Lindsey Morrill

Chapter 6

- Learning Objectives

1. Distinguish between the major types of Medicare and Medicaid prospective payment systems for inpatients.
   - Medicare reimbursement system for inpatient services provided in an acute-care setting. The acute care setting excludes psychiatric units, long term care units and rehab units. Medicare is an insurance program whereas Medicaid is an assistance program.
2. Explain the concept of prospective payment.
   - Healthcare providers will always receive the same payment for providing the same specific type of treatment. These plans have pay fixed rates, providers and insurers can better manage and estimate cost and payments.
3. Explain the common models and policies of payment for inpatient Medicare and Medicaid prospective payment systems.
   - DRGs- payment rate is adjusted based on age, sex, secondary diagnosis. CMGs determines payment rate per stay.
4. Describe the elements of the inpatient prospective payment system.
   - The prospective payment system uses DRGs to reimburse short term hospitals at a group rate for Medicare inpatient services.
5. Illustrate MS-DRG assignment.
   - Linking like patients with like-resource consumption allows hospitals to perform cost management by DRG or DRG groupings
6. Describe severity of illness adjustment of MS-DRGs.
   - SOI refers to the degree of illness, extent of physiological decompensation or organ system loss. SOI differentiation is MS-DRGs is assigned using complication and comorbidity conditions.
7. Discuss the provisions of the inpatient prospective payment system.
   - The IPPS uses provisions to provide additional payments for specialized programs and unusual admissions that historically have added significant cost to patient care.

- 6.1

1. Prospective payment rates are payment in full – Payment rates are no automatically determined by the hospitals current or past cost.
2. Ignored

3. CC and MCC codes are both used in the MSDRG process. CC or MCC codes are reported as secondary diagnosis.
4. The IPPS allows for additional payments for cases that exceed an established high cost threshold.
5. It is where the patient goes for care after discharge. If it indicates post care after hospital stays it is then sent to PACT.

- 6.2

1. Requirements were to develop a per diem system that shows the cost differences throughout the various IPFs.
2. Per diem w/ adjustment
3. (77.135 x .75 x .1.145) + (771.35 x .25) = 855.24
4. Length of stay, MSDRG, comorbid conditions, electroconvulsive therapy, and age of the patient.
5. Initial stay provision- Higher payment is provided for initial days of stay to compensate for the higher costs associated with admission. Medical necessity provision- must be established for every patient on admission to IPF.

- Chapter 6 Review quiz

1. Medicare hospital deductible expanded, creating a burden for Medicare beneficiaries. The reporting requirements of the cost-based system were some of the most burdensome in the federal government.
2. Predetermined payment for each MSDRG is full payment for all hospital services performed during an encounter, facilities accept profit or loss based on the cost of providing the services.
3. Pre-MDC assignment, Major diagnostic category determination, Medical/surgical determination, and refinement.
4. Because sometimes the costs are very high when compared with the average costs for cases in the same MSDRG- the outlier provision provides some financial relief for those cases.
5. 30,528.96
6. The LOS adjustment was implemented because data showed that per diem costs for psychiatric cases decreases the LOS increase. Age of patient adjustment regression analysis shows the cost per day is increasing with increasing age.
7. 70.317% labor portion – 29.683% non-labor
8. CMS didn’t want to provide an incentive for facilities to prematurely discharge patients and them potentially re-admitting them because the LOS adjustment weighed heavier for the beginning days for admission.

9. Medical necessity must be established by the physician at the start of inpatient admission for psychiatric care and must be re-evaluated and established for admissions that extend past the 18th day.
10. Wage index adjustment.

- Chatper 6 Labs

2. IPF PPS Adjustments (Level 2 – Understanding)

The IPF PPS includes patient- and facility-level adjustments. The adjustments are included in the following table. For each adjustment label if it is patient- or facility-level, then describe the adjustment using nontechnical language.

Adjustment	Patient- or Facility-Level	Description
Wage index	Facility Level	Account for wage differences among geographic areas
Cost of living	Facility Level	Nonlabor share portion of the federal per diem base rate will be adjusted by the adjustment factor provided for the country where the facility is located
Electroconvulsive therapy	Facility level	Add-on payment
Rural location	Facility level	Providing psychiatric services requires a set of minimum fixed costs that cannot be avoided or decreased
Length of stay	Patient level	As LOS increases the cost decreases
Comorbid condition	Patient level	17 categories are applicable for adjustment
Teaching status	Facility level	Adjustment is similar to the med education adjustment made upper IPPS
MS-DRG	Patient level	17 MSDRG are applicable for adjustment
Full-service ED	Facility level	Adjustment is provided by higher adjustment factor for the day- 1 applied to each day
Patient age	Patient level	As the patient gets older- cost increases

Chapter 6 PPS Grids

Complete the following grids by using the information in your textbook.

Payment System	Inpatient Acute Care Facility	Inpatient Psychiatric Facility
Reimbursement Methodology	Yes, uses IPPS reimbursement methodology- based on case rate	Yes, uses IPF PPS reimbursement – based on per diem
Classification System, if applicable	Yes, uses both ICD-10-CM/PCS	Yes, uses both ICD-10-CM/PCS
Packaging concepts	No, it applies to OPPS	No, is applies to OPPS
Severity of illness component	Yes, it is used to determine the category a secondary CC condition falls under. SOI effects the level that DRG falls under	No, IPFs have a comorbidity component and does not use complications as a factor for reimbursement
Low-income patient provision	Yes, hospitals receive additional payment because they provide treatment to patients who are unable to pay for services rendered	No, the income status of the patient isn't a factor alone when determining IPR PPS provisions
Rural hospital adjustment	No, instead of a rural hospital adjustment there are provisions for inpatient acute care hospitals located in urban areas	Yes, the cost to treat patients in rural locations is 17 percent greater than it is when treating patients in urban locations
Outlier provisions	Yes, outlier payment provision provides financial relief for cases with extreme cost compared to the average costs for cases in the same MSDRG	Yes, IPF PPS provides outlier payments for high cost admissions
Other provisions and adjustments	Yes, facilities providing new medical/technologies are allowed additional payment. The payment provisions allows for full MSDRG payment plus some	Yes, initial stay and readmission provisions and medical necess.
Adjustment for wages	No, adjustments are based on SOI	Yes, wages are adjusted according the IPFs geographic area and is based on the federal per diem base rate
Adjustment for cost-of-living	No, adjustment for cost-of-living is not main credential for determining IPPS for inpatient acute care facilities.	Yes, cost-of-living is considered when determining IPFs PPS.

3. MS-DRG Calculations (Level 4 – Analyzing)

For this exercise use the Excel file titled: *Ch06 StudentWorkbookExercises.AB202017*, tabs *MS-DRG Calculation Example* and *MS-DRG Calculations*. This assignment consists of 10 inpatient acute care admissions; 5 for Happy Hospital and 5 for Sunshine Memorial Hospital. Calculate the MS-DRG reimbursement rate for each admission. Notice the fully adjusted base rate, charges and cost-to-charge ratio are different for each facility. Remember, the fully adjusted base rate already includes adjustments for IME, DSH and wage index. Once you have completed the calculations, answer the following questions.

Question	Answer
Which figure has the biggest impact in determining profit/loss for an admission; base rate or cost-to-charge ratio (CCR)? Why?	The CCR has the biggest determination on the profit or loss because it will show what the charges really are compared to what was charges
What is the definition of a CC/MCC? How does the presence of a CC/MCC code impact the reimbursement for an admission	CC is complications and comorbidities. MCC is major complications and comorbidities. Having CC/MCC adds an additional adjustment factor which contributes to the profit or loss
Why do surgical cases tend to have a higher relative weight (RW), and in turn payment, than medical cases?	RW is based on the cost for the case. Surgery cost more money than a regular medical case.
What can Sunshine Memorial Hospital do to improve their profit?	Lower their CCR

4. IPPS Outlier Calculations (Level 4 – Analyzing)

For this exercise use the Excel file titled: *Ch06 StudentWorkbookExercises.AB202017*, tabs titled *IPPS Outlier Example* and *IPPS Outlier Calculations*. This assignment consists of 4 different claims that will be examined for 4 different hospitals. Review the hospital and claim information provided. Calculate the cost, MS-DRG payment, outlier add-on amount, total payment and profit/loss for each claim for each provider. The IPPS high-cost threshold for FY 2018 is $26,601.00 Once you have completed the calculations, answer the following questions.

Question	Answer
Which hospital(s) made a profit on an outlier	

encounter? Why?	None- the system isn't designated to allow profit on an outlier account
Which hospital had more outlier cases, A or B? Why?	Hospital B- They have higher CCR than hospital A. Higher cost
Which hospital had more outlier cases, B or D, Why?	Hospital b has a greater loss for cases because Hospital D has a higher base rate which resulted in a higher MSDRG payment and reduced the amount of the loss
Why is it important for facilities to monitor their outlier percentage (percent of cases from their inpatient population that received an IPPS outlier payment)?	Medicare payment for inpatient services is prospective, hospitals will profit or loss for individual cases whose reimbursement exceeds or falls short of the cost. Payment provided to facilities is an average amount.

5. IPPS Transfer Calculations (Level 4 – Analyzing)

For this exercise use the Excel file titled: *Ch06 StudentWorkbookExercises.AB202017*, tab titled *IPPS Transfer Calculations.* This assignment will help you understand the distinct types of transfer payments executed under IPPS. For each type of transfer an example is provided. After you have reviewed the example, complete the transfer calculation for cases 1-4

provided on the right (columns L-S). The fully adjusted hospital base rate is $7,500.00. Once you have completed the calculations, answer the following questions.

Question	Answer
Why is a per diem payment scheme utilized for Transfer Type 1 cases?	Partial payment is made to the transferring hospital because the full course of treatment was not provided.
What is the monetary impact of the Transfer Types 1 and 2 payment adjustment for the cases with MS-DRG 330?	When type transfer payment methodology is used
Why would CMS utilize PACT methodology for certain MS-DRGs? What is this policy incentivizing/preventing?	Post-acute care transfer policy ensures that an incentive is not created for hospitals to discharge patient early to reduce cost.
What types of cases warrant 50% MS-DRG payment on the first day as required by the PACT Special payment adjustment?	PACT applies mostly to surgical cases. Surgical intervention is more expensive than medical intervention.

CMI Calculations

Table 1 - CMI Example

MS-DRG	MDC	TYPE	MS-DRG Title	2018 RW	Vol	Weighted Volume
405	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.2847	15	79.2705
406	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.7939	55	153.6645
407	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	2.0171	78	157.3338
				TOTALS	148	390.2688
					CMI	**2.6370**

Table 2A						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**2018 RW**	**Vol**	**Weighted Volume**
034	01	SURG	CAROTID ARTERY STENT PROCEDURE WITH MCC	3.9918	20	79.8360
035	01	SURG	CAROTID ARTERY STENT PROCEDURES W CC	2.2278	80	178.2240
036	01	SURG	CAROTID ARTERY STENT PROCEDURES W/O CC/MCC	1.7636	35	61.7260
				TOTALS	135	319.7860
					CMI	**2.3688**

Table 2B						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**2018 RW**	**Vol**	**Weighted Volume**
034	01	SURG	CAROTID ARTERY STENT PROCEDURE WITH MCC	3.9918	35	139.7130

035	01	SURG	CAROTID ARTERY STENT PROCEDURES W CC	2.2278	65	144.8070
036	01	SURG	CAROTID ARTERY STENT PROCEDURES W/O CC/MCC	1.7636	35	61.7260
				TOTALS	135	346.2460
					CMI	**2.5648**

Q. Why is the CMI for table 2B higher than the CMI for table 2A?

CMI increased because volume increased for MSDRG

Q. Why does MS-DRG 034 have a higher RW than MS-DRGs 035 and 036?

Has a higher relative weight because the patient had a major complication/comorbidity.

Table 2C

MS-DRG	MDC	TYPE	MS-DRG Title	2018 RW	Vol	Weighted Volume
034	01	SURG	CAROTID ARTERY STENT PROCEDURE WITH MCC	3.9918	20	79.8360
035	01	SURG	CAROTID ARTERY STENT PROCEDURES W CC	2.2278	65	144.8070
036	01	SURG	CAROTID ARTERY STENT PROCEDURES W/O CC/MCC	1.7636	50	88.1800
				TOTALS	135	312.8230
					CMI	**2.3172**

Q. Why is the CMI for table 2C lower than the CMI for table 2A?

CMI decreased because vaolume increased

Q. Why does MS-DRG 036 have a lower RW than MS-DRGs 034 and 035?

Because the patient did no have a CC or MCC

Discussion Question. Which has more influence on the CMI: RW or Volume?

The combo of 2 is what really influences the CMI- neither of them have greater without the other

Claim 1

Adjustment Category		***Adjustment Factor***
MS-DRG	056	1.05
Rural location	YES	1.17
Comorbidity	Cardiac condition	1.11
Age	72	1.13
Total Adjustment Factor		1.5409
Adjusted Per Diem Amount		**$ 1,188.58**

Claim 2

Adjustment Category		***Adjustment Factor***
MS-DRG	876	1.22
Rural location	NO	0
Comorbidity	Oncology treatment	1.07
Age	65	1.1
Total Adjustment Factor		1.4359
Adjusted Per Diem Amount		**$ 1,107.61**

Claim 3

Adjustment Category		***Adjustment Factor***
MS-DRG	896	0.88
Rural location	YES	1.17
Comorbidity	Artificial openings	1.08

Age	76	1.15
	Total Adjustment Factor	1.2788
	Adjusted Per Diem Amount	**$ 986.37**

Claim 4

Adjustment Category		***Adjustment Factor***
MS-DRG	884	1.03
Rural location	NO	0
Comorbidity	Coagulation factor deficits	1.13
Age	81	1.17
	Total Adjustment Factor	1.3618
	Adjusted Per Diem Amount	**$ 1,050.40**

Claim 5

Adjustment Category		***Adjustment Factor***
MS-DRG	885	1
Rural location	NO	0
Comorbidity	None	0
Age	63	1.07
	Total Adjustment Factor	1.07
	Adjusted Per Diem Amount	**$ 825.34**