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Essentials of Provider Reimbursement: Inpatient Hospital

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No healthcare organization goes very far without understanding how it is paid. Even if you aren't the one negotiating reimbursement, it's helpful to know the essentials. Reimbursement is a frequent topic at senior management meetings and you don't want to be left out of the discussion.

This article is about the different types of payments that inpatient hospitals receive when contracting with insurance carriers.

Diagnosis Related Groupings

Diagnosis Related Groupings (DRG's) provide the foundation for classifying inpatients and measuring case mix. A single DRG is assigned to each inpatient stay. DRG's utilize principal diagnosis, additional diagnoses, principal and additional procedures if present, age, sex, and discharge status. Diagnoses and procedures assigned using ICD-9-CM codes determine DRG assignment. It is critical that accurate ICD-9-CM coding of every inpatient claim occurs for correct DRG assignment and subsequent reimbursement.

Virtually all principal diagnoses fall into one of 25 Major Diagnostic Categories (MDC's) corresponding to a single organ system. Some groupings are very costly and complex, so they are placed in a separate grouping based on procedures, not principal diagnoses. These DRG's include both solid organ and bone marrow transplants and Extracorporeal Membrane Oxygenation (ECMO), for example.

Patients are classified by operating room procedure, if present. A surgical hierarchy exists within each MDC and patients with multiple procedures are assigned to the highest acuity DRG.

If a procedure is not present, a claim is categorized as medical. In the DRG system and its variants, including AP-DRG's and MS-DRG's, each claim is additionally analyzed for age, sex, discharge status and/or the presence of a comorbidity or complication, and the DRG is assigned. The DRG variants perform a more precise analysis than DRG's.

Hospitals are paid a fixed amount for each claim, arrived at by multiplying the specific DRG weight by the base rate or conversion factor that is typically hospital specific. Each DRG weight will vary by acuity and as a reflection of the resource consumption projected for that DRG. DRG's with groups of patients who are expected to consume more resources will have a higher weight.

In general, all cases that group to the same DRG in the same hospital will generate identical reimbursement regardless of the length of stay.

Per Diem Reimbursement

Per diem reimbursement is the payment of a fixed amount per inpatient day. Per diem contracts typically utilize medical, surgical, and ICU/CCU per diems, with the rest of the pricing being a combination of case rates and percent of charge amounts. Carriers will try to match per diems to costs, lowering reimbursement as costs decrease with length of stay. Obstetrics is a prime example, where the acuity and cost tends to be in the early days of the stay, with later days typically consisting of monitoring. In these cases, per diem contracts usually pay less per day as the stay progresses.

Per diems may be dying out. They were the carriers attempt to keep reimbursement down by lowering lengths of stay. The problem is that an army of nurses must stay in constant contact with hospitals to ensure lengths of stay are as low as possible. The costs associated with hiring and retaining nurses often offsets any savings the carriers can achieve by monitoring utilization. Therefore, a number of formerly per diem based carriers have quietly migrated to fixed pricing in recent years.

Per Case Reimbursement

Per case reimbursement is only used by carriers that do not want to make the investment in a DRG based grouping methodology. Per case amounts are broken out typically into medical, surgical, ICU/CCU, and OB categories. Per case pricing does not have the sophistication adjusting for acuity and severity that DRG's have, so it can be costlier to the carriers.

Percent of Charges Reimbursement

This type of reimbursement is usually employed by carriers only where the other cost controlling methodologies are not in their interest. This is most often the case with financially challenged rural hospitals. Lowering reimbursement to these hospitals presents risk to the carriers as the demise of a rural hospital would leave nowhere for the carrier's members to receive hospital care. The only other circumstance compelling percent of charge use is when a hospital has commanding leverage over the carriers. The only pediatric specialty hospital in a major metropolitan setting with an aggressive negotiator, for example, can usually demand and get a high percentage of charges, again because the carriers have nowhere else locally to send their membership.

Outlier Protection

Additional payments are made when charges and therefore costs exceed fixed reimbursement by negotiated threshold amounts. There are a number of outlier methodologies. They often center around charges compared to payments, but can also correlate to total patient days, or cost data in the case of governmental carriers.

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