

Consistency of Hospital Pricing Data in Life Care Planning

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Life care planners are charged with determining the needs and costs associated with the care for the catastrophically injured or ill. Within the Standards of Practice established by the International Academy of Life Care Planners is the assigned function of listing options and their associated costs for every component of the patient's care (IACCP, 2002).

The determination of medical costs can be a less than exact process that has the life care planner traversing many paths. A call to the hospital billing office for inpatient costs often is the first stop followed by perusing the Internet for useful data sites and possibly purchasing data publications. Regardless of the methods employed, the issues of accuracy and consistency of the information are ever present.

Accuracy is always going to be difficult to determine because hospitals and data vendors have their own methodologies for aggregating and reporting data. The only common ground that may exist in these methodologies is that most use diagnosis related groups (DRGs), Current Procedural Terminology (CPT) or International Classification of Diseases (ICD) for aggregation. Beyond this point, the concern of the life care planner may shift to whether charge, reimbursement or diagnosis related group price is being reported. Furthermore, the possibility exists that the data being referenced could originate from a particular third party payor's negotiated fee schedule and not accurately reflect the true price for the service.

The consistency of the data can become a concern as a resource is used year after year. In other words, will a call to a hospital requesting a price for a knee replacement generate the same answer six months later, taking into consideration that inflation is a factor? Will the web site continue to report averages or will there be a subtle shift to the use of medians?

The resolution to the accuracy concern is extremely important; however, the focus of this brief study is on the significance of consistency in how one requests hospital inpatient pricing information. Accuracy questions may best be resolved by asking the purveyors of data how their information is gathered and calculated, but the life care planner has no control of the computations. On the other hand, the life care planner can help insure consistency by understanding how to ask for the data.

Research Methodology

The DRG that was most frequently researched by life care planners on the author's web site Health-mart.net, was Major Joint and Limb Reattachment of Lower Extremity (DRG 209). The assumption was made that this DRG was selected by life care planners due to its association with knee replacements.

The Medicare Analysis Provider and Review (MEDPAR) file prepared by the Centers for Medicare and Medicaid Services (previously the Health Care Financing Administration) and made available to the author's company by way of a Data Use Agreement was used to query for DRG 209 for a specific hospital. The MEDPAR contained approximately eleven million individual Medicare claims that make it one of the largest, if not the largest, databases of inpatient claims in existence.

The queries conducted on the MEDPAR for the specific hospital were as follows:

1. Knee Replacement (ICD 8154) without other procedures
2. Knee Replacement with other procedures
3. Major Joint and Limb Reattachment of Lower Extremity (DRG 209)

Each query was designed to report the following: length of stay, DRG price, covered charge and reimbursement. Length of stay represented the average stay for the procedure or DRG. DRG price was the average price established by Medicare for the DRG associated with knee replacements. Covered charge was an average of charges that Medicare recognized as being qualified for reimbursement, and reimbursement was defined as the average Medicare payment for the procedure or DRG.

The query for ICD 8154 without other procedures returned 29 claims, and ICD 8154 with other procedures produced 37 records. The query on DRG 209 generated 95 records.

Limitations of the Research

The database used in this research consisted solely of Medicare claims. By definition, the use of Medicare data excludes patients under sixty-five years of age unless the patient is disabled. An argument could be made that pricing in this patient population may be higher due to existing comorbidities.

Only one procedure was studied. While the finding would seem to logically apply across procedures, more research is required to validate that assumption.

Findings

Differences exist in pricing and length of stay for each of the aforementioned queries; however, one could argue that for the purposes of life care planning, possibly the differences are not significant. On the other hand, these variations could have an impact on the life care plan if the patient required multiple hospitalizations for the same procedure or condition.

	Stay	Medicare DRG Price	Medicare Covered Charge	Medicare Reimbursement
ICD 8154				
Average	6.14	\$9,110	\$22,459	\$7,695
Median	5	\$8,689	\$22,424	\$7,913
ICD 8154 w/multiple procedures				
Average	7.81	\$10,301	\$25,498	\$7,912

Median	6	\$8,689	\$22,861	\$7,913
DRG 209	8.45	\$9,445	\$23,206	\$8,086
Average	8	\$8,689	\$21,758	\$7,913
Median				

Source: Medicare Analysis Provider and Review file and MetroHealth America, Inc.

ICD 8154 with multiple procedures had the highest average DRG price, covered charge and reimbursement amounts while ICD 8154 without other procedures had the lowest values for the same categories. Median DRG price and reimbursement were identical across the three queries. Length of stay was shortest for ICD 8154 without multiple procedures and longest for DRG 209.

Conclusion

The article demonstrates that how a life care planner researches data need may have an impact on the results that are obtained. Simply requesting from a hospital or searching on the Internet for information on knee replacements without considering that there may be attendant procedures such as arthrocentesis, knee structure division, relaxation of scar or injection of steroid would likely produce length of stay and charge data that differ from more complex knee replacements.

An anecdotal example of the above comment is that a recent call to the hospital billing office of the institution studied in this paper asking for a price for a knee replacement produced the following response. The hospital said that the cost of the surgery, operating room and recovery would be about \$15,000. That estimated amount falls considerably below the values discovered in this paper.

Life care planners probably are aware that a DRG is usually an aggregation of similar procedures or conditions. If DRG level data are used in life care plans, a general idea of length of stay and charges can be presented, but the data will reflect an average of the values associated with the conditions and procedures within the DRG. In many cases, this level of accuracy may be acceptable.

The specific procedure or condition query will give more precise information; however, often vendors of hospital data cannot release information at that level due to insufficient claims and the attendant patient confidentiality issues. One has to ascertain the level of preciseness required for the plan and then proceed with acquiring the needed data. Finally, the life care planner has to be comfortable with substantiating the validity of the information in the plan.

IACLP (2002) Standards of Practice (retrieved from internationalacademyoflifecareplanners.com)

Biography

Cy Rosenblatt is president and founder of MetroHealth America, Inc., a healthcare consulting firm specializing in market research. He has been involved in the healthcare industry for 25 years with experience in both public and private service delivery issues.

A political science major, he graduated from Southern Methodist University as a member of Phi Beta Kappa, a national academic honorary. Rosenblatt received his Masters in Public Administration from the University of Virginia.

