request need only identify the claims of interest, the response includes information about where the claim is in the adjudication process and why.\footnote{Id. at 14-15.}

The response, through the use of status category codes, will tell the provider whether a claim is (1) in the pre-adjudication stage (not yet processed), (2) in the adjudication stage, (3) pended, or (4) finalized (fully adjudicated), among other things.\footnote{Id.} For example, category code A1 acknowledges that the payer received the claim; A2 means the payer accepted the claim and is adjudicating it; P3 means the payer suspended processing until the provider sends more information; and F0 means the payer fully adjudicated the claim.\footnote{Wash. Pub. Co., Claim Status Category Codes - Current, July 1, 2010, available at http://www.wpc-edi.com/content/view/730/1.}

The response may also communicate information about individual services, through status codes, represented on the claim.\footnote{STATUS REQUEST AND RESPONSE (276/277), supra note 517, at 8.} For instance, status code 21 means there was missing or invalid information on the claim (this code must accompany another code that identifies the missing or invalid data).\footnote{Wash. Pub. Co., Health Care Claim Status Codes – Current, July 1, 2010, http://www.wpc-edi.com/content/view/718/1.} Status code 20 means the payer accepted the claim for processing.\footnote{Id.} And status code 102 means the claim is for a newborn, but the payer processed the charges for the newborn as part of the mother’s claim.\footnote{Id.}

For most claims, satisfying the transaction standards’ technical requirements and
successfully submitting the claims is the end of the road. But a certain percentage of such claims still remain in the provider’s work queue because the payer denies payment for all or part of those claims.

C. Claim Reconciliation

A payer may deny payment for services for several reasons, including: a patient’s policy does not cover the service; payment would exceed coverage limits; or, more commonly, because the claim exhibited a coding error or other problem. A provider’s failure to deal with denials effectively could result in a loss of more than 20% of revenue. A claim denial means the provider, the insured, or both could be on the hook for the cost of services to the extent that the payer has adjusted reimbursement for those services. Before determining what course of action to take, it is important to a revenue-cycle manager to sort out those denials that are its responsibility from those that are the insured’s responsibility.

i. Finding Out About Denials

Once a payer has adjudicated a claim, it sends an explanation of benefits (EOB) to the insured listing the “services provided, the amount billed, and the payment made.” Medicare also sends a beneficiary a Medicare Summary Notice that tells the beneficiary what financial responsibility the beneficiary has for the bill. Federal law and regulations require an

526 Claims Receipt and Processing Times, supra note 461, at 4.
527 Id.
528 See supra, Part III(A)(vi) (discussing claim scrubbing and editing).
531 FAZEN, supra note 82, at 96.
532 CMS REMITTANCE ADVICE, supra note 27.
explanation for any denial under an employee benefit plan.\textsuperscript{533} Similarly, the payer sends a payment and remittance advice (RA) to the provider containing like information.\textsuperscript{534}

CMS has adopted the ANSI X12 835 transaction set as the standard transaction for electronic explanation of benefits (EOB) and remittance advice (RA).\textsuperscript{535} But CMS still accommodates a paper remittance advice format.\textsuperscript{536} In addition to providing adjudication information to a provider, a payer can also use the 835 to make a payment to a provider, directly or indirectly, through a depository financial institution (DFI), or to recover overpayment from a provider through an electronic-funds transfer (EFT).\textsuperscript{537}

The RA’s electronic and paper forms explain the reasons for any payment adjustments through a three-tiered reason-code hierarchy.\textsuperscript{538} The top-level code, called a “Claim Adjustment Group Code” (group code) reports whether the payer believes the adjustment amount (1) is the patient’s responsibility (PR), (2) is the provider’s responsibility due to a contractual obligation (CO), (3) is not the patient’s responsibility (PI), or (4) belongs to some other adjustment category (OA).\textsuperscript{539}

The second level in the RA-code hierarchy is a “Claim Adjustment Reason Code” (reason code) that accompanies the group code.\textsuperscript{540} For example, reason code 1 indicates that the payer adjusted the billed amount to account for a deductible; reason code 2 means the payer adjusted the billed amount for coinsurance; and reason code 45 reports that the billed amount

\textsuperscript{534} ASC X12 INS. SUBCOMM., HEALTH CARE CLAIM PAYMENT/ADVICE (835) 3 (2006); CMS REMITTANCE ADVICE, supra note 27. The acronyms EOB and RA are often used interchangeably.
\textsuperscript{535} Standards for Health Care Payment and Remittance Advice Transaction, 45 C.F.R. § 162.1602 (2009).
\textsuperscript{536} CMS REMITTANCE ADVICE, supra note 27.
\textsuperscript{537} HEALTH CARE CLAIM PAYMENT/ADVICE (835), supra note 534, at 3.
\textsuperscript{538} CMS REMITTANCE ADVICE, supra note 27.
\textsuperscript{539} HEALTH CARE CLAIM PAYMENT/ADVICE (835), supra note 534, at 22.
\textsuperscript{540} Id. at 4, 29.
exceeded the amount the applicable fee schedule allows. So a combination of CO45 means
that an amount exceeded the fee-schedule allowable amount and is the provider’s responsibility.
A common combination is CO18, which means the claim was a duplicate.

Finally, the third level in the RA code hierarchy is called the “Remittance Advice
Remark Code” (remark code). Payers use remark codes to report “information about
remittance processing or to provide a supplemental explanation for an adjustment already
described by a Claim Adjustment Reason Code.” Specifically, remark code MA15 means that
the payer split the claim into multiple claims and will send separate RAs for each split claim.

ii. Managing Denials

Denials are usually the result of administrative or clinical problems. Typically, these
problems involve “[i]nadequate information technology (IT), changes in billing and coding
regulations,” or inadequate training. Sometimes a payer denies payment for a service simply
because the payer wants a provider to correct or fill in missing information and resubmit the
claim. But providers must take care to ensure that payers do not view the resubmission as...

541 Id. at 29; Wash. Pub. Co., Claim Adjustment Reason Codes – Current, July 1, 2010, http://www.wpc-
edi.com/content/view/698/1.
542 See Claims Receipt and Processing Times, supra note 461, at 4 (noting that of all claims pended in 2006, 48%
were due to duplicate submissions).
543 HEALTH CARE CLAIM PAYMENT/ADVICE (835), supra note 534, at 36.
edi.com/content/view/742/1.
545 HEALTH CARE CLAIM PAYMENT/ADVICE (835), supra note 534, at 36.
546 MICHAEL NOWICKI, THE FINANCIAL MANAGEMENT OF HOSPITALS AND HEALTHCARE ORGANIZATIONS 200 (3d
ed. 2004).
547 Jackie Hodges, Effective Claims Denial Management Enhances Revenue: Claims Denial Management has
Become a Critical Component of a Hospital's Strategic Effort to Offset the Adverse Impact of Balanced Budget Act
http://findarticles.com/p/articles/mi_m3257/is_8_56/ai_90317285/.
548 DEBORAH VINES ET AL., COMPREHENSIVE HEALTH INSURANCE BILLING, CODING, AND REIMBURSEMENT 465
(2008).
duplicate billing.\textsuperscript{549}

Effective denial management begins when a patient schedules a visit and continues throughout the entire revenue cycle.\textsuperscript{550} First, denial management must focus on prospective efforts to improve charge capture, coding, scrubbing, and editing.\textsuperscript{551} This may involve a multi-department effort, perhaps using a dedicated team, to keep abreast of rule changes, Medicare program memoranda, advisory notices, and compliance programs such as the National Correct Coding Initiative (NCCI).\textsuperscript{552} A continuing-education program is essential to preventing as many denials as possible.\textsuperscript{553} And revenue-cycle managers should develop effective reporting mechanisms that track trends in denials by payer, dollar amount, and reasons for denials.\textsuperscript{554}

Second, denial management must embody an effective process for dealing with claims that payers have already denied.\textsuperscript{555} Providers should focus appeal efforts on “on denials with the greatest likelihood of being reversed.”\textsuperscript{556} Effective technology can be a help in this area and a number of companies have offerings in the denial management arena.\textsuperscript{557} Technology tools are essential because payers have and use them, and providers who do not equip themselves appropriately find themselves at a distinct disadvantage.\textsuperscript{558}

\textbf{iii. Inherent Dangers for Providers}

An inordinate number of denials or specific types of denials could place a provider at risk

\textsuperscript{549} Id.
\textsuperscript{550} Id.
\textsuperscript{551} Id.
\textsuperscript{552} Id.
\textsuperscript{553} Id.
\textsuperscript{554} \textit{Tough Denial Management}, supra note 529.
\textsuperscript{555} Hodges, supra note 547, at 40.
\textsuperscript{556} Id.
of sanctions, lawsuits, or criminal and civil penalties. The Office of the Inspector General (OIG) has identified claims preparation and submission as the largest single risk area for hospitals.\textsuperscript{559} Submitting duplicate claims, unbundling procedures, or intentionally manipulating code assignments to get a larger payment may constitute fraud.\textsuperscript{560} Some problems the OIG has uncovered are (1) billing inpatient procedures on outpatient claims; (2) submitting claims for medically unnecessary services; (3) failing to follow the NCCI; (4) submitting incorrect claims because of outdated chargemasters; (5) circumventing multiple-procedure discount rules; (6) improperly coding for evaluation or observation services; (7) failing to bill (on a single claim) all outpatient services provided to a single patient on a single day; (8) submitting same-day discharges and readmissions; (9) violating post-acute-care-transfer policies; (10) improperly reporting cost-pass-through articles; (11) abusing DRG outlier payments; (12) submitting improper clinical trial claims; (13) using improper organ procurement costs; and (14) filing improper cardiac rehab claims.\textsuperscript{561}

The False Claims Act makes anyone who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval” to the federal government subject to civil penalties.\textsuperscript{562} A person acts knowingly if the person (1) actually knows the claim is false; (2) is deliberately ignorant about the false claim; or (3) acts with reckless disregard about the false claim.\textsuperscript{563} Violations can result in fines of up to $11,000 per occurrence.\textsuperscript{564} Further, the OIG can seek Civil Monetary Penalties (CMPs) under the Civil Monetary Penalties Law for improperly filed or fraudulent claims.\textsuperscript{565} In addition to stiff fines, the government can seek damages of up to

\begin{thebibliography}{9}
\bibitem{560}70 Fed. Reg. at 4,860.
\bibitem{561}Id.
\bibitem{563}§§ 3729(b)(1)(A)(i)-(iii).
\bibitem{564}Adjustments to Penalties, 28 C.F.R. § 85.3(a)(9) (2010).
\bibitem{565}42 U.S.C. § 1320a-7a (2010).
\end{thebibliography}
three times the amount billed and seek to exclude an offending provider from participation in any federal health care programs.\textsuperscript{566} In recent years, the government has recovered billions of dollars in judgments and settlements under the False Claims Act (FCA)—with a large proportion of those dollars coming from the healthcare industry.\textsuperscript{567}

A common danger for providers (physicians in particular) is the practice of \textit{upcoding}—“billing for procedures more complex than were actually performed.”\textsuperscript{568} In litigation involving a psychiatrist, the doctor’s billing office submitted claims requesting reimbursement for 23 patient sessions lasting 45-50 minutes (CPT code 90844) and five sessions lasting 25-30 minutes (CPT code 90483) totaling 21.5 hours of service in one twenty-four-hour period.\textsuperscript{569} The billing office simply assumed that most visits were longer sessions without even consulting the doctor.\textsuperscript{570} The court held that the doctor acted in reckless disregard of the claims’ falsity and found the doctor liable under the False Claims Act.\textsuperscript{571}

Another danger for providers is \textit{unbundling}—splitting individual procedures or services from a standard grouping for billing.\textsuperscript{572} In the early 1990s, SmithKline Beecham Clinical Laboratories, among others, marketed a standard bundle of tests to doctors telling them that the additional tests in the grouping would not increase billings to Medicare or any other public payers.\textsuperscript{573} But the laboratories billed Medicare separately for each test.\textsuperscript{574} In 1996, SmithKline settled an FCA action with the government for an astonishing $295 million.\textsuperscript{575}

\textsuperscript{566} Id.
\textsuperscript{567} Todd P. Photopulos & Graham W. Askew, Having Your Cake and Eating it Too—The (Un)Enforceability of Releases on Future Qui Tam Claims, 1 J. HEALTH & LICE SCI. L. 145, 145 (2008).
\textsuperscript{568} Univ. of Med. & Denistry v. Corrigan, 347 F.3d 57, 61 (3d Cir. 2003).
\textsuperscript{570} Id. at 11.
\textsuperscript{571} Id. at 13-14.
\textsuperscript{572} United States ex rel. Merena v. SmithKline Beecham Corp., 205 F.3d 97, 98 (3d Cir. 2000).
\textsuperscript{573} Id.
\textsuperscript{574} Id.
\textsuperscript{575} Id. at 99.
Providers should be mindful that not only can the government bring a civil action under the False Claims Act, patients and employees can also bring *qui tam* actions as relators and receive a share of any recovery in a successful action.\(^\text{576}\) And it may be almost impossible for providers to block a *qui tam* action under the FCA by entering into a settlement and release with an employee.\(^\text{577}\)

The FCA allows a relator to settle with a defendant if the government decides not to intervene.\(^\text{578}\) But in *United States ex rel. Green v. Northrop Corporation*,\(^\text{579}\) the Ninth Circuit held that if the relator settles with the defendant without the government’s knowledge and consent *before* filing a *qui tam* action under the FCA, the settlement does not prevent the *qui tam* action from going forward.\(^\text{580}\) The plaintiff, Michael Green, originally filed a number of state-court actions in California because, he alleged, Northrop terminated him for bringing information to light regarding double charging the U.S. Air Force.\(^\text{581}\) Northrop and Green agreed to a settlement, and Green signed a release that purported to settle all the matters between them.\(^\text{582}\) But several months later, Green filed a *qui tam* complaint under the FCA alleging that Northrop double billed the government.\(^\text{583}\) After investigating the claim, the government declined to intervene in the suit.\(^\text{584}\)

The district court granted summary judgment to Northrop, holding that the release barred any recovery for Green under the FCA and that because the government had declined to

\(^{577}\) Photopulos, *supra* note 567, at 153.
\(^{579}\) *id.* at 969.
\(^{580}\) *id.* at 956.
\(^{581}\) *id.*
\(^{582}\) *id.*
\(^{583}\) *id.*
\(^{584}\) *id.* at 956-57.
intervene, there were no public policy considerations that required the suit to continue.\textsuperscript{585} But the Ninth Circuit reversed the district court and held that enforcing the release would undermine the FCA’s incentives to encourage insiders to report abuses.\textsuperscript{586}

The Eighth Circuit carved out a narrow exception to the \textit{Northrop} rule. It held that a release is enforceable when a plaintiff fails to list a possible FCA claim as an asset during a bankruptcy proceeding.\textsuperscript{587} In \textit{Gebert}, Transport Administration Services (TAS) terminated Greg Gebert and his wife because it suspected that the Geberts had misappropriated the company’s property.\textsuperscript{588} Ten months later, the Geberts filed for bankruptcy but did not list any possible claims against the company as assets.\textsuperscript{589} The company filed a $506,000 claim against the Geberts and the Geberts countered with a $1.2 million claim against the company in the bankruptcy proceeding.\textsuperscript{590} The parties later settled their claims and the Geberts agreed to release the company “from any and all manner of action, causes of action, claims, debts, demands, damages, liabilities, controversies . . . suits, known or unknown, that the Geberts . . . now have or at any time heretofore had.”\textsuperscript{591} Three years later, the Geberts filed a \textit{qui tam} action under the FCA against TAS alleging that it had filed false information with the Small Business Administration.\textsuperscript{592}

The district court dismissed the Geberts’ complaint and the Eighth Circuit affirmed—holding that the doctrine of judicial estoppel prevented the Geberts from taking inconsistent positions in the same or related litigation.\textsuperscript{593} It determined that the unique situation involving

\begin{itemize}
\item \textsuperscript{585} \textit{Id.} at 957.
\item \textsuperscript{586} \textit{Id.} at 963.
\item \textsuperscript{587} United States \textit{ex rel.} Gebert v. Transport Admin. Servs., 260 F.3d 909, 919 (8th Cir. 2001).
\item \textsuperscript{588} \textit{Id.} at 911-12.
\item \textsuperscript{589} \textit{Id.} at 912.
\item \textsuperscript{590} \textit{Id.}
\item \textsuperscript{591} \textit{Id.}
\item \textsuperscript{592} \textit{Id.}
\item \textsuperscript{593} \textit{Id.} at 917-18.
\end{itemize}
bankruptcy distinguished *Gebert* from *Northrop* because the Geberts were unlikely to receive any benefit, other than perhaps discharging their debt, in the bankruptcy proceeding.\(^594\) This exception is so narrow, it offers little or no help to providers who try to avoid FCA liability by settling with current or former employees.

For more egregious cases, the government can pursue criminal actions for “conspiracy to defraud Medicare and Medicaid, health care fraud, wire fraud and money laundering.”\(^595\) Conviction can result in multi-million dollar fines and long prison sentences.\(^596\) For example, a dermatologist who told patients they had cancer when tests showed they did not was sentenced to more than ten years in prison and ordered to pay $1.475 million in restitution and fines.\(^597\) The doctor had fraudulently upcoded services, performed unnecessary procedures, and improperly billed follow-up visits.\(^598\)

Further, in 2006 Congress authorized a permanent Recovery-Audit Contractor (RAC) program after a three-year demonstration project.\(^599\) The RAC program allows CMS to contract with private auditors to examine Medicare Part A and B claims and recover overpayments on a contingency basis.\(^600\) The initial demonstration project turned out to be a success, recovering $1.03 billion in improper payments that were overwhelmingly the result of medically unnecessary care or coding errors.\(^601\) The Obama administration has set a goal to cut improper

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\(^594\) *Id.* at 917.


\(^596\) *Id.*


\(^598\) *Id.*


\(^600\) *Id.*

Medicare payment in half by 2012.\textsuperscript{602}

Private payers also conduct claim audits involving random samples of claims, or more comprehensive audits that examine every claim for a specific period.\textsuperscript{603} A number of third-party vendors offer retrospective-claim-audit services to insured plans, self-funded plans, and providers.\textsuperscript{604} Some commentators argue that auditing private payments is one of the most important things a hospital can do to guarantee revenue does not go uncollected due to \textit{underpayment}.\textsuperscript{605} But those audits may also uncover \textit{overpayments} that create large risks.\textsuperscript{606} Improper denials often cause underpayments or overpayments.\textsuperscript{607} A retrospective audit can help identify the root causes of denials and help “resolve claims that do get denied.”\textsuperscript{608} So providers should conduct retrospective audits regularly to ensure compliance with public payment systems, identify underpayments, and “protect the organization from disastrous rebooking of revenue if overpayments occur.”\textsuperscript{609} Once a provider identifies improperly denied claims, the procedure for appealing those claims depends on the payer’s identity.

\textit{iv. Appealing Medicare Claims}

Under Medicare, fiscal intermediaries (FIs) or Medicare Administrative Contractors

\textsuperscript{602} Id.
\textsuperscript{605} Abbott & Keller, \textit{supra} note 604, at 107.
\textsuperscript{606} Id.
\textsuperscript{607} Id.
\textsuperscript{608} Id.
\textsuperscript{609} Id.
Entities called “carriers” (private insurance companies under contract with CMS) make initial determinations for Part B (physician services) claims.

Participating providers generally have a right to appeal these initial determinations. In the late 1990s, the OIG reported that denial appeals were successful 50% to 70% of the time. But CMS reported that only 33.3% of RAC appeals were successful during the RAC demonstration project. More than 25 years ago, the Supreme Court held that beneficiaries and providers who appeal denials must exhaust their administrative remedies before turning to the courts. CMS outlines a five-level appeals process for denied claims.

First, a provider may request, on Form CMS-20027, a redetermination from the entity that made the initial determination (a carrier, FI, or MAC) within 120 days of receiving the initial determination. The contractor must complete the redetermination within 60 days.

Second, if the redetermination is unfavorable, the provider may request, on form CMS-20033, a reconsideration from a Qualified Independent Contractor (QIC)—a panel of physicians or other healthcare professionals who conduct an independent review—within 180 days of

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611 Id.
612 Id.
616 Medicare Initial Determinations, Redeterminations and Appeals: General Description, 42 C.F.R. § 405.904(2) (2009); The Medicare Appeals Process, supra note 610, at 2.
receiving the redetermination. The QIC must complete the reconsideration within 60 days.  

Third, if the reconsideration is unfavorable, the provider may request a hearing with an Administrative Law Judge (ALJ) in writing. The provider must make the request within 60 days of receiving the QIC’s reconsideration result and involve an amount in controversy of at least $130. If the QIC met its deadline for finalizing the reconsideration, the ALJ must decide, dismiss, or remand the appeal to the QIC within 90 days. But if the appeal was escalated to a hearing because the QIC failed to make its determination within the 60 days allocated to it, then the ALJ must decide, dismiss, or remand within 180 days. 

Fourth, if the ALJ’s decision is unfavorable, the provider may request review from the Medicare Appeals Council, which reviews an ALJ decision de novo. The provider must file a written request for review within 60 days of the ALJ’s decision. The appeals council may also decide to review an ALJ decision on its own or CMS may refer a case to the council. The council must issue a final decision within 90 days. But like ALJ hearings, regulations extend that period to 180 days if the ALJ failed to make its decision within the proper time. 

Finally, if the provider is still not satisfied, it may appeal the appeals-council decision to

621 § 405.904(2); Request for an ALJ Hearing, 42 C.F.R. § 405.1014(a) (2009).
624 § 405.1016(c).
626 Request for MAC Review when ALJ Issues Decision or Dismissal, 42 C.F.R. § 405.1102 (2009).
627 MAC Reviews on its Own Motion, 42 C.F.R. §§ 405.1110(a)-(b) (2009).
628 § 405.1100(c).
629 § 405.1100(d).
a federal district court within 60 days in most circumstances.\textsuperscript{630} The court must give the administrative findings great weight; it must affirm if substantial evidence supports the findings.\textsuperscript{631} In worst-case circumstances, it could take as long as 27 months to reach a federal judge and a final resolution could take much longer. So it is in a provider’s interests to avoid having to appeal very many claims.

v. Appealing Private Insurance Claims

Many times, a denial or payment adjustment is due to a minor error in a provider’s workflow.\textsuperscript{632} The provider can usually solve the problem with a simple phone call to the payer.\textsuperscript{633} But other situations may require a more formal appeal, such as when the provider (1) fails to get timely authorization because of unusual circumstances; (2) believes reimbursement was inadequate; (3) disagrees with an insurer’s preexisting-condition determination; or (4) believes treatment was affected by a patient’s unusual circumstances.\textsuperscript{634}

The Employee Retirement Income Security Act (ERISA) of 1974 governs claim appeals for all employer-sponsored healthcare plans.\textsuperscript{635} If the employer self-insures the plan, then ERISA preempts any state laws regarding the appeal; the only available appeal process is the one ERISA provides.\textsuperscript{636} But if a commercial payer provides insurance for the plan—a fully-insured employer-sponsored plan—ERISA merely defines the minimum requirements for the claim

\textsuperscript{630} Medicare Initial Determinations, Redeterminations and Appeals: General Description, 42 C.F.R. § 405.904(2) (2009); Effect of MACs Decision, 42 C.F.R. § 405.1130 (2009).
\textsuperscript{631} Judicial Review, 42 C.F.R. § 405.1136(f) (2009).
\textsuperscript{632} VINES ET AL., supra note 548, at 468.
\textsuperscript{633} Id. at 466.
\textsuperscript{634} Id. at 469.
appeal process and state law may impose additional requirements. The contract between the payer and the employer may further augment the appeal process as long as it complies with ERISA’s minimum requirements. ERISA regulations do not apply to individual policies so only state law and the policy’s terms govern the appeal process. The provider can generally pursue a claim appeal on the patient’s behalf if the patient assigns payment to the provider.

For self-insured plans, ERISA § 503 requires a plan to offer a beneficiary a full and fair review for any claim denial. The administrator of an ERISA plan must (1) notify a beneficiary of an adverse claim determination within a reasonable time; (2) state the reasons for the determination; (3) reference the applicable plan provisions; and (4) describe any “additional material or information necessary for the claimant to perfect the claim and [explain] why such material or information is necessary.” After two appeals, a beneficiary can file a civil suit under § 502(a). And a beneficiary need not exhaust all state-law mandated appeals to be able to file suit under ERISA.

For authorization and appeal, ERISA divides claims and services into three categories: (1) urgent care, (2) pre-service, and (3) post-service claims and requests for authorization. For urgent-care claims, a plan’s administrator must make a benefit determination within seventy-two hours. For pre-service claims, the administrator must make the determination within fifteen

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638 29 C.F.R. § 2560.503-1(b).
640 29 C.F.R. § 2560.503-1(b)(4).
642 29 C.F.R. § 2560.503-1.
643 § 2560.503-1(c)(2).
644 § 2560.503-1(k)(2)(ii).
645 § 2560.503-1(f).
646 § 2560.503-1(f)(2)(i).
days. And for post-service claims, the administrator has up to thirty days to make a coverage decision.

ERISA allows patients up to 180 days to appeal adverse benefit determinations. For urgent-care claims, the plan must notify the beneficiary an appeal’s results within seventy-two hours. For pre-service claims, if the plan allows two appeals, the administrator must complete review within fifteen days, but if the plan allows for only one appeal, the administrator must complete the review in thirty days. For post-service claims, if the plan allows two appeals, the administrator must complete review within thirty days, but if the plan allows for only one appeal, the administrator must complete the review in sixty days.

For fully-insured plans or individual policies, a provider may be able to appeal to the state’s insurance agency. Some states require that contracts between payers and provider contain a dispute resolution mechanism that provides “reasonable due process” and a peer review process. And for repeated unjustified denials from a particular payer, many states have a “clean-claim” or “prompt-pay” law that requires insurers to pay compliant claims in full within a specific time (usually 30 to 45 days) or pay significant fines.

Each payer may have its own procedures and policies for conducting appeals, but they usually require the provider to file certain paperwork or send a letter in a timely fashion. If an initial appeal is unsuccessful, a provider may be able to request peer review where “an objective,
unbiased group of physicians determines what payment is adequate for services provided.”657

vi. Coordination of Benefits (COB)

Coordination of benefits (COB) is a procedure used to determine which plan will make what payments when a patient is covered by more than one insurance plan.658 When COB is an issue, it usually arises under one of two main scenarios: (1) more than one private insurance plan covers a particular patient, or (2) a private plan and a public plan cover a particular patient.659 The first COB task is to determine which payer is the “primary payer” and which payer is the “secondary payer.”660 A 2003 survey identified COB as the main reason for claim denials, so an efficient COB process is very important to revenue-cycle management.661 This section discusses COB between two or more private payers in the context of insurance policy provisions and state law and COB when one payer is Medicare.

a. Two or More Private Policies

When a COB issue arises between two private plans, the plan terms and state law generally govern which plan is primary.662 The National Association of Insurance Commissioners (NAIC) maintains a set of Model Rules for COB.663 Most states have adopted

657 Id. at 471.
660 WHO PAYS FIRST, supra note 659, at 5.
663 Id.
the NAIC rules or very similar rules. The NAIC Model Rules permit—but do not require—
plans to adopt COB rules to coordinate payment between multiple insurers to reduce redundant
payment. Another important NAIC Model Rule provision states that the primary insurer must
pay a claim as though the secondary insurer did not exist. But the secondary plan may take
into account payments the primary plan makes. Several states have adopted such
provisions.

As a threshold matter, the NAIC Model Rules consider a plan to be primary if (1) it does
not have COB rules, (2) its COB rules differ from the NAIC Model Rules, or (3) the order-of-
benefit rules make it the primary plan. If the third option applies, then the first applicable
order-of-benefit rule determines which plan is the primary plan.

The NAIC Model Rules contain seven main order-of-benefit rules: (1) nondependent/dependent rule—the primary plan is the one for which the patient is the employee,
member, or subscriber and not a dependent; (2) birthday rule—for dependent children whose
parents are married or are living together and both maintain coverage for the child, the primary
plan is the one that belongs to the parent whose birthday occurs first during a calendar year (and
if the parents have the same birthday, then the plan one parent has had longer is the primary
plan); (3) court-order rule—for a dependent child whose parents are divorced, separated, or do
not live together, if a court decree specifies that one parent is responsible for the child’s
healthcare and the plan has actual knowledge of the court decree, that parent’s plan is the

664 Id.
665 Id.
666 Id.; Sonja Allen, Understanding Coordination of Benefits, AHCINC.COM (2008), available at
667 1 N.Y. COMP. CODES R. & REGS. § 52.23(n)(1) (2010); 2009 COBRA HANDBOOK, supra note 662, at § 14.03;
Allen, supra note 666.
668 E.g., 11 N.Y. COMP. CODES R. & REGS. §§ 52.23(c), (n)(1); 28 TEX. ADMIN. CODE ANN. § 3.3508(a)(1) (West
2010).
669 2009 COBRA HANDBOOK, supra note 662, at § 14.03.
670 Id.
primary plan; (4) no-court-order rule— for a dependent child whose parents are divorced,
separated, or do not live together, if there is no court decree assigning responsibility for the
child’s healthcare to one parent, then the primary plan is (a) the plan belonging to the custodial
parent, if any; (b) the plan belonging to the custodial parent’s spouse, if any; (c) the plan
belonging to the noncustodial parent, if any; or (d) the plan belonging to the noncustodial
parent’s spouse, if any; (5) active/inactive rule—if a plan covers a patient as an active employee
and another plan covers the patient as a retired or laid-off employee, the primary plan is the one
that covers the patient as an active employee; (6) continuation-coverage rule—if a plan covers a
patient as an active employee and continuation coverage such as COBRA also covers the patient,
the primary plan is the plan than covers the patient as an active employee unless one of the plans
does not contain this provision—in which case it is ignored; and (7) length-of-coverage rule—if
no other rules apply, the plan that has covered the patient longer is the primary plan.671 Table 15
depicts these rules in the order a payer should apply them to determine the primary payer.672

<table>
<thead>
<tr>
<th>Rule</th>
<th>Circumstances</th>
<th>Primary Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nondependent / Dependent Rule</td>
<td>Two plans cover the patient, one as a dependent and one as a nondependent. Usually occurs when a spouse’s plan covers the patient as a dependent.</td>
<td>The plan that covers the patient as a nondependent.</td>
</tr>
<tr>
<td>Birthday Rule</td>
<td>The parents are married or live together and have plans that cover a dependent child. The parents’ birthdays are not the same.</td>
<td>The plan that belongs to the parent whose birthday occurs first in a calendar year.</td>
</tr>
<tr>
<td></td>
<td>The parents are married or live together and have plans that cover a dependent child. The parents’ birthdays are the same.</td>
<td>The plan that has covered one parent the longest.</td>
</tr>
</tbody>
</table>

Table 15. NAIC Coordination-of-Benefits Rules.673

Some state law makes certain COB rules void.674 For example, in Texas, any COB term in a plan that limits or reduces the plan’s liability because the patient also has a hospitalization confinement indemnity plan, a plan that covers a specified disease, or a plan that has a limited

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674 TEX. INS. CODE ANN. §§ 1203.002-.003 (West 2010).
benefit is void. And some courts have held that when two plans contain COB provisions that are repugnant to each other, the parties must ignore the conflicting provisions and the plans must act as co-primary plans and pay a pro rata share of benefits.

Unlike primary plans, secondary plans may account for primary plan payments when determining what to pay. The secondary plan may limit its payment to what it normally would have paid less any amounts paid by other plans.

It is one thing for a provider to appropriately apply COB rules to determine the primary payer, but it is another thing entirely for a provider to recognize when it needs to apply the rules. Revenue-cycle managers can take a cue from tests an insurance company uses to determine if there could be a COB issue with a claim including whether: (1) the claim is an inpatient claim; (2) an EOB from another insurance company is attached to the claim; (3) the claim contains information for another insurance company; (4) the patient is sixty-five years old or older; (5) the provider has COB information for other family members on file; or (6) the patient’s last name is different from the plan subscriber’s last name. If any of these conditions exists for a particular claim, a payer may deem it “unclean” and not subject to a state’s prompt-pay laws until the provider or insured provide the necessary information to resolve the issue. But sometimes, a plan’s terms or state law require the plan to pay first and investigate COB

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675 Id.
677 E.g., 28 TEX. ADMIN. CODE. ANN. § 3.3509(a) (West 2010); Allen, supra note 666.
678 § 3.3509(b).
679 See NATIONAL PROVIDER HANDBOOK, supra note 658, at F-2 (describing when to apply COB rules).
681 28 TEX. ADMIN. CODE ANN. § 21.2803(b)(1)(Q) (West 2010); NATIONAL PROVIDER HANDBOOK, supra note 658, at F-2; see also infra, Part III(D)(iii)(b) (describing clean-claim and prompt-payment laws).
issues later. In that case, the plan usually retains a right of recovery in cases where it overpays a claim.

b. Private Coverage and Medicare Coverage

In its original form, Medicare automatically assumed the primary-payer role in any COB situation except when workers’ compensation was responsible for a claim. This state of affairs remained essentially unchanged until Congress passed the Medicare and Medicaid Amendments of 1980 as part of that year’s Omnibus Reconciliation Act. The Act amended section 1862(b) of the Social Security Act with what has become known as the Medicare Secondary Payer Act (MSPA)—an amendment that made Medicare a secondary payer in a number of situations. Congress has expanded the MSPA’s scope several times since 1980.

The MSPA describes certain situations in which a non-Medicare plan may not “take into account” an insured’s Medicare eligibility or enrollment. CMS regulations define “taking into account” to mean that a payer: (1) failed to pay primary benefits its policy requires; (2) offered secondary coverage to a Medicare or Medicare-eligible beneficiary; (3) terminated coverage because a person became eligible for Medicare; (4) terminated large group health plan coverage for a Medicare-eligible disabled member without terminating coverage for similarly situated members who were not eligible for Medicare; (5) imposed certain limitations on Medicare-

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682 28 TEX. ADMIN. CODE ANN. § 21.2809(a) (West 2010); NATIONAL PROVIDER HANDBOOK, supra note 658, at F-2; COORDINATION OF BENEFITS ATTACHMENT A, supra note 680, at 3.
eligible members without imposing the same limitations on members who were not eligible for Medicare; (6) charged higher premiums to Medicare-eligible members; (7) imposed a longer waiting period for the beginning of coverage for Medicare-eligible members; (8) paid providers less for Medicare-eligible member services; (9) used misleading or incomplete information to induce Medicare-eligible individuals not to enroll in an employer plan; or (10) distributed information to beneficiaries and providers to bill Medicare first without considering whether Medicare is a secondary payer. All this is just a very detailed way to say that a primary payer must generally pay a claim as though Medicare did not exist.

The MSPA sets out most rules for determining whether a private payer or Medicare is the primary payer. Many rules hinge on whether the private plan is a group health plan (GHP) or large group health plan (LGHP) as defined in the tax code. The tax code defines a GHP as a health plan—including a self-insured plan—an employer provides or contributes to. And it defines an LGHP the same way except that it applies to employers that normally employ at least 100 employees.

If a patient is entitled to Medicare and belongs to a GHP after retirement or owns a Medigap policy, Medicare is the primary payer. Usually, a private plan requires that the patient belong to both Medicare Part A and Medicare Part B before the private plan will pay as a secondary payer.

If a patient is 65 or older and a GHP covers the patient because the patient or the patient’s

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690. See 2009 COBRA HANDBOOK, supra note 662, at § 14.03 (describing how the NAIC Model Rules require a primary private payer to pay a claim).
691. 42 U.S.C. § 1395y(b).
692. §§ 1395y(b)(1)(A)(v), (B)(iii).
694. § 5000(b)(2).
696. WHO PAYS FIRST, supra note 659, 14-15.
spouse still works for an employer with fewer than twenty employees, Medicare is the primary payer. But if the employer sponsoring the GHP has more than twenty employees, the GHP is the primary payer.

Medicare is the primary payer if an LGHP covers a Medicare-eligible patient because the patient still works or is a dependent on a family member’s policy, the patient is disabled, and the employer (who normally has 100 or more employees) actually has fewer than 100 employees. But if the LGHP sponsor has, in fact, 100 or more employees, the LGHP is the primary payer.

If a GHP—even a retirement plan—or COBRA covers a patient who is eligible for Medicare and the patient has end-stage renal disease (ESRD), the GHP is the primary payer for the first thirty months of Medicare eligibility and Medicare is the primary payer thereafter. But if a patient has COBRA coverage and is 65 or older or disabled, Medicare is the primary payer.

If a no-fault or liability policy covers medical services for an accident, or workers’ compensation covers a job-related illness or injury, then Medicare is the secondary payer for related illnesses and injuries.

And finally, if a patient is entitled to both Medicare and other federal healthcare programs such as veterans’ benefits, the Department of Defense Triple Option managed health care program (TRICARE), or the federal black-lung program, Medicare is usually the primary payer for Medicare-related services and the other federal program is the primary payer for

698 Id.
699 § 1395y(b)(1)(B)(i).
700 Id.
services it covers.\textsuperscript{704} Table 16 contains a quick reference to the Medicare COB rules.\textsuperscript{705}

<table>
<thead>
<tr>
<th>Patient’s Coverage</th>
<th>Circumstances</th>
<th>Primary Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group health retirement plan or Medigap policy</td>
<td>Patient is Medicare eligible and retired</td>
<td>Medicare</td>
</tr>
<tr>
<td>Group health plan through employment or spouse’s</td>
<td>Patient is 65 or older and employer has fewer than 20 employees</td>
<td>Medicare</td>
</tr>
<tr>
<td>employment</td>
<td>Patient is 65 or older and employer has 20 or more employees</td>
<td>Group health plan</td>
</tr>
<tr>
<td>Large group health plan through employment or family</td>
<td>Patient is disabled, entitled to Medicare, and employer has fewer than 100</td>
<td>Medicare</td>
</tr>
<tr>
<td>member’s employment</td>
<td>employees</td>
<td></td>
</tr>
<tr>
<td>Group health plan including retirement plan or COBRA</td>
<td>Patient is disabled, entitled to Medicare, and employer has 100 or more</td>
<td>Large group health plan</td>
</tr>
<tr>
<td></td>
<td>employees</td>
<td></td>
</tr>
<tr>
<td>COBRA</td>
<td>Patient is 65 or older or disabled</td>
<td>Medicare</td>
</tr>
<tr>
<td>No-fault or liability insurance for an accident or</td>
<td>Patient is entitled to Medicare</td>
<td>No-fault, liability,</td>
</tr>
<tr>
<td>workers’ compensation for a job-related illness or</td>
<td></td>
<td>or worker’s compensation for related illness or injury</td>
</tr>
<tr>
<td>injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veteran’s benefits, TRICARE, Black Lung, or most other</td>
<td>Patient is entitled to Medicare</td>
<td>Other federal program</td>
</tr>
<tr>
<td>federal programs</td>
<td></td>
<td>for related benefits</td>
</tr>
</tbody>
</table>

Table 16. Medicare Secondary Payer Rules.\textsuperscript{706}

The MSPA allows Medicare to make conditional payments in certain situations but if it turns out that another payer is primary, that payer must reimburse Medicare appropriately.\textsuperscript{707}

The MSPA also provides mechanisms to gather information—including the authorization to contact employers and payers—to determine whether Medicare is primary or secondary.\textsuperscript{708}

\textsuperscript{704} § 1395y(b)(2)(A); CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE SECONDARY PAYER (MSP) MANUAL CHAPTER 1 – BACKGROUND AND OVERVIEW §§ 10.4, 20 (2009); CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE SECONDARY PAYER (MSP) MANUAL CHAPTER 5 - CONTRACTOR PREPAYMENT PROCESSING REQUIREMENTS § 20.3 (2010).
\textsuperscript{705} Infra, Table 16.
\textsuperscript{707} 42 U.S.C. § 1395y(b)(2)(B).
\textsuperscript{708} §§ 1395y(b)(5)-(6).
facilitate more rapid and accurate secondary-payer determination, CMS provides a Coordination of Benefits Agreement (COBA) to willing payers that allows CMS and those payers to exchange eligibility and claim data electronically.709

The MSPA requires providers to gather specific information to support the COB process with Medicare and provides for a $2,000 penalty per incident when providers “knowingly, willfully, and repeatedly” fail to provide accurate COB information on claims.710 To help providers gather the proper information, CMS provides guidance on questions providers should ask patients.711 These questions include (1) whether the patient has any group coverage related to employment or former employment; (2) how many employees the patient’s employer has; (3) whether the patient has any group coverage related to a spouse’s or other family member’s employment or former employment; (4) how many employees work for the family member’s employer; (5) whether the patient is receiving Black Lung, workers’ compensation, or other government benefits; and (6) whether the patient is receiving treatment for an injury or illness related to an accident covered under automobile or no-fault insurance.712 A good time for these questions in the revenue-cycle process would be during scheduling or registration.

Recent litigation supports the conclusion that the MSPA preempts state law regarding Medicare billing issues. In Speegle v. Harris Methodist Health System,713 a Texas appellate court held that federal law preempted a state law that required providers to timely bill Medicare whenever they were authorized and not recover payments that might be due from Medicare from

710 § 1395y(b)(6).
712 Id.
713 303 S.W.3d 32 (Tex. App.—Fort Worth 2009, pet. denied).
beneficiaries.\textsuperscript{714} In that case, Larry Dean Speegle was injured in a car accident with an employee of SpectraSite Construction, Inc. and received a settlement from the company that included an amount for his medical bills.\textsuperscript{715}

Though Speegle was entitled to Medicare, Harris Methodist Fort Worth secured a hospital lien against Speegle instead of billing Medicare as state law required.\textsuperscript{716} The court noted that the Health Care Financing Administration (HCFA, now CMS) issued a 1995 memorandum where it interpreted the MSPA to allow, but not require, a hospital to bill Medicare for a conditional payment after other sources of payment fail to pay within 120 days.\textsuperscript{717} The court afforded deference to HCFA’s MSPA construction and its resulting regulations, holding that the hospital had a right to maintain its lien against Speegle’s settlement.\textsuperscript{718}

One aspect of the Speegle case that makes it important to revenue-cycle managers is that if the hospital had opted to bill Medicare, it would have had to accept Medicare’s payment—usually a much smaller amount than billed charges—as payment in full and collect only deductibles and copayments from Speegle.\textsuperscript{719} But because the hospital instead pursued compensation from a liability-insurance settlement, it was able to get a lien for the full amount of billed charges.\textsuperscript{720}

The MSPA also creates a private right of action against any primary payer that fails to make a required payment.\textsuperscript{721} But courts have rebuffed attempts to turn this into a \textit{qui tam}
In *Woods*, the plaintiff complained that a Medicare carrier allowed Medicare to pay a medical claim even though Medicare was not the primary payer. The only injury the plaintiff alleged was that he had been hurt by the unnecessary payment as a taxpayer. Citing *Lujan v. Defenders of Wildlife*, the Second Circuit held that the plaintiff lacked standing to sue because his alleged injury “was too generalized and attenuated to constitute an actual injury to himself.” The court held that the MSPA’s private right of action applies only when a “private party has itself suffered an injury, ordinarily because a primary plan has failed to make a required payment to or on behalf of that party.” Therefore, the court said, the MSPA does not create a *qui tam* cause of action in which a private party may sue on the government’s behalf.

In *Stalley*, the plaintiff, Douglas B. Stalley, alleged that “on numerous occasions,” Orlando Regional Healthcare System’s (ORHS) hospitals injured Medicare recipients and billed Medicare for the subsequent treatments instead of footing the bill for the results of its own conduct. Stalley alleged no injury to himself—nor to any other particular person. The Eleventh Circuit ruled that Stalley had no Article III standing to bring suit and analyzed whether the MSPA allowed him to bring suit as a *qui tam* complainant. The court noted a significant distinction between the private right of action the MSPA grants and *qui tam* actions under other federal laws such as the False Claims Act (FCA)—namely, that a plaintiff who sues under the

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723 *Woods*, 574 F.3d at 94-95.
724 *Id.* at 94.
726 *Woods*, 574 F.3d at 96.
727 *Id.* at 100.
728 *Id.* at 100-01.
730 *Id.*
731 *Id.* at 1233.
MSPA, unlike a plaintiff who sues under the FCA, is entitled to the full recovery.\footnote{Id. at 1234.} The court also pointed out that Congress created the private right of action in the same month that it added the \textit{qui tam} cause of action to the FCA, which indicated that Congress did not intend to create an MSPA \textit{qui tam} action.\footnote{Id.}

At least one commentator is very concerned that a recent amendment to the MSPA allowing the government to recover Medicare payments from private tort settlements may prevent such settlements in many cases.\footnote{Rick Swedloff, \textit{Can’t Settle, Can’t Sue: How Congress Stole Tort Remedies from Medicare Beneficiaries}, 41 AKRON L. REV. 557, 606 (2008).} Section 301 of the Medicare Modernization Act of 2003 (MMA) amended the MSPA to allow the government to “bring an action against any or all entities that are or were required or responsible (direct as an insurer or a \textit{self-insurer} . . .) . . . to make payment . . . under a primary plan.”\footnote{Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301, 117 Stat. 2066, 2222 (2003) (codified as amended at 42 U.S.C. § 1395y(b)(2)(B)(iii) (2007)) (emphasis added).} This amendment overturned a number of cases that held that the MSPA did not allow the government to recover against certain settlements because a settling tortfeasor was not “ipso-facto, a ‘self-insurer.’”\footnote{Thompson v. Goetzmann, 337 F.3d 489, 497 (5th Cir. 2003).} Professor Swedloff argues that even if a defendant disclaims any responsibility for a plaintiff’s injuries in a settlement document, the defendant is still liable for Medicare’s conditional payments and the government can recover the conditional payments from a plaintiff who receives a settlement payment.\footnote{Swedloff, \textit{supra} note 734, at 584.} He notes that this creates a disincentive to settle because a defendant automatically becomes liable upon settlement and is, therefore, stripped of its defenses.\footnote{Id. at 606-07.} He argues that a better approach would be for CMS to step into the beneficiary’s shoes and bring independent tort claims against a defendant as the
vii. Accounts Receivable and Write Offs

State law often requires providers, especially hospitals, to file financial reports containing an accurate accounting of charges and receivables. And Medicare requires institutional providers to file annual cost reports that include the hospital’s financial data. For these reasons (and more), accurate accounting is imperative.

Accounts receivable (A/R) for healthcare providers differs from accounts receivable in other businesses because the billed, or gross, charges are almost always substantially different from what providers ultimately collect. A very important benchmark for revenue-cycle performance is the accounts-receivable days—an aggregate average of amounts and lengths of time accounts stay in the receivable state—so it is very important for revenue-cycle managers to know with as much precision as possible what their receivables actually are from moment to moment.

The gross charges for a claim are the total charges documented for the claim. To calculate the receivable for the claim, a provider must deduct certain amounts (called allowances) and any amounts the patient has already paid from the gross charges. Allowances generally belong to one of four categories: (1) charity allowances—discounts the provider gives to indigent patients; (2) courtesy allowances—discounts the provider gives to certain patients

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739 Id. at 607-08 (citing 42 U.S.C. § 1395y(b)(2)(B)(iv) (2007)).
741 42 U.S.C. § 1395g (2010); Financial Data and Reports, 42 C.F.R. § 413.20(b) (2010).
742 WILLIAM O. CLEVERLEY, HANDBOOK OF HEALTH CARE ACCOUNTING & FINANCE 17 (2d ed. 1989).
743 Hammer, supra note 28, at 48.
744 Supra, Part III(A)(iii).
745 CLEVERLEY, supra note 742, at 17.
such as employees, other caregivers, and the clergy; (3) doubtful-account allowances—charges, even heavily discounted ones, that a provider does not expect to collect from a patient; and (4) contractual allowances—discounts given to third-party payers (including public payers) “under contractual agreements.”

The gross receivable for a claim is the gross charges minus any allowances the provider knows about at the time it bills the claim and any amounts the patient already paid. The net receivable is then the gross receivable less the contractual allowance and any amounts the patient still owes.

Calculating a contractual allowance depends on payer claim adjudication. After the provider receives an RA or EOB from a payer showing the amount the payer paid for a claim (the allowable amount), the provider can calculate the contractual allowance by subtracting other allowances, any amounts the patient is responsible for, and the amount the payer remitted from the gross charges. The sum of all the allowances is the amount the provider writes off (or writes down) from the account.

But many providers have the ability to calculate an expected reimbursement (also called the expected amount) for a claim. This allows a provider to more accurately estimate accounts receivable before it receives RAs from payers, which gives the provider an important tool for RCM. Combined with good eligibility and preauthorization processes, the ability to calculate an expected amount allows the provider to know with greater accuracy what the patient and the

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746 TEX. HEALTH & SAFETY CODE ANN. § 311.031(3) (West 2010); CLEVERLEY, supra note 742, at 17.
747 Hammer, supra note 28, at 48; VINES ET AL., supra note 548, at 444-45.
748 Hammer, supra note 28, at 48; VINES ET AL., supra note 548, at 444-45.
749 See CMS REMITTANCE ADVICE, supra note 27 (describing notice of “final claim adjudication and payment information”); Hammer, supra note 28, at 48.
750 VINES ET AL., supra note 548, at 444-45.
751 Id.
753 Hammer, supra note 28, at 48.
payer owe. Even with this capability, the provider still needs to calculate adjustments to its accounts and additional write offs when it receives RAs from payers.

To minimize the need to make these adjustments and to improve account management, providers need good systems for calculating expected amounts. These systems not only help revenue-cycle managers maintain more accurate financials; they can also help with denials, appeals, and underpayment recovery. But a comprehensive process for revenue management still includes a strong patient-collection process.

viii. Patient Collection and Billing

Many revenue-cycle managers regard patient collection and bad-debt reduction as top priorities. A number of authorities stress the need to engage patients early on in the treatment process to improve collection for copayments, coinsurance, deductibles, and services excluded from coverage. Some authorities also suggest that providers who make online information and payment services available to their patients can improve collections.

To collect patient payments up front, a provider must know what the patient will owe after treatment. Generally, the copayment amount is the easiest amount to determine because it

754 See supra Part III(A)(ii) (explaining that eligibility and authorization enable a provider to determine a patient’s financial responsibility in advance).
755 VINES ET AL., supra note 548, at 444-45.
758 Id.
760 Conley, supra note 759.
usually appears on the patient’s insurance card.\textsuperscript{761} The deductible amount is a bit more
problematic, requiring the provider to have good (preferably real-time) eligibility and
authorization processes.\textsuperscript{762} Several factors may affect the deductible, such as an individual
deductible amount, family deductible amount, a yearly maximum out-of-pocket expense, or a
yearly or lifetime limit on coverage.\textsuperscript{763} Good eligibility and authorization processes can also
identify any services the patient’s insurance policy excludes from coverage.\textsuperscript{764} But it is generally
more difficult for the provider to determine the patient’s coinsurance amount because it is
usually a percentage of the payer’s allowed amount.\textsuperscript{765} Some providers have solved this problem
by adopting point-of-service systems that calculate the allowed, or expected, amount (or at least
a reasonable estimate) during the scheduling phase or when the patient presents for treatment.\textsuperscript{766}

These solutions can have an impact on participating providers (providers who contract
with a patient’s insurance company), but they may have little effect when a patient is uninsured,
derunderinsured, or presents at the emergency room of a non-participating provider.\textsuperscript{767} This
problem often occurs in the latter circumstances either because an ambulance brought the patient
there, or because the patient was nearby when the need for emergency care arose.\textsuperscript{768} And even if
the hospital is a participating provider, certain on-call specialists such as radiologists,
anesthesiologists, and pathologists may not be.\textsuperscript{769} As a result, the provider may bill the patient’s
insurance or bill the patient directly for the gross charges; in the case of an uninsured patient, the

\textsuperscript{761} VINES ET AL., supra note 548, at 416, 430-31.
\textsuperscript{762} Supra, Part III(A)(ii).
\textsuperscript{763} VINES ET AL., supra note 548, at 430.
\textsuperscript{764} Supra, Part III(A)(ii).
\textsuperscript{765} VINES ET AL., supra note 548, at 431.
\textsuperscript{766} MedAssets, Patient Liability Estimation, http://www.medassets.com/Our-Solutions/Revenue-
Management/Access-Integrity/Pages/Patient-Liability-Estimation.aspx (last visited Dec. 22, 2010); Patty Enrado,
Colorado Health System Transforms Patient Collection Process, HEALTHCARE FINANCE NEWS, Sept. 15, 2010,
process.
\textsuperscript{767} Lucas & Williams, supra note 16, at 137.
\textsuperscript{768} Id.
\textsuperscript{769} Id.
provider may bill the patient directly for the gross charges; and even if the provider is a participating provider, the payer may limit payment to usual and customary rate (UCR).\footnote{Id. at 138; Vines et al., supra note 548, at 433.} If emergency care is with a non-participating provider, the payer may refuse to pay the gross charges and pay only what it determines to be the UCR.\footnote{Vines et al., supra note 548, at 433.} Some states address this situation by requiring payers to reimburse non-participating providers an amount less than the gross charges, but there is no consistent scheme across these state laws for calculating the proper amount to pay.\footnote{See, e.g., Okla. Stat. tit. 36, § 6571(C) (2010) (requiring the payer to supply the provider with a rationale upon request); Colo. Rev. Stat. § 10-16-704(c) (2010) (requiring the payer to reimburse the lesser of the participating provider rate, UCR, or billed charges); Fla. Stat. § 641.513(5) (2010) (requiring the payer to reimburse the lesser of billed charges, UCR, or some agreed amount); Utah Code Ann. § 31A-22-617(2) (West 2010) (requiring the payer to reimburse at least 75% of the participating provider rate).} This issue has given rise to some arguably unethical payer practices.\footnote{Infra, Part III(D)(iii)(g).}

In any of these cases, the provider may attempt to bill the patient directly for any unpaid balance—this is called “balance billing.”\footnote{Lucas & Williams, supra note 767, at 147; Vines et al., supra note 548, at 433.} Most states prohibit providers from balance billing patients who belong to a plan the provider contracts with—usually called “hold harmless” laws—but do not preclude non-participating providers from doing it.\footnote{Lucas & Williams, supra note 767, at 147 (internal citations omitted).} At least one state prohibits balance billing involving ambulance services; at least one other prohibits balance billing for any service the patient’s policy normally covers; and at least one state prohibits balance billing to any patient enrolled in an HMO.\footnote{Id. at 148 (internal citations omitted).} In most cases, Medicare imposes a fifteen-percent cap on physician balance billing.\footnote{42 U.S.C. § 1395w-4(g)(1)(A)(i) (2010).}

But balance billing for uninsured patients has been even more problematic. Some states have criminalized any provider practice of voluntarily waiving a right to collect copayments and deductibles from a patient—in effect accepting any insurance reimbursement as payment in
full—and courts upheld those statutes.\textsuperscript{778} In Colorado, for example, the legislature viewed this practice as undermining patient’s considered use of healthcare services, thus driving up the cost of healthcare insurance and services.\textsuperscript{779} For that reason, and because of fears of federal antikickback prosecution and Medicare exclusion, providers were unwilling to give discounts to uninsured patients.\textsuperscript{780} They continued to charge uninsured patients as much as six times what an insurer would pay for the same services.\textsuperscript{781}

But in 2004, HHS signaled its approval of uninsured discounts and issued clarifying guidance.\textsuperscript{782} As a result, a number of hospital systems began offering discounts to uninsured patients.\textsuperscript{783} More recently, some states have passed statutes that limit the amount hospitals may charge uninsured patients.\textsuperscript{784} The Illinois Hospital Uninsured Patient Discount Act, passed in 2008, limits yearly collections from an uninsured patient whose income is not greater than 600\% of the federal poverty line to 25\% of the patient’s family income.\textsuperscript{785}

Nonprofit hospitals across the country have an incentive and an obligation to work with patients who have trouble paying their hospital bills.\textsuperscript{786} The challenge for revenue-cycle managers in these hospitals is to maximize collection while fulfilling community-benefit...

\textsuperscript{778} Parrish v. Lamm, 758 P.2d 1356, 1359-60 (Colo. 1988).
\textsuperscript{779} Id. at 1360 n.4.
\textsuperscript{780} Kenneth T. Bowden II, Determining a Reasonable Price for Health Care in the United States: Is This Possible?, 34 A.B.A. BRIEF 26, 29 (2005).
\textsuperscript{781} Id. at 28.
\textsuperscript{783} Bowden II, supra note 780, at 29.
\textsuperscript{784} Ill. Hosp. Uninsured Patient Discount Act of 2008, S.B. 2380 (codified at 210 ILL. COMP. STAT. § 89/10 (2010)).
\textsuperscript{785} Id.
requirements. But federal restrictions and antikickback compliance means that Medicare-accredited hospitals, both for-profit and nonprofit, must at least pursue reasonable collection efforts before federal law allows them to waive any deductibles or copayments.

D. Managed-Care Contracts

Federal and state law and regulation generally govern the relationship between providers and public payers, but contracts govern providers’ relationships with commercial payers. And the predominant form of contracting in today’s healthcare market involves providers contracting with managed-care organizations (MCOs) such as HMOs and PPOs. It is not unusual for a provider, whether it is a hospital or a physician group, to be engaged in hundreds of concurrent contractual relationships with payers or MCOs. Individual physicians typically engage in at least a dozen managed-care contracts at any given time, perhaps more.

An important thing for providers to keep in mind is that they are the sellers of their services and payers (or MCOs) are the buyers. But while hospital system consolidation has improved the negotiating strength of some providers, the market strength of payers and MCOs puts smaller providers, particularly physicians and small practice groups, at a relative disadvantage in negotiating contracts. The AMA and others have made a number of

787 Id.
789 Flowers, supra note 77.
790 Id.
792 BONNEY & SMITH, supra note 203, at 15.
recommendations to providers concerning things to look for in managed-care contracts. But there are also a number of contracting environment aspects providers should consider—not just the contract itself.

When signing a contract with a particular payer or MCO, a provider should consider how other payers and MCOs might react. The provider should also consider whether it can effectively administer the new contract’s terms (e.g., it should examine whether it can calculate an accurate allowed-amount estimate for a claim under the contract). And it should think about whether the contract will attract patients, and in the case of practice groups and hospitals, whether it will help attract doctors. Finally, a provider should take steps to prevent a payer or MCO from shopping around the provider’s proposals and then pressuring the provider for lower rates—a practice that is probably unethical, but happens.

Most managed-care contracts cover at least four major areas: (1) the provider’s responsibilities; (2) the plan or managed-care entity’s responsibilities (plan administration); (3) general provisions, including termination; and (4) the reimbursement terms or fee schedule. This section focuses on key parts in the first three of these areas and addresses acute problem areas for providers including determination of medical necessity, silent PPOs, retrospective audits, dispute resolution, and indemnification. Part IV addresses reimbursement in detail. While there are some differences in provisions between hospital contracts and physician or

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794 See generally, e.g., MODEL MANAGED CARE CONTRACT, supra note 158 (describing recommended terms in managed-care contracts); DeBlasio, supra note 22 (describing key things providers should look for in managed-care contracts).
795 BONNEY & SMITH, supra note 203, at 165.
796 Id.
797 Id. at 91, 165.
798 Id. at 166.
799 See generally, e.g., MODEL MANAGED CARE CONTRACT, supra note 158 (dividing a managed-care contract into eleven major sections); BONNEY & SMITH, supra note 203, at 170-77 (dividing major provisions into nine separate sections); Contract between Hospital and PPO (on file with author) (dividing the contract into four major sections).
800 Infra, Part IV.
physician-group contracts, most provisions are similar or identical.

i. The Provider’s Responsibilities

This section does not attempt to discuss all the provider’s responsibilities under a managed-care contract, but rather certain parts that providers may overlook or that are of particular importance and significance.

a. Quality Assurance and Utilization Review

A managed-care contract usually requires hospitals to maintain and implement a quality-assurance plan and requires both hospitals and physicians to comply with the MCOs utilization-review (UR) procedures. A managed-care contract usually requires hospitals to maintain and implement a quality-assurance plan and requires both hospitals and physicians to comply with the MCOs utilization-review (UR) procedures. It will also likely require providers to make medical records available to the MCO for UR purposes upon request and payment of a reasonably copying fee. Providers should take care to make sure that the contract incorporates the MCO’s UR procedures by reference and that the provider can opt out of any unilateral changes the MCO makes to those procedures. They should ensure that the contract provides for confidentiality of any information given to the MCO as part of UR and that the MCO must comply with internal provider procedures. Further, the contract should provide that qualified physicians make any decisions related to service authorization or denial.

b. “Hold Harmless” Clause and Emergency Services

Another common provision, a “hold harmless” clause, requires the provider to accept the

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801 BONNEY & SMITH, supra note 203, at 270-72; Contract between Hospital and PPO (on file with author).
802 Contract between Hospital and PPO (on file with author).
803 DeBlasio, supra note 22.
804 BONNEY & SMITH, supra note 203, at 270.
805 Id.
contractual allowance as payment in full—that is, the provider may not balance bill the patient. The contract may assign responsibility for eligibility and authorization inquiry to the provider. And it may require the provider to accept a patient for emergency services without regard to whether the patient can afford to pay any copayment, coinsurance, or deductible. But the provider must be sure that the MCO is required to provide answers to eligibility and authorization requests related to emergency treatment within a short time frame, usually twenty-four hours (perhaps by telephone).

c. **Staff Changes**

A managed-care contract usually requires hospitals or practice groups to notify the MCO of any changes to physician membership or privileges. But the provider should make sure the MCO cannot interfere with its credentialing, ability to transfer member providers, or terminate the provider merely because a single member physician fails to meet the agreement’s requirements or obligations.

d. **Timely Claim Filing and Payment**

Usually, a contract specifies a time-limit for filing claims. Some contracts require that a provider submit claims within ninety days of rendering services but others require filing within 180 days. Related provisions typically require payers to submit payment to the provider within thirty days after the payer receives the claim, but the AMA recommends shortening the

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806 Contract between Hospital and PPO (on file with author).
807 DeBlasio, supra note 22.
808 Contract between Hospital and PPO (on file with author).
809 BONNEY & SMITH, supra note 203, at 271; DeBlasio, supra note 22.
810 BONNEY & SMITH, supra note 203, at 262.
811 Id.
812 MODEL MANAGED CARE CONTRACT, supra note 158, at 10.
813 Id.; Contract between Hospital and PPO (on file with author).
payment period to fourteen days if the provider submits claims to the payer electronically (another incentive to use EDI). The contract usually provides instructions on where the provider must send claims and how to code them, although that kind of information may be part of an attached operating manual. In any case, the provider should ensure that the contract prevents the payer from improperly bundling (combining procedure codes while paying for only one) or downcoding (replacing higher-paying procedure codes with similar, lower-paying procedure codes) claims.

**e. Referral**

Some contracts require a provider to refer a patient to another provider if the provider cannot supply optimal treatment. The contract will usually require that the provider refer the patient to another provider that has a contract with the MCO, but the provider should be careful with referrals to affiliated providers to avoid any antikickback issues. Some this section’s suggestions overlap with the MCO’s responsibilities.

**ii. The Managed-Care Organization’s Responsibilities**

Like the previous section, this section does not cover all the MCO’s responsibilities under a managed-care contract. It, too, focuses on provisions that may be very important to providers and does not cover any MCO obligations treated in the previous section.

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814 MODEL MANAGED CARE CONTRACT, supra note 158, at 12-13.
815 Id. at 10-11; Contract between Hospital and PPO (on file with author).
816 MODEL MANAGED CARE CONTRACT, supra note 158, at 10-11, 56.
817 Contract between Hospital and PPO (on file with author); Contract between Practice Group and PPO (on file with author).
818 Everett, supra note 25.
a. **Utilization Review**

Providers should ensure that the contract contains language requiring the MCO to adhere to the hospital’s reasonable internal utilization review procedures, such as a requirement to conduct some reviews on site.\(^{819}\)

b. **Administrative Procedures**

Similar to Medicare, MCOs may prepare an operating manual to describe the administrative procedures the MCO and provider must follow.\(^{820}\) Providers should make sure that this type of document is a contract attachment and that the MCO may not modify it unilaterally—or at least must post notification of any minor modification and receive the provider’s assent, in writing, to any material modification.\(^{821}\)

c. **Benefit Design**

Managed-care contracts frequently require that providers offer “covered services” to the MCO’s members.\(^{822}\) The MCO should provide a comprehensive list of these services—its benefit design—in a schedule or exhibit attached to the contract.\(^{823}\) This list of services can often be a deciding factor in whether a provider agrees to the contract and can have a large impact on the rates a provider negotiates for its services.\(^{824}\) The contract should require adequate

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\(^{819}\) BONNEY & SMITH, *supra* note 203, at 262; Contract between Hospital and PPO (on file with author).

\(^{820}\) Contract between Hospital and PPO (on file with author); Contract between Practice Group and PPO (on file with author); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE MANAGED CARE MANUAL (2010), *available at* http://www.cms.gov/manuals/downloads/mc86c01.pdf (defining operating procedures for Medicare Managed Care);

\(^{821}\) MODEL MANAGED CARE CONTRACT, *supra* note 158, at 17.

\(^{822}\) MODEL MANAGED CARE CONTRACT, *supra* note 158, at 5.

\(^{823}\) *Id.*; BONNEY & SMITH, *supra* note 203, at 172.

\(^{824}\) BONNEY & SMITH, *supra* note 203, at 172.
notice of any changes to benefit design.825

d. **Steerage**

In addition, the MCO generally imposes higher copayment, coinsurance, deductible, and maximum out-of-pocket rates against patients who use non-participating providers.826 This can be a key factor that drives, or steers, patients to participating providers, so it is important that the provider ensures that contract language requires an MCO to enforce copayment, coinsurance, and deductible collection by non-participating providers.827

e. **Assignment of Benefits**

An MCO usually requires its patients (or in the case of a PPO, its payer’s patients) to assign payment to the provider.828 This practice reduces administrative costs and collection activities and guarantees that the provider will be paid at least the amount due from the payer.829

f. **Customer Service**

A managed-care contract usually requires that the MCO provide a customer-service representative during normal business hours and ready access to eligibility and authorization services.830 Providers should consider the quality, availability, and responsiveness of these services and perhaps request a service-level agreement for them.

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825 Id. at 260.
826 Id. at 172.
827 Id.
828 Contract between Hospital and PPO (on file with author); Contract between Practice Group and PPO (on file with author).
829 Everett, supra note 25.
830 BONNEY & SMITH, supra note 203, at 261; MODEL MANAGED CARE CONTRACT, supra note 158, at 6; Contract between Hospital and PPO (on file with author); Contract between Practice Group and PPO (on file with author).
iii. Contracting Dangers for Providers

Managed-care contracts also contain a number of general provisions that can have a dramatic influence on providers and plan performance. A few stipulations are: (1) definitions of key terms such as “medical necessity,” “clean claim,” and “emergency condition”; (2) retrospective audit provisions; (3) dispute resolution provisions; (5) termination and renewal provisions; and (6) provisions that control whether an MCO can sell or rent its network—which can result in silent PPO activity.\(^{831}\)

a. Medical Necessity

Insurers will generally pay only for medically necessary services.\(^{832}\) And some managed-care contracts allow an MCO medical director or physician to determine the standards for medical necessity and to override the treating physician’s judgment—without assuming any legal liability.\(^{833}\)

The AMA and other authorities recommend that managed-care contracts define medical necessity using an objective “prudent physician” standard in conjunction with generally-accepted medical practice standards and clinical appropriateness.\(^{834}\) Providers should be careful that the definition of medical necessity does not include any considerations of cost.\(^{835}\) Some authorities also recommend that the contract contain a clause that prevents the MCO from “intervene[ing] in any manner in the methods or means” of medical care.\(^{836}\)

\(^{831}\) See infra, Part III(D)(iii)(g) (describing silent PPO activity).


\(^{833}\) MODEL MANAGED CARE CONTRACT, supra note 158, at 3.

\(^{834}\) Id.; BONNEY & SMITH, supra note 203, at 259; FAZEN, supra note 82, at 160.

\(^{835}\) MODEL MANAGED CARE CONTRACT, supra note 158, at 3.

\(^{836}\) Id. at 18; BONNEY & SMITH, supra note 203, at 262.
b. **Clean Claim**

Some MCOs delay payment because they allege the provider submitted a claim or claims that were not “clean.” So a manageable definition of a “clean claim” is an important element of a managed-care contract. Some states have passed laws in this area to require that MCOs pay clean claims promptly or suffer penalties. To align the contract with state and federal laws, some authorities recommend using Social Security Act’s definition of a clean claim: “The term ‘clean claim’ means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. . . .” But state laws regarding clean claims have largely been ineffective. Insurance companies have turned clean claim statutes into a shell game—e.g., “insurers have denied payment because the patient’s middle initial is missing.”

To combat this problem, the AMA recommends that providers add a provision to managed-care contracts assessing the payer or MCO with an interest penalty comprising the prime rate plus 3% on claims it should have paid promptly. And some commentators argue that state laws should give state insurance agencies more authority to audit and penalize insurance companies that employ questionable payment practices.

Some states have moved to clarify their clean claim definitions. In 2003, Texas amended its prompt-pay statute with a far more detailed definition of a clean claim than the Social

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837 MODEL MANAGED CARE CONTRACT, supra note 158, at 60.
838 E.g., TEX. INS. CODE ANN. § 843.338 (West 2010); 28 TEX. ADMIN. CODE ANN. § 21.2815 (West 2010); Romero, supra note 655; MODEL MANAGED CARE CONTRACT, supra note 158, at 60.
839 MODEL MANAGED CARE CONTRACT, supra note 158, at 61; BONNEY & SMITH, supra note 203, at 258.
842 Id. at 409.
843 MODEL MANAGED CARE CONTRACT, supra note 158, at 61.
844 Flynn, supra note 717, at 414-15.
Security Act’s definition.\textsuperscript{845} For electronic claims, Texas law defines a clean claim as any electronic claim that complies with federal electronic transaction standards.\textsuperscript{846} For paper claims, the Texas law defines the elements required on a clean claim in terms of CMS-1500 and UB-04 claim forms.\textsuperscript{847} Table 17 shows the data elements the Texas law requires on a physician or non-institutional paper claim to achieve clean-claim compliance\textsuperscript{848} and Table 18 shows the required data elements for institutional claims.\textsuperscript{849}

<table>
<thead>
<tr>
<th>Data Element</th>
<th>CMS-1500 Field</th>
<th>Data Element</th>
<th>CMS-1500 Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber/patient plan ID</td>
<td>1a</td>
<td>Patient name</td>
<td>2</td>
</tr>
<tr>
<td>Patient date of birth and gender</td>
<td>3</td>
<td>Subscriber name if shown on patient’s ID card</td>
<td>4</td>
</tr>
<tr>
<td>Patient address</td>
<td>5</td>
<td>Patient relationship to subscriber</td>
<td>6</td>
</tr>
<tr>
<td>Subscriber address</td>
<td>7</td>
<td>Other insured or enrollee name if patient covered by additional plan</td>
<td>9</td>
</tr>
<tr>
<td>Other insured or enrollee policy/group number if patient covered by additional plan</td>
<td>9a</td>
<td>Other insured or enrollee date of birth if patient covered by additional plan</td>
<td>9b</td>
</tr>
<tr>
<td>Other insured or enrollee plan name if patient covered by additional plan</td>
<td>9c</td>
<td>Other insured or enrollee HMO or insurer name if patient covered by additional plan</td>
<td>9d</td>
</tr>
<tr>
<td>Whether patient’s condition is related to employment, an auto accident, or other accident</td>
<td>10</td>
<td>“D” if the claim is a duplicate or “C” if the claim is corrected</td>
<td>10d</td>
</tr>
<tr>
<td>Subscriber policy number</td>
<td>11</td>
<td>HMO or insurance company name</td>
<td>11c</td>
</tr>
<tr>
<td>Whether the patient is covered by an additional plan</td>
<td>11d</td>
<td>Patient or authorized person’s signature or notation that the provider has the signature on file</td>
<td>12</td>
</tr>
<tr>
<td>Subscriber or authorized person’s signature or notation that the provider has the signature on file</td>
<td>13</td>
<td>Date of injury if due to an accident</td>
<td>14</td>
</tr>
<tr>
<td>Name of referring physician if applicable</td>
<td>17</td>
<td>Referring physician’s ID if applicable</td>
<td>17a</td>
</tr>
<tr>
<td>National provider identifier of referring physician if applicable</td>
<td>17b</td>
<td>Narrative description of procedure if unlisted or unclassified procedure code or an NDC code for drugs</td>
<td>19</td>
</tr>
</tbody>
</table>

\textsuperscript{845} 28 TEX. ADMIN. CODE ANN. § 21.2803 (West 2010).
\textsuperscript{846} § 21.2803(e).
\textsuperscript{847} § 21.2803(b).
\textsuperscript{848} Infra, Table 17.
\textsuperscript{849} Infra, Table 18.
<table>
<thead>
<tr>
<th>Data Element</th>
<th>CMS-1500 Field</th>
<th>Data Element</th>
<th>CMS-1500 Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least one diagnosis code, but up to four are allowed</td>
<td>21</td>
<td>Prior authorization or verification number</td>
<td>23</td>
</tr>
<tr>
<td>Date of service</td>
<td>24A</td>
<td>Place-of-service code</td>
<td>24B</td>
</tr>
<tr>
<td>Procedure/modifier code</td>
<td>24D</td>
<td>Diagnosis code by specific service</td>
<td>24E</td>
</tr>
<tr>
<td>Charge for each listed service</td>
<td>24F</td>
<td>Number of days or units</td>
<td>24G</td>
</tr>
<tr>
<td>National provider identifier for rendering physician</td>
<td>24J</td>
<td>Physician or provider’s federal tax ID</td>
<td>25</td>
</tr>
<tr>
<td>Whether assignment was accepted if Medicare assignment accepted</td>
<td>27</td>
<td>Total charge</td>
<td>28</td>
</tr>
<tr>
<td>Amount paid if an amount has been paid by the patient or subscriber</td>
<td>29</td>
<td>Signature of provider or notation that the signature is on file with the payer</td>
<td>31</td>
</tr>
<tr>
<td>Name and address of facility where services were rendered</td>
<td>32</td>
<td>National provider identifier of facility where services were rendered if applicable</td>
<td>32a</td>
</tr>
<tr>
<td>Physician or provider’s billing name, address, and telephone number</td>
<td>33</td>
<td>National provider identifier of billing provider if applicable</td>
<td>33a</td>
</tr>
<tr>
<td>Provider number if payer requires it and notified providers of the requirement before June 17, 2003</td>
<td>33b</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 17. Texas Clean Claim Data Elements for a Physician or Non-Institutional Claim.\(^{850}\)

<table>
<thead>
<tr>
<th>Data Element</th>
<th>UB-04 Field</th>
<th>Data Element</th>
<th>UB-04 Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider name, address, and telephone number</td>
<td>1</td>
<td>Patient control number</td>
<td>3a</td>
</tr>
<tr>
<td>Type of bill code</td>
<td>4</td>
<td>Provider federal tax ID</td>
<td>5</td>
</tr>
<tr>
<td>Statement period</td>
<td>6</td>
<td>Patient name</td>
<td>8a</td>
</tr>
<tr>
<td>Patient address</td>
<td>9a-9e</td>
<td>Patient date of birth</td>
<td>10</td>
</tr>
<tr>
<td>Patient gender</td>
<td>11</td>
<td>Admission date</td>
<td>12</td>
</tr>
<tr>
<td>Admission hour</td>
<td>13</td>
<td>Type of admission</td>
<td>14</td>
</tr>
<tr>
<td>Source of admission</td>
<td>15</td>
<td>Discharge hour</td>
<td>16</td>
</tr>
<tr>
<td>Discharge status code</td>
<td>17</td>
<td>Condition codes if appropriate</td>
<td>18-28</td>
</tr>
<tr>
<td>Occurrence codes and dates if appropriate</td>
<td>31-34</td>
<td>Occurrence span codes and dates if appropriate</td>
<td>35-36</td>
</tr>
<tr>
<td>Value codes and amounts for inpatient admissions if appropriate</td>
<td>39-41</td>
<td>Revenue code</td>
<td>42</td>
</tr>
<tr>
<td>Revenue code description</td>
<td>43</td>
<td>HCPCS/Rates if Medicare is a primary or secondary payer</td>
<td>44</td>
</tr>
<tr>
<td>Service date</td>
<td>45</td>
<td>Bill submission date</td>
<td>45, line 23</td>
</tr>
<tr>
<td>Units</td>
<td>46</td>
<td>Total charge</td>
<td>47</td>
</tr>
</tbody>
</table>

\(^{850}\) § 21.2803(b)(1).
New York provides very similar requirements via regulation, but not all states are as clear as Texas about what constitutes a clean claim. California requires prompt payment of a “completed claim” but defines such a claim in vague terms:

A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim.

This definition would appear to give payers the leeway to introduce payment delay in the same manner as the Social Security Act’s definition, which allows delay if a claim presents a

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851 § 21.2803(b)(3).
853 CAL. INS. CODE § 10123.47 (West 2010).
854 § 10123.47(c).
“particular circumstance requiring special treatment that prevents timely payment from being made.”855

In the past, there seems to have been some question as to whether providers could sue under prompt-pay laws or similar contractual provisions.856 In Soloman v. U.S. Healthcare Systems of Pennsylvania,857 a neurologist sued Aetna under the Pennsylvania Quality Health Care Accountability and Protection Act for failure to make timely claim payments.858 The Pennsylvania law required payment of clean claims, defined as claims that have “no defect or impropriety,” within forty-five days or the state could impose interest charges of 10%.859 The court agreed that the neurologist was a member of the class of individuals the legislature intended to benefit but held that the violation of a statute resulting in harm to an individual did not “automatically give rise to a private cause of action.”860 The court examined the law’s legislative history and found no intent to create a private right of action.861 And it further reasoned that the presence of an administrative complaint procedure for prompt-pay violations vitiated the need for a private cause of action.862

The Pennsylvania Superior Court’s position was not long-lived. A year after the Soloman case, a federal district court in Pennsylvania came to the opposite conclusion.863 That court held that “it would be absurd to conclude that the . . . legislature wrote such a specific requirement . . . to promptly pay the undisputed, ‘clean claims’ of health care providers, but did not want health

857 Id.
858 Id. at 348.
859 Id. at 352.
860 Id. at 352-53.
861 Id. at 353.
862 Id.
care providers to have the means to be made whole on the underlying claims.\textsuperscript{864}

In 2006, the Florida Supreme Court went even further and ruled that even though Florida’s prompt-pay law did not explicitly create a private right of action, the prompt-pay law was implicitly incorporated into contracts between providers and HMOs.\textsuperscript{865} Westside EKG Associates sued seven HMOs for breach of contract for failing to comply with Florida’s prompt-pay law.\textsuperscript{866} The supreme court held that the contracts between providers and HMOs involved an area of law “surrounded by . . . extensive statutory limitations and requirements” so the prompt-pay provisions of Florida’s HMO Act were implicitly part of every HMO contract.\textsuperscript{867}

More recently, Baylor won a victory in federal court regarding breach of prompt-pay provisions in its contract with a PPO.\textsuperscript{868} Baylor and several of its hospitals agreed to a contract with Private Health Care Systems (PHCS) that contained a Hospital Services Agreement requiring payers to pay claims within forty-five days or lose the negotiated discounts.\textsuperscript{869} Insurers Administrative Corporation (IAC) is a third-party administrator (TPA) that signed a Payor Acknowledgment agreement with PHCS binding IAC to the Hospital Services Agreement.\textsuperscript{870} As a third-party administrator, IAC “receives, reviews, and pays claims on behalf of employers and insurers.”\textsuperscript{871} IAC is not itself an insurer and, at least sometimes, it waits to pay claims until it receives funds from the insurers for whom it administers claims.\textsuperscript{872} Because of this, IAC argued that it was not actually a payer and therefore was not obligated to adhere to the prompt-pay

\textsuperscript{864} Id. at *31.
\textsuperscript{865} Foundation Health v. Westside EKS Assocs., 944 So. 2d 188, 194 (Fla. 2006).
\textsuperscript{866} Id. at 191.
\textsuperscript{867} Id. at 195.
\textsuperscript{869} Id. at *1-2.
\textsuperscript{870} Id. at *1.
\textsuperscript{871} Id.
\textsuperscript{872} Id. at *6.
provisions.873 The court was not convinced.874 Baylor asserted that IAC had breached the contract with regard to four medical claims.875 Baylor submitted the first claim and IAC paid it thirty-five days later.876 Baylor later submitted a corrected claim and IAC paid it twenty days later.877 The court held that IAC did not breach the contract for the first claim because it could not be held liable for paying the correct amount on an incorrect claim.878 Baylor similarly submitted a corrected claim for the second claim, but this time the court held that IAC breached the contract because it delivered payment more than forty-five days after Baylor submitted the corrected claim.879 Finally, the court held that IAC breached the contract regarding the third and fourth claims by waiting longer than forty-five days to pay them because it was waiting until it received funding from its insurers.880

Another formative question about clean-claim laws concerned whether ERISA might preempt them.881 In Baylor University Medical Center v. Arkansas Blue Cross Blue Shield,882 Baylor finalized a contract with Blue Cross Blue Shield of Texas that granted a discount not only to Blue Cross Blue Shield of Texas, but also to any out-of-state Blue-Cross-Blue-Shield insurer—including Arkansas Blue Cross Blue Shield (ABCBS).883 Baylor treated an ABCBS member, Bobby Wall, and submitted a clean claim to ABCBS.884 Baylor later sued ABCBS alleging that (1) ABCBS breached its contract with Baylor because it made only part of the

873 Id. at *5.
874 Id.
875 Id. at *2.
876 Id. at *5.
877 Id.
878 Id.
879 Id.
880 Id.
881 See Baylor Univ. Med. Ctr. v. Ark. Blue Cross Blue Shield, 331 F. Supp. 2d 502, 512 (N.D. Tex. 2004) (denying the plaintiffs’ request for costs because “the nonremovability of [the] case is not so obvious as to warrant an award of costs.”).
882 Id.
883 Id. at 504-05.
884 Id. at 505.
payment the contract required, and (2) ABCBS was liable for the entire gross charges on Wall’s claim because it violated Texas’s prompt-pay law by not paying the claim for more than forty-five days.\textsuperscript{885} ABCBS removed the case to federal court claiming that ERISA preempted Baylor’s claims.\textsuperscript{886}

The federal court first addressed whether ERISA preempted Baylor’s state-law breach-of-contract claim.\textsuperscript{887} The court found that Baylor’s claim was “neither dependent upon nor derived from Wall’s rights to recover benefits under an ERISA plan.”\textsuperscript{888} And the court reasoned that the breach-of-contract claim did “not directly affect of modify” ABCBS’s relationship with its plan participants or beneficiaries.\textsuperscript{889} Therefore, because Baylor’s claims were governed by the contract between Baylor and ABCBS—not the ERISA benefit plan between ABCBS and Wall—the court held that ERISA did not preempt Baylor’s state-law breach-of-contract claim.\textsuperscript{890}

The court then turned to Baylor’s prompt-pay claims.\textsuperscript{891} The court noted that ERISA does not preempt state laws that have only tenuous, remote, or peripheral connections to ERISA plans.\textsuperscript{892} It found that the Texas Insurance Code—not the ERISA plan—was the basis of Baylor’s claim.\textsuperscript{893} The court sternly held that it would “not, in the name of ERISA, insulate an insurer from liability against a third-party health care provider seeking to enforce its rights under a state statute that requires prompt payment of claims.”\textsuperscript{894} The court further held that the case was not removable, though it said that conclusion was not obvious at the outset, and remanded it

\textsuperscript{885} Id.
\textsuperscript{886} Id.
\textsuperscript{887} Id. at 509-10.
\textsuperscript{888} Id. at 509.
\textsuperscript{889} Id.
\textsuperscript{890} Id. at 510.
\textsuperscript{891} Id. at 511-12.
\textsuperscript{892} Id. at 511 (citing Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983)).
\textsuperscript{893} Id. at 512.
\textsuperscript{894} Id. at 511.
to state court.\textsuperscript{895}

In 2005, a New Jersey court granted class certification to providers that alleged that the state’s largest HMO systematically and repeatedly delayed claim payments.\textsuperscript{896} The plaintiffs also alleged that the HMO engaged in improper bundling, downcoding, and refusal to recognize modifiers.\textsuperscript{897} The parties entered into a settlement agreement that the trial court approved after a fairness hearing that involved no testimony.\textsuperscript{898} After certain class members objected to the settlement agreement, the appellate court remanded the agreement to the trial court for a new testimonial fairness hearing so the objectors could cross examine witnesses concerning the settlement’s valuation.\textsuperscript{899} But the importance of this case is not the technical difficulty of reaching an approved settlement; it is the fact that the court, to begin with, certified the case as a class action.

There still seems to be disagreement between some jurisdictions about when a payer can delay payment to request and evaluate additional information about a claim. In \textit{University Hospitals of Cleveland v. South Lorain Merchants Association},\textsuperscript{900} the Sixth Circuit held that the defendant was not liable for a payment delay caused by a calculation error and a subsequent audit.\textsuperscript{901} The contract between the hospital and the payer provided that the payer would not be entitled to a discount if payment took longer than sixty days from receipt of a clean claim—defined as a claim devoid of “any omissions of pertinent information.”\textsuperscript{902} Because of a calculation error, the defendant underpaid a $195,132.98 claim by $14,561.58.\textsuperscript{903} The contract

\begin{itemize}
\item \textsuperscript{895} \textit{Id.} at 512.
\item \textsuperscript{897} \textit{Id.}
\item \textsuperscript{898} \textit{Id.} at 514.
\item \textsuperscript{899} \textit{Id.} at 522.
\item \textsuperscript{900} Univ. Hosps. of Cleveland v. S. Lorain Merchs. Ass’n, 441 F.3d 430 (6th Cir. 2005).
\item \textsuperscript{901} \textit{Id.} at 436.
\item \textsuperscript{902} \textit{Id.} at 435.
\item \textsuperscript{903} \textit{Id.} at 436.
\end{itemize}
between the hospital and the payer allowed for an audit of questionable claims. The hospital contended that the clock for prompt payment began to tick when the payer received a tentative audit-result summary. But the court ruled that the time did not run until the payer received the audit’s final results, and because the payer made the payment within sixty days of receiving those final results, it was still entitled to take the discount.

But in 2003, a Louisiana state appeals court held that merely seeking more information about a claim was not sufficient to delay payment. In early 2000, Minden Medical Center treated Clotiel Houston for a malignant brain tumor. Ms. Houston died not long after her hospitalization and her son, Bobby Ray Parker, attempted to collect on the supplemental cancer policy his mother had with Blue Cross Blue Shield of Louisiana. He engaged in a frustrating back-and-forth with the insurance company for more than four months and eventually filed suit under Louisiana’s prompt-pay law. The Louisiana law required payment within thirty days of proof of claim “unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist.” The court held that even though the payer would have preferred to have the information in a different form, it had sufficient information to pay the claim and therefore no “just and reasonable grounds” existed for delaying payment.

c. Emergency Condition

MCOs have often denied payment for emergency treatment even though all those present

904 Id. at 433.
905 Id. at 435.
906 Id. at 436.
908 Id. at 544.
909 Id. at 545.
910 Id. at 545-46.
911 Id. at 547.
912 Id. at 550.
at the time clearly perceived the situation to be an emergency. The AMA recommends defining an “emergency condition” according to an objective “prudent layperson” standard. So an emergency condition is one in which a prudent layperson having ordinary medical knowledge would expect a provider to treat a patient immediately.

**d. Retrospective Audits, Overpayments, and Offsets**

MCOs may reserve a right to conduct retrospective claim audits—sometimes encompassing several years of claim history. These audits may result in the MCO attempting to recover “overpayments” directly from a provider, or it may use “offsets”—reducing reimbursement on other claims—to recover overpayments. Providers are usually at a disadvantage because MCOs and payers have far more sophisticated systems for examining claims than they.

Providers can turn the table on MCOs and payers by contracting with outside auditors or third-party vendors to monitor payer performance on a continuous basis. The AMA recommends that providers add contract provisions that specifically preclude offsets and overpayment recovery more than ninety days after payment. Failing that, providers should at least try to push through a reasonable limit on the scope of any retrospective audit, such as limiting any audit to no more than one year’s claims. But there is a danger that limiting the scope of an MCO’s overpayment recovery could cause the MCO to demand similar limits on the

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913 MODEL MANAGED CARE CONTRACT, supra note 158, at 3.
914 Id.
915 Id.
916 MODEL MANAGED CARE CONTRACT, supra note 158, at 62.
917 Id.
918 Id.
919 QuadraMed, supra note 756; MedAssets, Reimbursement Integrity, supra note 756.
920 MODEL MANAGED CARE CONTRACT, supra note 158, at 62.
921 BONNEY & SMITH, supra note 203, at 261.
provider’s ability to recover underpayments—another reason it is so important to monitor MCO performance on a continuous basis.\textsuperscript{922}

e. Dispute Resolution

Most providers simply do not have the financial resources to pursue costly litigation if payment issues arise.\textsuperscript{923} And it is a matter of common sense that if a payment dispute involves only a few thousand dollars—an amount that could well be very important to a provider, particularly a solo practitioner or small practice group—a costly court battle is not a cost-effective solution.\textsuperscript{924}

Some authorities recommend that managed-care contracts embody a multi-step approach to resolving disputes with the main goal being to resolve the dispute early through meetings between the parties.\textsuperscript{925} If these initial steps fail, the next step would be to take the dispute to mediation; if that fails, the parties would enter into binding arbitration.\textsuperscript{926} This approach reduces costs for both the MCO and the provider, levels the playing field for the provider, and resolves the matter far more quickly than litigation.\textsuperscript{927}

f. Renewal and Termination

Many managed-care contracts contain evergreen clauses—that is, the contract automatically renews on a yearly basis.\textsuperscript{928} Providers should ensure that any automatic renewal either allows for renegotiation of reimbursement rates or reverts to a favorable blanket

\textsuperscript{922} Flowers, \textit{supra} note 77; Everett, \textit{supra} note 25.
\textsuperscript{923} \textsc{Model Managed Care Contract, supra} note 158, at 28.
\textsuperscript{924} Everett, \textit{supra} note 25.
\textsuperscript{925} \textsc{Model Managed Care Contract, supra} note 156, at 29; \textsc{Bonney & Smith, supra} note 203, at 263.
\textsuperscript{926} \textsc{Model Managed Care Contract, supra} note 158, at 29; \textsc{Bonney & Smith, supra} note 203, at 263.
\textsuperscript{927} \textsc{Model Managed Care Contract, supra} note 158, at 29.
\textsuperscript{928} \textsc{Bonney & Smith, supra} note 203, at 272; \textsc{Model Managed Care Contract, supra} note 158, at 29; Contract between Hospital and PPO (on file with author); Contract between Practice Group and PPO (on file with author).
percentage-of-charge discount at the end of a contract term.929 Also, providers should ensure that reimbursement under any continuation-of-care provisions—terms requiring that the provider continue inpatient treatment when the contract terminates—is based on the usual and customary charge or some other acceptable payment scheme.930

g. Silent PPOs

A silent PPO situation occurs when an MCO sells or rents its PPO network to another MCO or payer in return for a percentage of any resulting discounted payment to a provider.931 Silent PPO reimbursements are very difficult for providers to identify because the only indication of a silent PPO discount is a reference to the discounting PPO on the EOB or RA.932 A similar situation can also arise when a provider has contracted with a PPO that later merges with another PPO.933

The following hypothetical describes a typical, simple silent-PPO situation: (1) Montgomery Scott Hospital contracts with Galactic PPO, giving Galactic a 40% discount off gross charges for emergency cardiac catheter procedures performed on Galactic’s members; (2) Universal PPO has a contract with Leonard McCoy Hospital that gives Universal the same discount for the same procedure; (3) James Kirk, who is enrolled in Galactic PPO (and not Universal PPO), needs an emergency cardiac catheter procedure and Galactic instructs him to go to Montgomery Scott Hospital across town; (4) instead, Kirk goes to the nearest facility, Leonard

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929 BONNEY & SMITH, supra note 203, at 272; MODEL MANAGED CARE CONTRACT, supra note 158, at 29.
930 BONNEY & SMITH, supra note 203, at 264; DeBlasio, supra note 22.
932 MODEL MANAGED CARE CONTRACT, supra note 158, at 40.
McCoy Hospital, which does not have a contract with Galactic; (5) Leonard McCoy Hospital treats Kirk and bills Galactic for out-of-network payment, expecting Galactic to reimburse its usual and customary charge; (6) Galactic contacts a third-party administrator (TPA) or broker and discovers that Universal PPO has a contract with Leonard McCoy Hospital; (7) Universal “sells” Galactic the right to use its discount for a fee—probably a percentage of the 40% savings; (8) Galactic pays Leonard McCoy Hospital 60% of gross charges under Universal’s agreement instead of the hospital’s usual and customary charge; (9) Galactic sends the hospital an EOB or RA listing Universal as the payer; and (10) Galactic instructs Leonard McCoy Hospital to collect any out-of-network deductible amounts owed, instead of a small copayment, from James Kirk.934 Figure 14 illustrates this scenario.935

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934 See MODEL MANAGED CARE CONTRACT, supra note 158, at 40 (describing a silent PPO arrangement between a contracted PPO and a non-participating indemnity insurer as applied to a physician claim).
935 Infra, Figure 14.
Figure 14. Silent PPO: Galactic Takes Universal’s Discount.

More simply stated, a silent PPO situation occurs when a provider sends a claim to a claims administrator (a payer, PPO, broker, or third-party administrator), the administrator shops around for all the PPOs to which the provider belongs, and then picks the one with the lowest reimbursement—even though the patient is not a member of the PPO with the lowest reimbursement.936

936 Id.; Everett, supra note 25.
A number of states have enacted provisions to counter this type of activity.937 But these laws do little good if the managed-care contract contains an “all payors” clause or an open-ended definition of “payors.”938 And recent litigation indicates that it may be very difficult for providers to pursue effective remedies in the courts.939

In Christie Clinic, P.C. v. MultiPlan, Inc., the plaintiff, a professional clinic, filed a class-action suit against MultiPlan, a PPO network, and two payers.940 Christie Clinic signed an agreement with MultiPlan’s PPO network where it agreed to discount its services to network payers in return for a promise that the payers would offer an incentive to its members to use the clinic.941 The clinic alleged that MultiPlan engaged in secret agreements with the payers that allowed the payers to take advantage of the clinic’s discounts, but the payers failed to provide the agreed incentives to their patients because they imposed higher copayments than the clinic’s contract with MultiPlan specified.942 The court examined seventy-seven of MultiPlan’s other contracts and found that none of them contained the same “complementary network client access” provisions.943 As a result, the court held that the clinic’s arrangement with MultiPlan was unique and therefore denied class certification because the clinic had not met its burden to show typicality.944

The plaintiff in Roche v. Zenith Insurance Co. suffered much the same fate.945 Kathleen Roche, a chiropractor, agreed to discounts with First Health’s PPO so that First Health would

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937 E.g., TEX. INS. CODE ANN. § 1301.056 (West 2010); N.C. GEN. STAT. § 58-63-70 (2010).
938 MODEL MANAGED CARE CONTRACT, supra note 158, at 2, 42.
940 Christie Clinic, 2009 WL 175030, at *1.
941 Id.
942 Id. at *1-2.
943 Id. at *7, 9.
944 Id. at *9.
direct patients to her.946 Zenith was a worker’s compensation payer that had contracted to be a payer for First Health.947 In return for access to First Health’s provider network, Zenith agreed to pay First Health a percentage of any savings resulting from First Health’s contracted discounts.948 But Zenith never took any steps to direct patients to Roche or any other First Health provider, though it “expressly agreed to ‘advise’ its claimants as to the identities of [First Health’s] preferred providers and ‘encourage’ claimants to seek treatment from preferred providers.”949 In 2007, Zenith paid Roche for a patient’s claim but took a $160.63 discount and the EOB Zenith sent to Roche contained the language: “A PREFERRED PROVIDER DISCOUNT HAS BEEN TAKEN ON YOUR BILL IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT.”950

Roche first alleged breach of contract, asserting that her contract with First Health and Zenith’s contract with First Health were actually a single, unified contract.951 The court rejected this theory and dismissed the claim because neither agreement expressly incorporated the other.952 Next, the court examined whether Roche was a third-party beneficiary to the payer contract between First Health and Zenith.953 Because Zenith had agreed in the payer contract to advise its members about First Health’s providers and encourage them to use those providers, the court granted Roche leave to amend her complaint to seek relief as a third-party beneficiary.954 But in a later hearing, the court found that in any class action, it would have to hold separate evidentiary hearings for each class member, which could number in the hundreds or

947 Id.
948 Id.
949 Id. at *2, 6.
950 Id. at *2.
951 Id.
952 Id. at *3.
953 Id.
954 Id. at 6-7.
thousands.955 Because of this, the court held that Roche “failed to establish that questions of fact and law common to the class predominate over individual issues” and it denied class certification.956

The rulings denying class certification come as a mortal blow to those seeking to eliminate silent PPO activity through the courts because individual lawsuits over $160.63 discounts make little sense. But courts have at least helped in one regard by allowing claims of fraud, conversion, breach of contract, and Racketeering-Influenced and Corrupt Organizations (RICO) Act violations against a silent PPO payer to proceed when the payer failed to identify itself on EOBs sent to providers and failed to pay the PPO network rental fee.957

Accordingly, there is a continuing effort to get legislators across the country to take decisive action.958 In 2008, the National Conference of Insurance Legislators (NCOIL) proposed a Model Act to govern healthcare-provider-network rentals.959 The NCOIL Model Act changes the current default of allowing network rental unless a network’s contract with a provider specifically prohibits it.960 Instead, it prohibits network rental unless the contract specifically grants it.961 And even if the contract allows network rental, the network must make a current list of all third-party entities that rent the network available to providers.962

956 Id.
960 Id. at § IV(A).
961 Id.
962 Id. at § IV(B).
E. The Future of Revenue-Cycle Management

Revenue-cycle management is a complex, multidisciplinary field that has been changing relatively slowly. But change is almost certain to accelerate dramatically because of two main drivers: (1) healthcare information technology, and (2) healthcare reform. Private industry and government are the major players involved in the coming changes—and the two are inextricably intertwined.

i. Industry Trends

Some commentators suggest that the major trends in revenue-cycle management include focusing on collection from uninsured patients, preparing for new regulatory standards such as ICD-10-CM and ANSI X12 5010 transactions, and merging the goals of RCM with the provider’s overall objectives. To achieve all these goals, it is critical that a provider’s clinical and financial information technology be well-integrated and able to accommodate a process-centered RCM model.

A recent study reported that 60% of healthcare systems surveyed were seriously considering replacing or upgrading their RCM systems within two years. The reasons for this are varied and point to many problems revenue-cycle managers face: (1) differing legacy systems within an organization; (2) differing systems resulting from mergers or acquisitions; (3) the need for better integration with clinical systems; (4) the need to reduce the cost to collect; (5) the need to reduce days in accounts receivable; (6) the need to keep up with regulatory and audit

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963 See, e.g., CDC ICD-10-CM, supra note 266 (noting that it will be thirty-five years between adoption of ICD-9 and ICD-10-CM).
965 Id.; Schneider, supra note 14, at 63.
requirements; (6) the need to update outdated hardware and software; and (7) the desire to improve patient satisfaction.967

The study also asked healthcare vendors what solutions they were planning to adopt; vendors that could provide a comprehensive, sole-source solution were the favorites.968 This approach poses certain risks, however, because many sole-source vendors’ solutions are not mature and may not fulfill certain needs.969 Many times, these single-source systems may not able to check eligibility or automate preauthorization.970 But often, they at least allow providers to manage and model contracts, perform denials management, calculate discounts for uninsured patients, and calculate an insured patient’s complete estimated liability during registration.971

In some cases, a better approach might be to pick a best-in-breed third-party solution because even though fully-integrated products may provide a solution, the solution may be inadequate to meet the provider’s needs.972 Contract management is a particularly important area to providers—calculating the correct reimbursement and making the correct write downs is critical to maximizing revenue from payers and avoiding problems with overpayments and audits.973 Finding an effective contract-management solution may well require a provider to look beyond a single-source vendor.974 The difficulties of using third-party add-on software have decreased in recent years because of more widespread use of standard transaction sets that can

967 HFMA Roundtable, supra note 142, at SS1.
969 Id.
970 Id.
971 Id.
972 See id. (noting that some providers often want greater functionality in single-source vendors’ contract management and modeling solutions).
973 MAXIMIZING CONTRACT REVENUES, supra note 77, at 3-4.
974 Gale, supra note 968, at 80.
easily communicate clinical and claim data between disparate systems.975

But, the barriers to upgrading systems are formidable and can involve a substantial cash outlay, significant training expenses, organizational disruptions, uncertain implementation timelines and implementation expenses, and long payback periods.976 Still, the rewards also can be great. In fact, one administrator reported that adopting a new RCM system reduced his organization’s accounts receivable days by 35 days and significantly improved the organization’s financials.977 Another reported that his hospitals were far better able to collect patient payments up front for elective procedures.978

Importantly, a provider can reduce the cost and burden of implementing a new system—especially a third-party add-on system—by choosing a vendor who offer services via cloud computing (software and information-technology services offered via the internet).979 Services delivered in the cloud tend to require far less investment in infrastructure and offer a pay-as-you-go scheme rather than a large up-front expenditure.980 But because of security, privacy, and ethics issues, providers must be cautious and thorough when selecting a cloud vendor.981

There may be other small avenues providers can pursue to improve their financial performance. One expert has suggested a possible solution to the silent PPO problem: When a provider treats an out-of-network patient, the provider could call the patient’s payer and negotiate a one-off case rate—with a small copayment for the patient—instead of tossing a claim

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975 See, e.g., supra, Part III(B)(ii) (describing healthcare claim transaction sets); supra, Part III(A)(i) (describing HL7 transactions used for clinical data and scheduling).
976 HFMA Roundtable, supra note 142, at SS1.
977 Id.
978 Id.
980 Id. at 285.
981 Id. at 284-85.
into the ether and expecting payment based on UCR.\textsuperscript{982} The disadvantages to this approach are that the negotiated case rate would probably be much less than any anticipated payment based on UCR and the provider’s personnel must spend at least a small amount of time on it.\textsuperscript{983} But the advantages are threefold: (1) the patient would not get stuck with a large bill; (2) the hospital would not have to spend a great deal of time collecting or writing off a bad debt; and (3) if not for the one-off case rate, the payer would probably just take a silent PPO discount anyway, which would likely amount to even less than the one-off case rate.\textsuperscript{984}

Also, hospitals and ambulatory-care facilities that have good eligibility, authorization, and estimated liability processes can use financial counseling calls to patients before registration or service to improve both up-front collections and patient satisfaction.\textsuperscript{985} Finally, hospitals can employ revenue-cycle clinicians (doctors trained in utilization management and patient accounting) to assist in managing authorization, denials, and appeals.\textsuperscript{986}

\textbf{ii. Healthcare Reform}

The Affordable Care Act promises to have a significant effect on RCM in the future. Among other things, it (1) introduces new transaction standards; (2) requires certain appeal procedures for claim or coverage denials; (3) expands Medicaid coverage and increases its reimbursement to physicians; (4) enacts new requirements for nonprofit hospital community-needs assessments; (5) limits nonprofit hospital billing and collection practices; (6) broadens

\textsuperscript{982} Everett, supra note 25.
\textsuperscript{983} Id.
\textsuperscript{984} Id.
liability for Medicare overpayments; (7) requires plans to cover certain preventive services without any copayment; and (8) indirectly affects emergency services and silent PPO activity. And the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 offers incentives to physicians and hospitals to adopt electronic health record (EHR) technology.

a. New Transaction Standards

The Affordable Care Act amends HIPAA to require payers to use new standard transactions that provide for (1) a unique health plan identifier; (2) electronic fund transfers; (3) determining a patient’s eligibility and financial responsibility; (4) “timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals)”; and (5) electronic claims attachments consistent with the ANSI X12 5010 transaction standards. CMS must issue regulations for the unique plan identifier and make those regulations effective not later than October 1, 2012. And it must issue regulations for electronic fund transfers no later than January 1, 2012 to be effective no later than January 1, 2014.

The healthcare industry and the government have sought a national unique health plan identifier for at least a dozen years to help with claim routing. Currently, plan identifiers are a hodgepodge of group codes, plan codes, and payer codes and there is no guarantee of

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990 Id. at § 1104(c)(1), 124 Stat. at 153.
991 Id. at § 1104(c)(2).
This often creates difficulties for providers and clearinghouses who attempt to make sure electronic claims wind up with the correct payer. But the most important function the identifier can serve is to mitigate the silent-PPO problem by identifying exactly which plan paid a claim. Another advantage is that the identifier would allow providers to “to more correctly match encounter information with expected reimbursement.” That, in turn, would allow providers to more closely monitor contract performance, manage receivables, and identify underpayments and overpayments.

New standards for electronic fund transfers and eligibility have been in place for some time and experience widespread use. But paper-based EOBs and RAs still plague the industry—and sometimes providers receive a confusing mix of paper and electronic EOBs and RAs. Similarly, CMS has already adopted standards for claim status transactions. But CMS has not adopted an official standard for acknowledgement transactions, though the industry has used the ANSI X12 997 transaction standard for years to acknowledge receipt of other standard transactions. Washington Publishing Company has published an implementation guide for the ANSI X12 277CA standard that allows payers to acknowledge receipt of claims.

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993 Everett, supra note 25.
994 Id.
996 Id.
997 Id.
999 Kahlich, supra note 355.
1000 74 Fed. Reg. at 3326; see also supra, Part III(B)(iv) (describing the ANSI X12 276 and 277 transaction sets for claim status).
without provider solicitation. And it has published an implementation guide for the ANSI X12 999 transaction set that allows trading partners to report syntactical errors in other transaction submissions. It expects CMS to adopt both of these transaction standards.

Finally, CMS published a proposed rule for electronic-claims attachment transactions in September 2005. CMS intended the standards to facilitate exchange of clinical information that improves claims adjudication. In 1996, HIPAA only encouraged CMS to adopt a standard for electronic-claims attachments—it did not require it—and CMS never issued a final rule. But the Affordable Care Act does require that CMS adopt standard transaction sets for electronic claims attachments no later than January 1, 2012 to be effective no later than January 1, 2014. It is likely that CMS will adopt the standards it proposed in 2005, or something very similar to them, with additions for other scenarios.

b. New Appeal Procedures

The Affordable Care Act requires non-grandfathered group or individual health plans to implement a uniform internal and external appeals process for coverage determinations. The health plan must provide enrollees with notice of the appeals process and appropriate

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1003 Id.
1004 Id.
1006 Id.
1009 Id. at § 10101(g), 124 Stat. at 887-88 (codified at 42 U.S.C. § 300gg-19 (2010)).
The health plan must allow enrollees to “review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the appeals process outcome.” And the plan’s internal appeal procedure must comply with regulations established for ERISA plans.

Further, the health plan must also provide external review in accordance with the Uniform Health Carrier External Review Model Act (Model Act). The Model Act requires an enrollee to exhaust internal review procedures before requesting external review. It provides for expedited review if the normal review procedures “would seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function.” The Model Act requires that only approved independent review organizations conduct the review. And it makes external review binding on all parties except when a party has other remedies under state law. This reform will probably have a positive effect on RCM because it establishes a more uniform appeals process and ensures that providers and patients have to access independent, unbiased coverage-denial review.

Recently, a federal court in California ruled that a hospital could pursue claims against an external review for a third-party administrator’s claim underpayment. In Doctors Medical Center of Modesto v. Global Excel Management, Inc., the hospital treated a foreign citizen in its

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1010 Id. at § 10101(g), 124 Stat. at 887.
1011 Id.
1012 Id. at § 10101(g), 124 Stat. at 887-88; Claims Procedure, 29 C.F.R. § 2560.503-1 (2010).
1014 UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT, supra note, § 7.
1015 Id. at § 9(A)(2)(a).
1016 Id. at § 12.
1017 Id. at § 11.
emergency room and hospitalized the patient for three days.\footnote{Id. at *1.} The hospital sent Global, who was a third-party administrator, a bill for $159,207.21.\footnote{Id. at *2.} Global hired an external reviewer, Maximus, Inc., to evaluate the claim and Maximus recommended that Global pay the hospital $46,404.26 for the emergency treatment and hospitalization.\footnote{Id.} The hospital sued both Global and Maximus to recover the $112,802.95 balance.\footnote{Id.}

Maximus moved to dismiss the case on the ground that it was acting as Global’s agent and therefore could not be held liable for intentional interference with Global’s contractual relations.\footnote{Id. at *3.} The court found that the relationship between Global and Maximus did not look like a typical agency relationship and rejected Maximus’s motion to dismiss on that ground.\footnote{Id. at *5.} But the court held that the hospital failed to show that Maximus acted with malice—“a state of mind arising from hatred or ill will, evidencing a willingness to vex, annoy or injure another person”—and granted summary judgment for Maximus on that ground with leave for the hospital to amend its complaint.\footnote{Id. at *4-5.}

c. Expansion of Medicaid

The Affordable Care Act expands Medicaid coverage to certain individuals under 65 years of age who have an income as high as 133% of the federal poverty line.\footnote{Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001(a), 124 Stat. 119, 271-73 (2010) (codified as amended at 42 U.S.C. § 1396a (2010)).} And states even have an option to extend Medicaid coverage to higher income levels.\footnote{Id. at § 2001(e), 124 Stat. at 278-79.} These extensions

\footnotesize{\begin{itemize}
\item \footnote{Id. at *1.}
\item \footnote{Id. at *2.}
\item \footnote{Id.}
\item \footnote{Id.}
\item \footnote{Id. at *3.}
\item \footnote{Id. at *5.}
\item \footnote{Id. at *4-5.}
\item \footnote{Id. at § 2001(e), 124 Stat. at 278-79.}
\end{itemize}
promise to expand the Medicaid rolls by as many as 16 million people in the next few years.  

Beginning in 2014, the federal government will increase its federal medical assistance percentages (FMAPs) to states to help fund the increase in the number of patients covered under Medicaid. And in 2013 and 2014, primary care physicians with specialties in “family medicine, general internal medicine, or pediatric medicine” will receive reimbursement (for treating Medicaid patients) equal to the reimbursement they would receive under Medicare Part B. To facilitate this, the federal government will compensate the states for any difference between Medicaid and Medicare reimbursement rates. The assumption is that after 2014, the patients taking advantage of expanded Medicaid eligibility will be able to purchase subsidized insurance through a state health-insurance exchange. But these measures may not be enough to stem the current tide of doctors leaving Medicaid programs in states like Texas.

d. Community-Needs Assessments for Nonprofit Hospitals

The Affordable Care Act requires that nonprofit hospitals complete a community-needs assessment and make it publicly available to maintain their non-taxable status. It also requires that nonprofit hospitals make a written financial assistance policy publicly available that includes: (1) criteria for eligibility; (2) details about whether service is free or merely discounted under the policy; (3) the basis for calculating amounts charged; (4) the method for applying for

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1028 Nix, supra note 36; Hassett, supra note 36.
1031 Id. at § 1202(b), 124 Stat. at 1053.
1032 Susan Feigin Harris, Partner, Baker Hostetler, Presentation to Texas Health Law Conference (Oct. 11, 2010).
financial assistance; and (5) collection procedures for nonpayment.\textsuperscript{1035}

Some commentators hope this will increase transparency and accountability and ramp back aggressive collection procedures against uninsured patients.\textsuperscript{1036} The two penalties are severe and should capture the attention of any responsible revenue-cycle manager in a nonprofit setting: (1) the possible loss of tax-exempt status, and (2) a $50,000 excise tax for noncompliance.\textsuperscript{1037} But the Affordable Care Act goes even further to constrain nonprofit hospitals’ collection activities.

e. Limits on Nonprofit Hospital Billing and Collection Practices

The Affordable Care Act prohibits a provider from using gross charges to bill patients who are eligible for financial assistance for “emergency or other medically necessary care.”\textsuperscript{1038} For such patients, it also limits the amount billed to “the amounts generally billed” to patients who have insurance.\textsuperscript{1039} The Act does not define “amounts generally billed,” so this language could create some interpretive challenges. Providers generally “bill” gross charges to patients who have insurance.\textsuperscript{1040} But negotiated rates, or allowed amounts, usually reflect a discount.\textsuperscript{1041} Because the Act specifically prohibits billing gross charges to patients given financial assistance, it is clear that Congress was talking about something other than gross charges.\textsuperscript{1042}

Some experts argue that any of at least three different methods could pass muster: (1) the

\textsuperscript{1035} Id. at § 9007(a), 124 Stat. at 856-57.
\textsuperscript{1038} Id. at § 9007(a), 124 Stat. at 857.
\textsuperscript{1039} Id. at § 10903, 124 Stat. at 1016.
\textsuperscript{1040} See supra, Part III(C)(vi) (noting that gross charges are the total amount of charges on a claim).
\textsuperscript{1041} Id.
\textsuperscript{1042} § 9007(a), 124 Stat. at 857.
lowest negotiated commercial rate; (2) an average of the three lowest commercial rates; or (3) Medicare reimbursement rates.\textsuperscript{1043} But no one can predict. In any case, these provisions stress the need for revenue-cycle managers to have the ability to calculate point-of-service discounts for uninsured or underinsured patients.\textsuperscript{1044}

The Affordable Care Act further prohibits providers from engaging in “extraordinary collection actions” before determining whether a patient is eligible for financial assistance.\textsuperscript{1045} Again, Congress does not define “extraordinary collection actions” but some experts interpret it to mean garnishment, liens, or attachment.\textsuperscript{1046} So providers can avoid problems at the revenue cycle’s end by thoroughly checking—early in the revenue cycle—whether a patient qualifies for financial assistance.

\textbf{f. Liability under the False Claims Act}

Revenue-cycle managers need to pay very special attention to any overpayments they may receive from Medicare or any other federal government payer. Approximately 60\% of the $24 billion the government has recovered under False Claims Act (FCA) cases since 1986 has come from the healthcare sector.\textsuperscript{1047} The Affordable Care Act expands the FCA’s reach and makes it a per se violation for a provider to fail to report and return—within 60 days—any overpayments on claims.\textsuperscript{1048} Further, CMS can suspend payments for any and all other claims “pending an investigation of a credible allegation of fraud.”\textsuperscript{1049} And if that is not enough, the civil penalties for False Claims Act violations can be severe: between $5,000 and $10,000

\begin{footnotes}
\textsuperscript{1043} Harris, \textit{supra} note 1032.
\textsuperscript{1044} See \textit{supra}, Part III(C)(vii) (describing balance billing).
\textsuperscript{1045} § 9007(a), 124 Stat. at 857.
\textsuperscript{1046} Harris, \textit{supra} note 1032.
\textsuperscript{1047} James J. Belanger & Scott M. Bennett, \textit{The Continued Expansion of the False Claims Act}, 4 J. HEALTH & LIFE SCI. L. 26, 27 (2010).
\textsuperscript{1048} § 6402(a), 124 Stat. at 755 (codified at 42 U.S.C. § 1320a-7k (2010)).
\textsuperscript{1049} \textit{Id.} at § 6402(h), 124 Stat. at 760.
\end{footnotes}
(inflation-adjusted) plus three times the claim’s value.\textsuperscript{1050}

Even before Congress passed the Affordable Care Act in 2010, it passed the Fraud Enforcement and Recovery Act (FERA) of 2009 to give the government more tools to root out fraud and abuse in healthcare.\textsuperscript{1051} FERA made retention of any government overpayment a false claim.\textsuperscript{1052} It lowered the standard for materiality, and it made sure that the FCA covered claims submitted to intermediaries.\textsuperscript{1053}

Again, these provisions underscore the need for providers to match the sophistication of their payers—particularly public payers—to be able to identify and deal with overpayments in a timely fashion.\textsuperscript{1054} Under FERA and the Affordable Care Act, providers who submit claims to public payers need the capability to monitor the quality and characteristics of their claims on a continuous basis more than ever before.\textsuperscript{1055}

g. **Preventive Services**

The Affordable Care Act provides that non-grandfathered plans must provide certain preventive services for in-network patients without any cost-sharing (copayments, coinsurance, or deductibles).\textsuperscript{1056} Among these services are: (1) services rated “A” or “B” by the United States Preventive Services Task Force; (2) certain immunizations that the Centers for Disease Control and Prevention recommends; (3) certain preventive care and screening services for infants,

\textsuperscript{1050} 31 U.S.C. § 3729(a) (2006); see also supra, Part III(C)(iii) (describing the False Claims Act’s reach before the Affordable Care Act).
\textsuperscript{1053} §§ 3829(a)(1)(G), (a)(2), (b)(2).
\textsuperscript{1054} See MODEL MANAGED CARE CONTRACT, supra note 158, at 62 (pointing out that physicians are at a disadvantage during a retrospective audit because most payers have “advanced and sophisticated information databases” at their disposal).
\textsuperscript{1055} Supra, Part III(D)(iii)(d).
children, and adolescents that Health Resources and Services Administration guidelines recommend; and (4) preventive care and screening services for women that Health Resources and Services Administration guidelines recommend.1057

Providers might be concerned that this provision could undermine incentives to steer patients to use their services. But because the provider may charge separately for the office visit and the screening service in some situations, copayments may still apply to the office visit (though not the screening procedure).1058 A cholesterol test is an example of a preventive screening service that providers often bill separately from an office visit.1059 And if the office visit’s primary purpose is unrelated to the screening service, the plan may still allow the provider to collect a copayment even if the provider bills the office visit and screening service together.1060

h. Emergency Services

The Affordable Care Act does not alter Emergency Medical Treatment and Active Labor Act (EMTALA) requirements to provide emergency services regardless of ability to pay.1061 But a notable difference is that the Affordable Care Act defines an “emergency medical condition” using a prudent layperson standard—the standard the AMA recommended in 2000 in its Model Managed Care Contract.1062 While this change may seem minor, the Affordable Care Act

1057 Id.
1058 Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726, 41,728 (July 19, 2010).
1059 Id.
1060 Id.
significantly affects payment and collection for emergency services in at least two ways.

First, though EMTALA mandates emergency services, it has no mechanism to ensure payment to providers.\textsuperscript{1063} An underlying assumption about the Affordable Care Act is that it will dramatically expand coverage, thus giving providers some relief for the costs of emergency services.\textsuperscript{1064}

Second, if a qualified plan provides emergency services, it must not require prior authorization for emergency services.\textsuperscript{1065} And if the provider is not in the plan’s network, the plan must impose the same cost-sharing requirements (copayments or coinsurance) on the patient as it would if the provider belonged to its network.\textsuperscript{1066} The Act seems to rule out any possibility of balance billing to out-of-network patients because it strictly limits cost-sharing.\textsuperscript{1067} But it does not say how the plan will pay the provider—leaving open the door to silent-PPO activity.\textsuperscript{1068} So it would seem that providers, and perhaps state legislatures and Congress, still need to pursue solutions to the unauthorized provider-payment discount problem.

\textit{i. The HITECH Act and Health Information Exchanges}

The HITECH Act creates incentives to providers to adopt electronic health record (EHR) technology.\textsuperscript{1069} Physicians receive up to $44,000 in incentives from the federal government over five years if they engage in meaningful use of EHRs.\textsuperscript{1070} Hospitals can get incentive payments

\begin{footnotesize}
\textsuperscript{1063} Harris, \textit{supra} note 1032.
\textsuperscript{1064} \textit{Id.}
\textsuperscript{1065} § 10101(h), 124 Stat. at 888-89.
\textsuperscript{1066} \textit{Id.} § 10101(h), 124 Stat. at 889.
\textsuperscript{1067} \textit{See supra}, Part III(C)(vii) (describing balance billing)
\textsuperscript{1068} \textit{See supra}, Part III(D)(iii)(g) (describing silent PPOs).
\textsuperscript{1070} \textit{Id.} § 4101, 123 Stat. at 468.
\end{footnotesize}
through a complicated formula based on hospital discharges. The major goals of EHR systems are to (1) improve the quality of care; (2) reduce duplicate testing; (3) eliminate avoidable adverse drug events; (4) increase latest clinical research’s availability and use through automated evidence-based guidelines; and (5) to empower patients to take control of their care.

EHR systems usually employ computerized physician order entry (CPOE)—prescribing drugs and scheduling services—and clinical decision support systems. Widespread adoption of EHR systems could potentially eliminate as many as 200,000 adverse drug events and save as much as $1 billion in hospital costs each year. And some estimates show that efficiency savings could top $77 billion per year. The technology also shows potential to help with short-term preventive care and chronic disease management. The improved accuracy, completeness, and efficiency of coding capture using EHR systems could pay big dividends in the revenue cycle. But there is a dark side to EHR systems. They can be very difficult to implement and they can present inadequate user interfaces that cause as many problems as they solve.

The reasons for providers to adopt EHR technology are compelling, but the keys to successful adoption and use include “interoperability and robust information exchange

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1071 Id. § 4102, 123 Stat. at 477-78.
1074 Id. at 1109.
1075 Id. at 1107.
1076 Id. at 1110, 1112-13.
networks,” which must be a cooperative enterprise. 1079 A number of states have begun to develop health-information exchanges (HIEs) in public/private partnerships that allow providers to share patients’ medical records and other information using EHR technology. 1080 The AHRQ recently published positive, but sobering, results from five-year demonstration projects in Colorado, Indiana, Rhode Island, Tennessee, Utah, and Delaware. 1081 The report concluded that it requires a significant amount of time and resource to truly understand the complexity of effective HIEs. 1082 But it maintained that HIEs still possess enormous potential to transform healthcare. 1083

IV. Healthcare Reimbursement

Kill thy physician, and the fee bestow Upon the foul disease. 1084

Some say the Affordable Care Act is merely a subsidy for private insurance—not healthcare reform. 1085 And while much of the Act focuses on insurance, there are several important provisions that deal with the quality of care. 1086 Many of these provisions have a significant impact on public as well as private reimbursement for healthcare services.

To understand how these provisions affect reimbursement, it is important to first

1079 Hillestad et al., supra note 1073, at 1115.
1081 AHRQ PUB. NO. 10-0075-EF, supra note 1080, at 4-2.
1082 Id.
1083 Id.
1084 WILLIAM SHAKESPEARE, KING LEAR act 1, sc. 1.

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understand the major reimbursement systems in place today. Part IV of this paper discusses the
uts and bolts of major reimbursement methodologies that government and commercial
insurance carriers employ.

There are a great many public programs that provide health coverage to various
population segments. These programs include: (1) Medicare Part A—for hospital inpatient and
outpatient facilities, skilled nursing facilities (SNFs), long-term care hospitals (LTCHs),
inpatient rehabilitation facilities (IRFs), and inpatient psychiatric facilities (IPFs); (2) Medicare
Part B—for physician services, ambulatory-care settings, and ambulance services; (3) Medicare
Part C—for the same services as Part A and Part B, using managed-care plans; (4) Medicare Part
D—for prescription drug coverage; (5) Medicaid—a joint federal-state program, administered by
each state—for low-income people and families; (6) Temporary Assistance for Needy Families
(TANF)—a program that provides grants money to states for low-income families; (7) the State
Children’s Health Insurance Program (SCHIP)—for children whose families cannot qualify for
Medicaid but also cannot afford health insurance; (8) TRICARE—for active duty and retires
U.S. armed-forces personnel; (9) the Civilian Health and Medical Program: Veterans
Administration (CHAMPVA)—for spouses, children, and survivors of veterans; (10) the Indian
Health Service (IHS)—health coverage and services for federally-recognized tribe members; and
(11) the Federal Employees’ Compensation Act (FECA)—for federal employees’ work-related
injuries.1087

Part IV does not cover all these programs; rather, it focuses on public reimbursement
methodologies for (1) hospital inpatients under Medicare Part A; (2) hospital outpatients under
Medicare Part A; and (3) physician services and ambulatory surgery under Medicare Part B.
Similarly, Part IV examines private managed-care reimbursement for (1) hospital inpatients; (2)

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hospital outpatients; and (3) physician services (including physician reimbursement for
ambulatory-surgery services). This sets the stage for Part IV to examine industry trends in
reimbursement and the effects of healthcare reform measures on reimbursement.

A. Public Payment

The current public payment system originated in 1953 when President Eisenhower
created the Department of Health, Education, and Welfare (HEW), a cabinet-level
department.\textsuperscript{1088} HEW assumed responsibility for most Federal Security Agency’s (FSA)
regulatory functions, which included the Social Security Administration (SSA).\textsuperscript{1089} In 1965,
President Johnson signed legislation that created the Medicare and Medicaid programs, for
providing government-sponsored health insurance for the elderly and the poor, respectively.\textsuperscript{1090}

The SSA originally administered Medicare and the Social and Rehabilitative Service
(SRS) originally administered Medicaid.\textsuperscript{1091} In 1977, HEW created the Health Care Financing
Administration (HCFA, often pronounced “hick-fuh”) and transferred responsibility for
administering Medicare and Medicaid from the SSA and SRS to the new agency.\textsuperscript{1092} In 1979,
Congress changed the name of HEW to the Department of Health and Human Services
(HHS).\textsuperscript{1093} And in 2001, Secretary Thompson changed HCFA’s name to the Centers for

\textsuperscript{1089} Id. § 8.
sections of 42 U.S.C.).
\textsuperscript{1091} Id.; Ctrs. for Medicare & Medicaid Servs., \textit{Key Milestones in Medicare and Medicaid History, Selected Years:
1&datefilterinterval=&filtertype=data&datafiltertype=3&datafiltervalue=2005+Winter&keyword=&intNumPerPage
=10&cmdFilterList=Show+Items \textit{[hereinafter Milestones]}
\textsuperscript{1092} Id.
§ 3508 (2010)).
CMS administers the Medicare program today and is responsible for creating regulations that govern claim adjudication for Medicare Part A and Part B.

This section addresses the prospective payment systems (PPS) for Medicare Part A inpatient (IPPS) and outpatient services (OPPS) as well as physician reimbursement under Medicare Part B.

i. Medicare Hospital Inpatient Reimbursement

In 1972, Congress (dissatisfied with the results of fee-for-service) charged HEW (now HHS) to create prospective-payment system demonstration projects for Medicare Part A inpatient payment. The demonstration projects followed four guiding principles: (1) the payment rates were established in advance; (2) payment did not depend on the actual cost of services (not based on charges); (3) CMS considered any payment as payment in full (no balance billing); and (4) the hospital retained any payment in excess of cost and absorbed any shortfall. As part of this program, New Jersey initiated a payment system based on diagnosis-related groups (DRGs) in 1980.

Based on the New Jersey project’s success and other demonstrations, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which amended Title XVIII of the Social Security Act to require that Medicare pay for hospital-inpatient services on a

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1094 Milestones, supra note 1091, at 3.
1095 Id.
1097 CASTO & LAYMAN, supra note 11, at 102.
prospective basis. In 1983, Congress adopted the New Jersey DRG model as Medicare’s new prospective-payment system for hospital inpatient services.

Payment under the Medicare IPPS depends on a number of elements. The most important of these elements is the Medicare-Severity DRG (MS-DRG) code that CMS assigns to a claim. Medicare’s payment to a hospital for the claim then depends on (1) a base-payment rate adjusted for wages and geographic factors; (2) a capital base-payment rate; (3) a relative case-mix weight associated with the DRG code on the claim; (4) the hospital’s direct expenses related to graduate medical education; (5) the hospital’s indirect expenses related to graduate medical education; (6) the hospital’s treatment of a large number of low-income patients; (7) whether the treatment employed new technology; (8) whether the treatment involved unusually high costs (high cost outliers); and (9) whether the hospital transferred the patient to another facility before completing treatment (low length-of-stay reductions). Once CMS determines the value or state of each of these elements, it can calculate a final payment for a claim.

a. Base-Payment Rates

To calculate the MS-DRG reimbursement amount for a claim, CMS first needs to know the base-payment rates for a hospital. These include an operating base-payment rate and a capital base-payment rate.

CMS calculates a “national adjusted operating standardized amount” for each fiscal
year—applicable to all hospitals—and publishes it in the Federal Register.\textsuperscript{1104} The initial standard-operating amount, first calculated for FY 1984, was based on Medicare cost reports from hospitals for the prior cost-reporting period.\textsuperscript{1105} Since 1984, CMS has updated the standard-operating amount using a market-basket index established by its Office of the Actuary (OACT).\textsuperscript{1106} A market-basket index is a factor that expresses “how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in a base period.”\textsuperscript{1107} OACT calculates market-basket indexes using Medicare cost reports that providers submit to CMS on a yearly basis.\textsuperscript{1108} Beginning in FY 2011, CMS must use the market-basket index less 0.25 percentage points.\textsuperscript{1109}

Since 2006, CMS has actually calculated two different standard-operating amounts. The Deficit Reduction Act of 2005 required CMS to reduce—by two percentage points—the market-basket index used to update the standard-operating amount for hospitals that do not supply CMS with quality-reporting data.\textsuperscript{1110} Consequently, for FY 2011, the market-basket update for hospitals that supply quality-reporting data is 2.35\% (the full update) and the market-basket update for hospitals that do not supply quality-reporting data is 0.35\% (the reduced update).\textsuperscript{1111} As a result, the full-update standard-operating amount for FY 2011 is $5,164.11 and the reduced-

\textsuperscript{1104} Federal Rates for Inpatient Operating Costs for Federal Fiscal Year 2005 and Subsequent Fiscal Years, 42 C.F.R. § 412.64 (2009); Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Final Rule, 75 Fed. Reg. 50,041, 50,451 (Aug. 16, 2010).
\textsuperscript{1106} Federal Rates for Inpatient Operating Costs for Federal Fiscal Years 1984 through 2004, 42 C.F.R. § 412.63 (2009); § 412.64.
\textsuperscript{1108} Id. at 4.
\textsuperscript{1109} 42 C.F.R. § 412.64(d)(ii)(B).
\textsuperscript{1111} 75 Fed. Reg. at 50,451.
update standard-operating amount for FY 2011 is $5,063.21.\textsuperscript{1112}

CMS further divides the standard-operating amounts into two components: (1) the labor-related portion, and (2) the nonlabor-related portion.\textsuperscript{1113} CMS allocates the labor and nonlabor portions according to wage indexes based on “relative differences in labor costs among geographic areas.”\textsuperscript{1114} If the wage index for a particular hospital is greater than 1.0, the standard-operating amount’s labor-related portion is 68.8% and the nonlabor-related portion is the remaining 31.2%.\textsuperscript{1115} If the wage index for the hospital is less than or equal to 1.0, the standard-operating amount’s labor-related portion is 62% and the nonlabor-related portion is the remaining 38%.\textsuperscript{1116} CMS publishes these allocations in the Federal Register each year in Final Rule’s Table 1A and Table 1B.\textsuperscript{1117} Table 19 depicts the standard-operating amount’s breakdown according to the labor and nonlabor portions and the wage index threshold for FY 2011.\textsuperscript{1118}

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<td>Labor-Related</td>
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Table 19. Standard-operating amounts for FY 2011.\textsuperscript{1119}

CMS publishes the wage index for each hospital by provider number in Final Rule Table 2.\textsuperscript{1120} The CMS website also contains a downloadable file that contains provider numbers

\textsuperscript{1112} Id.
\textsuperscript{1113} Id. at 50,179, 50,451.
\textsuperscript{1114} Id.
\textsuperscript{1115} Id.
\textsuperscript{1116} Id.
\textsuperscript{1117} Id.
\textsuperscript{1118} Infra, Table 19.
\textsuperscript{1119} 75 Fed. Reg. at 50,451. Final Rule Table 1C lists operating amounts CMS uses for hospitals in Puerto Rico. Id.
\textsuperscript{1120} Id. at 50,179, 50,451.
indexed by hospital name. Alternatively, CMS publishes wage index information for urban hospitals in Final Rule Table 4A and for rural hospitals in Final Rule Table 4B.

To calculate the *operating base-payment rate* for a hospital: (1) determine whether the hospital qualifies for the full update standard-operating amount based on reporting the necessary quality data to CMS; (2) determine the wage index for the hospital from Final Rule Table 2, Table 4A, or Table 4B; (3) select the appropriate labor-related amount from Final Rule Table 1A or Table 1B; (4) multiply the hospital’s wage index by the labor-related amount to get the *adjusted labor-related amount*; (5) select the appropriate nonlabor-related amount from Final Rule Table 1A or 1B; (6) add the adjusted labor-related amount to the nonlabor-related amount to get the final operating base-payment rate. The operating base-payment rate is augmented further or changed for low-volume, sole-community, and Medicare-dependent hospitals.

\[
\text{Operating Base-Payment Rate} = (\text{Labor-Related Amount} \times \text{Hospital Wage Index}) + \text{Nonlabor-Related Amount}
\]

**Figure 15. Operating Base-Payment Rate Calculation.**

The second major IPPS reimbursement component is the *capital base-payment rate*. CMS publishes a capital standard federal-payment rate each year in Table 1D of its Final Rule for the Medicare IPPS. The capital standard federal-payment rate for FY 2011 is $420.01. CMS also publishes capital-geographic-adjustment factors (GAFs) for urban areas in Table 4A.

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1122 75 Fed. Reg. at 50,511, 50,516.
1123 Id. at 50,433. For hospitals in Alaska and Hawaii, CMS multiplies the nonlabor-related amount by a cost-of-living-adjustment factor before adding it to the adjusted labor-related amount. Id.
1124 75 Fed. Reg. at 50,433.
1125 Id.
1126 CMS IPPS, supra note 1102, at 4.
1128 Id.
and rural areas in Final Rule Table 4B.\textsuperscript{1129} To calculate the capital base-payment rate for a hospital (1) determine the appropriate GAF for the hospital from Final Rule Table 4A or Table 4B, and (2) multiply the capital standard federal-payment rate by the GAF.\textsuperscript{1130}

$$\textit{Capital Base-Payment Rate} = \left( \text{Capital Standard Federal-Payment Rate} \times \text{Capital Geographic Adjustment Factor} \right)$$

\textbf{Figure 16. Capital Base-Payment Rate Calculation.}\textsuperscript{1131}

Consider Leonard McCoy Hospital as an example and assume that it provides CMS with quality-reporting data. Also assume that the hospital is equivalent to Abilene Regional Medical Center (provider number 450558). The wage index from Final Rule Table 4A for Abilene, Texas is 0.8377.\textsuperscript{1132} Because the wage index is less than or equal to 1.0 and because the hospital is entitled to the full-update amount, the appropriate labor-related amount, $3,201.75, comes from the first column of Final Rule Table 1B.\textsuperscript{1133} Therefore the adjusted labor-related amount is $3,201.75 \times 0.8377 = 2,682.11. The appropriate nonlabor-related amount from Final Rule Table 1B is $1,932.06 so the operating base-payment amount is $2,682.11 + $1,932.06 = $4,614.17.\textsuperscript{1134} The appropriate GAF for the hospital from Final Rule Table 4A is 0.8858.\textsuperscript{1135} And the capital standard-federal-payment rate for FY 2011 from Final Rule Table 1D is $420.01.\textsuperscript{1136} Thus, the capital base-payment rate for the hospital is $420.01 \times 0.8858 = $372.04.\textsuperscript{1137}

\textsuperscript{1129} Id. at 50,511, 50,516.
\textsuperscript{1130} Payment Based on the Federal Rate, 42 C.F.R. § 412.312 (2009).
\textsuperscript{1131} Id. Again, for hospitals in Alaska and Hawaii, CMS applies a cost-of-living adjustment to the calculation. Id.
\textsuperscript{1132} 75 Fed. Reg. at 50,511.
\textsuperscript{1133} Id. at 50,451; supra, Table 19.
\textsuperscript{1134} 75 Fed. Reg. at 50,451; supra, Table 19.
\textsuperscript{1135} 75 Fed. Reg. at 50,511.
\textsuperscript{1136} Id. at 50,451.
\textsuperscript{1137} 42 C.F.R. § 412.312.
b. Relative Case-Mix MS-DRG Weight

For each MS-DRG, CMS assigns a weight that expresses the relative hospital costs and resource usage associated with a particular MS-DRG compared to the costs and resource usage associated with all the other MS-DRGs—a relative case-mix methodology.\textsuperscript{1138} To determine reimbursement, CMS multiplies the MS-DRG weight for a claim’s MS-DRG by the hospital’s operating base-payment rate and capital base-payment rate.\textsuperscript{1139} CMS publishes a list of updated MS-DRG weights in Table 5 of its Final Rule each fiscal year.\textsuperscript{1140} Table 20 lists some common MS-DRG codes along with their weights.\textsuperscript{1141}

<table>
<thead>
<tr>
<th>MS-DRG Code</th>
<th>Description</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>163</td>
<td>Major chest procedures w MCC</td>
<td>5.0828</td>
</tr>
<tr>
<td>165</td>
<td>Major chest procedures w/o CC/MCC</td>
<td>1.7758</td>
</tr>
<tr>
<td>193</td>
<td>Simple pneumonia &amp; pleurisy w MCC</td>
<td>1.4796</td>
</tr>
<tr>
<td>194</td>
<td>Simple pneumonia &amp; pleurisy w CC</td>
<td>1.0152</td>
</tr>
<tr>
<td>195</td>
<td>Simple pneumonia &amp; pleurisy w/o CC/MCC</td>
<td>0.7096</td>
</tr>
<tr>
<td>246</td>
<td>Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents</td>
<td>3.1802</td>
</tr>
<tr>
<td>247</td>
<td>Perc cardiovasc proc w drug-eluting stent w/o MCC</td>
<td>1.9691</td>
</tr>
<tr>
<td>248</td>
<td>Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents</td>
<td>2.9248</td>
</tr>
<tr>
<td>249</td>
<td>Perc cardiovasc proc w non-drug-eluting stent w/o MCC</td>
<td>1.7732</td>
</tr>
<tr>
<td>391</td>
<td>Esophagitis, gastroent &amp; misc digest disorders w MCC</td>
<td>1.1550</td>
</tr>
</tbody>
</table>

\textsuperscript{1138} DRG Classification and Weighting Factors, 42 C.F.R. § 412.60 (2010); CASTO & LAYMAN, supra note 11, at 103.

\textsuperscript{1139} 75 Fed. Reg. at 50,433; § 412.312(a).

\textsuperscript{1140} 75 Fed. Reg. at 50,547.

\textsuperscript{1141} Infra, Table 20.
<table>
<thead>
<tr>
<th>MS-DRG Code</th>
<th>Description</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>392</td>
<td>Esophagitis, gastroent &amp; misc digest disorders w/o MCC</td>
<td>0.7173</td>
</tr>
<tr>
<td>469</td>
<td>Major joint replacement or reattachment of lower extremity w MCC</td>
<td>3.4724</td>
</tr>
<tr>
<td>470</td>
<td>Major joint replacement or reattachment of lower extremity w/o MCC</td>
<td>2.1039</td>
</tr>
<tr>
<td>689</td>
<td>Kidney &amp; urinary tract infections w MCC</td>
<td>1.2185</td>
</tr>
<tr>
<td>690</td>
<td>Kidney &amp; urinary tract infections w/o MCC</td>
<td>0.7864</td>
</tr>
</tbody>
</table>

Table 20. Example MS-DRG Codes, Descriptions, and Weights.\(^{1142}\)

Note that the groups that involve complication or comorbidity (marked “w CC” or “w MCC”) have substantially larger weights, which results in substantially higher reimbursement.\(^ {1143}\) Returning to the McCoy Hospital example: MS-DRG 163 (a case involving a major complication or comorbidity) would result in an operating payment of $4,614.17 X 5.0828 = $23,452.90 and a capital payment of $372.04 X 5.0828 = $1,891.00. But a similar case with no complication or comorbidity, MS-DRG 165, would result in an operating payment of $4,614.17 X 1.7758 = $8,193.84 and a capital payment of $372.04 X 1.7758 = $660.67.\(^ {1144}\)

c. Disproportionate-Share Hospital (DSH) Payment

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 amended section 1886(d)(5) of the Social Security Act to allow an additional payment under the Medicare IPPS to hospitals that serve a disproportionate number of low-income patients.\(^ {1145}\) These are

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\(^{1142}\) 75 Fed. Reg at 50,547-66.
\(^{1143}\) Id.; supra, Table 20.
\(^{1144}\) 75 Fed. Reg. at 50,433; § 412.312(a) ; supra, Part IV(A)(i)(a).
called disproportionate-share-hospital (DSH, often pronounced “dish”) payments.1146

Once a hospital qualifies for DSH payments, CMS determines two factors that apply to
each claim.1147 The first factor, the operating DSH adjustment factor, applies only to the
operating base-payment amount.1148 The second factor, the capital DSH adjustment factor,
applies only to the capital base-payment amount.1149

There are two ways a hospital can qualify for the additional operating payment.1150 A
hospital usually qualifies by the first method if its disproportionate-patient percentage (DPP) is
greater than or equal to 15%.1151 CMS determines the DPP using four elements: (1) the
Medicare SSI days—the number of inpatient days for patients eligible for both Medicare Part A
and Supplemental Security Income (excluding patients who receive only state
supplementation);1152 (2) the total Medicare days—all inpatient days covered by Medicare Parts
A and C;1153 (3) the Medicaid non-Medicare days—all inpatient days for patients eligible for
Medicaid but not eligible for Medicare;1154 and (4) the total inpatient days—all inpatient days
regardless of patients’ eligibility for any government program.1155 CMS periodically publishes a
file containing the SSI ratios for each Medicare hospital.1156 Figure 17 shows the final
calculation for the disproportionate patient percentage.1157
A hospital can qualify by the second method—called the “pickle method”—if it is a large urban hospital with more than 100 beds and can show that “more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.”

Further, regulations prescribe two methods for calculating the operating DSH adjustment factor depending on whether the hospital qualifies for DSH payments because its DPP is greater than or equal to 15%, or whether it qualifies for DSH payments by the pickle method.

For hospitals that qualify for DSH payments using a DPP greater than 15%, the regulation contains a number of provisions for calculating the adjustment factor based on the hospital’s bed count and its status as a rural or urban hospital. This complexity appears to be superfluous—and may represent nothing more than placeholders for future regulation—because an analysis of all the provisions reveals that the bed count and urban/rural status play no role in the basic calculation. In the end, CMS determines the adjustment factor in one of two ways:

1 if the DPP is greater than 20.2%, the adjustment factor is 5.88% plus 82.5% of the difference

Figure 17. Disproportionate-Patient Percentage Calculation.

\[
\text{Disproportionate Patient Percentage} = 100 \times \left( \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid Non-Medicare Days}}{\text{Total Inpatient Days}} \right)
\]
between the DPP and 20.2%; or (2) if the DPP is less than or equal to 20.2%, the adjustment factor is 2.5% plus 65% of the difference between the DPP and 15%. The regulation caps the adjustment factor at 12% except for Medicare-dependent or small rural hospitals. Table 21 illustrates this calculation.

<table>
<thead>
<tr>
<th>Disproportionate Patient Percentage</th>
<th>Disproportionate Patient Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 20.2%</td>
<td>&lt;= 20.2%</td>
</tr>
<tr>
<td>Adjustment Factor =</td>
<td>Adjustment Factor =</td>
</tr>
<tr>
<td>(\min(12%, \ 5.88% + [82.5% \times (\text{DPP} - 20.2%)]))</td>
<td>(\min(12%, \ 2.5% + [65% \times (\text{DPP} - 15%)]))</td>
</tr>
</tbody>
</table>

Table 21. Operating DSH Adjustment Factor: DPP >= 15%.

As an example, consider Leonard McCoy Hospital and assume that it is an urban hospital with 114 beds. Further assume that McCoy Hospital posted 426 Medicare SSI days, 2,201 total Medicare days, 36 Medicaid, non-Medicare days, and 3,204 total inpatient days. The DPP calculation for McCoy Hospital is \(100 \times \left[\frac{426}{2201} + \frac{36}{3204}\right] = 20.5\%\). Because McCoy Hospital’s DPP is greater than 20.2%, the operating DSH adjustment factor is \(\min(12\%, \ 5.88\% + [82.5\% \times (20.5\% - 20.2\%)]\) = \(\min(12\%, \ 5.88\% + .25\%) = 6.13\%\). This means that CMS will increase the operating base-payment amount by 6.13% for all Medicare claims McCoy Hospital files. So for MS-DRG 163, this would result in an operating DSH payment of \$23,452.90 \times 0.0613 = \$1,437.66\.

For hospitals that qualify for DSH payments using the pickle method, the regulation

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1163 Id.
1165 *Infra*, Table 21.
1166 §§ 412.106(d)(2)(i)-(iv). The notation “\(\min(A, B)\)” means to use the lesser of A or B. See Richard R. Goldberg, *Methods of Real Analysis* 14 (1976) (describing the notation for taking the minimum of two functions).
1167 § 412.106(b)(4).
1168 §§ 412.106(d)(2)(i)-(iv).
1169 § 412.106(d)(1).
1170 Id.; *supra*, Part IV(A)(i)(b).
If Leonard McCoy Hospital qualified for this adjustment factor, its operating DSH payment for MS-DG 163 would be $23,452.90 \times 0.35 = $8,208.52.\textsuperscript{1172}

The regulations also specify how to calculate the capital DSH adjustment factor.\textsuperscript{1173} A hospital qualifies for this additional payment in one of two ways.\textsuperscript{1174} First, the hospital qualifies if it is an urban hospital with at least 100 beds and would qualify for the operating DSH payment because (1) its DPP is greater than or equal to 15%, or (2) it satisfies the pickle method.\textsuperscript{1175} If the hospital qualifies because it satisfies the pickle method, the capital DSH adjustment factor is the same as the operating DSH adjustment factor: 35%.\textsuperscript{1176} But if the hospital qualifies because its DPP is greater than or equal to 15%, CMS calculates the capital DSH adjustment factor according to the mathematical formula shown in Figure 18.\textsuperscript{1177}

\begin{center}
\textbf{Capital DSH Adjustment Factor = $e^{0.2025 \times DPP} - 1$}
\end{center}

\textbf{Figure 18. Capital DSH Adjustment Factor Calculation: DPP $\geq$ 15%.}\textsuperscript{1178}

The natural antilog of 1, \( e \) is an irrational, transcendental number that has an approximate value of 2.71828.\textsuperscript{1179} So in the Leonard McCoy Hospital example where the DPP was 20.5%, the capital DSH adjustment factor would be 

\[e^{0.2025 \times 0.205} - 1 \approx 2.718280.0415125 - 1 \approx\]

\[2.71828 \times 0.04152 = 0.1146374\]

\textsuperscript{1171} § 412.106(d)(2)(v).
\textsuperscript{1172} Id.; supra Part IV(A)(i)(b).
\textsuperscript{1173} Disproportionate Share Adjustment Factor, 42 C.F.R. § 412.320 (2009).
\textsuperscript{1174} §§ 412.320(a)(1)-(2).
\textsuperscript{1175} Id.
\textsuperscript{1176} §§ 412.320(b)(2), .106(d)(2)(v).
\textsuperscript{1177} § 412.320(b)(1); infra, Figure 18.
\textsuperscript{1178} § 412.320(b)(1).

\[e = \lim_{x \to \infty} \left[ 1 + \frac{1}{x} \right]^x\]  

0.0424 = 4.24%.\textsuperscript{1180} Thus, for MS-DRG 163, the hospital would be entitled to a \textit{capital DSH payment} of $1,981.00 \times 0.0424 = $83.99.\textsuperscript{1181}

One complexity hospitals face in getting appropriate DSH payments is determining the number of Medicaid non-Medicare days. In 2008, the Seventh Circuit held that hospitals could not include inpatient days attributable to state-only general-assistance programs in the Medicaid non-Medicare days number.\textsuperscript{1182} The court explained that at the DSH-payment program’s outset, it was unclear whether such patient days could be included.\textsuperscript{1183} But it noted that in 1999, HCFA (now CMS) issued a memorandum to fiscal intermediaries (FIs) clarifying that FIs could not include patient days attributable to state-only assistance programs—programs not part of Medicaid—in the DSH-payment calculation.\textsuperscript{1184} The memorandum, however, included a “hold harmless” clause that allowed fiscal intermediaries to include those days in DSH-payment calculations for claims filed before October 15, 1999 if hospitals had included them or appealed their inclusion before that date.\textsuperscript{1185}

Rush University Medical Center challenged CMS’s treatment of its DSH payments for 1991.\textsuperscript{1186} The Seventh Circuit held that the hospital was not entitled to include general-assistance program patient days for 1991 because it had not filed claims for those days before October 15, 1999.\textsuperscript{1187} The hospital pointed to a position paper it filed in 1998 that requested the FI to “include all inpatient hospital days as directed by HCFA Ruling 97-2.”\textsuperscript{1188} The court found that such a blanket demand for payment was not specific enough to satisfy the 1999 CMS

\begin{footnotes}
\item \textsuperscript{1180} § 412.320(b)(1).
\item \textsuperscript{1181} \textit{Id.}; \textit{supra}, Part IV(A)(i)(b).
\item \textsuperscript{1182} Rush Univ. Med. Ctr. v. Leavitt, 535 F.3d 735, 740 (7th Cir. 2008).
\item \textsuperscript{1183} \textit{Id.} at 738.
\item \textsuperscript{1184} \textit{Id.} at 739.
\item \textsuperscript{1185} \textit{Id.}
\item \textsuperscript{1186} \textit{Id.}
\item \textsuperscript{1187} \textit{Id.}
\item \textsuperscript{1188} \textit{Id.} at 740.
\end{footnotes}
memorandum’s hold-harmless clause and held that CMS did not act in an arbitrary or capricious manner when it disregarded the hospital’s position paper.\footnote{1189}

In 2010, the Ninth Circuit relied on the Seventh Circuit’s analysis in a similar case involving eight Arizona hospitals and an Arizona medical assistance program.\footnote{1190} In \textit{Phoenix Memorial Hospital v. Sebelius}, the state of Arizona had instituted a program—the Arizona Health Care Cost Containment System (AHCCCS)—that provided assistance to both Medicaid patients and non-Medicaid patients whom the state classified as “Medically Needy/Medically Indigent” (MN/MI).\footnote{1191} The court held that the hospital could include those patients eligible for Medicaid in the DSH-payment calculation because they were part of an approved Medicaid demonstration project and therefore constituted part of an “expansion population.”\footnote{1192} But it held that under the 1999 memorandum, CMS did not have to include the MN/MI patients in the calculation.\footnote{1193} And the court further held that the hospital could get no relief under the hold-harmless provision because the hospital was on notice that from 1990 onward, MN/MI patients would not be included in the DSH-payment calculation.\footnote{1194} These two cases, along with the 1999 HCFA memorandum, help clarify what patient days a hospital may include in DSH payment calculation and present significant barriers to a hospital’s attempts to recover what it perceives as underpayments for the pre-1999 period when the rules were more permissive.

d. Direct Graduate Medical Education (DGME) Payment

COBRA also amended section 1886(h) of the Social Security Act to provide additional
payments to hospitals for their direct costs related to graduate medical education.\textsuperscript{1195} These direct graduate medical education (DGME) payments are not part of the Medicare IPPS so this paper gives them only passing treatment.\textsuperscript{1196} DGME payments depend on a hospital’s costs per resident, the number of residents the hospital employs, and the proportional load of Medicare patients the hospital treats.\textsuperscript{1197}

e. **Indirect Medical Education (IME) Payment**

In 1985, Congress amended section 1886(d)(5)(B) of the Social Security Act to provide additional payments to hospitals for their indirect costs related to medical education.\textsuperscript{1198} These are called indirect-medical-education (IME) payments.\textsuperscript{1199}

Like the procedure CMS uses to determine DSH payments, CMS applies two IME factors to each claim.\textsuperscript{1200} The first factor, the *operating IME adjustment factor*, applies only to the operating base-payment amount.\textsuperscript{1201} The second factor, the *capital IME adjustment factor*, applies only to the capital base-payment amount.\textsuperscript{1202}

Determining the operating IME adjustment factor for a hospital involves three major steps. First, CMS determines the ratio of full-time equivalent residents to the hospital’s number of beds.\textsuperscript{1203} Second, CMS adds 1.00 to that ratio, raises the sum to the power of 0.405, and then

\begin{footnotes}
\footnote{CMS IPPS, \textit{supra} note 1102, at 5.}
\footnote{\textit{Id.}}
\footnote{CMS IPPS, \textit{supra} note 1102, at 5.}
\footnote{Special Treatment: Hospitals the Incur Indirect Costs for Graduate Medical Education Programs, 42 C.F.R. § 412.105(e)(1) (2009); Indirect Medical Education Adjustment Factor, 42 C.F.R. § 412.322 (2009).}
\footnote{\textit{Id.}}
\footnote{Payment Based on the Federal Rate, 42 C.F.R. § 412.312(a) (2009).}
\footnote{\textit{Id.}}
\end{footnotes}
reduces the result by 1.00. Third, CMS multiplies the result by 1.35 for discharges during and after FY 2008. Figure 19 illustrates the complete calculation.

\[
\text{Operating IME adjustment factor} = 1.35 \times \left[ \left(1 + \frac{\text{number of residents}}{\text{number of beds}} \right)^{0.405} - 1 \right]
\]

**Figure 19. Operating IME Adjustment Factor Calculation.**

Determining the capital IME adjustment factor for a hospital also involves three major steps. First, CMS calculates the *average daily census* by dividing the hospital’s total number of inpatient days by the number of days in the cost reporting period. Second, CMS calculates the *teaching-activity measurement* by dividing the number of full-time equivalent residents by the average daily census. The teaching-activity measurement cannot be more than 1.5. And third, CMS calculates the final capital IME adjustment factor by raising \(e\) to the power of 0.2822 times the teaching-activity measurement and subtracting 1.00 from the result. Figure 20 illustrates the capital IME adjustment factor calculation.

\[
\text{Capital IME adjustment factor} = e^{\min(1.5, \frac{\text{number of full time equivalent residents}}{\text{number of inpatient days} - \text{number of days in cost reporting period}})} - 1
\]

**Figure 20. Capital IME Adjustment Factor Calculation.**

Continuing with the Leonard McCoy Hospital example, suppose the hospital employed

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1204 §§ 412.105(c), (d)(1)-(2).
1206 *Infra*, Figure 19.
1207 § 412.105(d).
1208 Indirect Medical Education Adjustment Factor, 42 C.F.R. § 412.322(a)(2) (2009).
1209 § 412.322(a)(3).
1210 *Id.*
1211 § 412.322(b).
1212 *Infra*, Figure 20.
1213 §§ 412.322(a)(2)-(3), (b).
eleven full-time equivalent residents and had 114 beds, 22,929 inpatient days, and 365 days in
the cost-reporting period. Assume also that 2.71828 is a reasonable approximation of $e$. The
operating IME adjustment factor would be $1.35 \times [(1 + 11/114)^{0.405} - 1] = 0.0513 =
5.13\%$. The operating IME adjustment factor would be $2.71828^{\min\left(\frac{1}{1.5}, \frac{11}{22,929 + 365}\right)} - 1 = 2.71828^{0.17511} - 1 = 0.1914 = 19.14\%$. So for MS-DRG 163, CMS would pay the hospital a capital IME payment of $1,891.00 \times 0.1914 = $361.94.

The Rush University Medical Center case in the Seventh Circuit that addressed the scope
of DSH payments also addressed certain issues arising under the IME payment system. The
hospital wanted to include three residents in its fiscal-year 1991 IME payment calculation that
were enrolled in a residency program that CMS did not approve as an IME-eligible program until
one month after the fiscal year’s end. The court held that although CMS could have made
exceptions for the three residents and allowed their inclusion in the IME payment calculation, it
was not arbitrary and capricious for CMS to enforce the letter of the law.

Further, the court upheld CMS’s determination that even if the residents were enrolled in
approved programs, the hospital failed to show that the residents were present in an appropriate
place in the hospital on the census date. The court held that the burden was on the hospital to
prove that the hospital assigned the residents to appropriate hospital rotations on the census date
and that CMS had no obligation to prove that the residents were not present in an appropriate

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1214 Russell, supra note 1179, at 66.
1215 Special Treatment: Hospitals the Incur Indirect Costs for Graduate Medical Education Programs, 42 C.F.R. §
412.105(d) (2009).
1216 Id.; supra, Part IV(A)(i)(b).
1217 §§ 412.322(a)(2)-(3), (b).
1219 Id. at 741.
1220 Id.
1221 Id.
hospital location on that date. Because the hospital’s rotation schedules for the census date did not show that two of the residents were in the hospital and failed to show the third resident’s the approximate location inside the hospital, the hospital failed to carry its burden of proof. Based on this decision, it is clear that revenue-cycle managers must make sure that a hospital keeps meticulous records about the exact location of its residents and their program-enrollment status.

**f. New Technology Adjustments**

In 2000, Congress further amended section 1886(d)(5) of the Social Security Act to allow additional payments to hospitals for using new medical services or technology. Under the amendments, the medical service or technology must be (1) new—not “substantially similar” to an existing service or technology; (2) paid inadequately under the MS-DRG payment system; (3) an advancement that “substantially improves” diagnosis or treatment; and (4) one that causes the entire case’s cost to exceed the normal MS-DRG payment. A claim must meet all four of these criteria to be eligible for the additional new-technology payment. There is usually a two or three-year lag from the time the FDA approves a new technology to the time CMS gathers data on the new technology and factors it into the MS-DRG payment system. During that

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1222 Id. at 741-42.
1223 Id. at 742.
1225 Additional Payment for New Medical Services and Technologies: General Provisions, 42 C.F.R. § 412.87(b) (2009); Additional Payment for New Medical Service or Technology, 42 C.F.R. § 412.88(b)(2) (2009); Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Final Rule, 75 Fed. Reg. 50,041, 50,137 (Aug. 16, 2010).
1226 § 412.87(b).
1227 75 Fed. Reg. at 50,137.
limbo period, CMS may consider the technology eligible for the additional payment.\textsuperscript{1228}

CMS does “not consider a service or technology to be new if it is \textit{substantially similar} to one or more existing technologies.”\textsuperscript{1229} To determine if a technology is substantially similar to an existing technology, CMS considers whether the technology (1) “uses the same or similar mechanism of action to achieve a therapeutic outcome”; (2) usually gets assigned to the same or different MS-DRG; and (3) treats the same kind of disease in a similar patient population.\textsuperscript{1230}

If CMS determines that the technology is not similar to an existing technology, it considers the second element (whether the normal payment would be adequate) of eligibility for the new-technology payment, otherwise the claim is not eligible for an additional new-technology payment.\textsuperscript{1231} The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 amended Social Security Act section 1886(d)(5)(K) to add a new test for whether a normal MS-DRG payment is adequate.\textsuperscript{1232} If the gross charges for a claim exceed a certain charge threshold, CMS considers the normal MS-DRG payment inadequate.\textsuperscript{1233} CMS publishes a list of appropriate charge thresholds in the rule’s Table 10, so it simply looks up the threshold amount in that table for the MS-DRG code that appears on the claim.\textsuperscript{1234}

If the gross charges for the claim are greater than the threshold amount for the claim’s MS-DRG code, CMS considers the third eligibility element (whether the technology represents a substantial improvement in diagnosis or treatment); otherwise the claim is not eligible for the additional new-technology payment.\textsuperscript{1235} A new technology represents a substantial improvement

\textsuperscript{1228} § 412.87(b)(2).
\textsuperscript{1229} 75 Fed. Reg. at 50,138 (emphasis added).
\textsuperscript{1230} Id.
\textsuperscript{1231} Id.
\textsuperscript{1233} § 412.87(b)(3); 75 Fed. Reg. at 50,138-39.
\textsuperscript{1234} 75 Fed. Reg. at 50,139, 50,605-13.
\textsuperscript{1235} Id. at 50,139.
when it “reduces mortality, decreases the number of hospitalizations or physician visits, or reduces recovery time.”\textsuperscript{1236}

CMS initially made these determinations on its own, but the MMA amended section 1886(d)(5)(K)(viii) of the Social Security Act to require CMS to go through a formal notice and public comment procedure before deciding whether a new technology represents a substantial improvement over existing technologies.\textsuperscript{1237} The provision requires that hospitals, doctors, and manufacturers have an opportunity to meet with CMS regarding technological advances and improved diagnosis and treatment.\textsuperscript{1238} The most recent meeting, held on February 19, 2010, allowed manufacturers to present data regarding technology for which they had requested CMS provide an additional new-technology payment.\textsuperscript{1239}

Once CMS determines whether a new technology qualifies for an additional payment, it publishes its findings in the Federal Register.\textsuperscript{1240} CMS also publishes an official \textit{average cost per case} for the new technology or service in the same provision.\textsuperscript{1241} For example, for FY 2011, CMS approved a new-technology payment for the Spiration\textsuperscript{®} IBV\textsuperscript{®} Valve System (a technology for treating prolonged air leaks in the lungs after surgery) and established its average cost at $6,875 per case.\textsuperscript{1242}

If CMS finds that a technology is eligible for the add-on payment, it must first calculate the entire case’s \textit{operating cost}—not just the new technology’s average cost.\textsuperscript{1243} To do that, CMS multiplies the gross charges for a claim by the \textit{operating cost-to-charge ratio} for the

\textsuperscript{1236} Id.
\textsuperscript{1238} Id.
\textsuperscript{1239} 75 Fed. Reg. at 50,140.
\textsuperscript{1240} E.g., id. at 50,141.
\textsuperscript{1241} E.g., id.
\textsuperscript{1242} Id.
\textsuperscript{1243} Additional Payment for New Medical Service or Technology, 42 C.F.R. § 412.88 (a)(2) (2009).
hospital to get the operating cost for the claim.\textsuperscript{1244} CMS determines the operating cost-to-charge ratio for each individual hospital from the cost reports hospitals submit on a yearly basis.\textsuperscript{1245} It periodically publishes a Provider Specific File containing the operating cost-to-charge ratio on its website.\textsuperscript{1246} If the operating cost is less than the normal MS-DRG payment, the regulations do not allow a new-technology add-on payment.\textsuperscript{1247}

Finally, to calculate the new-technology add-on payment, CMS takes the lesser of: half the new technology’s average cost per case; or half the difference between the operating cost and the normal DRG payment.\textsuperscript{1248}

Using the McCoy Hospital example: Assume that the hospital billed $150,000 in charges for a surgical claim that involved Spiration® IBV® Valve System use and assume that CMS assigned MS-DRG 163 to the claim. The threshold for determining whether payment would be inadequate for the claim for MS-DRG 163 from Final Rule Table 10 is $92,306.\textsuperscript{1249} Because the hospital’s charges of $150,000 exceed the $92,306 threshold, and because CMS has approved the IBV treatment for new-technology add-on payments, the next step is to determine whether the operating cost for the entire claim is greater than the full, normal MS-DRG payment, including additional payments for DSH and IME (but excluding any outlier payments).\textsuperscript{1250}

Recall that the operating payment for McCoy Hospital using MS-DRG 163 was

\textsuperscript{1244} Payment for Extraordinarily High-Cost Cases (Cost Outliers), 42 C.F.R. § 412.84(h) (2009); § 412.88(a)(2).
\textsuperscript{1245} § 412.84(h).
\textsuperscript{1247} § 412.88(a)(2).
\textsuperscript{1248} Id.
\textsuperscript{1249} Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Final Rule, 75 Fed. Reg. 50,041, 50,066 (Aug. 16, 2010).
\textsuperscript{1250} Additional Payment for New Medical Service or Technology, 42 C.F.R. § 412.88(a)(2) (2009); 75 Fed. Reg. at 50,139-40.
$23,452.90 and the corresponding capital payment was $1,891.00.\textsuperscript{1251} And recall that the operating DSH payment was $1,437.66, the capital DSH payment was $83.99, the operating IME payment was $1,203.13, and the capital IME payment was $361.94.\textsuperscript{1252} Adding all these amounts yields a normal MS-DRG payment of $23,452.09 + $1,891.00 + $1,437.66 + $83.99 + $1,203.13 + $361.94 = $28,429.81.\textsuperscript{1253} Assume that the operating cost-to-charge ratio for McCoy Hospital based on cost reports for FY 2010 is 38.0\%.\textsuperscript{1254} So the operating cost for the entire claim would be $150,000.00 \times 0.380 = $57,000.00.\textsuperscript{1255} Because the operating cost of $57,000 exceeds the normal payment of $28,429.81 (by $28,570.19), CMS will pay the hospital a new-technology add-on payment.\textsuperscript{1256}

The final new-technology add-on payment is the smaller of fifty percent of the new technology’s average cost or fifty percent of the difference between the operating cost and the normal MS-DRG payment.\textsuperscript{1257} Recall that CMS set the IBV’s average cost at $6,875 per case and note that the difference between the operating cost and the normal MS-DRG payment is $28,570.19.\textsuperscript{1258} So the new-technology add-on payment to McCoy Hospital under MS-DRG 163 when it uses the Spiration\textsuperscript{®} IBV\textsuperscript{®} Valve System is min($6975 \times 0.50, $28570.19 \times 0.50) = min($3487.50, $14285.10) = $3,487.50.\textsuperscript{1259} Finally, notwithstanding any more additional payments for outliers or reductions for transfers or early discharges, CMS would pay the hospital the normal MS-DRG payment plus the new-technology add-on payment for a total of $28,429.81

\textsuperscript{1251} Supra, Part IV(A)(i)(b).
\textsuperscript{1252} Supra, Part IV(A)(i)(c), (e).
\textsuperscript{1253} 75 Fed. Reg. at 50,139.
\textsuperscript{1254} See Inpatient PSF, supra note 1246 (showing the operating cost-to-charge ratio for Abilene Regional Medical Center).
\textsuperscript{1255} Payment for Extraordinarily High-Cost Cases (Cost Outliers), 42 C.F.R. § 412.84(h) (2009); Additional Payment for New Medical Service or Technology, 42 C.F.R. § 412.88(a)(2) (2009).
\textsuperscript{1256} § 412.88(a)(2).
\textsuperscript{1257} Id.
\textsuperscript{1258} 75 Fed. Reg. at 50,141; supra Part IV(A)(i)(f).
\textsuperscript{1259} § 412.88(a)(2).
+ $3,487.50 = $33,702.41.1260

g. Outlier Payments

CMS provides an additional outlier payment to a hospital when its costs exceed the total MS-DRG payment for a claim by a certain amount.1261 First, CMS calculates a fixed-loss cost threshold, which is the total MS-DRG payment including any IME, DSH, and new-technology add-on payment, plus an outlier threshold.1262 CMS determines the outlier threshold, also called a “fixed-loss amount,” and publishes it in the Federal Register each year.1263 The outlier threshold for FY 2011 is $23,075.1264 Figure 21 depicts the fixed-loss cost threshold formula.1265

\[
\text{Fixed-loss cost threshold} = \\
\text{Operating MS-DRG Payment + Capital MS-DRG Payment} \\
+ \text{Operating DSH Payment + Capital DSH Payment} \\
+ \text{Operating IME Payment + Capital DSH Payment} \\
+ \text{Outlier Threshold}
\]

Figure 21. Fixed-Loss Cost Threshold Calculation.1266

Second, CMS determines the estimated costs for the entire claim by multiplying the claim’s gross charges by the operating cost-to-charge ratio (operating CCR) plus the capital cost-to-charge ratio (capital CCR).1267 CMS publishes each provider’s CCRs, which are based on provider cost reports, in a Provider Specific File.1268 For FY 2011, if a provider’s operating CCR is greater 1.175 or its capital CCR is greater than 0.159, or if CMS is unable to calculate the

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1260 Id.
1262 Id.; 75 Fed. Reg. at 50,426-27.
1263 Payment for Extraordinarily High-Cost Cases (Cost Outliers), 42 C.F.R. § 412.84(k) (2009); 75 Fed. Reg. at 50,427, 50,441.
1264 75 Fed. Reg. at 50,441.
1265 Infra, Figure 21.
1266 § 412.80(a)(3); 75 Fed. Reg. at 50,426-27.
1267 § 412.80(a)(1)(ii), (3).
1268 Inpatient PSF, supra note 1246.
provider’s CCRs, CMS uses the statewide average CCRs that apply to the hospital.\textsuperscript{1269} For FY 2011, CMS published the list of statewide average operating CCRs in Table 8A and the statewide average capital CCRs in Final Rule Table 8B.\textsuperscript{1270} Figure 22 depicts the calculation for the estimated costs for a claim.\textsuperscript{1271}

\begin{equation*}
\text{Estimated Costs} = \text{Gross Charges} \times (\text{Operating CCR + Capital CCR})
\end{equation*}

\textbf{Figure 22. Estimated Cost Calculation.}\textsuperscript{1272}

If the estimated costs for a claim are greater than the fixed-loss cost threshold, the claim is eligible for an outlier payment.\textsuperscript{1273} The outlier payment is equal to the estimated costs minus the fixed-loss cost threshold with the result multiplied by a marginal-cost factor.\textsuperscript{1274} The marginal-cost factor for FY 2011 is 80\% for most cases (the same as it has been since 1995) and 90\% for certain burn cases.\textsuperscript{1275} Figure 23 shows the formula for calculating the outlier payment.\textsuperscript{1276}

\begin{equation*}
\text{Outlier Payment} = \text{Marginal-Cost Factor} \times (\text{Estimated Costs} – \text{Fixed-Loss Cost Threshold})
\end{equation*}

\textbf{Figure 23. Outlier Payment Calculation.}\textsuperscript{1277}

Assume in the McCoy Hospital example that its operating CCR is 0.38 (38\%) and its capital CCR is 0.042 (4.2\%). Based on the earlier examples using the claim assigned MS-DRG 163, the fixed-loss cost threshold for the claim is $23,452.90 + $1,891.00 + $1,437.66 + $83.99

\begin{itemize}
\item[\textsuperscript{1269}] Payment for Extraordinarily High-Cost Cases (Cost Outliers), 42 C.F.R. § 412.84(i)(3) (2009); 75 Fed. Reg. at 50,430.
\item[\textsuperscript{1270}] 75 Fed. Reg at 50,430-31, 50,590-92.
\item[\textsuperscript{1271}] Infra, Figure 22.
\item[\textsuperscript{1272}] § 412.80(a)(1)(ii), (3).
\item[\textsuperscript{1273}] Id.
\item[\textsuperscript{1274}] § 412.84(k).
\item[\textsuperscript{1275}] 75 Fed. Reg. 50,427.
\item[\textsuperscript{1276}] Infra, Figure 23.
\item[\textsuperscript{1277}] § 412.84(k).
\end{itemize}
+ $1,203.13 + $361.94 + $23,075.00 = $51,505.62.  
1278 The estimated costs for the claim are $150,000 X (0.38 + 0.042) = $63,300.  
1279 Because the estimated costs for the claim, $63,300, are greater than the fixed-loss cost threshold, $51,505.62, the claim is eligible for an outlier payment.  
1280 So the outlier payment would be 80% X ($63,300 – $51,505.62) = $9,435.50.  
1281 Therefore the full MS-DRG payment for the claim would be $23,452.90 + $1,891.00 + $1,437.66 + $83.99 + $1,203.13 + $361.94 + $9,435.50 = $37,866.12.  
1282 Outlier payments have been the source of some huge scandals and gigantic settlements that have rocked the healthcare industry over the last twenty years. In 2006, Tenet Healthcare Corporation agreed to pay the United States more than $900 million to settle False Claims Act violations.  
1283 A staggering portion of that settlement (more than $788 million) resolved claims over “turbocharging,” which is the practice of manipulating outlier payments by unjustifiably increasing charges.  
1284 In 2009, Thomas Mackey, Tenet’s former co-president and chief operating officer, whom the Securities and Exchange Commission called the turbocharging scheme’s “chief architect,” agreed to a settlement that disgorged $1.780 million plus interest in profits and imposed a $500,000 fine.  
1285 As serious as this was for Tenet, it could have been far worse.  

In 2005, Boca Raton Community Hospital (a non-Tenet facility) filed a class-action

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1279 §§ 412.80(a)(1)(ii), (3); supra, Part IV(A)(i)(f).
1280 §§ 412.80(a)(1)(ii), (3).
1281 § 412.84(k).
1282 § 412.80(a)(3); 75 Fed. Reg. at 50,426-27, 50,441; supra, Part IV(A)(i)(f).
1284 Id.; Boca Raton Cmty. Hosp. v. Tenet Health Care Corp., 582 F.3d 1227, 1230-31 (11th Cir. 2009).
lawsuit against Tenet related to the turbocharging scandal alleging a Racketeer Influenced and Corrupt Organizations (RICO) Act violation.\textsuperscript{1286} The complaint stated that because CMS attempts to keep outlier payments at or below a fixed percentage of Medicare payments, Tenet’s turbocharging scheme caused the Boca Raton hospital to receive less than its proper share of outlier payments.\textsuperscript{1287} But because the plaintiff’s method of calculating damages was inadequate and speculative, the Eleventh Circuit upheld the district court’s summary judgment grant to Tenet.\textsuperscript{1288} The court noted that Tenet had been properly admonished by the imposition of a fine of nearly a billion dollars and that the government had made changes to outlier payments that should prevent similar abuses.\textsuperscript{1289}

In late 2009, Our Lady of Lourdes Health Care Services, Inc. agreed to a $7.9 million payment to settle claims that two of its New Jersey hospitals (Lourdes Medical Center of Burlington County and Our Lady of Lourdes Medical Center in Camden) engaged in turbocharging.\textsuperscript{1290} In early 2010, Brookhaven Memorial Hospital Medical Center in Patchogue, New York agreed to pay $2.9 million to settle a turbocharging case.\textsuperscript{1291} In March 2010, Robert Wood Johnson University Hospital Hamilton in New Jersey agreed to a $6.35 million turbocharging settlement.\textsuperscript{1292} And in mid-2010, Saint John’s Health Center in Santa Monica, California agreed to pay the government $5.25 million to settle turbocharging claims stemming

\begin{itemize}
\item \textsuperscript{1286} \textit{Boca Raton}, 582 F.3d at 1230; 18 U.S.C. § 1962(c) (2006).
\item \textsuperscript{1287} \textit{Boca Raton}, 582 F.3d at 1231.
\item \textsuperscript{1288} \textit{Id.} at 1232, 1234.
\item \textsuperscript{1289} \textit{Id.} at 1234.
\item \textsuperscript{1290} New Jersey Hospital System to Pay $7.9 Million in Medicare Settlement, 14 Health Care Fraud Rep. (BNA) 26 (Jan. 1, 2010).
\item \textsuperscript{1291} New York Hospital to Pay $2.9 Million To Settle FCA Suit Over Outlier Payments, 14 Health Care Fraud Rep. (BNA) 211 (Mar. 10, 2010).
\item \textsuperscript{1292} Press Release, Dep’t of Justice, New Jersey Hospital to Pay $6.35 Million to Resolve Allegations of Inflating Charges to Obtain Higher Medicare Reimbursement (Mar. 19, 2010), available at http://www.justice.gov/opa/pr/2010/March/10-civ-293.html.
\end{itemize}
from activity in which the hospital engaged from 1996 to 2003. Most of these settlements involved activity that occurred before Medicare placed upper and lower bounds on cost-to-charge ratios, so perhaps the Eleventh Circuit’s optimistic assessment will prove to be true.

h. Transfer Reductions

In some situations, CMS regulations provide for a reduction in payment when a hospital transfers a patient to another provider. When a hospital discharges a patient, CMS considers it a transfer if the patient is readmitted on the same day to another acute-care hospital, critical-access hospital, or skilled-nursing facility, or the hospital sends the patient home with a “written plan of care for the provision of home health services from a home health agency.” In that situation, CMS pays the hospital a per-diem amount based on the full MS-DRG payment. The per-diem amount is the full MS-DRG payment for the claim divided by the geometric-mean length of stay for the MS-DRG CMS assigned to a claim. CMS publishes the geometric-mean length of stay for each MS-DRG code in Table 5 of its Final Rule. Figure 24 shows the per-diem amount calculation.

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1294 Id.; Boca Raton Cmty. Hosp. v. Tenet Health Care Corp., 582 F.3d 1227, 1234 (11th Cir. 2009); Payment for Extraordinarily High-Cost Cases (Cost Outliers), 42 C.F.R. § 412.84(i)(3) (2009); Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Final Rule, 75 Fed. Reg. 50,041, 50,430 (Aug. 16, 2010).
1296 § 412.4(b).
1297 § 412.4(f)(1).
1298 Id.
1300 Infra, Figure 24.
Figure 24. Transfer Per-Diem Amount Calculation.\textsuperscript{1301}

CMS pays the transferring hospital based on the patient’s length of stay (LOS): Twice the per-diem amount for the first day and the per-diem amount for each additional day of the stay.\textsuperscript{1302} The transfer payment may not be more than the full MS-DRG amount.\textsuperscript{1303} Figure 25 illustrates the transfer calculation.\textsuperscript{1304}

\[
\text{Transfer Payment} = \min[\\text{Full MS-DRG Payment,} \\
(2 \times \text{Per-Diem Amount}) + ((\text{Length of Stay} - 1) \times \text{Per-Diem Amount})]
\]

Figure 25. Transfer Payment Calculation.\textsuperscript{1305}

In another situation at McCoy Hospital, assume that the patient’s LOS for the MS-DRG 163 claim was eight days before the hospital transferred the patient to another Medicare acute-care hospital. The geometric-mean length of stay for MS-DRG 163 for FY 2011 is 11.5.\textsuperscript{1306} The per-diem amount for the claim would be $37,866.12 / 11.5 = $3,292.71.\textsuperscript{1307} So the transfer payment to McCoy Hospital for an eight-day stay would be min[$37,866.12, (\$3,292.71 \times 2) +

\begin{equation}
\begin{align*}
\text{Per-Diem Amount} = & \quad (\text{Operating MS-DRG Payment + Capital MS-DRG Payment} \\
& + \text{Operating DSH payment + Capital DSH Payment} \\
& + \text{Operating IME payment + Capital DSH Payment + Outlier Payment}) \\
& \div \text{Geometric-Mean Length of Stay}
\end{align*}
\end{equation}
($3,292.71 \times 7) = $29,634.39.^{1308}

\section*{i. Deductibles and Coinsurance}

Medicare regulations provide that the beneficiary is responsible for a fixed deductible for the first hospitalization in a benefit period.\(^{1309}\) CMS reduces the amount it pays to a hospital by the deductible amount.\(^{1310}\) CMS publishes the deductible amount each year in the Federal Register.\(^{1311}\) For claims filed in 2011, the deductible amount is $1132.\(^{1312}\)

Medicare also imposes coinsurance on beneficiaries that depend on the number of days of hospitalization during a benefit period.\(^{1313}\) Additionally, CMS deducts any copayments from what it pays a hospital.\(^{1314}\) Medicare coinsurance is one-fourth of the deductible amount for each day of hospitalization between the sixty-first and ninetieth day.\(^{1315}\) For CY 2011, the coinsurance for that period is $283 per day.\(^{1316}\) For the ninety-first through the 150th day, the coinsurance amount is half the deductible.\(^{1317}\) During CY 2011, that amount will be $566 per day.\(^{1318}\)

\section*{ii. Medicare Hospital Outpatient Reimbursement}

Section 4533 of the Balanced Budget Act of 1997 added section 1833(t) to the Social Security Act to require Medicare to institute a prospective-payment system—titled the Hospital

\begin{footnotesize}
\begin{enumerate}
\item \footnotesize\textsuperscript{1308} § 412.4(f)(1).
\item \footnotesum\textsuperscript{1309} Inpatient Hospital Deductible, 42 C.F.R. § 409.82 (2009).
\item \footnotesum\textsuperscript{1310} Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for CY 2011, 75 Fed. Reg. 68,799, 68,800 (Nov. 9, 2010).
\item \footnotesum\textsuperscript{1311} § 409.82(b).
\item \footnotesum\textsuperscript{1312} 75 Fed. Reg. at 68,800.
\item \footnotesum\textsuperscript{1313} Inpatient Hospital Coinsurance, 42 C.F.R. § 409.83 (2009).
\item \footnotesum\textsuperscript{1314} 75 Fed. Reg. at 68,800.
\item \footnotesum\textsuperscript{1315} § 409.83(a)(2).
\item \footnotesum\textsuperscript{1316} 75 Fed. Reg. at 68,801.
\item \footnotesum\textsuperscript{1317} § 409.83(a)(3).
\item \footnotesum\textsuperscript{1318} 75 Fed. Reg. at 68,801.
\end{enumerate}
\end{footnotesize}
Outpatient Prospective Payment System (OPPS)—for outpatient claims.\textsuperscript{1319} CMS subsequently adopted an Ambulatory-Payment Classification (APC) system comprising packaged services for outpatient reimbursement.\textsuperscript{1320} As Part III(A)(v)(b) discusses, CMS groups related services under a single APC code related to one or more HCPCS Level I or Level II codes.\textsuperscript{1321} But unlike MS-DRG code assignment, CMS may assign multiple APC codes to a single claim.\textsuperscript{1322} CMS must review, with the aid of an outside expert advisory panel, the OPPS and make necessary updates and changes to its various components on a yearly basis; and it publishes those changes in the Federal Register.\textsuperscript{1323}

The OPPS excludes payment for certain services that CMS reimburses under other programs.\textsuperscript{1324} Some of those services include physician, nurse practitioner, physician assistant, anesthesiologist, diagnostic laboratory, ambulance, and other services paid under other government programs.\textsuperscript{1325} Further, the OPPS pays for certain items differently depending on the type of item.\textsuperscript{1326} For example, CMS reimburses hospitals for certain drugs, biologicals, and medical devices on a cost pass-through basis rather than through the conventional APC reimbursement methodology.\textsuperscript{1327} This section focuses only on those items CMS pays for using the conventional APC reimbursement methodology.

\begin{thebibliography}{9}
\footnotesize
\item\textsuperscript{1320} Hospital Outpatient Prospective Payment System, 63 Fed. Reg. 47,552, 47,560 (Sept. 8, 1998) (codified at 42 C.F.R. pts. 409 et al.).
\item\textsuperscript{1321} Basis of Payment, 42 C.F.R. § 419.2 (2009); Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule, 74 Fed. Reg. 60,315, 60,320-21 (Nov. 10, 2009).
\item\textsuperscript{1322} Payment Reductions for Procedures, 42 C.F.R. § 419.44(a) (2009).
\item\textsuperscript{1323} Annual Review, 42 C.F.R. § 419.50 (2009); 74 Fed. Reg. at 60,315.
\item\textsuperscript{1324} Hospital Outpatient Services Excluded from Payment Under the Hospital Outpatient Prospective Payment System, 42 C.F.R. § 419.22 (2009).
\item\textsuperscript{1325} \textit{Id.}
\item\textsuperscript{1326} Transitional Pass-Through Payments: General Rules, 42 C.F.R. § 419.62 (2009).
\item\textsuperscript{1327} Transitional Pass-Through Payments: Drugs and Biologicals, 42 C.F.R. § 419.64 (2009); Transitional Pass-Through Payments: Medical Devices, 42 C.F.R. § 419.66 (2009).
\end{thebibliography}
a. Payment Status Indicators

The type of payment methodology the OPPS uses for a particular APC or HCPCS code depends on the APC code’s payment status indicator (SI). CMS publishes the SIs in its Final Rule for the OPPS. Table 22 describes the list of SIs for calendar year 2010.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Services not paid under the OPPS (e.g., ambulance, diagnostic lab, non-implantable prosthetic and orthotic devices, physical therapy, dialysis, etc.).</td>
</tr>
<tr>
<td>B</td>
<td>Services not paid when a provider submits them on an outpatient hospital bill.</td>
</tr>
<tr>
<td>C</td>
<td>Procedures that a hospital should only bill on inpatient claims.</td>
</tr>
<tr>
<td>D</td>
<td>Discontinued APC codes.</td>
</tr>
<tr>
<td>E</td>
<td>Services that Medicare does not cover.</td>
</tr>
<tr>
<td>F</td>
<td>Corneal tissue acquisition, certain Certified Registered Nurse Anesthetist services, and hepatitis B vaccines paid on a reasonable-cost basis.</td>
</tr>
<tr>
<td>G</td>
<td>Pass-through drugs and biological paid on a cost basis.</td>
</tr>
<tr>
<td>H</td>
<td>Pass-through devices paid on a cost basis and not subject to a copayment.</td>
</tr>
<tr>
<td>K</td>
<td>Non-pass-through drugs and non-implantable biological paid under the OPPS with a separate APC payment.</td>
</tr>
<tr>
<td>L</td>
<td>Influenza and pneumococcal pneumonia vaccine paid on a reasonable-cost basis and not subject to any deductible or copayment.</td>
</tr>
<tr>
<td>M</td>
<td>Items and services a provider cannot bill.</td>
</tr>
<tr>
<td>N</td>
<td>Items and services packaged together under one APC for a single payment under the OPPS.</td>
</tr>
<tr>
<td>P</td>
<td>Services subject to a per-diem APC rate because the patient was only partially hospitalized.</td>
</tr>
<tr>
<td>Q1</td>
<td>Packaged services that aggregate multiple HCPCS codes assigned payment status indicators S, T, V, or X and billed on the same date of service.</td>
</tr>
<tr>
<td>Q2</td>
<td>Multiple significant procedures packaged together because they have payment status indicator T and the provider billed them on the same date of service.</td>
</tr>
<tr>
<td>Q3</td>
<td>Codes paid through a composite APC that represents bundling of combinations of services.</td>
</tr>
<tr>
<td>R</td>
<td>Blood and blood products given a separate APC payment.</td>
</tr>
<tr>
<td>S</td>
<td>Significant procedure not subject to a multiple procedure discount.</td>
</tr>
<tr>
<td>T</td>
<td>Significant procedure subject to a multiple procedure discount.</td>
</tr>
<tr>
<td>U</td>
<td>Brachytherapy sources.</td>
</tr>
</tbody>
</table>

1328 74 Fed. Reg. at 60,592.
1329 74 Fed. Reg. at 60,592-94.
1330 Infra, Table 22.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V</td>
<td>Clinic or emergency department visit.</td>
</tr>
<tr>
<td>X</td>
<td>Ancillary services.</td>
</tr>
</tbody>
</table>

Table 22. APC Payment-Status Indicators.\textsuperscript{1331}

CY 2010 Final Rule Addendum A lists all the APC codes along with their payment status indicators, relative weights, national unadjusted payment rates, and minimum unadjusted copayments.\textsuperscript{1332}

In 2008, CMS introduced the concept of composite APCs to move closer to an episode-of-care system of payment.\textsuperscript{1333} CMS wanted to incentivize hospitals to improve the quality, and therefore reduce the costs, of “services that are typically performed together during a single clinical encounter and that result in the provision of a complete service.”\textsuperscript{1334} Composite APCs extend the idea of packaging multiple items or services even further and currently encompasses five areas: (1) extended assessment and management services (APCs 8002 and 8003); (2) low dose rate prostate brachytherapy (APC 8001); (3) cardiac electrophysiologic evaluation and ablation (APC 8000); (4) mental health services (APC 0034); and (5) multiple imaging services (APCs 8004, 8005, 8006, 8007, and 8008).\textsuperscript{1335} This trend is significant to revenue-cycle managers because CMS intends to continue to develop larger payment bundles as part of the long-term strategy for the OPPS.\textsuperscript{1336} Because these composite APCs bundle more services than other APCs, they tend to produce higher-than-normal reimbursements when compared with other APCs.\textsuperscript{1337}

\textsuperscript{1331} 74 Fed. Reg. at 60,592-94, 60,944-45.
\textsuperscript{1332} 74 Fed. Reg. at 60,682.
\textsuperscript{1333} 74 Fed. Reg. at 60,391.
\textsuperscript{1334} Id.
\textsuperscript{1335} Id.
\textsuperscript{1336} Id.
\textsuperscript{1337} See 74 Fed. Reg. at 60,690 (showing a relative weight of 150.1090 for APC 8000).
b. Conversion Factor

Like the MS-DRG reimbursement system for inpatient-hospital claims, the outpatient-reimbursement system assigns a weight to each APC code and applies that weight to a base amount called a conversion factor.¹³³⁸ Unlike MS-DRG payment, however, the conversion factor is not different for each hospital but is based on a standardized national payment rate.¹³³⁹ CMS updates the conversion factor from year to year based on its hospital inpatient market-basket increases and other factors.¹³⁴⁰

In 2006, Congress required that CMS reduce the market-basket update applied to the conversion factor by 2.0 percent for any hospital that had failed to supply it with certain quality data in the previous year.¹³⁴¹ As a result, for CY 2010, CMS applies the full conversion factor of $67.406 to hospitals that comply with the quality reporting requirements and the reduced conversion factor of $66.086 for those hospitals that fail to comply.¹³⁴² The quality measures hospitals must report to receive the full payment rate generally, among other things, have to do with how quickly a hospital administers aspirin to a heart-attack patient, administration of prophylactic antibiotics to surgical patients, and follow-up rates for mammography tests.¹³⁴³

The conversion factor and weights take into account both operating and capital costs of services related to performing a procedure, such as (1) use of an operating, procedure, treatment, and recovery room or observation bed; (2) anesthesia and certain drugs and biologicals; (3)

¹³³⁸ Ambulatory Payment Classification (APC) System and Payment Weights, 42 C.F.R. § 419.31(b) (2010); Calculation of Prospective Payment Rates for Hospital Outpatient Services, 42 C.F.R. § 419.32(c) (2010); 74 Fed. Reg. at 60,419.
¹³³⁹ Basis of Payment, 42 C.F.R. § 419.2(b) (2009).
¹³⁴⁰ § 419.32(b)(1)(iv) (2010); 74 Fed. Reg. 60,419.
¹³⁴² 74 Fed. Reg. at 60,419.
medical, anesthesia, and surgical supplies; (4) intraocular lenses; (5) incidental services; (6) implantable items for testing; (7) implantable durable medical equipment; (8) implantable prosthetic devices; and (9) costs of donor tissue procurement.1344

c. APC Payment

CMS bases most OPPS payments on the conventional APC payment method, which applies to APC codes having payment status indicators of P, Q1, Q2, Q3, R, S, T, U, V, or X.1345 For each APC code, CMS multiplies the APC code’s relative weight by the full conversion factor to produce the full national unadjusted payment rate.1346 CY 2010 Final Rule Addendum A contains the full national unadjusted payment rate for each APC code for CY 2010.1347 If the hospital fails to comply with quality-data reporting requirements, then CMS multiplies the reduced conversion factor by the APC code’s relative weight to get the reduced national unadjusted payment rate.1348 Alternatively, CMS could simply multiply the full national unadjusted payment rate by 0.98 (representing a 2.0 percent reduction) to get the reduced national unadjusted payment rate.1349

In the second step, CMS multiples the national unadjusted payment rate (whether the full rate or the reduced rate) by 60% to get the labor-related portion.1350 Since the OPPS program’s beginning in 2000, CMS has used 60% to represent the portion of outpatient service costs attributable to labor.1351

Third, CMS determines the wage index for the hospital either by consulting the hospital’s

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1344 § 419.2(b).
1345 74 Fed. Reg. at 60,429.
1346 Id.
1349 Id.
1350 Id.
1351 Id.
cost reports, or by using a wage area index if there is not yet enough data to determine a hospital-specific wage index. CMS then determines whether the hospital is located in a qualifying county by consulting Final Rule Addendum L. Qualifying counties are those counties where a large percentage of hospital employees live in the county but work in another county with a higher wage index. If the hospital’s provider number appears in Addendum L, the hospital is located in a qualifying county and CMS adds the corresponding out-migration adjustment from Addendum L to the hospital’s wage index to get the adjusted wage index for the hospital.

Fourth, CMS multiplies the national unadjusted payment rate’s labor-related portion to determine the wage-adjusted labor-related portion. And finally, CMS multiplies the national unadjusted payment rate by 40% to get the nonlabor-related portion and it adds the wage-adjusted labor-related portion to the nonlabor-related portion to determine the adjusted Medicare payment for the APC code. Figure 26 depicts a canonical form for the adjusted Medicare payment calculation for APC codes having a payment status indicator of P, Q1, Q2, Q3, R, S, T, U, V, or X.

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1352 74 Fed. Reg. at 60,430; see also supra, Part IV(A)(i)(a) (describing the sources for hospital wage indexes).
1353 74 Fed. Reg. at 60,430, 60,969-81.
1354 74 Fed. Reg. at 60,430.
1355 Id.
1356 Id.
1357 Id.
1358 Infra, Figure 26.
Special rules apply to some surgical APC codes. For these codes, if a hospital performs more than one surgical procedure during a “single surgical encounter,” Medicare pays the full adjusted Medicare payment for the highest-paying APC and it pays half the adjusted Medicare payment for other applicable procedures. But this payment reduction rule applies only to those surgical APC codes associated with payment-status indicator T.

Other payment reduction rules apply when a surgery is interrupted because of “extenuating circumstances or circumstances that threaten the well-being of the patient.” Medicare pays the full amount if the procedure involves anesthesia but the hospital staff stops the procedure any time after it administers anesthesia to the patient. If the procedure does not require anesthesia or the hospital staff stops the procedure before it administers anesthesia, Medicare pays half the adjusted Medicare payment.

Again, consider the Leonard McCoy Hospital example and assume that it provides CMS with quality-reporting data. Recall that the hospital wage index for McCoy Hospital is 0.8377

\[
\text{Adjusted Medicare Payment} = \left[ \begin{array}{c}
\text{Conversion Factor} \times \text{APC Relative Weight} \times 0.60 \\
\times (\text{Hospital Wage Index} + \text{Out-Migration Adjustment}) \\
\end{array} \right] + \left( \begin{array}{c}
\text{Conversion Factor} \times \text{APC Relative Weight} \times 0.40 \\
\end{array} \right)
\]
and assume that Addendum L lists an out-migration adjustment of 0.0245 for the hospital. Further assume that on a particular claim, the hospital performed four surgical procedures: (1) gastrointestinal procedure with stents (APC 0384); (2) level V drug administration (APC 0440); (3) level II vascular access procedures (APC 0622); and (4) critical care (APC 0617).  

The relative weight for the first APC (0384) is 26.4913 and the payment-status indicator is T.  Recalling that the full conversion factor for FY 2010 is $67.406, the adjusted Medicare payment for APC 0384 would be \[
[67.406 \times 26.4913 \times 0.60 \times (0.8377 + 0.0245)] + (67.406 \times 26.4913 \times 0.40) = (1,071.4035 \times 0.8622) + 714.269 = 1,638.03.\]

The relative weight for the second APC (0440) is 3.2632 and the payment-status indicator is S.  So the adjusted Medicare payment for APC 0440 would be \[
[67.406 \times 3.2632 \times 0.60 \times (0.8377 + 0.0245)] + (67.406 \times 3.2632 \times 0.40) = (131.97555 \times 0.8622) + 87.9837 = 201.77.\]

The relative weight for the third APC (0622) is 25.3344 and the payment-status indicator is T.  Therefore, the adjusted Medicare payment for APC 0622 would be \[
[67.406 \times 25.3344 \times 0.60 \times (0.8377 + 0.0245)] + (67.406 \times 25.3344 \times 0.40) = (1,024.6143 \times 0.8622) + 683.06544 = 1,566.49.\]

The relative weight for the fourth APC (0617) is 7.3492 and the payment-status indicator is S.  Therefore, the adjusted Medicare payment for APC 0617 would be \[
[67.406 \times 7.3492 \times 0.60 \times (0.8377 + 0.0245)] + (67.406 \times 7.3492 \times 0.40) = (297.2281 \times 0.8622) + 1366 74 Fed. Reg. at 60,685.
1367 Id.
1369 74 Fed. Reg. at 60,685.
1371 74 Fed. Reg. at 60,685.
1373 74 Fed. Reg. at 60,685.
$198.15206 = $454.42.\textsuperscript{1374}

Because the claim contains two surgical APC codes (0384 and 0622) with payment-status indicator T, the multiple-surgery payment-reduction rule applies.\textsuperscript{1375} The full payment for APC 0384 was $1,638.03 and the full payment for APC 0622 was $1,566.49, so CMS will reduce the latter payment by half.\textsuperscript{1376} Thus, the payment for the entire claim would be $1,638.03 + $201.77 + ($1,566.49 X 0.5) + $454.42 = $3,077.47.\textsuperscript{1377} But this is not the final payment the hospital is entitled to from Medicare because the patient, or Medicare beneficiary, must also make a copayment for the hospital outpatient services and the hospital may also be entitled to a high-cost outlier payment.\textsuperscript{1378}

d. APC Beneficiary Copayments

The Social Security Act provides that a Medicare beneficiary must make a copayment for hospital outpatient services of not less than 20% and not more than 40% for CY 2010.\textsuperscript{1379} CMS regulations limit the amount of any copayments paid during a year to the inpatient hospital deductible amount for that year.\textsuperscript{1380} And hospitals may elect to reduce copayments for a calendar year and advertise the reduced copayments to attract patients.\textsuperscript{1381} But a hospital may not reduce any copayment for a service below 20% of the normal OPPS payment for that service.\textsuperscript{1382}

To determine the beneficiary copayment for a particular APC code, CMS must first
determine the beneficiary-payment percentage.\textsuperscript{1383} CMS uses Final Rule Addendum A to accomplish this in one of two ways: (1) if Addendum A lists a national-unadjusted copayment amount for a particular APC, then the beneficiary-payment percentage is the national-unadjusted copayment from Addendum A divided by the national-unadjusted payment rate from Addendum A; or (2) if Addendum A does not list a national-unadjusted copayment amount for the APC, then the beneficiary-payment percentage is 20%.\textsuperscript{1384}

The next step is to determine the wage-adjusted copayment amount.\textsuperscript{1385} The wage-adjusted copayment amount is the adjusted Medicare amount multiplied by the beneficiary-payment percentage.\textsuperscript{1386} If the hospital fails to comply with the quality-data reporting requirements, CMS multiplies the wage-adjusted copayment amount by 0.98 to get the beneficiary copayment.\textsuperscript{1387} Otherwise, the beneficiary copayment is simply the wage-adjusted copayment amount.\textsuperscript{1388}

Consider the McCoy Hospital example from the previous section.\textsuperscript{1389} Addendum A does not list national-adjusted copayment amounts for APCs 0384, 0440, or 0622, so the beneficiary-payment percentage for each of these APCs is 20%.\textsuperscript{1390} But APC 0617 shows a national-unadjusted copayment of $111.59 so CMS must determine the beneficiary-payment percentage for it.\textsuperscript{1391} Because the national-unadjusted payment rate for APC 0617 is $495.38, the beneficiary-payment percentage is ($111.59 / $495.38) = 22.5%.\textsuperscript{1392} Recall that the adjusted Medicare payments for the four APCs in the example were

\begin{thebibliography}{99}
\bibitem{1383} 74 Fed. Reg. at 60,430.
\bibitem{1384} 74 Fed. Reg. at 60,431.
\bibitem{1385} \textit{Id.}
\bibitem{1386} \textit{Id.}
\bibitem{1387} \textit{Id.}
\bibitem{1388} \textit{Id.}
\bibitem{1389} \textit{Supra}, Part IV(A)(ii)(c).
\bibitem{1390} 74 Fed. Reg. at 60,431, 60,685.
\bibitem{1391} \textit{Id.}
\bibitem{1392} \textit{Id.}
\end{thebibliography}
$1,638.03 for APC 0384, $201.77 for APC 0440, $783.25 for APC 4622 after the multiple-
surgery reduction, and $454.42 for APC 0617.\footnote{Supra, Part IV(A)(ii)(c).} So the total beneficiary copayment amount
for the claim is ($1,638.03 X 20\%) + ($201.77 X 20\%) + ($783.25 X 20\%) + ($454.42 X 22\%) =
$624.58.\footnote{74 Fed. Reg. at 60,431.} Finally, because CMS reduces the amount Medicare pays for a claim by the amount
of any copayment, coinsurance, or deductible, the amount the government is obligated to pay for
the entire claim is $3,077.47 – 624.58 = $2,452.89.\footnote{Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinurance
Amounts for CY 2011, 75 Fed. Reg. 68,799, 68,800 (Nov. 9, 2010).}

\textbf{e. Outlier Payments}

CMS will pay a hospital an additional amount for high-cost outpatient services that
satisfy certain conditions.\footnote{Adjustments to National Program Payment and Beneficiary Copayment Amounts, 42 C.F.R. § 419.43(d) (2009).} To find out whether a claim is eligible for an outlier payment,
CMS must first determine the proper cost-to-charge ratio (CCR) to use for the hospital and apply
it to the charges for a particular APC to get the \textit{cost of furnishing the service}.\footnote{Id.; 74 Fed. Reg. at 60,428.} Though the
regulation specifies that CMS must use the “overall \textit{ancillary} cost-to-charge ratio,” CMS has
interpreted that to mean the hospital’s \textit{overall CCR} rather than any departmental CCRs.\footnote{\textsection 419.43(d)(5)(ii) (emphasis added); CTRS. FOR MEDICARE & MEDICAID SERVS., PUB. 100-04 MEDICARE
CLAIMS PROCESSING, TRANSMITTAL 1657 9 (2008), available at
overall CCR is the operating CCR plus the capital CCR that come from the most recent provider
cost reports that CMS publishes in a Provider Specific File.\footnote{\textsection 419.43(d)(5)(ii); Inpatient PSF, supra note 1246.} CMS may alternatively use
statewide CCRs that it publishes the IPPS Final Rule’s Table 8A and Table 8B.\footnote{Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long
Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Final Rule, 75 Fed. Reg. 50,041, 50,590-92 (Aug. 16, 2010).} Figure 27

\footnotesize
\begin{itemize}

\item \footnote{Supra, Part IV(A)(ii)(c).}
\item \footnote{74 Fed. Reg. at 60,431.}
\item \footnote{Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinurance
Amounts for CY 2011, 75 Fed. Reg. 68,799, 68,800 (Nov. 9, 2010).}
\item \footnote{Adjustments to National Program Payment and Beneficiary Copayment Amounts, 42 C.F.R. § 419.43(d) (2009).}
\item \footnote{Id.; 74 Fed. Reg. at 60,428.}
\item \footnote{\textsection 419.43(d)(5)(ii) (emphasis added); CTRS. FOR MEDICARE & MEDICAID SERVS., PUB. 100-04 MEDICARE
CLAIMS PROCESSING, TRANSMITTAL 1657 9 (2008), available at
\item \footnote{\textsection 419.43(d)(5)(ii); Inpatient PSF, supra note 1246.}
\item \footnote{Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long
Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Final Rule, 75 Fed. Reg. 50,041, 50,590-92 (Aug. 16, 2010).}
\end{itemize}
shows the formula for calculating the cost of furnishing the service.\footnote{Infra, Figure 27.}

\[\text{Cost of Furnishing a Service} = \frac{(\text{Operating CCR} + \text{Capital CCR}) \times \text{Charges for the APC}}{}\]

Figure 27. Cost of Furnishing the Service for a Particular APC.\footnote{74 Fed. Reg. at 60,428.}

Once CMS determines the cost of furnishing the service, it must compare it to the adjusted Medicare payment for the service.\footnote{\S 419.43(d)(1).} If the cost of furnishing the service exceeds 1.75 times the adjusted Medicare payment and it exceeds the adjusted Medicare payment plus a fixed-dollar threshold, the APC is eligible for an outlier payment.\footnote{74 Fed. Reg. at 60,426.} For CY 2010, the fixed-dollar threshold is $2,175.\footnote{74 Fed. Reg. at 60,428.} Finally, the outlier payment is equal to 50% of the difference between the cost of furnishing the service and 1.75 times the adjusted Medicare payment.\footnote{Id.} Figure 28 depicts the APC outlier payment.\footnote{Infra, Figure 28.}

\[\text{APC Outlier Payment} = \begin{cases} \frac{\left(\left((\text{Operating CCR} + \text{Capital CCR}) \times \text{Charges for the APC}\right) - (\text{Adjusted Medicare Payment} \times 1.75)\right)}{0.5} \end{cases}\]

Figure 28. APC Outlier Payment Calculation.\footnote{74 Fed. Reg. at 60,428.}

Recall that in the McCoy Hospital example, the hospital’s operating CCR is 0.38 (38%) and its capital CCR is 0.042 (4.2%).\footnote{Supra, Part IV(A)(i)(g).} Recall also that the adjusted Medicare payment for APC

\footnotesize{\begin{tabular}{l}
1401 Infra, Figure 27. \\
1402 74 Fed. Reg. at 60,428. \\
1403 § 419.43(d)(1). \\
1404 74 Fed. Reg. at 60,426. \\
1405 74 Fed. Reg. at 60,428. \\
1406 Id. \\
1407 Infra, Figure 28. \\
1408 74 Fed. Reg. at 60,428. \\
1409 Supra, Part IV(A)(i)(g). \\
\end{tabular}}
0384 was $1,638.03. Assume that the charges associated with APC 0384 were $9,300. The cost of furnishing the service would be $(0.38 + 0.042) \times 9,300.00 = 3,924.60. The two thresholds would be $1.75 \times 1,638.03 = 2,866.55$ and $2,175 + 1,638.03 = 3,183.03. Because the cost ($3,924.60) is greater than both thresholds ($2,866.55 and $3,183.03), the resulting APC outlier payment for APC 0384 would be $[(0.38 + 0.042) \times 9,300.00] - 2,866.55 \times 0.5 = ($3,924.60 - 2,866.55) \times 0.5 = 1,058.05 \times 0.5 = 529.03$.

### iii. Ambulatory-Surgery Center (ASC) Reimbursement

An Ambulatory-Surgery Center (ASC) is any facility that furnishes surgical services to patients when treatment is not expected to last more than twenty-four hours. To qualify for payment under Medicare Part B, an ASC must meet certain conditions and have an agreement with Medicare. In 2003, the Medicare Modernization Act amended the Social Security Act to require CMS to implement a revised payment system for ASCs no later than January 1, 2008. CMS phased revisions into the system in over a period of years and will rely on it completely beginning in CY 2011. CMS based the revised system on the HCPCS coding system and the Medicare OPPS APC groups and relative weights. CMS publishes updates to the ASC payment methodology and related data in the Federal Register annually.

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1410 Supra, Part IV(A)(ii)(c).
1411 74 Fed. Reg. at 60,428.
1412 Id.
1413 Id.
1415 Id.; Basic Requirements, 42 C.F.R. § 416.25(b) (2010).
1417 Determination of Payment Rates for ASC Services, 42 C.F.R. § 416.171(c)(4) (2010).
1418 Basis of Payment, 42 C.F.R. § 416.167 (2010).
The ASC system pays for certain surgical procedures and ancillary services.\textsuperscript{1420} Covered surgical procedures are those that neither “pose a significant safety risk” nor normally require “active medical monitoring and care at midnight following the procedure.”\textsuperscript{1421} They include the CPT Category I codes in the surgical range (codes 10000 through 69999), HCPCS Level II codes, and CPT Category III codes that crosswalk, or are clinically similar, to other procedure codes that do not pose a significant safety risk and do not require an overnight stay.\textsuperscript{1422} They do not include more complex procedures that usually result in more than nominal blood loss, require extensive or prolonged invasion, involve major arteries or veins, or are emergency or life-threatening procedures, among others.\textsuperscript{1423}

The revised payment system represents packaged rates that include (1) the procedure; (2) nursing and technical services; (3) the facility’s use; (4) certain laboratory tests; (5) certain drugs and biologicals; (6) specific medical and surgical supplies; (7) equipment and surgical dressing; (8) some kinds of prosthetics and durable medical equipment; (9) certain radiology services; (10) administration and recordkeeping; (11) anesthesia supervision; and (12) other services and articles.\textsuperscript{1424} But CMS excludes some other services from payment because it pays for those services under Code of Federal Regulations Title 42, Part 414.\textsuperscript{1425} These involve (1) physician services; (2) anesthetist services; (3) non-integral radiology services; (4) unrelated diagnostic procedures; (5) ambulance services; (6) limb braces; (7) prosthetic limbs; and (8) particular prosthetic devices and durable medical equipment.\textsuperscript{1426} Addendum AA to the Final Rule contains

\begin{footnotes}
\item[1420] Definitions, 42 C.F.R. § 416.2 (2009).
\item[1421] Covered Surgical Procedures, 42 C.F.R. § 416.166(b) (2009).
\item[1423] § 416.166(c).
\item[1424] Scope of ASC Services, 42 C.F.R. § 416.164(a) (2009).
\item[1425] § 416.164(c).
\item[1426] Id.
\end{footnotes}
a list of covered surgical procedures.\textsuperscript{1427}

The ASC system also pays for ancillary services and items that are integral to a covered procedure.\textsuperscript{1428} These services comprise this group: (1) brachytherapy (targeted radiation) sources; (2) certain implants; (3) articles and services designated as “contractor-priced”; (4) specific drugs and biologicals entitled to separate payment; and (5) certain radiology services entitled to separate payment.\textsuperscript{1429} A list of covered ancillary services appears in Final Rule Addendum BB.\textsuperscript{1430}

\textit{a. Payment Status Indicators}

As the previous section discusses, CMS does not pay for all ASC services using the OPPS methodology based on APC relative weights.\textsuperscript{1431} To determine which methodology to use, CMS provides ASC payment-status indicators for each procedure code appearing in Final Rule Addenda AA and BB.\textsuperscript{1432} Final Rule Addendum DD1 contains the ASC payment-status indicators.\textsuperscript{1433} The ASC payment system actually uses seven major payment methodologies based on (1) the APC relative weight; (2) Medicare physician reimbursement; (3) a contractor-priced rate; (4) no payment at all; (5) an adjusted rate; (6) reasonable cost; or (7) a special payment methodology.\textsuperscript{1434} Table 23 contains the complete list of ASC payment-status indicators.\textsuperscript{1435}

\textsuperscript{1427} Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule, 74 Fed. Reg. 69,501, 69,505 (Dec. 31, 2009).
\textsuperscript{1428} Definitions, 42 C.F.R. § 416.2 (2009).
\textsuperscript{1429} § 416.164(b).
\textsuperscript{1430} 74 Fed. Reg. at 69,630.
\textsuperscript{1431} Determination of Payment Rates for ASC Services, 42 C.F.R. §§ 416.171(b), (d) (2009).
\textsuperscript{1432} 74 Fed. Reg. at 69,505, 69,630.
\textsuperscript{1433} Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule, 74 Fed. Reg. 60,315, 60,945-46 (Nov. 20, 2009).
\textsuperscript{1434} Id.
\textsuperscript{1435} Infra, Table 23.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2</td>
<td>Surgical procedure on ASC list in 2007 – payment based on APC.</td>
</tr>
<tr>
<td>D5</td>
<td>Deleted or discontinued – no payment.</td>
</tr>
<tr>
<td>F4</td>
<td>Corneal tissue acquisition or hepatitis B vaccine – paid at reasonable cost.</td>
</tr>
<tr>
<td>G2</td>
<td>Non office-based surgical procedure added in CY 2008 or later – payment based on APC.</td>
</tr>
<tr>
<td>H2</td>
<td>Brachytherapy source paid separately – payment based on APC.</td>
</tr>
<tr>
<td>H8</td>
<td>Device-intensive procedure on ASC list in CY 2007 – paid at adjusted rate.</td>
</tr>
<tr>
<td>J7</td>
<td>Pass-through device paid separately – payment contractor-priced.</td>
</tr>
<tr>
<td>J8</td>
<td>Device-intensive procedure added to ASC list in 2008 or later – paid at adjusted rate.</td>
</tr>
<tr>
<td>K2</td>
<td>Drugs and biological paid separately – payment based on APC.</td>
</tr>
<tr>
<td>K7</td>
<td>Unclassified drugs and biological – payment contractor-priced.</td>
</tr>
<tr>
<td>L1</td>
<td>Influenza or pneumococcal vaccine – no separate payment made.</td>
</tr>
<tr>
<td>L6</td>
<td>New technology intraocular lens – special payment.</td>
</tr>
<tr>
<td>N1</td>
<td>Packaged service or item – no separate payment made.</td>
</tr>
<tr>
<td>P2</td>
<td>Office-based surgical procedure – payment based on APC.</td>
</tr>
<tr>
<td>P3</td>
<td>Office-based surgical procedure – payment based on physician payment.</td>
</tr>
<tr>
<td>R2</td>
<td>Office-based surgical procedure – payment based on APC.</td>
</tr>
<tr>
<td>Z2</td>
<td>Radiology service entitled to separate payment – payment based on APC.</td>
</tr>
<tr>
<td>Z3</td>
<td>Radiology service entitled to separate payment – payment based on physician payment.</td>
</tr>
</tbody>
</table>

Table 23. ASC Payment-Status Indicators.\(^{1436}\)

Because the vast majority of claims primarily rely on the ASC payment methodology that uses APC relative weights for procedures having a payment-status indicator of A2, G2, K2, P2, R2, and Z2, this paper focuses on that methodology and does not address other payment methodologies.\(^{1437}\)

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\(^{1436}\) 74 Fed. Reg. at 60,945-46.

\(^{1437}\) Id.
b. **Conversion Factor**

Like the OPPS system based on APCs, the ASC payment system uses a single *conversion factor* for all surgery centers in the country.\(^{1438}\) CMS updates the conversion factor each year based on budget-neutrality considerations and wage indexes or based on U.S. city average consumer-price index.\(^{1439}\)

In 2006, Congress required that CMS reduce the update applied to the conversion factor by 2.0 percent for any ASC that had failed to supply it with certain quality data in the previous year.\(^{1440}\) So while the *full conversion factor* for CY 2010 is $41.873, failure to report quality data results in CMS using $41.036 as the *reduced conversion factor*.\(^{1441}\) ASCs must report on quality measures that are similar to those required of hospital outpatient departments under the OPPS.\(^{1442}\)

c. **ASC Payment**

CMS bases most ASC payments on the APC-based method, which applies to procedure codes having a payment-status indicator of A2, G2, K2, P2, R2, or Z2.\(^{1443}\) For each procedure code on a claim with one of these payment-status indicators, CMS determines the *relative weight* for the it by finding the procedure code in Final Rule Addendum B.\(^{1444}\) Then CMS multiplies the full conversion factor by the relative weight to get the *full national unadjusted payment rate* for

\(^{1438}\) Determination of Payment Rates for ASC Services, 42 C.F.R. § 416.171(a) (2009).
\(^{1439}\) 74 Fed. Reg. at 60,628.
\(^{1441}\) 74 Fed. Reg. at 60,629.
\(^{1442}\) *Id.; see also supra* Part IV(A)(ii)(b) (describing some OPPS quality measures).
\(^{1443}\) 74 Fed. Reg. at 60,945-46.
\(^{1444}\) 74 Fed. Reg. at 60,752.
the procedure code. If the ASC fails to comply with the quality-reporting requirements, CMS multiplies the reduced conversion factor by the relative weight to get the reduced national unadjusted payment rate for the procedure code.

Next, CMS multiplies the national unadjusted rate (whether the full rate or the reduced rate) by 50% to determine the labor-related portion, which is equal to the nonlabor-related portion. CMS adjusts the labor-related portion using a hospital wage index categorized by Core Based Statistical Areas that the Office of Management and Budget issued in 2003. The FY 2011 Final Rule for the Hospital IPPS highlights the most recent urban and rural hospital wage indexes in Tables 4A and 4B, respectively. Once CMS knows the hospital wage index, it multiplies the labor-related portion by the hospital wage index to determine the geographically-adjusted labor-related portion. CMS adds the geographically-adjusted labor-related portion to the nonlabor-related portion, which determines the geographically-adjusted payment rate. Finally, CMS multiplies the lesser of the geographically-adjusted payment rate and the amount actually charged for the procedure on the claim by 80% to produce the full ASC procedure amount. Figure 29 shows how CMS arrives at the full ASC procedure amount.

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1445 Determination of Payment Rates for ASC Services, 42 C.F.R. § 416.171(a) (2010).
1446 Id.; 74 Fed. Reg. at 60,629.
1447 74 Fed. Reg. at 60,625.
1448 Adjustments to National Payment Rates, 42 C.F.R. § 416.172(c) (2009); 74 Fed. Reg. at 60,625.
1449 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Final Rule, 75 Fed. Reg. 50,041, 50,511, 50,516 (Aug. 16, 2010).
1450 § 416.172(c); Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule, 74 Fed. Reg. 60,315, 60,625 (Nov. 20, 2009).
1451 § 416.172(c); 74 Fed. Reg. at 60,625.
1452 § 416.172(b); Basis and Scope, 42 C.F.R. § 416.160(2) (2009).
1453 Infra, Figure 29.
Similarly, CMS multiplies the lesser of the geographically-adjusted payment rate and the amount actually charged for the procedure on the claim by 20% to produce the beneficiary copayment for the procedure.\(^{1455}\)

If a claim contains multiple procedures, then CMS may reduce the payment for secondary procedures.\(^{1456}\) This *multiple-procedure rule* applies only to procedures that CMS designates as subject to multiple-procedure reductions according to Final Rule Addendum AA.\(^{1457}\) Under the multiple-procedure rule, CMS will pay the full amount for the procedure with the highest full ASC procedure amount and will pay other procedures at 50% of their full ASC procedure amounts.\(^{1458}\)

Like APC payment under the OPPS, other payment reduction rules apply when a surgery is interrupted because of “extenuating circumstances or circumstances that threaten the well-being of the patient.”\(^{1459}\) Medicare pays the full amount if the procedure involves anesthesia but the ASC staff stops the procedure any time after it administers anesthesia to the patient.\(^{1460}\) If the

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\(^{1454}\) Basis and Scope, 42 C.F.R. § 416.160(2) (2009); Determination of Payment Rates for ASC Services, 42 C.F.R. § 416.171(a) (2009); § 416.172(c); 74 Fed. Reg. at 60,625, 60,629. Substitute 0.2 for 0.8 in this formula to calculate the beneficiary coinsurance. Amounts of Payment, 42 C.F.R. § 410.152(i)(2) (2009).

\(^{1455}\) § 410.152(i)(2).

\(^{1456}\) § 416.172(e).

\(^{1457}\) 74 Fed. Reg. at 60,629, 60,692.

\(^{1458}\) 74 Fed. Reg. at 60,629.

\(^{1459}\) § 416.172(f).

\(^{1460}\) § 416.172(f)(1).
procedure does not require anesthesia or the ASC staff stops the procedure before it administers anesthesia, Medicare pays half the ASC procedure amount.\textsuperscript{1461}

To arrive at a final payment for a claim after CMS has made all the necessary adjustments, it adds all the ASC procedure amounts.\textsuperscript{1462} But CMS may limit payment on the claim because the beneficiary has yet to satisfy the yearly Medicare Part B deductible.\textsuperscript{1463} For CY 2010, the Medicare Part B deductible is $155.\textsuperscript{1464} CMS deducts any unsatisfied deductible portion from the final payment for the claim.\textsuperscript{1465}

As an example, consider a hypothetical ASC located in Abilene, Texas, called Chapel Care Center (CCC), and assume that it complies with the quality data reporting requirements, which entitles it to use the full conversion factor, $41.873. Further assume that the surgeon working at CCC removed bone from a patient for a graft (CPT 20902), performed a bone graft on the patient’s mandible (CPT 21210), and CCC billed $1,500 for each procedure.\textsuperscript{1466} Presume that the patient has already paid $50 in deductibles during the calendar year. The wage index for Abilene is 0.8377.\textsuperscript{1467}

The APC relative weight for procedure 20902 is 31.7717.\textsuperscript{1468} So the geographically-adjusted payment rate for procedure 20902 would be \((31.7717 \times 41.873 \times 0.5 \times 0.8377) + (31.7717 \times 41.873 \times 0.5) = 557.23 + 665.19 = 1,222.42.\textsuperscript{1469} CCC charged $1,500 for procedure 20902, which is more than the procedure’s geographically-adjusted payment rate of

\textsuperscript{1461} §§ 416.172(f)(1)-(3).
\textsuperscript{1462} See § 416.172(e) (describing handling of multiple procedures).
\textsuperscript{1463} § 416.172(d).
\textsuperscript{1465} § 416.172(d).
\textsuperscript{1466} 74 Fed. Reg. at 60,761-62.
\textsuperscript{1467} Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Final Rule, 75 Fed. Reg. 50,041, 50,511 (Aug. 16, 2010).
\textsuperscript{1468} 74 Fed. Reg. at 60,761.
\textsuperscript{1469} §§ 416.160(2), .171(a), .172(c); 74 Fed. Reg. at 60,625, 60,629.
$1,222.42, so the full ASC amount for procedure 20902 would be $1,222.42 \times 0.8 = $977.94.\textsuperscript{1470}

The APC relative weight for procedure 21210 is 42.9827.\textsuperscript{1471} The geographically-adjusted payment rate for procedure 21210 would be \((42.9827 \times $41.873 \times 0.5 \times 0.8377) + (42.9827 \times $41.873 \times 0.5) = $753.85 + $899.91 = $1,653.76.\textsuperscript{1472} But CCC charged $1,500 for procedure 21210, which is less than the geographically-adjusted payment rate of $1,653.76, so the full ASC procedure amount for procedure 21210 would be $1,500.00 \times 0.8 = $1,200.00.\textsuperscript{1473}

Because both procedures are subject to the multiple-procedure reduction rule, the payment for procedure 20902 would be reduced to $977.94 \times 0.5 = $488.97.\textsuperscript{1474} And because the patient has yet to satisfy the $155 yearly deductible, the final payment for the entire claim would be $1,200.00 + $977.94 – ($155 – $50) = $2,072.94.\textsuperscript{1475}

Similarly, the patient would have to pay a copayment of $1,222.42 \times 0.2 = $244.48 for procedure 20902 and $1,500.00 \times 0.2 = $300.00 for procedure 21210.\textsuperscript{1476} So the patient’s total liability including deductible would be $244.48 + $300.00 + $105.00 = $649.48.\textsuperscript{1477}

iv. Physician Reimbursement

In the 1980s, the prevailing system for reimbursing physicians, even under public-payment systems, involved the use of usual, customary, and reasonable (UCR) charges.\textsuperscript{1478} Experts criticized that method of payment for creating perverse incentives that encouraged

\textsuperscript{1470} §§ 416.160(2), .172(b).
\textsuperscript{1471} 74 Fed. Reg. at 60,672.
\textsuperscript{1472} Basis and Scope, 42 C.F.R. § 416.160(2) (2009); Determination of Payment Rates for ASC Services, 42 C.F.R. § 416.171(a) (2009); § 416.172(c); 74 Fed. Reg. at 60,625, 60,629. Substitute 0.2 for 0.8 in this formula to calculate the beneficiary coinsurance. Amounts of Payment, 42 C.F.R. § 410.152(i)(2) (2009); 74 Fed. Reg. at 60,625, 60,629.
\textsuperscript{1473} §§ 416.160(2), .172(b).
\textsuperscript{1474} 74 Fed. Reg. at 60, 629, 60,699-700.
\textsuperscript{1475} § 416.172(d); see also § 416.172(e) (describing handling of multiple procedures).
\textsuperscript{1476} Amounts of Payment, 42 C.F.R. § 410.152(i)(2) (2009).
\textsuperscript{1477} § 416.172(d); see also § 416.172(e) (describing handling of multiple procedures).
\textsuperscript{1478} William C. Hsiao et al., Estimating Physicians’ Work for a Resource-Based Relative-Value Scale, 319 NEW ENG. J. MED. 835, 835 (1988) [hereinafter Hsiao RBRVS].
doctors to specialize, practice mainly in urban areas, and work primarily in hospital settings even though stated national policies encouraged primary care, rural and suburban practice, and non-hospital services.1479 Others criticized the UCR method for being complex and inflationary (although it is hard to imagine how today’s “reformed” system, which produces thousands of pages of regulation each year, could be characterized as simple and cost-effective).1480 Doctors criticized the UCR payment method “as irrational, inequitable, and possibly leading to abuse.”1481

As early as the 1940s, providers and payers developed and experimented with relative-value-scale concepts, but progress was subject to fits and starts.1482 In 1982, the Supreme Court held that two medical associations engaged in illegal price fixing when they used relative values and conversion factors to set billing rates.1483 Not long after that, the Federal Trade Commission (FTC) advised the American Society of Internal Medicine (ASIM) that its proposal to develop and distribute relative-value guides for physicians might create a “combination or conspiracy that unreasonably restrains competition among physicians in violation of Section 5 of the Federal Trade Commission Act.”1484 Nevertheless, in 1985, Congress pressed forward and directed the Congressional Office of Technology Assessment to study and develop a relative-value scale for physician services payment.1485

As part of that effort, Dr. William Hsiao of Harvard University School of Public Health led a team that devised a system of classifying services using a resource-based relative-value

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1479 Id.
1481 Id.
In 1989, Congress amended section 1848 of the Social Security Act to require the Health Care Financing Administration (HCFA, now CMS) to implement a relative-value scale for physician reimbursement to begin no later than January 1, 1992. HCFA adopted the Hsiao team’s RBRVS design and, in CY 1992, began phasing it in. Today, the RBRVS system is responsible for calculating 85% of physician’s Medicare payments.

The RBRVS system applies to a wide range of physician services, primarily (1) professional services of doctors of medicine, osteopathy, optometry, podiatry, dental surgery and dental medicine, and chiropractors; (2) supplies incident to these services; (3) certain diagnostic tests; and (4) bone mass measurement and mammography. It comprises a payment method that employs relative-value units, geographical practice-cost indices, payment-status indicators, and a national conversion factor.

a. Relative-Value Units (RVUs)

The Medicare RBRVS system for physician payment uses a schedule of HCPCS codes that adjusts the payment for an individual code, package of codes (multiple codes tied to a particular service), or code bundle (all the codes for a particular service) according to the amount of work a physician does to deliver the service, the expenses to the physician’s practice for the service, and the physician’s expenses for malpractice insurance. It employs three distinct relative-value units (RVUs) matched to each procedure code: (1) a physician-work relative-value unit (Work RVU); (2) a practice-expense relative-value unit (PE RVU); and (3) a malpractice-
insurance relative-value unit (MP RVU). CMS publishes this schedule of codes and RVUs in Final Rule Addendum B for each calendar year.

The Work RVU is a scaling factor that rates the amount of work required to perform a particular service to the amount of work required to perform other services. It takes the physician’s skill and expertise into account as well as the service’s complexity. For example, for a relatively simple analysis of readouts from a spine infusion pump (CPT 62368), the Work RVU for CY 2010 is 0.75. But for a more complex procedure such as a lung removal (CPT 32445), it is 63.84.

The PE RVU is based on average historical practice costs and considers general categories of expenses such as office rent, and personnel costs. CMS also considers the costs of most medical supplies to be part of the physician’s practice expense and factors those costs into the PE RVU. Final Rule Addendum B contains both a facility and a non-facility PE RVU for each procedure code and CMS applies the appropriate PE RVU, depending on the setting. CMS reduces the PE RVU when the physician performs a procedure in a “facility setting” because the facility bills for facility-related expenses separately from the physician. Facility settings are primarily (1) hospital outpatient facilities, clinics, and emergency rooms; (2) hospital inpatient facilities; (3) outpatient and inpatient rehabilitation facilities; (4) inpatient...

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1492 Relative Value Units (RVUs), 42 C.F.R. § 414.22 (2009).
1493 Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Final Rule, 74 Fed. Reg. 61,737, 62,014, 62,017 (Nov. 25, 2009).
1494 § 414.22(a)(1).
1495 74 Fed. Reg. at 61,742.
1498 § 414.22(b)(1); 74 Fed. Reg. at 61,742.
1499 Payment for Services and Supplies Incident to a Physician’s Service, 42 C.F.R. § 414.34(a) (2009).
1501 Determining Payments for Certain Physicians’ Services Furnished in Facility Settings, 42 C.F.R. § 414.32(b) (2009).
psychiatric facilities; and (5) skilled-nursing facilities. The adjustment applies to services that a physician would ordinarily render in the physician’s office—not a more formal setting. But the adjustment does not apply to (1) rural health clinics; (2) certain surgeries performed in ASCs; (3) anesthesiology; or (4) diagnostic and therapeutic radiology services. Using the previous examples, spine infusion pump analysis (CPT 62368) performed in a doctor’s office yields a PE RVU of 0.84, but the same procedure performed in a facility setting has a PE RVU of 0.31—barely more than a third of the PE RVU for the office setting. And a doctor can only perform more complex procedures like the lung removal procedure (CPT 32445) in a facility, so the PE VU is 22.60.

The MP RVU is a scaling factor based on relative malpractice insurance resources. CMS determines the MP RVUs using data from across the country concerning medical malpractice insurance premiums. The spine infusion-pump analysis (CPT 62368) MP RVU for CY 2010 is 0.06. But the lung removal procedure (CPT 32445) MP RVU is 10.80—180 times the MP RVU for the simpler procedure.

CMS publishes new RVUs in the Federal Register each year for new and revised HCPCS Level I and II codes. And it must publish any changes to RVUs for HCPCS Level I and II codes at least every five years. But carriers (fiscal intermediaries or Medicare Administrative

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1502 § 414.32(a).
1503 § 414.32(c).
1504 § 414.32(d).
1506 74 Fed. Reg. at 62,047. Note that for procedures that a doctor can only perform in a facility setting, the “Fully Implemented Non-Facility PE RVUs” and “Year 2010 Transitional Non-Facility PE RVUs” entries in Addendum B contain “NA.” 74 Fed. Reg. at 62,015.
1507 Relative Value Units (RVUs), 42 C.F.R. § 414.22(c)(3) (2009).
1508 74 Fed. Reg. at 61,742.
1512 § 414.24(b).
Contractors) establish RVUs for any local codes after securing approval from CMS.\textsuperscript{1513}

\textbf{b. Geographical Practice Cost Indices (GPCIs)}

CMS used to apply a geographic-adjustment factor (GAF) to the overall fee-schedule payment, but federal law required it to develop separate Geographical Practice Cost Indices (GPCIs, pronounced “gypsies”) for the work, practice-expense, and malpractice components.\textsuperscript{1514} The GPCIs measure differences in resource cost for localities as compared to a national average for each fee-schedule component.\textsuperscript{1515} CMS must review and update the GPCIs every three years.\textsuperscript{1516} CMS publishes the GPCIs for each state and Medicare locality in Final Rule Addendum E.\textsuperscript{1517}

For example, for rural Montana in CY 2010, the Work GPCI is 0.950, the PE GPCI is 0.847, and the MP GPCI is 0.673.\textsuperscript{1518} But in urban San Francisco, California, the Work GPCI is 1.059, the PE GPCI is 1.441 (almost twice as much), and the MP GPCI is 0.414.\textsuperscript{1519}

\textbf{c. Payment-Status Indicators}

The payment-status indicator column of Final Rule Addendum B shows how carriers price each code and whether the carrier will pay the code separately.\textsuperscript{1520} But it does not indicate whether Medicare will actually pay for the code.\textsuperscript{1521} CMS generally makes national coverage

\begin{flushright}
\textsuperscript{1513} § 414.24(c).
\textsuperscript{1514} 42 U.S.C. § 1395w-4(e)(1)(A) (2010); 74 Fed. Reg. at 61,756.
\textsuperscript{1515} 74 Fed. Reg. at 61,756.
\textsuperscript{1516} § 1395w-4(e)(1)(C) (2010).
\textsuperscript{1517} 74 Fed. Reg. at 62,148.
\textsuperscript{1518} Id.
\textsuperscript{1519} Id.
\textsuperscript{1520} 74 Fed. Reg. at 62,015, 62,017.
\textsuperscript{1521} 74 Fed. Reg. at 62,015.
\end{flushright}
determinations for each code, but if it has made no national coverage decision for a code, the coverage determination for that code is left to the carrier.1522 Table 24 shows the payment-status indicators for the RBRVS system.1523

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Active code paid separately.</td>
</tr>
<tr>
<td>B</td>
<td>Bundled code paid under the aegis of another code.</td>
</tr>
<tr>
<td>C</td>
<td>Carriers price the code separately—generally following a documentation review.</td>
</tr>
<tr>
<td>D</td>
<td>Deleted or discontinued code.</td>
</tr>
<tr>
<td>E</td>
<td>Code excluded from the fee schedule but may be paid under a reasonable charge procedure.</td>
</tr>
<tr>
<td>F</td>
<td>Deleted or discontinued code not subject to a ninety-day grace period.</td>
</tr>
<tr>
<td>G</td>
<td>Invalid code—Medicare generally uses another code to pay for this service.</td>
</tr>
<tr>
<td>H</td>
<td>Deleted modifier—generally refers to TC (technical component) and PC (professional component) modifiers.</td>
</tr>
<tr>
<td>I</td>
<td>Invalid code—Medicare generally uses another code to pay for this service.</td>
</tr>
<tr>
<td>L</td>
<td>Local code—carriers determine the RVUs and payments for these codes.</td>
</tr>
<tr>
<td>M</td>
<td>Measurement codes used only for reporting purposes.</td>
</tr>
<tr>
<td>N</td>
<td>Non-covered service—no payment made.</td>
</tr>
<tr>
<td>R</td>
<td>Restricted coverage—generally priced by the carrier.</td>
</tr>
<tr>
<td>T</td>
<td>Only paid if the provider bills no other payable services on the same date.</td>
</tr>
<tr>
<td>X</td>
<td>Codes excluded by statute as not fitting the statutory definition of “physician services.”</td>
</tr>
</tbody>
</table>

Table 24. RBRVS Payment-Status Indicators.1524

CMS continually reviews claim data—in cooperation with the AMA’s Relative Value System Update Committee—for nonsurgical services that providers often bill together to determine whether those codes should be bundled under a single payment.1525 And the payment-

1522 Id.
1523 Infra, Table 24.
1525 74 Fed. Reg. at 61,775-76.
status indicators drive that bundling process.\footnote{74 Fed. Reg. at 62,015 (describing payment-status indicators that group codes together for a single payment).}

d. Conversion Factor

In what must now be a familiar drill, the RBRVS payment system employs a national conversion factor that CMS updates each year in a manner similar to the APC and ASC payment systems.\footnote{Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6102, 103 Stat. 2106, 2174-75 (codified at 42 U.S.C. § 1395w-4 (2010)); Conversion Factors, 42 C.F.R. § 414.28 (2009).} CMS applies updates to the conversion factors according to the Medicare Economic Index adjusted to account for physician services expenditures in preceding years.\footnote{Conversion Factor Update, 42 C.F.R. § 414.30(a) (2009).} Until recently, CMS applied a budget-neutrality adjustor to the Work RVU; but in CY 2009, it started rolling the budget-neutrality adjustor into the conversion factor.\footnote{74 Fed. Reg. at 61,743.} The conversion factor for CY 2010 was originally slated to be $28.4061 and would have represented more than a 21% decrease from CY 2009.\footnote{74 Fed. Reg. at 61,968.} But CMS posted a correction notice on May 11, 2010 that changed the conversion factor to $36.0791 for the period from January 1, 2010 to May 31, 2010.\footnote{Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Corrections; Final Rule, 75 Fed. Reg. 26,349, 26,350 (May 11, 2010).} In June 2010, Congress mandated that the conversion factor be increased 2.2% to $36.8729 for the period from June 1 through November 30, 2010.\footnote{Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, Pub. L. No. 111-192, § 101(a), 124 Stat. 1280, 1280 (2010) (codified as amended at 42 U.S.C. § 1395w-4(d) (2010)).}

e. RBRVS Payment

Payment for physician services, the payment amount, under the RBRVS system is the
The lesser of the charges or the fee-schedule amount adjusted to account for coinsurance.\textsuperscript{1533} The use of payment modifiers complicates this seeming simplicity.\textsuperscript{1534} CMS establishes policies for handling payments of codes that use modifiers.\textsuperscript{1535} It handles the professional component (26) and technical component (TC) modifiers by creating three distinct entries for applicable codes in the fee schedule—the first with no modifier, the second with the 26 modifier, and the third with the TC modifier.\textsuperscript{1536} For other modifiers, specific payment rules may apply.\textsuperscript{1537}

Generally, to calculate the fee-schedule amount for a code, CMS multiplies the conversion factor by the sum of the work, practice expense, and malpractice RVUs for the procedure code, each adjusted for the provider’s corresponding GPCIs\textsuperscript{1538}. Again, CMS compares the fee-schedule amount to the amount the provider charges for the service, and the payment amount is 80% of lesser of those two amounts.\textsuperscript{1539} Figure 30 shows the formula CMS uses to determine the payment amount from the fee-schedule amount and the amount charged for the service.\textsuperscript{1540}

\textsuperscript{1533} Medicare Payment Basis, 42 C.F.R. § 414.21 (2009); Amounts of Payment, 42 C.F.R. § 410.152(b)(4) (2009).
\textsuperscript{1534} See supra, Part III(A)(iv)(b) (describing payment modifiers).
\textsuperscript{1535} Coding and Ancillary Policies, 42 C.F.R. § 414.40(b)(3) (2010).
\textsuperscript{1536} Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Final Rule, 74 Fed. Reg. 61,737, 62,015 (Nov. 25, 2009).
\textsuperscript{1537} § 414.40.
\textsuperscript{1538} 74 Fed. Reg. at 61,743.
\textsuperscript{1539} Medicare Payment Basis, 42 C.F.R. § 414.21 (2009); Amounts of Payment, 42 C.F.R. § 410.152(b)(4) (2009).
\textsuperscript{1540} \textit{Infra}, Figure 30.
CMS also controls the rules for paying multiple procedures a provider renders to the same patient on the same date of service—called multiple-procedure payment reductions. CMS has a “longstanding policy of reducing payment for multiple surgical procedures performed on the same patient, by the same physician, on the same day.” In 1995, CMS revised the rule to pay the highest priced procedure at 100% of Medicare payment and the next four highest-priced procedures at 50% of Medicare payment. CMS pays the sixth and subsequent procedures “by report.” Under the Medicare Part B deductible rules, CMS also reduces any provider payment by the yearly deductible amount the patient has not yet met and the patient is responsible for this amount as well 20% coinsurance for each procedure. For CY 2010, the Medicare Part B deductible is $155.

As an example, recall the hypothetical ASC located in Abilene, Texas, Chapel Care

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**Figure 30. RBRVS Payment Amount Calculation.**

\[
\text{Payment Amount} = \min \left\{ \right. \\
\text{Amount Charged,} \\
\text{Conversion Factor} \times \\
\left[ \\
\text{(Work RVU} \times \text{Work GPCI)} \\
\text{+ (PE RVU} \times \text{PE GPCI)} \\
\text{+ (MP RVU} \times \text{MP GPCI)} \\
\right] \\
\times 0.8
\]
Center (CCC) and assume that Dr. Smith performed the surgeries involving removal of bone from patient Will Robinson for a graft (CPT 20902), performed a bone graft on Will’s mandible (CPT 21210), and billed Medicare $500 for each procedure. Also assume that Will Robinson has met $78 of his deductible for CY 2010. The GPCIs for Abilene from Final Rule Addendum E for CY 2010 are 0.968 for the Work GPCI, 0.879 for the PE GPCI, and 1.065 for the MP GPCI.\footnote{Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Final Rule, 74 Fed. Reg. 61,737, 62,148 (Nov. 25, 2009).}

The RVUs for the bone removal procedure (CPT 20902) for CY 2010 are 4.580 for the Work RVU, 3.14 for the PE RVU (the PE RVU for a facility setting), and 0.640 for the MP RVU.\footnote{74 Fed. Reg. at 62,024.} So the fee-schedule amount for this procedure would be $36.8729 \times [(4.580 \times 0.968) + (3.14 \times 0.879) + (0.640 \times 1.065)] = $36.8729 \times (4.43344 + 2.76006 + 0.6816) = $36.8729 \times 7.77606 = $286.73.\footnote{74 Fed. Reg. at 61,743.} Because Dr. Smith charged $500 for the procedure, the payment amount for the procedure would be \(\min($500, $286.73) \times 0.80 = $229.38.\footnote{Medicare Payment Basis, 42 C.F.R. § 414.21 (2009); Amounts of Payment, 42 C.F.R. § 410.152(b)(4) (2009).} Will Robinson would be responsible for a copayment of \(\min($500, $286.73) \times 0.20 = $57.35.\footnote{§ 410.152(i)(2).}

The RVUs for the bone graft procedure (CPT 21210) for CY 2010 are 11.69 for the Work RVU, 10.63 for the PE RVU (the PE RVU for a facility setting), and 1.05 for the MP RVU.\footnote{74 Fed. Reg. at 62,026.} Therefore, the fee-schedule amount for this procedure would be $36.8729 \times [(11.69 \times 0.968) + (10.63 \times 0.879) + (1.05 \times 1.065)] = $36.8729 \times (11.31592 + 9.34377 + 1.11825) = $36.8729 \times 21.77794 = $803.02.\footnote{§ 410.152(b)(4).} Again, because Dr. Smith charged $500 for the procedure, the payment amount for the procedure would be \(\min($500, $803.02) \times 0.80 = $400.00.\footnote{§ 414.21; § 410.152(b)(4).} And Will
Robinson would be responsible for a copayment of \( \min(500, 803.02) \times 0.20 = 100.00 \).\(^{1556}\)

Because Dr. Smith performed both surgeries on Will Robinson on the same day, CMS will apply the multiple-procedure payment-reduction rule and price lower valued procedure, CPT 20902, at 50% of the payment amount: \( 286.73 \times 0.50 = 143.37 \).\(^{1557}\) So the final payment to Dr. Smith from Medicare, accounting for the unmet portion of Will Robinson’s deductible, would be \( 400.00 + 143.37 - (155.00 - 78.00) = 543.37 - 77.00 = 466.37 \).\(^{1558}\) And Will Robinson’s liability for the services, including the remaining deductible amount, would be \( 57.35 + 100.00 + 77.00 = 234.35 \).\(^{1559}\)

B. Private Payment under Managed Care

When President Johnson signed it into law in 1965, Medicare based its reimbursement and claims processing methods on the private systems that existed at the time—primarily fee-for-service systems based on usual and customary charges.\(^{1560}\) But early on, Medicare faced pressure to control costs so it began to limit provider payments.\(^{1561}\) As the years passed, private payers faced the same kind of pressures, so they also began to implement measures to control costs through managed-care arrangements with providers.\(^{1562}\) Today, managed care dominates private health insurance plans.\(^{1563}\)

Managed-care schemes have tended to come in and out of vogue as providers have

\(^{1556}\) § 410.152(i)(2).

\(^{1557}\) Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; and Revisions to the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions; Proposed Rule, 73 Fed. Reg. 38,502, 38,526 (July 7, 2008).

\(^{1558}\) Id.; § 410.152(i)(2).

\(^{1559}\) § 410.152(i)(2).


\(^{1561}\) Payment Lessons, supra note 50.


\(^{1563}\) Id. at 268
experimented with various organizational structures and contractual arrangements. For example, in the 1990s, more than half of risk-sharing networks compensated physicians using capitation. But by 2001, at least one industry survey indicated that only 12% of risk-sharing networks paid physicians on a per-member per-month basis. The Accountable Care Organization model put forth in the Affordable Care Act closely resembles PHO arrangements that were popular in the 1990s. And the consumer-driven plans, marked by tax-exempt health-savings accounts (HSAs) combined with high-deductible insurance policies that gained favor in the early 2000s, suffered a serious blow when Congress placed limits on HSAs in the Affordable Care Act.

But managed-care plans, particularly HMOs, have experienced a consumer backlash that has worked its way into the popular culture as expressed in media and films. Some anxiety between consumers and payers, both private and public, may be attributable to the severe disconnect between what providers charge and what they get paid—a difference of as much as 62%.

Ironically, managed-care reimbursement has tended to follow methodologies that Medicare developed through the years, such as payment based on DRGs, APCs, and RBRVS.

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1564 Am. Acad. of Pediatrics, Survey Identifies Managed Care’s Impact, 11 AAP NEWS 20 (1995); see also supra, Part II(B) (describing capitated payment methods).
1568 Pendo, supra note 1562, at 267-68.
1569 Bowden II, supra note 780, at 29; see also Peter R. Kongstvedt, Essentials of Managed Health Care 142 (5th ed. 2007) (asserting that private and public payment is generally 38% of gross charges).
But estimates about private payment versus Medicare indicate that private payment exceeds Medicare payment by anywhere from 20% for physicians to as much as 200% for hospitals and 30% to 40% overall.1571

Some Medicare reimbursement complexities are deliberately simplified in private managed-care contracts.1572 Because payers negotiate these agreements with a single hospital or hospital system, they can “pre-calculate” DRG, APC, or RBRVS payments.1573 And they often short-cut the complexities of certain methodologies such as outlier payments using simplified algorithms.1574

Discovering the details of proprietary managed-care agreements can be very difficult and often relies on generalized surveys that do not expose the nuts and bolts.1575 Nevertheless, this section will explore, to the greatest extent possible, some details of private managed care contracts for hospital inpatient, hospital outpatient and ASC, and physician reimbursement.

i. Hospital Inpatient Reimbursement

Unlike Medicare, which reimburses hospitals for inpatient claims almost exclusively through the MS-DRG method, private payers reimburse hospitals using a variety of methods—

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1571 Robert J. Samuelson, Public Plan Mirage, Washington Post, Oct. 26, 2009, at A17, available at http://www.washingtonpost.com/wp-dyn/content/article/2009/10/25/AR2009102502041.html (asserting that Medicare rates are as much as 30% lower than private rates); see also Terry, supra note 12 (noting that Medicare doctors get paid 10.6% to 20.2% more under private contracts than by Medicare); Everett, supra note 25 (claiming that current hospital inpatient reimbursement generally exceeds Medicare reimbursement by as much as 200% and even 400% in some isolated cases).
1572 Everett, supra note 25; Flowers, supra note 77; Contract between Hospital and PPO (on file with author); Contract between Practice Group and PPO (on file with author); see also BLUE CROSS BLUE SHIELD OF N.D., ACUTE INPATIENT (DRGs) – HOSPITAL BILLING 1 (2010), available at https://www.thorconnect.org/nd/docs/29309770.pdf (describing a method of calculating DRG payments in advance) [hereinafter BCBS DRGs].
1573 Everett, supra note 25.
1574 BCBS DRGs, supra note 1572, at 2.
1575 Reimbursement Methods, supra note 1565.
even under a single agreement. This section discusses some of the most common methods, which include (1) percentage of charges; (2) per diem rates; (3) fee schedules; (4) case rates; (5) global payment; (6) cost pass-through provisions; and (7) stop-loss and stop-cap provisions. But because a single agreement between a payer and a hospital may involve one or more (or even all) these methods, and because a single inpatient stay may cross over the various boundaries, classifying and partitioning claims according to payment method necessarily becomes a relatively complex task. So this section also addresses how claims may be classified and partitioned for reimbursement according to the types of services a hospital renders and the resources it consumes.

a. Percentage of Charges

As many as a fifth of hospital contracts employ percentage-discounts off gross charges for reimbursement. If a hospital negotiates a discount off charges that remains above its costs to provide a particular service, it can minimize its financial risks and maximize the steerage effects that such a discount may create. Unfortunately, this method creates an incentive for the hospital to merely increase its charges arbitrarily to capture a higher reimbursement. On the other hand, PPOs often have a strong incentive to negotiate steeper discounts because payers typically pay PPOs a percentage of any discounts they are able to negotiate.

A couple of strategies that payers may use to counteract a hospital’s tendency to simply increase charges involves imposing a sliding scale on the percentage of discount or placing an

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1576 BONNEY & SMITH, supra note 203, at 18-28; NOWICKI, supra note 546, at 75-78; Contract between Hospital and PPO (on file with author).
1577 Flowers, supra note 77.
1578 Reimbursement Methods, supra note 1565.
1579 NOWICKI, supra note 546, at 75-76.
1580 BONNEY & SMITH, supra note 203, at 18.
1581 BONNEY & SMITH, supra note 203, at 18.
attenuated cap on charges.1582

The sliding-scale method typically adjusts the percentage of discount according to utilization. For example, a contract might allow a 20% discount for 0 to 200 bed days and increase to a maximum of 30% for higher utilization.1583 But this method is difficult to administer because it requires retrospective reconciliation at periodic intervals.1584

An attenuated cap on charges also creates administrative complexity, but at least it allows both payer and provider to keep up with the discount percentage on a daily basis.1585 An attenuated-cap contract provision typically requires the hospital to notify the payer of any planned increases in charges sixty to ninety days in advance.1586 The contract may permit an increase in charges below a predetermined percentage (called an “increase limitation”), usually between 2% and 5%, without any adjustment to the discount percentage.1587 But if the provider raises its charges beyond the increase limitation, the contract increases the discount.1588

For example, assume that a contract between McCoy Hospital and Galactic PPO calls for a discount of 30%—in other words, the contract pays 70% of gross charges—and imposes an increase limitation of 5%. Further assume that McCoy raises its gross charges 15%. The contract may call for an adjustment that multiplies the percentage of charges paid by the increase limitation and divides it by the actual increase to get the new percentage of charges the contract pays.1589 Figure 31 depicts this formula.1590

1582 Kongstvedt, supra note 1569, at 146-47; Contract between Hospital and PPO (on file with author).
1583 Kongstvedt, supra note 1569, at 146.
1584 Kongstvedt, supra note 1569, at 146-47.
1585 Contract between Hospital and PPO (on file with author).
1586 Id.
1587 Id.
1588 Id.
1589 Id.
1590 Infra, Figure 31.
So in this case, the new percentage of charges the contact pays is $[0.70 \times (1 + 0.05)] / (1 + 0.15) = 0.735 / 1.15 = 0.6391 = 63.91\%$.

A contract may also permit a slight increase in the discount when the payer pays claims in a timely manner, usually thirty days or less, or when the payer steers a certain volume of patients to the hospital. A contract may contain varying percentage discounts for different types of service. But increasingly, percentage-of-charges provisions represent a “catch-all” category that reimburses service types not paid using other methods.

b. Per-Diem Rates

Per-diem pricing is a quasi-prospective payment system in which a provider receives a fixed price for each day a patient is in the hospital that represents payment in full for the services rendered on those days. In negotiating per-diem rates, a hospital usually determines the overall, average cost of a particular service and the average length of stay.

For instance, if a hospital determines that the cost for a particular service averages $5,000 and the average length of stay is five days, it may attempt to negotiate a per-diem rate of $1,200
per day for five days, which would allow the hospital to realize a profit for each day. But the payer may negotiate a rate that is close to, or even below, the hospital’s average daily costs.

If the per-diem is open-ended—that is, it has no limit on the number of days in the stay—it could create an incentive for hospitals to keep patients longer than necessary to recoup their losses or produce additional profits. As a result, payers often impose a limit on the number of days paid under a per-diem arrangement, which encourages the hospital to better control utilization. But because most costs are incurred at the beginning of a hospitalization, many providers negotiate higher rates for the first day, or the first few days, of a per-diem pricing arrangement, with the rate decreasing for each day thereafter.

Per-diem rates typically apply to “medical, surgical, intensive care, step-down, mental health and substance abuse, neonatal intensive care, and acute rehabilitation services.”

c. Fee Schedules

Though more common in the outpatient and ASC settings, a very small percentage of inpatient contracts employ at least some fee-schedule pricing for certain services. Payers and providers usually limit inpatient fee-schedule reimbursement to services like mammography screening incident to a hospitalization or certain surgical procedures. And plans usually limit reimbursement to the amount charged.

1597 BONNEY & SMITH, supra note 203, at 19.
1598 NOWICKI, supra note 546, at 77.
1599 Id.
1600 BONNEY & SMITH, supra note 203, at 19.
1601 NOWICKI, supra note 546, at 77; KONGSTVEDT, supra note 1569, at 148.
1602 BONNEY & SMITH, supra note 203, at 19.
1603 Reimbursement Methods, supra note 1565.
1604 Contract between Hospital and PPO (on file with author).
1605 Id.
**d. Case Rates**

Of all the various methods managed-care contracts use to pay for inpatient service, case-rate pricing most resembles Medicare’s IPPS.\(^{1606}\) It is, in fact, most often founded on some variation of Medicare’s MS-DRG payment system.\(^{1607}\) Case rates generally represent payment in full for all services related to an inpatient visit.\(^{1608}\) Flat case rates generally represent less than 10% of payment hospitals receive.\(^{1609}\) Simplified variations on DRG payment are slightly more common than flat case rates.\(^{1610}\)

Blue Cross Blue Shield of North Dakota calculates payments for DRGs in advance using claims history, and then applies an outlier calculation similar to, but much simpler than, the Medicare MS-DRG outlier payment calculation.\(^{1611}\) It simply pays the pre-calculated DRG payment plus 80% of the difference between the gross charges and a fixed outlier threshold.\(^{1612}\)

As an example, assume that under a contract between McCoy Hospital and Galactic PPO, the outlier payment for MS-DRG is $22,000 and the outlier threshold is $58,000. Also assume that McCoy treats a patient under MS-DRG 163 and charges $75,000. The plan would pay $22,000 + [(($75,000 – $58,000) X 0.80] = $22,000 + $13,600 = $35,600.\(^{1613}\)

Some plans provide for “inlier” payment reductions.\(^{1614}\) If the total charge for a particular DRG is less than a fixed-threshold percentage of the DRG price, the plan pays fixed

\(^{1606}\) BONNEY & SMITH, supra note 203, at 22.

\(^{1607}\) Id.; KONGSTVEDT, supra note 1569, at 149.

\(^{1608}\) BONNEY & SMITH, supra note 203, at 22.

\(^{1609}\) Reimbursement Methods, supra note 1565.

\(^{1610}\) Id.; see also BCBS DRGS, supra note 1572, at 1-2 (describing a straight percentage outlier provision); Contract between Hospital and PPO (on file with author).

\(^{1611}\) BCBS DRGS, supra note 1572, at 1-2; see also supra, Part IV(A)(i)(g) (describing the Medicare MS-DRG outlier payment methodology).

\(^{1612}\) BCBS DRGS, supra note 1572, at 2.

\(^{1613}\) Id.

\(^{1614}\) Contract between Hospital and PPO (on file with author).
payment percentage of the total charge.\textsuperscript{1615}

To illustrate, assume that the fixed threshold for inlier payment is 60%, the fixed payment percentage is 50%, and the payment for DRG 031 (concussion) is normally $5,000. Further assume that McCoy hospital admits Will Robinson for a concussion and the hospital bills Galactic $2,000. The total charges are below the inlier threshold of $3,000 for DRG 031 so the inlier payment would be 50% of $2,000, or $1,000.\textsuperscript{1616}

e. Global Payment

Global payments represent a single dollar amount paid to all providers for the care of a single patient during a fixed time period or for a particular illness.\textsuperscript{1617} Medicare has experimented with global payment for the last few years through its Acute Care Episode (ACE) demonstration project.\textsuperscript{1618} But the concept has been around for much longer, particularly in relation to transplant services.\textsuperscript{1619}

Some transplant contracts make a global payment for organ and bone marrow transplants that covers all hospital and physician services for a “transplant period”; the transplant period generally encompasses the day before a transplant facility admits a patient for a transplant through the day the transplant facility discharges the patient.\textsuperscript{1620} The global payment may also include all organ acquisition costs including donor counseling, surgery to harvest the organ from

\begin{footnotes}
\item[1615] Id.
\item[1616] Id.
\item[1619] Everett, supra note 25.
\end{footnotes}
the donor, recovery, and the organ’s transport costs.1621 Some plans do not include services and charges before the transplant or post-transplant services.1622 But some plans do include post-transplant services, adding a global payment for a re-transplant within a certain period, usually one year.1623

Because transplant payments can be in the seven-figure range, many MCOs purchase reinsurance to cover those payments.1624


Like Medicare, many managed-care contracts contain carve-out provisions for high-cost implants and prosthetics.1625 These provisions usually pay the medical device’s full cost or a portion of it.1626 And they may require that the hospital submit an original invoice for the device as a claim attachment.1627 In the case of physical-therapy convenience items, the provider and payer may attach a fee schedule reflecting the cost of these items, which obviates the need for the provider to submit invoices to the payer.1628

g. Stop-Loss and Stop-Cap Provisions

Stop-loss provisions protect providers against gross underpayment of high-cost cases in much the same way MS-DRG outliers do.1629 Stop-cap provisions are rare and protect payers

1621 Id. at 2.
1622 Id. at 3.
1623 Everett, supra note 25.
1625 BONNEY & SMITH, supra note 203, at 24-25; Contract between Hospital and PPO (on file with author).
1626 Everett, supra note 25; Contract between Hospital and PPO (on file with author).
1627 Contract between Hospital and PPO (on file with author).
1628 Id.
1629 Everett, supra note 25; see also supra, Part IV(A)(i)(g) (describing the Medicare MS-DRG outlier payment methodology).
against severe claim overpayment.\textsuperscript{1630} Stop-loss provisions come in at least two flavors (aside from DRG outlier payments): (1) global stop-loss provisions, and (2) per-diem stop-loss provisions.\textsuperscript{1631}

Global stop-loss terms can cut across all the reimbursement methods applicable to a single claim and examine the total payment for the claim, but they may only apply to a particular service type.\textsuperscript{1632} Generally, if the payment for a service is less than a particular threshold calculated as a percentage of gross charges, the stop-loss provision will adjust the payment to be a predetermined percentage of gross charges.\textsuperscript{1633} For instance, a stop-loss provision may require the plan to pay 40\% of gross charges if the plan payment is below 40\% of gross charges.\textsuperscript{1634}

Similarly, a stop-cap provision may prescribe a payment reduction if the payment exceeds a certain percentage of gross charges.\textsuperscript{1635} For example, a stop-cap provision may dictate that final payment can be no more than the gross charges for a claim.\textsuperscript{1636}

Per-diem stop-loss provisions may require an additional payment plus the normal per-diem payment if the gross charges exceed a fixed-dollar threshold.\textsuperscript{1637} Specifically, a plan may require that if the gross charges for a claim paid at a per-diem rate exceed $50,000, the plan will pay the normal per-diem rate plus 65\% of the difference between the gross charges and the $50,000 threshold.\textsuperscript{1638} Some plans account for the higher costs incurred on the first day of a hospital visit by using a stop-loss designed for one-day stays reimbursed at a per-diem rate.\textsuperscript{1639}

\textsuperscript{1630} Everett, supra note 25.
\textsuperscript{1631} Contract between Hospital and PPO (on file with author).
\textsuperscript{1632} Id.
\textsuperscript{1633} Id.
\textsuperscript{1634} Id.
\textsuperscript{1635} Id.
\textsuperscript{1636} Id.
\textsuperscript{1637} Id.
\textsuperscript{1638} Id.
\textsuperscript{1639} Id.
So the contract may require a lower threshold for one-day per-diem stop-loss payment.\textsuperscript{1640}

\textbf{h. Classification and Resource Consumption}

Because most managed-care contracts for inpatient services involve various reimbursement methods, determining which method or methods to apply to a claim is critical.\textsuperscript{1641} Most contracts specify what payment method to use based on diagnosis, procedure, revenue, and DRG codes.\textsuperscript{1642}

Because there may be significant overlap among services, a well-constructed contract will define these services with a decreasing level of specificity for each service type.\textsuperscript{1643} In fact, a contract may define surgical obstetrics using specific MS-DRG (e.g., 765 or 766) or ICD-9-CM diagnosis codes (e.g., 74.0 through 74.99) and reimburse those cases at a per-diem rate.\textsuperscript{1644} Then it may define general surgical services using a series of revenue codes and pay those claims at another per-diem rate.\textsuperscript{1645} And finally, it may allow all other service types to fall into a catch-all category paid at a percentage of charges.\textsuperscript{1646}

Clarity in defining the different service types can prevent later payment disputes and ensure smoother operations.\textsuperscript{1647} Unfortunately, real-world claims are often more complex than many contracts contemplate, and a single claim for an inpatient stay may involve reimbursement according to several different reimbursement methods.\textsuperscript{1648} It is not unusual for a patient to spend

\begin{footnotesize}
\begin{enumerate}
\item \textit{Id.}
\item Flowers, \textit{supra} note 77.
\item \textit{Id.; BONNEY & SMITH, supra} note 203, at 19; Contract between Hospital and PPO (on file with author).
\item Flowers, \textit{supra} note 77.
\item Contract between Hospital and PPO (on file with author).
\item \textit{Id.}
\item \textit{Id.}
\item \textit{BONNEY & SMITH, supra} note 203, at 19.
\item Flowers, \textit{supra} note 77.
\end{enumerate}
\end{footnotesize}
one or two days in the ICU and then move to a regular hospital room or “step-down unit.”¹⁶⁴⁹

Because of this inevitability, payers and providers must attune themselves not only to what type of services the hospital provided, but also when the hospital provided them and how much of a given service a patient used.¹⁶⁵⁰ So to classify services properly, payers and providers must often pay attention to a service’s resource usage or resource consumption.¹⁶⁵¹ A service’s resource usage may be the number of units assigned to the resource (such as the number of units attached to a revenue code), the granular charges for the service, and the like.¹⁶⁵²

For example, revenue code 201 represents surgical ICU care and the number of units associated with it represents the number of days spent in the ICU.¹⁶⁵³ Revenue code 120 and its associated units indicate the number of days a patient spent in a regular room.¹⁶⁵⁴ If a contract pays for a regular room at a per-diem rate of $800 and it pays for ICU at $2,000 per day, the payer would reimburse $6,400 for a claim containing a revenue code of 201 with two units and a revenue code of 120 with three units.

ii. Hospital Outpatient and ASC Reimbursement

There tend to be fewer payment methods for outpatient services than inpatient services.¹⁶⁵⁵ And managed-care contracts usually treat hospital-outpatient departments and ambulatory-surgery centers the same.¹⁶⁵⁶

Formerly, the most popular reimbursement method was to calculate a percentage discount

¹⁶⁴⁹ KONGSTVEDT, supra note 1569, at 148.
¹⁶⁵⁰ Flowers, supra note 77.
¹⁶⁵¹ Id.
¹⁶⁵² Id.
¹⁶⁵⁴ Id.
¹⁶⁵⁵ See BONNEY & SMITH, supra note 203, at 31-34 (describing only three different payment methods for outpatient services).
¹⁶⁵⁶ Everett, supra note 25; Contract between Hospital and PPO (on file with author).
off charges, but that method has fallen into disfavor.\textsuperscript{1657} And though some plans have adopted Medicare’s APC payment method or its newer ASC payment method, most plans rely on Medicare’s predecessor to the current APC and ASC payment systems (\textit{ASC rates}), which used ambulatory-surgical-code groupings.\textsuperscript{1658} The ASC rates system organized surgical codes into nine groups and Medicare assigned a different payment rate to each group.\textsuperscript{1659} CMS based the nine payment rates on the cost of professional services and the cost of supplies and facility services for the procedures in each group.\textsuperscript{1660}

Managed-care contracts that use the ASC rates method may rely on Medicare’s groupings or modify the groupings according to the contracting parties’ needs.\textsuperscript{1661} Payment policies vary, but generally the plan pays the highest-value procedure at 100\% of the ASC rate for its group and subsequent surgeries performed by the same doctor on the same day at a reduced rate—usually 50\% of the ASC rate.\textsuperscript{1662}

One distinct advantage of using this method is that it makes contract renegotiation easier because only eight or nine ASC rates need to be set for each contracting period.\textsuperscript{1663} A disadvantage is that the payment rates are not very granular so a single underpriced surgical group can have a severe financial impact on a hospital-outpatient department or ambulatory-surgery center.\textsuperscript{1664}

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\footnote{1657}{\textsc{Bonney} \& Smith, \textit{supra} note 203, at 31.}
\footnote{1658}{Medicare Program; Update of Ambulatory Surgical Center List of Covered Procedures; Proposed Rule, 69 Fed. Reg. 69,177, 69,178-81 (Nov. 26, 2004); Everett, \textit{supra} note 25.}
\footnote{1659}{69 Fed. Reg. at 69,181.}
\footnote{1660}{69 Fed. Reg. at 69,178.}
\footnote{1661}{\textsc{Bonney} \& Smith, \textit{supra} note 203, at 31.}
\footnote{1662}{\textit{Id.}; Contract between Hospital and PPO (on file with author).}
\footnote{1663}{Everett, \textit{supra} note 25.}
\footnote{1664}{\textit{Id.}}
\end{footnotes}

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iii. Physician Reimbursement

Plans usually base physician reimbursement on a fee-schedule, but fee-for-service arrangements based on UCR are still prevalent. And even fee-schedule payments are typically modeled on the Medicare RVRVS payment system or the earlier, but similar, McGraw Hill Relative Values for Physicians system. A small percentage of physicians still receive payment on a capitated basis, but that number has declined over the years.

Still, even those fee schedules based on Medicare RBRVS tend to lag behind the current Medicare rates and rules—and for most physicians this is probably a good thing. Today, physicians still receive between 75% and 110% of customary charges for claims from managed-care plans. But while physicians still get as much as 20% more than Medicare from managed-care plans—a far cry from the 200% hospitals sometimes get—there is increasing pressure to bring physician reimbursement in line with Medicare.

Physician fee-schedule reimbursement generally employs a list of CPT-4® procedure codes and corresponding prices. Even if the fee-schedules are based on Medicare payment rates, determining the reimbursement amount usually involves just a simple table lookup because the complexities of RBRVS reimbursement are already built into the rates.

Managed-care plans often discount multiple surgeries in a manner very similar to

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1665 Reimbursement Methods, supra note 1565.
1667 Compare Survey Identifies Managed Care’s Impact, supra note 1564, with Reimbursement Methods, supra note 1565.
1668 Everett, supra note 25.
1670 Terry, supra note 12.
1671 Compare Survey Identifies Managed Care’s Impact, supra note 1564, with Reimbursement Methods, supra note 1565.
1672 Id.; Everett, supra note 25.
Medicare—that is, the plan pays the first procedure at 100% and subsequent procedures at 50% of the fee-schedule rate. There may also be rules that discount specific surgeries and procedures by a certain percentage when physicians perform them alone.

C. Trends in Reimbursement

For some time, public payment has moved toward prospective, rather than, retrospective payment. This trend is likely to continue, but with more of an emphasis on bundling multiple services into a single payment. In the early 2000s, policymakers and industry experts collaborated to develop a system of payment incentives to improve quality and drive down overall costs.

This section provides an overview of these trends including initiatives related to quality improvement through various incentives—some of them related to the Affordable Care Act. It also examines other provisions from the Affordable Care Act that affect reimbursement as well as one recent initiative from the National Care Network for handling out-of-network reimbursement.

i. Quality Improvement

In 2001, the Institute of Medicine (IOM) produced a highly influential report, CROSSING THE QUALITY CHASM, that proposed a number of measures to improve healthcare through quality measures, provider incentives, and other methods. The IOM proposal contained six major

1673 Contract between Practice Group and PPO (on file with author).
1674 Id.
1675 CASTO & LAYMAN, supra note 11, at 101, 171.
1677 CROSSING THE QUALITY CHASM, supra note 170, at 33-34.
1678 Id. at 39-40.
improvement goals for the U.S. healthcare system: (1) safety—avoiding additional injury to patients; (2) timeliness—reducing waits and delays; (3) effectiveness—avoiding underuse or overuse; (4) efficiency—avoiding waste; (5) equitable care—eliminating discrimination based on gender, race, or economic status; and (6) patient-centered care—responsiveness to a patient’s preferences, needs, and values.1679

These goals are admirable and lofty, but difficult to achieve (together, they are often referred to as “STEEEP”).1680 The goals to achieve effective care and reduce waste are the goals that probably have the most influence on reimbursement methods today, and though all six goals are intertwined, effective and efficient care primarily involves evidence-based practice (also called evidence-based medicine or EBM).1681

In short, EBM is the practice of following treatment guidelines that embody the best possible treatment practices based on clinical research, clinical expertise, and patient values.1682 For example, evidence-based clinical practice guidelines (CPGs) for an older woman who has hypertension, diabetes mellitus, osteoarthritis, osteoporosis, and chronic obstructive pulmonary disease (COPD) may comprise a number of patient recommendations including (1) joint protection; (2) energy conservation; (3) non-weight-bearing aerobic, muscle-strengthening, and range-of-motion exercise; (4) avoidance of environmental exposures that exacerbate COPD; (5) limited alcohol intake; and (6) maintenance of normal body weight.1683 The guidelines may also include (1) pneumonia and influenza vaccine administration; (2) blood pressure checks upon a doctor visit and sometimes at home; (3) evaluation of blood glucose self-monitoring; (4) foot

1679 Id. at 39-40.
1681 CROSSING THE QUALITY CHASM, supra note 170, at 47.
1682 Id.; Cynthia M. Boyd et al., Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Diseases—Implications for Pay for Performance, 294 JAMA 716, 716 (2005), available at http://www.ersnet.org/learning_resources_player/paper/RS/70.pdf.
1683 Boyd et al., supra note 1682, at 721.
examination; (5) regular lab tests for microalbuminuria, creatinine levels, cholesterol levels, liver function, and glycosylated hemoglobin levels; (6) referrals for physical therapy, ophthalmology, pulmonary rehabilitation, and x-rays; and (7) patient education for high-risk foot conditions and care, osteoarthritis, COPD medication and administration, and diabetes mellitus.1684

This section addresses continuing efforts to achieve more effective, less wasteful care. Such efforts include (1) pay-for-performance (P4P) systems; (2) value-based insurance design and patient-centered medical homes; (4) accountable-care-organizations (ACOs) from the Affordable Care Act; and (5) evidence-informed case rates.

a. Pay for Performance and Value-Based Purchasing

Pay-for-performance programs involve creating financial and other incentives for improved patient outcomes.1685 P4P programs, implemented through contractual arrangements with providers and policy provisions for beneficiaries, typically set performance benchmarks keyed to evidence-based clinical-practice guidelines to influence provider and patient behavior.1686 The programs use these benchmarks to create incentives for providers and patients.1687

These incentives may comprise (1) bonuses paid to providers for meeting performance benchmarks; (2) withholds from reimbursement that the program returns to providers if they meet performance benchmarks; (3) tiered fee-schedules for specialists adjusted retroactively based on performance; (4) quality grants to provider organizations to implement quality-

1684 Id.
1686 Id. at 4-5.
1687 Id. at 8-9.
improvement programs; (5) enhanced payment for chronic care, care management, and provider
information technology investment to improve point-of-care service; or (6) premium reductions
to beneficiaries that comply with certain wellness programs.\textsuperscript{1688}

But the incentives may include non-financial rewards such as (1) network steerage
provisions to drive patients to high-performing providers; (2) administrative relief—reducing
authorization requirements for top performers; and (3) public report cards or honor rolls that
compare providers and recognize excellence.\textsuperscript{1689} And they may also include rewards for
improved safety through adoption of information technologies such as electronic medical
records—incentives the government has recently implemented with the HITECH Act.\textsuperscript{1690}

Reacting to the 2001 IOM report, 52\% of HMOs reported using some form of P4P in
2006.\textsuperscript{1691} But the results were mixed—many providers reported negative results because of
small incentives and the short-term nature of some programs.\textsuperscript{1692}

A RAND Corporation study completed in 2009 suggests similar results.\textsuperscript{1693} While the
study found that some providers had altered their practices as a result of P4P, the “financial
incentives—generally about $1,500 to $2,000 annually per physician—were too small to
stimulate significant change among most doctors.”\textsuperscript{1694} Providers who participated in the study
“suggested the incentives needed to be two to five times higher in order to achieve quality

\textsuperscript{1688} \textit{Id.}
\textsuperscript{1689} \textit{Id.} at 9.
\textsuperscript{1690} \textit{Id.;} Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-05, tit. IV, §§ 4101-
\textsuperscript{1691} Meredith B. Rosenthal, Pay-for-Performance in Health Care: Trends and Impact on Quality of Care 2-3, Oct. 26,
\textsuperscript{1692} \textit{Id.} at 10.
\textsuperscript{1693} Press Release, RAND Corp., Pay-for-Performance for Medical Groups Stimulates Changes in Practice (Mar. 9,
\textsuperscript{1694} \textit{Id.}
improvements.1695 And a subsequent RAND Corporation study found that P4P programs could have a negative impact on the poor and minorities because they tended to divert resources away from poorer communities.1696

The AMA anticipated some of these results as early as 2005 and expressed them in guidelines it published for P4P programs.1697 The AMA was concerned that P4P programs might not be effective if doctors were forced to “eat” new administrative costs or if the rewards for meeting performance benchmarks were not sufficient to cover additional practice expenses and properly motivate providers.1698 It was very concerned about the impact P4P programs might have on minorities and uninsured patients—including the impact on the doctor-patient relationship.1699

The AMA guidelines also discussed the need to avoid de-selection (doctors dropping patients who failed to adhere to advice or who were not likely to have a good outcome).1700 And it urged P4P plans to adopt bonuses—not the earn-backs or withholds the Leapfrog Group had suggested as incentive alternatives—and to reward improvement and compliance with absolute measurements.1701 Finally, among other things, the AMA guidance document was adamant that physician report cards not be publicized (one feature of the Leapfrog Group’s proposals) or used against doctors for health plan credentialing.1702

P4P plans have seen widespread adoption, but the healthcare industry has continued to search for ways to improve their basic design. Value-based purchasing is very similar to P4P but

1695 Id.
1698 Id. at 3-4.
1699 Id. at 4.
1700 Id. at 2.
1701 Id. at 1, 4; BAKER, supra note 1685, at 3.
1702 AMA P4P GUIDELINES, supra note 1697, at 4; BAKER, supra note 1685, at 3.
also incorporates payment bundling to pay for an entire episode of care with a single payment.\textsuperscript{1703}

Beginning October 1, 2012, the Affordable Care Act requires CMS to make incentive payments to hospitals that engage in value-based purchasing practices.\textsuperscript{1704} Initially, CMS will make these incentive payments to hospitals that comply with evidence-based guidelines for at least five conditions: (1) acute myocardial infarction (heart attack); (2) heart failure; (3) pneumonia; (4) surgeries measured by the Surgical Care Improvement Project; and (5) healthcare-associated infections.\textsuperscript{1705} And the Affordable Care Act further requires CMS to develop a value-based purchasing program for ASCs.\textsuperscript{1706}

b. \textbf{Value-Based Insurance Design and Patient-Centered Medical Home (PCMH)}

Because of mixed or meager benefits associated with current P4P programs and other initiatives, some experts have urged that insurers redesign their plans to focus on value to animate positive effects on the healthcare equation’s demand side.\textsuperscript{1707} These experts argue that a model to increase patient cost-sharing as the price of services increases discourages patients from seeking out services and treatments that produce greater value.\textsuperscript{1708} For example, generic drugs usually have a small copayment while branded pharmaceuticals cost the patient significantly more out of pocket; though in the long run, the more expensive drugs may prevent future illness

\begin{footnotesize}
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\textsuperscript{1705} Id.
\textsuperscript{1706} Id.
\textsuperscript{1708} Id.
\end{footnotesize}
and generate lower costs overall.\footnote{1709}

While proponents of value-based insurance design do not argue that cost-sharing should be eliminated, they do argue that it should be “clinically sensitive.”\footnote{1710} For instance, they propose low or no copayments for high-value interventions—such as statin prescriptions for patients with a history of heart disease—and “higher cost sharing for interventions with little or no proven health benefit, such as total body computer tomographic scanning.”\footnote{1711}

The Affordable Care Act, in section 2713, embraces this philosophy by requiring group health plans to eliminate cost sharing for certain (1) evidence-informed high-value services; (2) immunizations; and (3) preventive care and screening for infants, children, adolescents, and women.\footnote{1712} It further authorizes CMS to develop additional guidelines for value-based insurance design.\footnote{1713}

The Patient-Centered Primary Care Collaborative (PCPCC) and the National Business Coalition on Health (NBCH) advocate combining the idea of value-based insurance design with the idea of a patient-centered medical home (PCMH).\footnote{1714} A PCMH represents a partnership between a patient and a personal physician in which the physician directs or coordinates almost all the care activities among the patient, the physician, specialists, and other providers in a team-oriented approach that affects the healthcare equation’s supply side.\footnote{1715}

Some attributes of a PCMH are (1) a patient’s personal relationship with a physician; (2)
team care directed by the physician; (3) a whole-person approach to the patient; (4) use of
evidence-based medicine; (5) effective use of technology to coordinate care (such as the
effective use of electronic medical records to eliminate duplicate testing and adverse treatment
events); (6) enhanced scheduling and personalized communication with the patient; and (7)
Improved reimbursement models.\textsuperscript{1716}

The Affordable Care Act supports the PCMH concept by providing grants “to establish
community-based interdisciplinary, inter-professional teams . . . to support primary care
practices, including obstetrics and gynecology” in certain areas.\textsuperscript{1717}

By integrating the value-based insurance design and PCMH strategies, demand-side and
supply-side incentives combine to produce more positive outcomes, reduced costs, and a better
bottom line for everyone involved.\textsuperscript{1718}

An advantage to providers of either, or both, of these approaches is reduction in
administrative cost because they would not be required to collect as many copayments or fret
with deductibles to the extent that they normally must do.

c. Accountable Care Organizations (ACOs)

One significant program the Affordable Care Act created is a demonstration project for
Accountable Care Organizations (ACOs).\textsuperscript{1719} The Act also created a demonstration project for
pediatric ACOs.\textsuperscript{1720} An ACO is an organization that comprises both doctors and hospitals
responsible for the overall care of Medicare beneficiaries CMS assigns to the ACO.\textsuperscript{1721}

\textsuperscript{1716} \textit{Id.}.
\textsuperscript{1717} § 3502, 124 Stat. at 513 (codified at 42 U.S.C. § 256a-1 (2010)).
\textsuperscript{1718} \textit{Fendrick, Sherman & White, supra} note 1714, at 12.
(codified at 42 U.S.C. § 1395jjj (2010)).
\textsuperscript{1720} § 2706, 124 Stat. at 325-26 (codified at 42 U.S.C. § 1396a).
\textsuperscript{1721} § 3022, 124 Stat. at 395-96.
CMS will still reimburse providers that belong to ACOs using the traditional methods, but by January 1, 2012 it must establish a shared-savings program that makes an additional payment to an ACO if it meets certain quality and reporting requirements.\footnote{\textsection 3022, 124 Stat. at 398.}

An ACO must have a formal legal structure and shared governance that allows it to “receive and distribute” these payments and it must agree to participate in the program for at least three years.\footnote{\textsection 3022, 124 Stat. at 395-96.} It must have a leadership and management structure governing both clinical and administrative functions.\footnote{Id.} It may comprise a combination of hospitals, hospital-based doctors, group practices, and any “other groups of providers and services” CMS deems appropriate.\footnote{\textsection 3022, 124 Stat. at 395.} An ACO must involve enough primary care doctors to provide sufficient services to at least 5,000 Medicare beneficiaries.\footnote{\textsection 3022, 124 Stat. at 396.} And it must employ evidence-based medicine processes and satisfy patient-centered care criteria that CMS will define.\footnote{Id.}

To qualify for bonus payments, an ACO must comply with clinical process, outcome, patient experience of care, and utilization measures, as well as quality-data-reporting standards.\footnote{\textsection 3022, 124 Stat. at 396.}

Like the patient-centered medical home model, it should practice coordination of care across specialties.\footnote{J. Peter Rich, Partner, Dermott, Will & Emery, Presentation to Strafford CLE, \textit{Accountable Care Organizations after Healthcare Reform} (July 7, 2010).} The ACO provisions leave open a number of issues related to eligibility and bonus payments that CMS will presumably flesh out with new regulations including (1) what number of primary-care physicians, specialists, hospitals, and other providers CMS will require in a given market to constitute an effective ACO; (2) what level of savings will make an ACO

\begin{thebibliography}{9}
\footnotetext[1722]{\textsection 3022, 124 Stat. at 398.}
\footnotetext[1723]{\textsection 3022, 124 Stat. at 395-96.}
\footnotetext[1724]{Id.}
\footnotetext[1725]{\textsection 3022, 124 Stat. at 395.}
\footnotetext[1726]{\textsection 3022, 124 Stat. at 396.}
\footnotetext[1727]{Id.}
\footnotetext[1728]{\textsection 3022, 124 Stat. at 396.}
\footnotetext[1729]{\textsection 3022, 124 Stat. at 396.}
\end{thebibliography}
eligible for bonus payments; (3) whether CMS will adjust benchmarks to account for providers that treat a large number of sick patients; and (4) how CMS will assign beneficiaries to an ACO.\textsuperscript{1730}

There are also remaining issues about what exact form an ACO’s organizational structure must take. Some suggest that providers can organize ACOs as section 501(a) organizations.\textsuperscript{1731} Beyond that, some experts propose that ACOs may take one of a number of possible structures such as (1) highly-integrated organizations—hospital employment, tax-exempt affiliated, or foundation models; (2) partially-integrated organizations based on joint ventures or PHO models; or (3) contractually affiliated organizations.\textsuperscript{1732}

Ultimately, reimbursement for ACOs will probably take the form of bundled or global payments after a transition period.\textsuperscript{1733} A closely-related Affordable Care Act provision, section 3023, establishes a five-year bundled-payment pilot program.\textsuperscript{1734} The provision allows CMS to select ten medical conditions for which it will make bundled payments that encompass both Medicare Part A and Part B services.\textsuperscript{1735} It defines the unit of payment as an “episode of care” that encompasses acute care, physician services, outpatient hospital services (including emergency-room care), and post-acute care (including home-health, skilled-nursing, rehabilitation, and long-term care services).\textsuperscript{1736}

An episode of care comprises the period three days before a hospital admission, the

\textsuperscript{1730} Id.
\textsuperscript{1731} I.R.C. § 501(a) (2010); Spencer R. Berthelsen, Chairman and Managing Director, Kelsey-Seybold Clinic, Presentation to Texas Health Law Conference (Oct. 11, 2010); Leah B. Stewart, Associate, Vinson & Elkins, Presentation to Texas Health Law Conference (Oct. 11, 2010).
\textsuperscript{1732} David Klatsky, Partner, Dermott, Will & Emery, Presentation to Strafford CLE, \textit{Accountable Care Organizations after Healthcare Reform} (July 7, 2010).
\textsuperscript{1733} C. Frederick Geilfuss, Partner, Foley & Lardner, Presentation to Strafford CLE, \textit{Accountable Care Organizations after Healthcare Reform} (July 7, 2010).
\textsuperscript{1735} §§ 3023, 10308, 124 Stat. at 399, 941.
\textsuperscript{1736} § 3023, 124 Stat. at 400.
hospital admission duration, and thirty days after discharge from the hospital—but CMS may alter this period of care for payment bundling as it sees fit. Further, CMS must develop quality measures in cooperation with the Agency for Healthcare Research and Quality to determine payment under the pilot program.

Unfortunately, like many other bundled-payment systems, the provisions do not define how ACOs must allocate payment among providers. And ACOs also present legal concerns relating to antitrust and self-referral, among other issues.

First, section 1 of the Sherman Act prohibits combinations in restraint of trade. The Supreme Court has established two tests to determine whether an entity violates section 1: (1) per se violations—conduct that is so obviously anticompetitive that there is no need to pursue a factual inquiry; and (2) rule of reason—whether the pro-competitive benefits of an organization’s conduct outweigh the anti-competitive effects. The Affordable Care Act requires ACOs to include enough providers in a service area to be effective in reducing costs and coordinating a spectrum of care. But it may be difficult for providers to do that without crossing over the line into anti-competitive behavior. If the government considers an ACO to be a single entity, it may not run afoul of section 1. But if the government considers an ACO to be a conglomeration of different entities, the ACO would probably have to demonstrate sufficient financial or clinical integration to be considered as a single entity for antitrust purposes.

Second, the Stark, antikickback, and civil monetary-penalty laws, as well as some state

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1737 Id.
1738 § 3023, 124 Stat. at 401-02.
1742 See Leegin, 551 U.S. at 903-04 (describing possible precompetitive effects of vertical integration).
1743 Id.
laws, prohibit self-referral and remuneration for referrals.\footnote{1744}{42 U.S.C. § 1395nn (2010); 42 U.S.C. § 1320a-7b(b) (2010); 42 U.S.C. § 1320a-7a(b)(1); e.g., \textit{Tex. Occ. Code. Ann.} § 102.001 (West 2010).} It is not clear how these laws may apply to shared-savings programs like ACOs, bundled-payment systems, and global capitation programs, but there seems to be reason for optimism.\footnote{1745}{Geilfuss, \textit{supra} note 1733.} In 2007, the FTC sent Greater Rochester Independent Practice Association (GRIPA) an advisory opinion saying that the FTC would not seek any enforcement action against GRIPA for establishing an evidence-based clinical-integration program.\footnote{1746}{Letter from Markus H. Meier, Assistant Director, FTC, to Christi J. Braun & John J. Miles, Ober, Kaler, Grimes & Shriver (Sept. 17, 2007), available at http://www.ftc.gov/bc/adops/gripa.pdf.} And in its Final Rule for Medicare Part B for 2009, CMS proposed new exceptions to the Stark law for incentive-payment programs and shared-savings programs.\footnote{1747}{Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; Final Rule, 73 Fed. Reg. 69,725, 69,795-93 (Nov. 19, 2008).} 

d. Evidence-Informed Case Rates

In the hubbub over pay-for-performance, value-based insurance design, patient-centered medical homes, value-based purchasing, and ACOs, one very important item tends to get lost in the cacophony: a detailed proposal for a workable payment system. The trend in these programs is more and more bundling of services into a single payment across various types of providers and treatments.\footnote{1748}{RAND \textit{Bundled Payment, supra} note 1676.}

The MS-DRG system bundles payments for services provided in a hospital for a single patient stay, but it does not cover presurgical services, physician and surgeon fees, follow-up care, monitoring, or rehabilitation.\footnote{1749}{\textit{Id.}; see also Part IV(B)(i) (explaining MS-DRG payment).} Bridges to Excellence, a Washington, D.C. healthcare research organization, under a grant from the Robert Wood Johnson Foundation, has been
developing and administering a new system it terms *Prometheus Payment*®.¹⁷⁵⁰

The Prometheus system uses *evidence-informed case rates* (ECR™).¹⁷⁵¹ Unlike the MS-DRG system and traditional P4P systems, the Prometheus system bundles payment for all providers across the entire spectrum of an episode of care for a patient.¹⁷⁵² Like typical P4P arrangements, the system rewards providers for meeting performance standards and it creates a provider score card.¹⁷⁵³

But the interesting system feature is that unlike the MS-DRG and other systems, it focuses on the actual severity and complexity of a case—not just complications and comorbidities.¹⁷⁵⁴ It uses evidence-informed clinical-practice guidelines and statistical modeling to create a budget for a case and then withholds a certain amount to be paid retrospectively after evaluating various scoring criteria.¹⁷⁵⁵ The system scores providers based on process, outcomes, patient experience, and relative efficiency with respect to other providers.¹⁷⁵⁶

Though the AMA may not like some of its features (such as the retrospective payment of withholds), the Prometheus system promises to dramatically reduce the administrative burden on provider.¹⁷⁵⁷ Potentially, it could reduce or eliminate (1) evaluation and management visit billing; (2) preauthorization requirements; (3) concurrent utilization review; (4) retrospective claim audits; and (5) formularies.¹⁷⁵⁸ But so far, the Prometheus system is not yet thoroughly

¹⁷⁵³ *Making Prometheus Payment Rates Real, supra* note 1751, at 3.
¹⁷⁵⁵ *Making Prometheus Payment Rates Real, supra* note 1751, at 5-7.
¹⁷⁵⁷ *Id.* at 27.
¹⁷⁵⁸ *Id.*
battle tested, and some providers have questioned its ability to deliver what it promises.\textsuperscript{1759}

ii. Other Health Reform Provisions

The Affordable Care Act contains a number of provisions that affect provider payment. This paper has focused on several major provisions, but there are numerous simpler provisions that still have a large impact on providers. Some provisions primarily impact hospitals and others impact physicians.

a. Provisions that Affect Hospitals

Beginning in 2015, CMS will reduce payments by 1\% to hospitals for certain hospital-acquired conditions (HACs).\textsuperscript{1760} These conditions include those that have a high cost or volume, cause a claim to have a higher payment rate, and are conditions the hospital reasonably could have prevented.\textsuperscript{1761} The payment reduction will apply to hospitals whose rate of HACs are in the top quartile of all hospitals nationally.\textsuperscript{1762}

CMS will also reduce payments to hospitals that have excessive readmissions for conditions the hospital potentially could have prevented.\textsuperscript{1763} CMS will base this payment reduction on the ratio of payments made for claims involving readmission to all payments made to the hospital.\textsuperscript{1764}

Starting October 1, 2013, CMS will reduce disproportionate-share (DSH) payments to
hospitals by 75%, with some adjustments.\textsuperscript{1765} The assumption is that there will be fewer uninsured or underinsured patients, so hospitals will be forced to take fewer write offs.\textsuperscript{1766} This assumption is bolstered by the requirement that Medicaid ultimately pay at least the same amount as Medicare.\textsuperscript{1767} But this provision has caused many hospitals great concern because they are dependent on DSH payments and the promise of greater insurance coverage is not certain.\textsuperscript{1768}

\textbf{b. Provisions that Affect Physicians}

The Affordable Care act extends, through 2014, incentives to physicians for reporting quality data.\textsuperscript{1769} But beginning in 2015, physicians must satisfactorily comply with quality-reporting requirements or suffer a 1.5\% reduction in payment.\textsuperscript{1770} The reduction is increased to 2\% in 2016 and thereafter for unsatisfactory reporting.\textsuperscript{1771}

CMS must design a new quality-based payment system for physicians that will phase in over two years beginning in 2015.\textsuperscript{1772} It will add a quality-based modifier (or factor) to the physician-fee-schedule calculations under RBRVS for those physicians who comply with quality and cost guidelines.\textsuperscript{1773}

Beginning immediately, CMS will reduce the practice-expense geographical practice cost

\begin{footnotes}
\item[1765] § 3133, 124 Stat. at 432-33 (codified as amended at 42 U.S.C. § 1395ww (2010)).
\item[1768] Rossman & Bates, supra note 1766; Everett, supra note 25.
\item[1770] § 3002, 124 Stat. at 364.
\item[1771] \textit{Id.}
\item[1772] § 3007, 124 Stat. at 373-76 (codified as amended at 42 U.S.C. § 1395w-4 (2010)).
\item[1773] § 3007, 124 Stat. at 374.
\end{footnotes}
index to account for differences in regional and national costs.\textsuperscript{1774}

To improve access to primary-care services, primary-care practitioners will receive a 10% bonus—in addition to the normal RBRVS payments—for calendar years 2011 through 2015.\textsuperscript{1775} A primary-care practitioner is defined as (1) a doctor “who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine”; (2) “a nurse practitioner, clinical nurse specialist, or physician assistant”; or (3) a provider who renders primary care at least 60% of the time.\textsuperscript{1776} This provision is likely to cause many physicians to scramble to get themselves recognized as primary-care practitioners.\textsuperscript{1777}

iii. Cost-Based Solutions

Some experts and companies have proposed a cost-based payment solution to combat the silent PPO problem for out-of-network claims.\textsuperscript{1778} National Care Network promotes a product called Data iSight that aggregates readily available cost data (such as Medicare cost reports) for providers and helps providers and payers determine an out-of-network payment that gives a provider a “reasonable margin” for claim payment.\textsuperscript{1779} While this may resemble the much-derided “cost-plus” systems that drove Medicare to adopt prospective payment and private payers to adopt managed care, it is not the same.\textsuperscript{1780}

Some experts proposed that this approach be based on Medicare cost reports and applied

\textsuperscript{1774} § 3102, 124 Stat. at 416-17 (codified as amended at 42 U.S.C. § 1395w-4 (2010)).
\textsuperscript{1775} § 5501, 124 Stat. at 652-54 (codified at 42 U.S.C. § 1395l (2010)).
\textsuperscript{1776} § 5501, 124 Stat. at 653.
\textsuperscript{1777} Susan F. Harris, Partner, Baker Hostetler, Presentation to Texas Health Law Conference (Oct. 11, 2010).
\textsuperscript{1778} Everett, supra note 25; Nat’l Care Network, Cost-Based Solutions, http://www.ncnlink.com/solutions/cost-based (last visited Dec. 22, 2010); see also supra Part III(D)(iii)(g) (describing silent PPOs).
\textsuperscript{1779} Nat’l Care Network, supra note 1778.
\textsuperscript{1780} LEIYU SHI & DOUGLAS A. SINGH, DELIVERING HEALTH CARE IN AMERICA—A SYSTEMS APPROACH 226 (4th ed. 2008); Everett, supra note 25.
only to hospitals for the out-of-network scenario.\textsuperscript{1781} They have called this innovation “PPO 2.0” and argue that it should include “more prevalent use of fixed pricing—not a percentage of charges, value-based purchasing—not just discounts, and physician-centered contracting for bundled payments.”\textsuperscript{1782}

These proposals are in their infancy and only time will tell whether they are viable solutions to the silent PPO dilemma.

V. Conclusion

\textit{Then he began a long and secret labour, and he summoned all his lore, and his power, and his subtle skill; and at the end of all he made the Silmarils.}\textsuperscript{1783}

“You know, when we do props like this, you stack it up and you repeat 2,400 pages, et cetera – the truth of the matter is that health care is very complicated,” said President Obama at the healthcare summit with Republican congressional leaders in February 2010.\textsuperscript{1784} Complicated indeed.

Solo practitioners face more and more hurdles under healthcare reform and it is becoming increasingly unlikely that they will be able to continue making it on their own.\textsuperscript{1785} Big bundled-payment systems like Prometheus and ACOs do not provide for payment allocation among providers. They are also vague about the details of exactly how such payment systems will work in practice.

But one advantage to bundled payment is that it could reduce exposure to false-claims

\textsuperscript{1781}Everett, \textit{supra} note 25.
\textsuperscript{1782}\textit{Id.}
\textsuperscript{1783}J.R.R. TOLKIEN, \textit{THE SILMARILLION} 59 (1979).
\textsuperscript{1785}Terry, \textit{supra} note 12; Spencer R. Berthelsen, Chairman and Managing Director, Kelsey-Seybold Clinic, Presentation to Texas Health Law Conference (Oct. 11, 2010).
liability because minor errors on claims would have little or no impact on reimbursement.
Upcoding would become almost meaningless. And an advantage of some case-rate models is
that providers may not have to submit large numbers of claims for a single case.

In many ways, the Affordable Care Act’s focus on quality is a positive development and
represents the culmination of many ideas with which the healthcare industry has experimented
and developed for decades. But it also discards other ideas such as consumer-directed healthcare
by placing new limits on medical savings accounts.1786

The Affordable Care Act leaves open many questions and may allow some unscrupulous
operators to game the system. For example, beginning in 2014, insurers may not decline an
individual’s request for coverage because of pre-existing conditions.1787 But the “individual
mandate” carries with it a relatively small penalty for individuals that fail to maintain essential
health coverage—and even that penalty only applies if a person is entitled to a tax refund.1788
While employers are encouraged—using a carrot and stick approach—to provide coverage, there
is no requirement to provide insurance to part-time employees.1789 So what is to prevent a
hospital from securing insurance coverage for an uninsured patient when the patient presents for
treatment at the hospital, billing the patient for the first premium, and then writing off the
premium under generally-accepted accounting principles? In effect, this would allow a person to
get hospitalization coverage for only a few hundred dollars a year. This and many other
questions and issues seem to have no solution as yet.

Nevertheless, the Affordable Care Act certainly displays “the inventiveness of a DaVinci

(codified at I.R.C. § 125 (2010)).
and the imagination of a Tolkien.\textsuperscript{1790} Whether it serves as a beacon of light to the healthcare system—in the way that Fëanor’s last Silmaril did to the weary travelers in the first and second ages of Middle Earth—remains to be seen.\textsuperscript{1791}

\textsuperscript{1790} ANTONIN SCALIA & BRYAN A. GARNER, MAKING YOUR CASE—THE ART OF PERSUADING JUDGES 119 (2008).
### Appendix B. CMS-1500 form

**HEALTH INSURANCE CLAIM FORM**

1. **MEDICARE**
   - Medicare (Medicare or Medicare Supplementary)

2. **PATIENT'S NAME** (Last Name, First Name, Middle Initial)
3. **PATIENT'S DATE OF BIRTH** (MM DD YYYY)
4. **SEX**
5. **PATIENT'S RELATIONSHIP TO INSURED**
   - Self
   - Spouse
   - Child
   - Other

6. **CITY**
7. **STATE**
8. **ZIP CODE**
9. **TELEPHONE** (Include Area Code)

10. **INSURED'S NAME** (Last Name, First Name, Middle Initial)
11. **INSURED'S POLICY GROUP OR FECA NUMBER**
12. **INSURED'S DATE OF BIRTH** (MM DD YYYY)
13. **EMPLOYER'S NAME OR SCHOOL NAME**
14. **INSURANCE PLAN NAME OR PROGRAM NAME**

**READ BACK OF FORM BEFORE COMPLETING & SENDING THIS FORM.**

15. **NAME OF REFERRING PROVIDER OR OTHER SOURCE**
16. **RESERVED FOR LOCAL USE**
17. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**
18. **HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**

19. **SIGNATURE**
20. **SIGNED**

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