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Complexities of Surgery Pricing and Implications for Life Care Planners

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Abstract

Life care planning is a method of determining current and future care needs with associated costs for individuals with a disability or chronic illness. Obtaining prices for future surgeries can be difficult for life care planners. Life care planning standards of practice indicate that a method of determining charges should be consistent, valid and reliable. In the authors' experience, data related to facility prices for surgeries can be quite variable. Knowing how to evaluate data is important to ensure that prices are appropriate for use in life care planning. The purpose of this article is to discuss some of the available methods for obtaining facility prices for surgeries in relation to best practices in life care planning. It is intended that this article will help life care planners understand the complexities of obtaining facility prices for surgeries and become more informed about evaluating different sources of pricing information.

Introduction

An integral part of life care planning is determining the costs for current and future needs of a person with a disability or chronic illness, referred to as the evaluee (Barros-Bailey, Carlisle, Graham, Neulicht, Taylor & Wallace, 2009). Cost information in a life care plan can be used to help resolve legal issues, manage health care resources, implement services, manage trusts, and do discharge, financial and estate planning. It is important to ensure that the costs in the life care plan are accurate or the evaluee could be prevented from receiving necessary services and treatment, negatively impacting rehabilitation outcomes.

Previous life care planning summits have explored the topic of best practices for identifying costs in a life care plan. The consensus has been that best practices include obtaining verifiable data from appropriately referenced sources; identifying costs that are geographically specific when appropriate and available; identifying non-discounted/market rate prices; and obtaining more than one cost estimate, when appropriate (Johnson, 2015). Consensus statements have been incorporated in published standards of practice in the field of life care planning (International Academy of Life Care Planners, 2015). *The Standards of Practice for Life Care Planners - Third Edition* indicates:

> The life care planner uses a consistent, valid and reliable approach to research, data collection, analysis, and planning . . . , researches appropriate options and charges for recommendations, using sources that are reasonably available to the evaluee . . . , and uses a consistent method to determine available choices and charges" (p. 9).

The American Association of *Nurse Life Care Planners Nurse Life Care Planning Scope and Standards of Practice* (2014) indicates that nurse life care planners "obtain costs for items and services in a life care plan using provider/vendor contacts . . . and obtain costs for items and services in a life care plan using internet sources" (p. 21).

There are a variety of resources available to life care planners for use in obtaining costs. The question addressed in this article is how to evaluate different resources to ensure that they meet life care planning standards, specifically with regard to obtaining facility charges for surgeries. Hospital facility charges include room and board, operating and recovery time, medical and surgical supplies, inpatient pharmacy, ancillary services such as blood work, x-rays and breathing treatments, inpatient therapies, and other hospital/facility based clinical services. Although the facility charge for surgery often does not include professional fees, such as charges for the surgeon, assistant surgeon, anesthesiologist, pathologist, monitoring specialist, etc., a discussion of how to obtain these additional costs is beyond the scope of this article.

One thing to keep in mind when obtaining costs for a life care plan is the difference between the charge/price/cost of an item or procedure and the reimbursement amount, which is the amount paid to the facility by patients and third-party payers. There are different reimbursement methods, including fee-for-service, usual, customary and reasonable (UCR), flat rate, per diem, and diagnosis related group (DRG). The amount reimbursed for an item or service is different than the hospital charge for the item or service, and this distinction must be kept in mind when obtaining prices to ensure that the price is non-discounted. Legal jurisdictional requirements will likely impact the types of pricing deemed admissible but this issue is beyond the scope of this article.

Definitions

A few terms used in this article which warrant definition are as follows:

> Charge/Price/Cost: The dollar amount for each service or item. (Cost can also mean the amount a hospital spends to provide care, but in the context of life care planning, "cost" is used interchangeably with "charge" or "price.")
>
> Chargemaster: A list of prices maintained by each hospital nationwide consisting of a description of the item provided or performed, a CPT or HCPCS code for

the item, and the amount charged by the facility for the item. The chargemaster is used to post charges to the patient's account and to bill the charges.

CPT (Current Procedural Terminology): A set of procedure codes used to describe medical procedures and services, maintained by the American Medical Association (AMA). This is Level I of the Healthcare Common Procedure Coding System (HCPCS).

ICD-10 (International Classification of Diseases, 10th Revision): A set of medical diagnostic codes maintained by the Centers for Disease Control and Prevention. This supersedes the ICD-9-CM.

Reimbursement: A method of payment, usually by a third-party payer (i.e. a government program, commercial payer or managed care plan), for hospital costs. Reimbursement is based on claims and documentation filed by providers using medical diagnosis and procedure codes.

Reimbursement Method: Various methods of reimbursement are used by third-party payer types. They include traditional (i.e. fee-for-service, percentage of accrued charges, and usual, customary and reasonable), fixed payment (i.e. capitation, or a fixed amount paid per member per month), and prospective payer system (DRG for hospital inpatient services).

Fee-for-Service: A reimbursement method where hospitals are paid a fee for each service performed based on an established fee schedule. Private insurers pay hospitals predominantly on the basis of fee-for-service payments.

DRG (Diagnosis Related Group): A system used by the federal Medicare program and other government programs in which the hospital is paid a fixed amount for each DRG based on average resources used to treat Medicare patients in that DRG. There is a base payment rate for each DRG which is adjusted by the Centers for Medicare & Medicaid Services (CMS) for each hospital based on geographic factors and case mix. The DRG payment includes routine nursing services, room and board, and diagnostic and ancillary services. CMS is responsible for annually adjusting DRG classifications and weights and for creating new codes.

MS-DRG (Medicare Severity Diagnosis Related Group): In 2007, CMS began to phase in the MS-DRG system, in which DRGs are classified into three levels of severity, including major complication/comorbidity (MCC), complication/comorbidity (CC) and no complication/comorbidity (non-CC). Medicare sets discharge payment rates for 751 MS-DRG codes.

Bundled Payment: A single payment for all providers and services needed by a patient for an episode of care, which is defined by the length of time and the range of providers and services which are covered for that episode. The bundled payment is determined by the payer.

Price Transparency: Attempts by the healthcare industry to provide meaningful information to consumers about the price of medical care.

Pricing Methodology

It is important to understand the type of price information provided by different resources, including the difference between billed amounts and reimbursed amounts for items and services. In this article, various types of pricing resources will be discussed in detail, including price transparency tools, databases of insurance claims, and price quotes from hospitals. Suggestions about how to evaluate various resources in terms of usefulness to life care planners will be provided.

One method life care planners use to obtain surgery costs is to call hospital price lines. Costs may vary significantly from hospital to hospital, based on factors such as geographic location, range and complexity of services provided, payer mix, capital expenses and staffing. Different hospitals have different charges for their services and each hospital maintains its own chargemaster. Hospitals provide price estimates using different data, including MS-DRG codes, chargemaster price by CPT/HCPCS codes, or an average of costs for similar procedures done at that hospital in the past. It is sometimes difficult to determine from the hospital representative who is providing the price estimate just how the price estimate is derived.

Often hospitals provide a price estimate based on an MS-DRG code. Each MS-DRG code includes many different operating room procedures, with one Medicare reimbursement rate for the whole group of procedures. For example, knee replacement is contained within DRG 470, major joint replacement or reattachment of a lower extremity, along with other procedures such as hip replacement, ankle replacement and reattachment of a leg. The life care planner is then presented with an aggregated rate rather than a charge for a specific procedure. Further, MS-DRG codes represent Medicare payment rates rather than private pay rates. Private payers may move toward adopting their own MS-DRG system in the future and this is currently in a trial phase. Private payers still primarily use a fee-for-service method. It is important to understand these issues when using prices by DRG code.

When hospitals provide an estimate by referencing similar procedures performed at that hospital in the past, it is hard to know how closely the estimate matches the surgery

being planned for the evaluee, and thus, how accurate the estimate will be. It is sometimes also difficult to determine whether the past cost represents the amount which was billed or the amount which was reimbursed by a third-party payer. This is an important distinction, as the amount reimbursed may be a negotiated rate and not the actual cost for the service.

When the hospital price line reports chargemaster prices by CPT code, this represents what the hospital will charge, before any discounts are applied. Obtaining prices from the hospital based on CPT codes avoids the aggregation of MS-DRG pricing and allows for specificity in terms of the procedure to be done. In order to get the most accurate price possible, the life care planner will need certain information, including the CPT code for the main procedure and any related procedures, the length of the procedure, whether the procedure is done on an inpatient or outpatient basis, if inpatient, how long the hospital stay is expected to be, time in the recovery room, therapies and testing needed during an inpatient stay, need for bracing, etc. The surgeon, the billing office or the surgery scheduler may be a good source for this information. The more a price estimate can be individualized to the evaluee, the closer the estimate is likely to be to the actual billed charge. It must be noted, however, that it is impossible to know all the different codes that will be billed before the surgery is done, and therefore, the quote will only be an estimate. There are some large ticket items which must be considered for the estimate to be as accurate as possible. For example, surgical implants can be a large part of the hospital charge for surgeries such as fusions, spinal cord stimulators, joint replacements, etc., and the life care planner should ensure that the charge for implants, when applicable, is included in the price estimate. Using a price estimate from the hospital where the evaluee's treating physician performs surgical procedures will help eliminate some of the variability of hospital pricing. However, the price may be inflated or artificially low when compared to other hospitals in the area for reasons related to volume of surgery performed, complexity of services provided, payer mix, capital expenses, private versus not-for-profit status and staffing, among other reasons. Sometimes it is not possible to obtain information from the treating physician or from the facility where the surgery will likely be done and the life care planner must utilize other available resources to obtain facility costs for a surgery.

Pricing Resources

There has been a move toward price transparency since the passage of the Patient Protection and Affordable Care Act, with hospital associations, health plans, consumer groups and state governments beginning to report health care prices (42 U.S.C. § 18001, 2010). The U.S. Government Accountability Office (GAO) definition of price transparency is "the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties" (GAO, 2011). The GAO defines price as follows:

> An estimate of a consumer's complete health care cost on a health care service or set of services that (1) reflects negotiated discounts; (2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician and lab fees; and, (3) identifies the consumer's out-of-pocket costs (such as co-pays, co-insurance and deductibles).

When using price transparency information, it is useful to understand that prices may reflect discounts. View the complete GAO report at: www.gao.gov/products/GAO-11-791.

Most states have also enacted legislation to improve transparency in health charges. The National Conference of State Legislators provides a summary of price transparency legislation by state (http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx) that is helpful for life care planners researching cost information in their particular state. The same criteria described above can be applied to state price transparency websites. In addition, many hospitals post price estimates for a limited number of procedures on their websites. There is frequently a disclaimer stating that the actual bill for services may differ substantially.

There are several questions to consider when using price transparency websites.

1. Is the information provided on the price transparency website based on discounts or reimbursement rates, or is the information based on billed charges?
2. Is information regarding the specific procedure available and consistent with the procedure that is being recommended for the evaluee? Price transparency websites often disclose only a small number of common procedures.
3. How old are the prices on the price transparency websites? In some cases, they may be quite outdated.
4. Is information provided for the type of facility where the surgery will be performed? Surgeries are not only performed at hospitals but also at outpatient facilities and ambulatory surgery centers, and costs vary by type of facility. Many price transparency websites do not include information from outpatient facilities and surgery centers.
5. Is there geographic specificity? Information may be provided based on national data, state data, zip code, and/or specific hospital.
6. Are professional fees included in the price? If not, these will need to be obtained separately, by calling offices of surgeons, anesthesiologists, monitoring specialists, etc. There are also published resources for physician fees, including *National Fee Analyzer, Physicians' Fee Reference, and Medical Fees*.

The authors undertook a comparison of various price

transparency websites to illustrate the type of information available regarding facility costs for surgery (see Table 1). We chose websites which are publically available and nationally representative, and chose two surgeries which are commonly encountered in life care planning as examples, knee replacement and cervical fusion. This information is summarized below. Data were pulled in February, 2017.

The Healthcare Cost and Utilization Project (HCUP) is an on-line query system which is part of the Agency for Healthcare Research and Quality (AHRQ), found at https://hcupnet.ahrq.gov/#setup. It is a federal, state and healthcare industry partnership. Inpatient databases include National Inpatient Sample (NIS), Kids' Inpatient Database (KID), and State Inpatient Databases (SID). Mean or median hospital charges for inpatient procedures can be obtained by DRG code or by Clinical Classifications Software (CCS) category, in which ICD-9-CM codes are collapsed into smaller categories. Data are based on hospital billing records from participating state organizations. The data contain the total hospital charge for hospital stays but do not include professional fees (i.e. surgeon, assistant surgeon, anesthesiologist). The most recent national data are from 2014, and the date of the last update varies by state. Information is not provided by zip code or specific hospital. (Source: https://hcupnet.ahrq.gov/#setup)

Healthcare Bluebook is a private, independently owned company. A search can be done for a procedure, test or service by zip code or by city and state. According to the website, a "Fair Price" is:

> The price that a person can expect to pay by being a prudent healthcare consumer. . . . Bluebook Fair Prices are based on the actual amount paid on the claim, not the billed amount, and reflect the discounts that the health plan has negotiated with the facility. . . . There is no guarantee that any specific provider will charge a specific rate. . . ."

Data sources and the analytics system used to evaluate the data are proprietary, and it is unknown how old the data are. In the authors' experience, the Fair Price is low compared to resources that provide billed charges rather than discounted rates. (Source: https://healthcarebluebook.com/)

HealthGrove by Graphiq provides average hospital charges in the U.S. in 2013 by procedure name. Their website states that it is a "health news and information site with an emphasis on data-driven analysis." Data sources include HCUP, Graphiq staff research, and the Centers for Medicare & Medicaid Services (CMS) data. (Source: http://medical-procedures.healthgrove.com/)

The Centers for Medicare & Medicaid Services (www.cms.gov) provides hospital-specific 2014 charge data regarding all MS-DRG discharges for the approximately 3,000 U.S. hospitals that receive Medicare Inpatient Prospective Payment System (IPPS) payments. In addition to hospital-specific charges, the average charge for services covered by Medicare for all discharges in the DRG are reported for the nation and for each state. (Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient2014.html).

The American Hospital Directory is available by paid subscription (www.ahd.com). It includes data from public and private sources, including Medicare claims data, hospital cost reports, and other files. Average charges are available by hospital and procedures can be searched by MS-DRG or description. Information is available by hospital for MS-DRGs with 10 or more discharges within a given year. The data are about 6 months old when they are made available, and files are updated each quarter.

Fair Health is a national, independent, nonprofit organization which owns a database with charge data for billed medical and dental services and procedures for all 50 states, Washington, D.C., Puerto Rico and the U.S. Virgin Islands. Data reflect the full undiscounted charges that healthcare providers report to payers as part of the claims process. Estimated charges are provided based on a selected percentile of charges in the database which are lower or higher than the estimate (50th through 90th percentile). Cost estimates are based on geozip, the first three digits of the zip code. Products include anesthesia, dental, HCPCS, inpatient facility (by DRG), medical/surgical (by CPT), and outpatient facility (by CPT). New charge data are added twice a year. There is a free consumer website which is for personal consumer use only. Use of the free consumer website for commercial purposes (i.e. life care planning) is prohibited.

Right is a table comparing price information provided on the price transparency websites discussed above. For websites which provide data by specific hospital, the authors used Denver, Colorado hospitals as examples of the data available, but a similar search can be performed for hospitals in other states.

Table 1

Comparison of Data from Health Care Transparency Websites

Website	**Hospital charge for cervical fusion**	**Hospital charge for knee replacement**
HCUPnet https://hcupnet.ahrq.gov/#setup Year of data: 2014 U.S. and Colorado hospital data (all payers)	**DRG 473, cervical spine fusion w/o cc/mcc** National: Mean hospital charge $63,933 Median hospital charge $53,318 Colorado: Mean hospital charge $84,883 Median hospital charge $79,549	**DRG 470, major joint replacement of lower extremity w/o mcc** National: Mean hospital charge $56,116 Median hospital charge $49,464 Colorado: Mean charge $73,179 Median charge $70,346
Healthcare Bluebook https://healthcarebluebook.com/ Zip code 80214 for Colorado (year or source of data not published)	**Procedure: spinal fusion, cervical, zip code 80214** Total Fair Price: $25,277 Hospital: $20,084 Physician: $3,465 Anesthesia: $1,728	**Procedure: total knee replacement, zip code 80214** Total Fair Price: $22,265 Hospital: $18,458 Physician: $2,697 Anesthesia: $1,110
HealthGrove http://medical-procedures.healthgrove.com/ Year of data: 2013 U.S. Data	**Procedure:** **spinal fusion** National average charge: $105,184	**Procedure: knee replacement** National average charge: $56,104
Medicare Provider Utilization and Payment Inpatient Charge Data https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient2014.html Year of data: 2014 U.S. and select Denver, CO hospitals	**DRG 473, cervical spine fusion w/o cc/mcc** National average covered charge: $63,565.80 Colorado average covered charge: $84,041.01 Rose Medical Center: $97,708.04 Swedish Medical Center: $79,803.73 St. Anthony Hospital: $107,935.67 North Suburban Medical Center: $88,417.64	**DRG 470, major joint replacement of lower extremity w/o mcc** National average covered charge: $55,995.63 Colorado average covered charge: $68,740.13 Rose Medical Center: $86,780.53 Swedish Medical Center: $81,863.93 St. Anthony Hospital: $81,588.84 North Suburban Medical Center: $101,567.58

The data in Table 1 illustrate the point that surgery pricing can be quite variable. In addition to the price transparency websites described above, there are also databases available to life care planners to assist in determining pricing for future surgeries that are for purchase or subscription.

Conclusions

Pricing is available from different sources which offer different types of data and the life care planner must be knowledgeable about which data to use. The authors have found that there are pros and cons to the use of various types of data. Obtaining price estimates using DRG data results in costs which are aggregated rather than procedure specific. However, DRG codes have the benefit of being all-inclusive in terms of the items and services provided, whereas pricing by CPT code may not reflect all charges until the actual procedure is performed. Some resources are based on actual charges, while others are based on negotiated or discounted rates. If the goal of the life care planner is to most closely approximate the amount the evaluee will be billed by a facility for a surgery, the most accurate estimate may be from the facility where the procedure will likely be done, using codes specific to the evaluee's need. However, this method may not always be possible and lacks the statistical power of a database with large amounts of data.

Any given source of pricing may not meet all the life care planning standards for information which is geographically specific, based on billed rather than reimbursed charges, specific to the procedure being costed, and current enough to be useful. When data are pulled from different sources, it often becomes apparent which prices are outliers and should be eliminated. It is important to understand what the best practice for each situation is. This can be done by applying clinical judgment, which means using valid, reliable and acceptable methodologies by a professional with specialized knowledge, education, training and/or experience (Field, Choppa & Weed, 2009).

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