Prospective payment systems (PPS) use diagnosis related groups (DRGs) to help with inpatient acute care reimbursement. DRGs are a collection of health care descriptions organized into statistically similar categories. In other words, patients are organized together according to common diagnosis, treatment, or even resources. The system functions under the assumption that patients with the same diagnosis will require the same type of care. By classifying the patients using DRGs and also giving an expectation of the resources necessary to treat them, a basis is formed for calculating the monetary values used in the PPS. The DRG system helps give a basis for hospital reimbursement by Medicare and other insurance payers. The DRG system starts by assigning a primary code to the patient, which then leads to the DRG assignment, and then is used for insurance reimbursement purposes. The accuracy and importance of the DRG system all stems on the correct code being assigned, which makes health information management personnel a very important part of health care reimbursement.

In the United States, DRGs stem from ICD-9-CM codes (Davis & LaCour, 2007). First, the principal diagnosis code must be given and accepted, then patients are assigned a major diagnostic category (MDC). From the MDC, codes for procedures will be examined, making sure they fit into the categories of either medical or surgical. Next, the MDC could be further grouped according to a secondary diagnosis code for comorbidity or complication (known as a CC code). After this, the DRG is assigned.

It is important to realize that insurance companies rely on the PPS and DRGs when analyzing a claim for payment and also when setting their payment scales. Medicare reimbursements are based on the relative weight of the DRG and also the hospital’s PPS rate (Davis & LaCour, 2007).

**Ambulatory Payment Classifications**

In 1997, the federal government, under the Balanced Budget Act, wanted to help control the costs of outpatient services. The government wanted to develop a PPS system for outpatient services to control Medicare costs. The system was implemented in 2000 and is referred to as ambulatory payment groups (APGs). The APC system relies on HCPCS/CPT-4 codes to group patients (Davis & LaCour, 2007). The system groups patients with similar clinical information and cost consumption. The APCs are categorized according to significant procedures, therapies, or services; medical visits; ancillary tests and procedures; partial hospitalization; drugs and biologicals; and devices (Davis & LaCour, 2007). Certain patients do fall into more than
one APC category allowing for multiple codes to be assigned. Reimbursement for services is generally done based on HCPCS/CPT-4 codes, code modifiers, and also revenue codes.

**Billing**

Patient related codes and classification systems all work together to help the health care facility to bill for the medical services rendered. Billing is generally handled by the patient accounts department. This department is responsible for ensuring all patients are billed according to the correct payer and that the health care facility in turn receives payment. Today, it is done electronically. The bill should contain the patient’s charges and an individual patient account number. Charges are the fees the facility assigns to items or services. They can be set by a fee schedule or internally by a cost-accounting system. A report listing all of the charges and items is called a *chargemaster*. This can also be referred to as a *charge data master* or a *charge description master* (Davis & LaCour, 2007). When charges are assigned to an individual patient, this is referred to as *charge capture*. For most ambulatory or outpatient facilities, the charges are sent to an encounter form also known as a *superbill*. From here, the information is recorded on a CMS-1500 form for the transmittal of information for the purpose of billing to insurance companies.

**Regulatory Issues and Coding Compliance**

On April 1, 2005, the CMS and NCHS set up regulatory guidelines regarding coding from incomplete health records (Davis & LaCour, 2007):

A joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the health care provider and coder in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical records cannot be over-emphasized. Without such documentation, accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

It is important to understand that, under the National Correct Coding Initiative (NCCI), incorrect coding or maximization can result in criminal
prosecution (Davis & LaCour, 2007).

To help ensure coding practices are in place along with data quality assurance, health care facilities should implement a coding compliance plan. This should be a part of the corporate compliance plan of the entire facility. It should include regular audits, both internally and externally.

**Reference**