
AMERICA'S HIDDEN HEALTHCARE CRISIS

\$100 Billion
in Payment Errors...
ANNUALLY

INDUSTRY RESEARCH CONDUCTED BY



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EXECUTIVE SUMMARY

Today's U.S. healthcare system is highly complex. Few people understand how the industry works "behind the scenes." In fact, most Americans are unfamiliar with even the fundamental business aspects of the U.S. healthcare system: how clinicians get paid for the care they deliver, and how private insurance companies and public programs like Medicare pay for these services. Even for people working within the industry, the complexities of medical coding and reimbursement often leads to confusion, misunderstandings, and errors.

This complex realm of medical coding and reimbursement faces a \$100-billion-a-year crisis. It is a crisis that affects every American's access to affordable healthcare, the nation's overall economy, and the solvency of the Medicare program. This crisis is the direct result of confusion, misunderstandings and errors relating to inexact medical coding and reimbursement practices. This confusion stems in no small part from convoluted and continuously changing Medicare regulations and the lack of time for the industry to assimilate those changes.

A recent study from the Centers for Medicare & Medicaid Services (CMS), "FY 2004 Improper Medicare Fee-for-Service Payment Report," documented a medical coding and reimbursement error rate of nearly 10% on payments made by the traditional Medicare program for services covered on a fee-for-service basis. But, the problem identified by this study is actually much bigger.

HSS estimates that these errors resulted in erroneous Medicare payments of \$30.4 billion in 2003 — with nearly \$29 billion in the form of overpayments. Extrapolating these findings to private insurance and state Medicaid programs, HSS projects that industry payment errors will range between \$88 billion and \$120 billion in 2005.

Operational inefficiencies within the healthcare industry result in substantial financial losses to healthcare organizations and consumers. In its report, CMS determined that 95% of payment errors involved overpayments. Although Medicare recently announced that it is taking steps to reduce these error rates, such cumulative, year-after-year losses substantially reduce the solvency of the Medicare program. Perhaps more importantly, these findings suggest an even larger crisis in the non-Medicare sectors where 75% of the healthcare expenditures occur.

This report:

- Reviews CMS' "FY 2004 Improper Medicare Fee-for-Service Payment Report," including the first (January 2005) update to the report;
- Analyzes the report's financial implications for the U.S. healthcare industry as a whole; and
- Provides recommendations for improving medical coding and reimbursement accuracy and efficiency.

MEDICARE CLAIMS PAYMENT ERROR REPORT

In December 2004, CMS released its latest analysis of payment errors for the Medicare program. CMS determines error rates for fee-for-service (FFS) claims paid under the Medicare program annually. CMS pays providers serving Medicare beneficiaries either on a FFS basis or under managed care (capitation). The former requires a claims payment process to handle reimbursements to providers, and it is the accuracy of this process that is evaluated in CMS' "FY 2004 Improper Medicare Fee-for-Service Payment Report."

CMS analyzed three specific types of errors:¹

- **Insufficient Documentation** — The provider did not include pertinent patient facts (i.e., the patient's overall condition, diagnosis, and extent of services performed) when asked to support proper billing of the case.
- **Lack of Medical Necessity** — Claims where the claim review staff identified enough documentation in the medical record to make an informed decision that the services billed to Medicare were not medically necessary.
- **Incorrect Coding** — Providers use a standard coding system to describe diagnoses and procedures when they bill Medicare. For most of the coding errors, the medical reviewers determined that providers submitted documentation that supported a lower code than the code submitted ("upcoded" claims). However, for some of the coding errors, the documentation supported a higher code than the code submitted by the provider ("undercoded" claims).

Two additional general types of errors were also analyzed in the CMS report:²

- **Non-Response Errors** — The provider did not submit any documentation to support the services provided. There were two types of non-response errors:
 - Nothing was received from the provider in response to a documentation request, and
 - The provider responded to a documentation request but did not provide a medical record to support payment of a claim.
- **Other Errors** — Provider's claims did not meet benefit category requirements or other billing requirements.

To better understand the context and implications of the CMS report, it is useful to review the important role of medical record documentation, coding, and billing in the payment process for healthcare services. Thus, before we review the findings of the Medicare FFS error report, the next section provides a brief overview of these issues.

The Importance of Documentation and Coding to Drive Billing

Healthcare providers are generally paid for their services in one of two ways: as services are provided (fee-for-service) to plan members, or under managed care arrangements where providers are paid a negotiated monthly fee to care for a population of plan members (capitation). In the latter situation, providers retain the financial responsibility of treating all patients, regardless of the number and types of services needed to treat them.³

Under capitation, providers retain nearly full financial responsibility and there are no service-related billing requirements. Thus, when members receive care, documenting (and coding) their overall condition, diagnosis, and extent of services performed is generally not required for the providers to get paid. At the time of service, the medical necessity of care is not a financial concern to anyone except the provider. All of these are very

1 FY 2004 Improper Medicare Fee-For-Service Payment Report, pp. 17, 22, and 24.

2 FY 2004 Improper Medicare Fee-For-Service Payment Report, pp. 20 and 26.

3 Insurance premiums received by HMOs and other managed care organizations also are sometimes referred to as "capitation rates." However, very few HMOs are direct providers of services. Most purchase healthcare services for their members from community-based providers. "Capitation" as used in this article refers to the payments made to those providers and not to the insurance premiums received by the plan.

important concerns, however, when the quality of care provided to plan members is evaluated. And from a financial perspective, the completeness and accuracy of this information is crucial to establishing fair capitation rates and adjustments in the future.

The world is much more complex under FFS reimbursement. Because payers retain most of the financial responsibility under FFS arrangements, they understandably require much more justification for services provided, and documentation of the patients' needs and the services performed. Depending on the complexity of the payment methods, the payer will require varying degrees of accurate and complete coding for appropriate payment calculations.

It is the variety and complexity of FFS payment methods that creates confusion, misunderstandings, and errors in the billing process and leads to significant payment errors. Generally, FFS approaches include (individually and combined):

- **Percent-of-Charge (Discounted Charge)** — Methods that generally pay providers as services are rendered, without limits on the number of services provided or the intensity (expense) of those services.
- **Fee Schedules** — Eliminate pricing discretion on the part of providers by establishing fixed prices for individual services. They also provide few financial incentives to constrain utilization.
- **Per-Diems** — Represent a simple strategy to share responsibility with providers by limiting what is paid for each day. This creates the incentive for hospitals to control daily costs and utilization. Payers and providers typically negotiate daily payment rates for hospital stays based on the type of stay, i.e., medical/surgical, delivery and intensive care.
- **Case Rates** — Shift even more responsibility to providers by establishing a bundled payment rate for all services needed to treat specific cases (e.g., labor and delivery, outpatient surgery cases). The obvious advantage of case rates is they encourage providers' ability to manage utilization and costs efficiently.
- **Casemix-Adjusted Case Rates (e.g., DRGs, APCs)** — Can be applied to most types of admissions and visits and generally achieve the most equitable distribution of risk between providers and payers. In contrast, unadjusted case rates are usually limited to a handful of situations where a "one-size fits all" rate fairly compensates providers (case types with clinically well-defined patients and little variability in medical needs).

These payment methods vary considerably in complexity, and a provider typically must manage a combination of these approaches. This is complicated by the fact that providers deal with multiple payers, of which no two have the same array of payment approaches and schedules.

Despite their differences, the various FFS payment approaches do have a consistent requirement that patient care be medically necessary, and that medical records be properly documented and coded. It is the complexity, lack of clarity, and frequency of changes to the regulations governing these requirements that pose enormous challenges to the healthcare industry. Providers and payers alike rely on timely, accurate, and complete information for an efficient payment process.

Thus, it is clear that medical record documentation and the coding of the medical record are two critical components for managing claims payment between providers and payers. It is no surprise, then, that CMS has recognized the need to measure and address the unacceptably high payment error rates (and billions of dollars) documented in its report. What may be surprising to many is the magnitude of these errors across the entire U.S. healthcare system.

FY 2004 CMS Report on Medicare Payment Errors

In December 2004, CMS released its latest analysis of Medicare payment errors entitled “FY 2004 Improper Medicare Fee-for-Service Payment Report,” and subsequently released its first scheduled update in January 2005. As documented in these reports, CMS contractors sampled 160,000 Medicare fee-for-service (FFS) claims and estimated payment error rates and related over- and underpayments to providers for the Medicare FFS program.

The study contractors reviewed FFS claims paid (primarily) during CY 2003, and CMS reported that \$213.5 B in FFS claims were paid during the timeframe of the study. CMS study contractors report⁴ that, of the \$213.5 B, there were:

- \$18.4 B in overpayments (8.6%); and
- \$0.9 B in underpayments (0.4%).

Thus, CMS estimates that the total payment (gross) errors amounted to \$19.3 B, or 9.0% of all FFS payments in 2003. Putting these results in a broader perspective, we estimate⁵ that these payment errors amount to an average of:

- \$23 for every Medicare FFS claim; and
- \$600 for every Medicare FFS beneficiary.

CMS reported the distribution of net payment errors (overpayments - underpayments) by type of error:

Type of Error	% of Errors
Insufficient Documentation	43.7%
Non-Response Errors	29.7%
Medically Unnecessary	17.2%
Incorrect Coding	7.7%
Other Errors	1.6%

Applying this distribution to the 9.0% total (gross) error rate yields gross error estimates by error type as follows:

Type of Error	Gross Error Rate
Insufficient Documentation	4.0%
Non-Response Errors	2.7%
Medically Unnecessary	1.6%
Incorrect Coding	0.7%
Other Errors	0.1%

⁴ January 05 Update to *FY 2004 Improper Medicare Fee-for-Service Payment Report*, CMS.

⁵ Estimated using claim volume and beneficiary counts from CMS 2004 Statistics, available for download from CMS at www.cms.hhs.gov/researchers/pubs/CMSstatistics/2004CMSstat.pdf.

Corrective Actions Proposed by CMS

According to CMS, one of its performance goals for FY 2004 was to reduce the gross payment error rate to 5.6%.⁶ The gross error rate of 9.0% in its FY 2004 report is 60% higher than that target. In response to this shortfall, CMS has decided to work with its contractors to “implement aggressive efforts to lower the paid error rate” by:⁷

- Developing a tool that generates state-specific hospital billing reports to help analyze administrative claims data;
- Increasing and refining one-on-one educational efforts with providers found to be billing in error; and
- Developing projects with its vendors to address state-specific admissions necessity and coding concerns, as well as conducting surveillance and monitoring of inpatient payment error trends by error type.

CMS has also directed its vendors to:⁸

- “...develop local efforts to lower the error rate by developing plans that address the cause of the errors, the steps they are taking to fix the problems, and other recommendations that will ultimately lower the error rate;”
and
- “...target for education and claims review those medically unnecessary services that are contributing to the high national paid claims error rate ... and initiate aggressive educational campaigns.”

⁶ FY 2004 Improper Medicare Fee-For-Service Payment Report, p. iv.

⁷ Ibid.

⁸ FY 2004 Improper Medicare Fee-For-Service Payment Report, p. v.

U.S. HEALTHCARE INDUSTRY IMPLICATIONS AND ESTIMATES

The Medicare FFS error estimate of \$19.3 B annually from the CMS report is a compelling number, but it is only the beginning of the story. The problems identified in this study extend further into the Medicare program and have even greater implications for other sectors of the healthcare industry, especially private insurance and state Medicaid programs. This section will use the results from the CMS report and estimate the system-wide implications.

Broader Implications for Medicare

The CMS study described earlier focused exclusively on Medicare program payments for services covered under the traditional Medicare fee-for-service program. However, the problems identified in this study also affect other dimensions of the Medicare program. For instance, beneficiaries who are enrolled in traditional Medicare are responsible for significant portions of their own medical bills through various coinsurance and deductible requirements. To the extent that coding and reimbursement errors lead to excess program payments, they also inflate copayments paid by beneficiaries or their supplemental insurance carriers.

In addition, Medicare managed care (Medicare Advantage) payments are directly affected by these payment errors because Advantage payment rates are set based on Medicare FFS payment levels. Thus, Medicare's overpayment of FFS providers is built directly into its managed care program. Furthermore, Medicare managed care organizations are in turn at risk because, in many instances, these plans use the same reimbursement methods as traditional Medicare FFS.

Further analysis of the CMS study results suggests that payment errors for the entire Medicare program may be as high as \$30.4 B. This estimate is based on the following personal healthcare expenditures (PHE) data from CMS for CY 2003⁹:

PERSONAL HEALTH EXPENDITURES, CY 2003

Type of Expenditure	Amount	% of Total
Out-of-Pocket Payments	\$230.5 B	16%
Private Health Insurance	\$518.7 B	36%
Medicare	\$274.9 B	19%
Medicaid	\$248.5 B	17%
Other	\$168.2 B	12%
Total Personal Healthcare Expenditures	\$1,440.8 B	100%

The difference between the \$274.9 B shown here and the \$213.5 B reported by CMS in its report is mostly due to the fact that the PHE Medicare expenditures are for FFS and managed care. CMS estimates that 86.6% of total Medicare benefits paid are FFS¹⁰, or \$238.1 B. The remaining \$24.6 B difference is likely due to the claim lag for claims occurring in the study timeframe, or other study design restrictions.

⁹ Available for download from CMS at <http://www.cms.hhs.gov/statistics/nhe/historical/t9.asp>.

¹⁰ From *CMS 2004 Statistics*, available for download from CMS at www.cms.hhs.gov/researchers/pubs/CMSstatistics/2004CMSstat.pdf

We believe that applying half of the 9.0% payment error rate (4.5%) to Medicare managed care expenditures is a reasonable, conservative assumption. As discussed above, the Medicare Advantage program and its participating managed care organizations are directly affected by the erroneous documentation, coding and billing practices that are driving the 9.0% payment error rate on FFS payments.

Also noted above, it is important to take into account out-of-pocket (OOP) expenditures by Medicare beneficiaries and privately insured individuals. OOP expenses in the National Health Accounts consist of spending by uninsured individuals, spending by insured individuals for non-covered services, and copayments (coinsurance and deductibles) paid by insured individuals for covered services. Thus, they are also vulnerable to coding and payment errors and need to be recognized in any quantitative assessment of this problem.

For these reasons, HSS believes that the \$19.3B price tag estimated by CMS significantly understates the magnitude of the problem, even in the Medicare context. Using the CY 2003 PHE data described above, we estimated broader payment errors for the Medicare program as follows:

- Medicare estimated as FFS with and without managed care (MC): As mentioned above, the PHE estimate of Medicare FFS is \$238.1 B, and total Medicare — FFS & MC — is \$274.9 B.
- Medicare FFS and FFS & MC estimates included OOP expenditures: We proportionately split the PHE estimate of OOP (\$230.5 B) between Medicare and private health insurance:
 - 34.6% ($\$274.9 \text{ B} / (\$274.9 \text{ B} + \$518.7 \text{ B})$) to Medicare, or \$79.8 B; and
 - 65.4% to private health insurance, or \$150.7 B.
- Error rate assumptions: 9.0% for FFS and OOP expenditures, and 4.5% for Medicare managed care.

Thus, as the table below shows, we estimate that payment errors for the entire Medicare program may be as high as \$30.4 B, nearly 60% above the initial CMS estimate.

HSS ESTIMATED MEDICARE PAYMENT ERRORS

Model Scenario	PHE	Payment Errors
Medicare FFS	\$238.1 B	\$21.5 B
Medicare FFS & MC	\$274.9 B	\$23.2 B
Medicare FFS w/ OOP	\$317.9 B	\$28.7 B
Medicare FFS & MC w/ OOP	\$354.7 B	\$30.4 B

U.S. Healthcare Industry Estimates

The Medicare program is the largest single source of payment for healthcare services in the United States, but it only accounts for about a quarter of all personal healthcare expenditures, taking into account Medicare-related out-of-pocket spending. We can approach the question of how large the potential magnitude of non-Medicare errors is by using an approach for Medicaid and private health insurance that is similar to that described above. In particular, we start with the 2003 PHE estimates:¹¹

¹¹ Available for download from CMS at <http://www.cms.hhs.gov/statistics/nhe/historical/t9.asp>.

PERSONAL HEALTH EXPENDITURES, CY 2003

Type of Expenditure	Amount	% of Total
Out-of-Pocket Payments	\$230.5 B	16%
Private Health Insurance	\$518.7 B	36%
Medicare	\$274.9 B	19%
Medicaid	\$248.5 B	17%
Other	\$168.2 B	12%
Total Personal Healthcare Expenditures	\$1,440.8 B	100%

and develop estimates of industry-wide payment errors by assuming that:

- 30% of private health insurance expenditures are associated with managed care
- 20% of Medicaid expenditures are associated with managed care arrangements
- 65.4% of OOP spending (\$150.7 B) is associated with services that are billed as if they were covered by private health insurance

Reasonable assumptions about error rates are somewhat problematic. Using the 9.0% error rate for FFS payment accuracy would assume that Medicaid and private insurance are as sensitive to medical record documentation and coding as is Medicare. In fact, the actual error rate will depend on the mix of payment approaches used by Medicaid and private insurance relative to Medicare. For example, because Medicare utilizes clinical coding into DRGs and APCs to a much greater extent than Medicaid and private insurance, Medicare payments are more sensitive to incorrect coding and documentation errors. To reflect this possibility, we modeled various assumptions and believe that 6% is a reasonable lower-end error rate assumption than the non-Medicare fee-for-service error rate. We assume that the error rate for managed care is similar to the 4.5% that we postulated for Medicare managed care.

These assumptions produce estimated, industry-wide payment errors (including Medicare from previous modeling above) that range between \$77 B and \$104 B in CY 2003:

INDUSTRY-WIDE ESTIMATES OF PAYMENT ERRORS, CY 2003

Healthcare Sector	PHE(w/ Allocated OOP)	Payment Errors Assuming 6.0% Non-Medicare Error Rate	Payment Errors Assuming 9.0% Non-Medicare Error Rate
Private Health Insurance	\$669.4 B	\$33.5 B	\$53.4 B
Medicare	\$354.7 B	\$30.4 B	\$30.4 B
Medicaid	\$248.5 B	\$12.8 B	\$20.2 B
Total	\$1,272.6 B	\$76.6 B	\$104.0 B

We can also project industry-wide payment errors using CMS' 2005 PHE projections. As shown below, the more than 15% increase in personal health care expenditures that has taken place in the last two years translates directly into increases in the cost of these errors to the U.S. economy. Industry-wide error estimates for CY 2005 range between \$88 B and \$120 B:

INDUSTRY-WIDE ESTIMATES OF PAYMENT ERRORS, CY 2005

Healthcare Sector	PHE(w/ Allocated OOP)	Payment Errors Assuming 6.0% Non-Medicare Error Rate	Payment Errors Assuming 9.0% Non-Medicare Error Rate
Private Health Insurance	\$787.0 B	\$39.3 B	\$62.8 B
Medicare	\$387.1 B	\$33.1 B	\$33.1 B
Medicaid	\$297.8 B	\$15.3 B	\$24.2 B
Total	\$1,471.9 B	\$87.8 B	\$120.1 B

DISCUSSION AND RECOMMENDATIONS

The economic implications of these payment errors are far-reaching. Overpayments undermine the financial integrity of Medicare, Medicaid, and private insurance carriers; while underpayments compromise the bottom line of organizations that provide care. In the end, the losses from overpayments and underpayments increase the cost of care. Eventually, these increases affect American businesses by forcing them to pay insurance premiums that are higher than necessary to provide health coverage for employees. Finally, consumers are hurt by higher premiums, which reduce take-home pay, and larger deductibles, which decrease discretionary spending.

For its part, CMS recognizes that changes are necessary in the Medicare program. In response to its annual \$20 B payment error problem, CMS has proposed a series of “corrective actions” as discussed above. But narrowly focusing on Medicare, and ignoring the industry-wide \$100 B implications of these findings, is dangerously short-sighted and points to a key factor in this crisis.

CMS consistently ignores the enormous impact that its policy decisions and regulations have on the entire healthcare industry. CMS also does not seem to understand the operational challenges it creates on the healthcare system through the administration of its programs and how those challenges multiply when other payers follow Medicare policies in their own contracting and operations.

CMS readily acknowledges this myopia. For example, in response to public comments regarding its proposed Medicare DRG changes for FY 2005, CMS stated that:¹²

“Our mission in maintaining the Medicare DRGs is to serve the Medicare population... However, we acknowledge the Medicare DRGs are sometimes used to classify other patient populations. [But, we] advise those non-Medicare systems that need a more up-to-date system to choose from other systems that are currently in use in the country, or to develop their own modifications.”

In its final FY 2005 rule, CMS added:¹³

“Decisions about the use of DRGs in Medicaid are made by the states. As we stated previously, the primary focus of our updates to the Medicare DRG classification system is on changes relating to the Medicare patient population.”

It is unfortunate that CMS fails to acknowledge or take into account in its policy deliberations the fact that Medicare DRGs are the “gold standard” in the industry today for casemix-adjusting inpatient discharge payments to hospitals. Not only do many private insurers and state Medicaid programs use Medicare DRGs for payment, these DRGs are the linchpin for much of the utilization, cost, and quality review analyses used in the healthcare industry. Thus, like it or not, DRGs are at the center of the healthcare system’s operational efficiency — from medical record documentation, coding, and billing to quality, compliance, cost, and utilization review.

The DRG classification system is but one of many areas where the Medicare program administration defines the operational rules in the industry today. The complexity and clarity of the Medicare system, and the process and timeliness of CMS updates to the system, have a direct impact on the operational challenges faced by essentially all payers and providers in the healthcare industry.

¹² Federal Register, Vol. 69, No. 96, p. 28210.

¹³ Federal Register, Vol. 69, No. 154, p. 48971.

Recommendations

Overhauling Medicare and America's health system has been a hot political and ideological topic for the past decade. And there continues to be an expectation that technological implementations will go a long way to correct this nation's ailing health system. However, the technologies being considered - electronic medical records, electronic prescribing, computerized physician order entry, and others - are complex and expensive systems that will take billions of dollars to purchase and years to implement on a nationwide scale. The benefits of these technologies are potentially huge but the realization of these benefits is a long way off.

More importantly, many of these technological solutions do not directly address the medical coding and reimbursement errors that are identified in the CMS report, much less the industry-wide problems they reflect. Even if these technological solutions were implemented in a timely and efficient manner, the industry would still continue to rack up hundreds of billions of dollars in losses each year due to coding and reimbursement errors.

While the industry is enamored with the promise of exciting new technologies, there is little focus on the decaying infrastructure within the core administrative systems at most healthcare providers. Twenty years ago hospitals replaced their core administrative technology, on average, every seven years. That cycle has stretched to 10 years and beyond. Many hospitals continue to use technology developed in the 60s and 70s. Managing a business as complex as healthcare with 10-plus year old technology is a recipe for exactly the problems discussed herein. Providing incentives to providers to adopt new administrative technology at a faster pace is a prerequisite to solving this problem.

Medical coding and reimbursement errors are tangible problems that require practical solutions. While some of these solutions may be supported by technology, the solutions themselves are not necessarily technology-driven. For example, revising the CMS regulatory update cycle to give health insurers and providers sufficient time to react and implement new regulations that change dozens of times throughout the year is a policy decision rather than a technology decision. CMS' frequent changes to regulations, and the minimal time that is often given before the regulations take effect, plays a substantial role in increasing medical coding and reimbursement errors. Hospitals and payers alike simply cannot assimilate the knowledge to effectively operationalize regulatory changes given the current CMS update policy.

Improving medical coding and reimbursement processes is another key opportunity area. Confusing regulations create an incentive for healthcare providers to undercode as a strategy to avoid rejection of their medical claims, which delays payment. This strategy enables healthcare providers to receive payment quicker and maintain positive cash flow, yet they are not paid for all the care that they deliver. In contrast, health insurers need a way to validate and group the medical claims that they receive from health providers to prevent overpayments to health providers that make mistakes, or are overly aggressive in their medical coding practices to increase the dollar amount of payments.

Increasing efficiency in deploying regulatory updates at health insurers and provider organizations is becoming more and more important to the industry. The pace of regulatory changes has increased dramatically in recent years and organizations that do not efficiently deploy the regulatory content greatly increase their chance of errors and losses. For example, the update process typically poses a dilemma for hospitals as they wait for changes to be deployed. Holding claims causes cash flow problems, while billing claims with errors increases workflow (e.g., denials management) and raises compliance risk. Both scenarios serve to significantly increase the cost of healthcare.

Thus, healthcare information vendors and healthcare providers need to look for ways to streamline their own deployment and implementation processes. Fortunately, emerging technologies, such as Web Services, offer real opportunities to streamline the update process, to improve productivity, to reduce redundant software purchases and, in short, to achieve meaningful administrative simplification and savings. However, embracing those new technologies will take a real commitment on the part of IS vendors and hospitals alike.

In the end, no single solution is likely to resolve a problem that requires a collective response on the part of CMS, other government agencies, providers, payers, and IT vendors. CMS needs to recognize and embrace its influence on the coding and billing practices of the entire industry. Payers should understand that they can save substantial money by streamlining contracting and claims processing practices that are often complicated, confusing and even downright arbitrary. At the same time, providers need to realize that complete and *accurate* coding and billing affect more than their bottom lines. They are essential to good patient care and to realizing the tremendous financial and clinical value available from emerging administrative technologies in the healthcare industry.

GLOSSARY

AMBULATORY PAYMENT CLASSIFICATION GROUPS (APCs)

A classification system that groups outpatient visits and procedures into payment categories for payment under the Medicare Outpatient Prospective Payment System (OPPS).

CAPITATION *

A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's healthcare services for a certain length of time.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The federal agency within the U.S. Department of Health and Human Services (HSS) that administers the Federal Medicare program, and jointly administers the State Medicaid program. (Formerly known as the Health Care Financing Administration (HCFA)).

COMPUTERIZED PHYSICIAN ORDER ENTRY

Emerging computerized systems (primarily in hospitals) designed to reduce medical errors and improve quality by replacing paper-based physician ordering. These automated systems are typically linked with medication error prevention software and decision-support systems.

DIAGNOSIS-RELATED GROUPS (DRGs) *

A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

ELECTRONIC MEDICAL RECORDS

The developing technology intended to provide a computer-based medical record containing most of the clinical information contained in the patients' paper-based medical records. For use by providers and health plans, this electronic health record will provide real-time access to patients' medical information.

ELECTRONIC PRESCRIBING

The developing technology for providers to enter a patient's medical prescription in a computer and then electronically transmitting the prescriptions to their pharmacist. Electronic prescribing tools are expected to provide a wealth of information used to support efficient management of pharmaceutical reimbursement and patient care.

FEE FOR SERVICE

The method of paying medical providers as services are provided, typically using fee schedules and discounts on charges.

FISCAL INTERMEDIARY *

A private company that has a contract with Medicare to pay Part A and some Part B bills.

GROUPING

The process of classifying patients (typically using computer software applications) into clinical groups used for payment (e.g., DRGs, APCs).

MEDICAL CODING

The use of classification systems by providers and health insurers to identify diagnoses, procedures, and services provided to patients, based on information documented on the patient's medical record. The resulting medical coding information is used to determine provider reimbursement, and analyze utilization and quality of care.

MEDICALLY NECESSARY *

Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

MEDICARE *

Medicare is the national health insurance program for: people age 65 or older, some people under age 65 with disabilities, and people with end-stage renal disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant.

MEDICARE BENEFICIARY

One of roughly 40 million Americans receiving medical benefits under the Medicare program.

MEDICARE CONTRACTOR *

A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC).

MEDICARE PART A *

Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

MEDICARE PART B *

Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

MEDICARE PART B CARRIER *

A Medicare contractor that administers the Medicare Part B (Professional) benefits for a given region.

OFFICE OF INSPECTOR GENERAL (OIG)

The Federal agency within the U.S. Department of Health and Human Services (HHS) responsible for the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs.

OVERCODED — see upcoded claims

PERSONAL HEALTH EXPENDITURES

Direct consumption of healthcare goods and services provided by hospitals, physicians, and other suppliers of medical care services and equipment.

PRIVATE INSURANCE

Non-governmental (commercial) health insurance purchased by employers for their employees, or purchased directly by consumers. Also includes supplemental insurance purchased to pay for services not fully covered by government insurance programs.

PROSPECTIVE PAYMENT SYSTEM (PPS) *

A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

REIMBURSEMENT

Payments made to providers by insurance programs (government and commercial) to pay for medical services provided to their beneficiaries.

REJECTION OF MEDICAL CLAIMS

The refusal, on the part of an insurance program, to pay for a medical claim due to the providers' failure to follow billing rules regarding, for example, documentation, medical necessity, and coding errors.

UNDERCODED CLAIMS

Medical claims where the documentation in the medical record would support a higher medical coding than was submitted by the provider.

UPCODED CLAIMS

Medical claims where the documentation in the medical record would support a lower medical coding than was submitted by the provider.

* Centers for Medicare & Medicaid Services (CMS) website, www.cms.hhs.gov.

ABOUT HSS

HSS, Inc. (www.hssweb.com) develops solutions that streamline the coding, regulatory and reimbursement processes at provider and payer organizations. HSS' experience with providers and payers enables it to provide the tools and methodologies for organizations to evaluate financial and operational performance, target areas of performance improvement and balance risk-assumption with profit opportunities. These solutions combine technology with HSS' nationally recognized healthcare expertise. HSS solutions are used by more than 900 hospitals and 160 managed-care organizations. They are also embedded in health information management applications offered by 27 of the industry's major software vendors.



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