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How Outpatient Hospital Reimbursement Works

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Outpatient hospital reimbursement has undergone a dramatic evolution. In the "old days" (circa 1986) outpatient hospital reimbursement was often an afterthought. DRG based inpatient reimbursement was still relatively new. Many commercial contracts paid outpatient activity on a percent of charges.

Things were beginning to change, though. The catalyst was the federal government. The feds realized that the DRG system established by Medicare in 1983 was beginning to control inpatient expense.

However, Medicare also recognized that outpatient activity was still uncontrolled and the volume of outpatient care was increasing dramatically. As such, Congress passed legislation in 1986 ordering the old Healthcare Financing Administration (HCFA, remember?) to begin laying the groundwork for an outpatient prospective payment system (OPPS) which would affect outpatient reimbursement in a manner similar to DRGs.

After many years and many fee schedules HCFA implemented Ambulatory Patient Groupings (APGs). I helped implement APGs for the old Blue Cross of Washington and Alaska (BCWA, remember them?)/Premera in the mid-late 1990s. Note the general pattern of the federal government establishing a payment methodology which was subsequently mimicked by the commercial insurance industry. True to form, when the government moved away from APGs in favor of the more comprehensive Ambulatory Patient Classifications (APCs), most commercial carriers followed suit.

Today most outpatient hospital reimbursement is OPPS based, increasingly driven by APCs, and attempts to eliminate as much percent-of-charge based reimbursement as possible. It is tempting to think of APCs as "outpatient DRG's." In reality, APCs are very complex and a more sophisticated reimbursement format than DRGs and their variants.

OPPS based payment methodologies typically include fixed payments for surgeries and significant procedures, emergency department treatments, radiology, chemotherapy, radiation therapy, pathology, clinic visits, diagnostic services and implants and supplies.

Additionally, most carriers have linked reimbursement for drugs, especially high cost drugs, to OPPS even though they may not technically fall under a methodology like APCs.

The wizards who gave us APCs created a system that groups outpatient care into classifications based on resource consumption. Like DRGs, APCs are assigned weights which are multiplied by a conversion factor to arrive at an amount of reimbursement. Unlike DRGs, there can be multiple APCs on a given claim. If a patient has two outpatient procedures with a hip x-ray, three APCs will potentially be assigned and paid. If someone has an outpatient procedure with a hand x-ray, two APCs may be assigned and paid. Conversely, if these types of care were delivered on an inpatient basis, there would only be one DRG assigned in each separate case.

The increased complexity of the APC methodologies often confounded hospital billers and expected reimbursement systems when they were rolled out, especially when the number of APCs on a single claim were 9 or 10 instead of 2 or 3.

The government and commercial carriers also established APC bundling and packaging techniques often described benignly as measures encouraging increased hospital efficiency when delivering outpatient services. That is a polite way of saying that services that used to be reimbursed would no longer be paid. Bundled and packaged services typically include anesthesia, supplies, and drugs, which are often grouped into the payment for a particular APC on a claim, usually one for a significant procedure performed.

APC based OPPS also include multiple procedure discounting. This occurs when more than one significant procedure is allowed on a claim, but full payment is made only on the procedure with the highest weighted APC. Procedures performed with lower weighting are paid at a discount of the regular APC allowable, often 50%. Many carriers use a 100/50/25% format, meaning they will pay 100% of the allowable of the highest weighted procedure, 50% of the allowable of the next highest weighted procedure, and 25% of the allowable on any procedures remaining.

Depending on the carrier, OPPS/APCs can become much more complex. Think Geometric Means, Wage Index Adjusting, Status Indicators (including the notorious Status Indicator C) and the like.

Finally, those remaining services not paid via OPPS are typically reimbursed on some variant of a CMS fee schedule; the commercial carriers' frequent use of the CMS clinical lab fee schedule is a prime example.

In conclusion, outpatient hospital reimbursement has evolved from being an afterthought to perhaps the most complex piece of the hospital reimbursement puzzle. As such, a thorough understanding of outpatient hospital reimbursement can only benefit a hospital's bottom line, now and in the future.

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