Chapter 7
Medicare Hospital Outpatient Payment System

Learning Objectives

- Define bundling
- Define packaging
- Describe how payment status indicators represent reimbursement methodologies
- Illustrate how packaging is utilized in OPPS reimbursement
- Describe the OPPS provisions

Key Terms

Ambulatory payment classification (APC)
Bundling
Conversion factor (CF)
National unadjusted payment
Outpatient Code Editor (OCE)
Packaging
Partial hospitalization program (PHP)
Pass-through
Payment status indicator (SI)
Sole-community hospital (SCH)

Before the implementation of the Medicare Hospital Outpatient Payment System, Medicare payment for hospital outpatient services was based on an estimate of the cost incurred by the provider. The estimated cost of services was calculated by converting total charges for each encounter to cost by using department-specific cost-to-charge ratios (CCRs) developed from cost report statistics. However, as healthcare costs continued to rise, CMS moved toward a prospective payment system (PPS) to encourage a more efficient delivery of care for outpatient beneficiaries (CMS 2004, 50450). The Medicare Hospital Outpatient Payment System was implemented in August 2000 and is the payment system used for hospital-based outpatient encounters. The Medicare Payment Advisory Commission (MedPAC) and others use this name on webpages and documents. However, this payment system is also referred to as the hospital Outpatient Prospective Payment System (OPPS) throughout CMS webpages, documents, and the *Federal Register*. In this chapter, the acronym OPPS is used for this payment system. Most Medicare reimbursement systems utilize one reimbursement methodology to determine payment rates for services and supplies. However, OPPS is unique in that the system incorporates multiple reimbursement methodologies. In the following section we discuss this unique approach.

Reimbursement for Outpatient Hospital Services

CMS uses three reimbursement methods to reimburse facilities for hospital outpatient services: fee schedule payment, prospective payment, and reasonable cost payment. The primary standard that distinguishes a PPS from a fee schedule system is that, in the PPS, the costs for certain items and secondary services associated with a primary procedure are packaged into the payment for that procedure, which is determined

page 114 - 115 to answer the questions

before the service is provided (prospectively). A fee schedule system establishes a separate payment amount for each item or service and no packaging occurs (CMS 2004, 50505). Since most of the services in the OPPS are paid via a prospective methodology, the overall system is considered prospective even though there are a few services reimbursed under fee scheduled arrangements or by reasonable cost. The third methodology, cost-based, is used for specified services and certain pharmaceutical items. Pharmaceutical items are paid based on the average sales price (ASP) plus 5 percent. The addition of the so-called ASP plus 5 percent methodology is designed to pay providers for the cost of the drug (ASP) and the added cost required for processing and administration (plus 5 percent). The other services assigned the reimbursement methodology are determined by multiplying the facility charge times the hospital CCR.

Ambulatory Payment Classification System

Most ambulatory services under OPPS are paid via **ambulatory payment classification** (APC). The APC system combines procedures or services that are clinically comparable, with respect to resource use, into groups called APCs. All procedures or services assigned to an APC group must meet the "two-times rule," which establishes that the median cost of the most expensive item or service within a group cannot be more than two times greater than the median cost of the least expensive item or service within the same group (CMS 2004, 50454). CMS can propose exceptions to the two-times rule based on the following criteria:

- Resource homogeneity
- Clinical homogeneity
- Hospital concentration (few hospitals provide the service)
- Frequency of service (low volume)
- Opportunity for upcoding and code fragments (CMS 2004, 50463)

Violations of the two-times rule are reviewed by the APC Advisory Panel. After analysis of each situation, the panel makes recommendations for each group that violated the rule. CMS uses the recommendations proposed by the panel and makes the final determination. In the following section, we will explore characteristics and components of the APC system, including the level of packaging and the use of payment status indicators (SIs).

Partially Packaged System Methodology

Packaging and bundling concepts are used in OPPS to combine payment for multiple services. In the 2008 OPPS final rule, CMS defines packaging and bundling:

- **Packaging** occurs when reimbursement for minor ancillary services associated with a significant procedure is combined into a single payment for the procedure.
- **Bundling** occurs when payment for multiple significant procedures or multiple units of the same procedure related to an outpatient encounter or to an episode-of-care is combined into a single unit of payment. (CMS 2007, 66610)

The concepts of packaging and bundling allow CMS to provide financial incentives for healthcare facilities to improve their efficiency by avoiding unnecessary ancillary services, supplies, and pharmaceuticals, and by substituting less expensive, but equally effective, options.

Packaging is extensive in OPPS. Ancillary and supportive services are packaged with significant, surgical, and evaluation procedures. When packaging occurs, the reimbursement for the ancillary and supportive services is automatically combined into the significant procedure, surgical service, or evaluation APC payment rate. Example 7.1 illustrates packaging in OPPS.

Example 7.1

A patient is seen in radiology for an MRI of the lumbar spine with contrast (Current Procedure Terminology (CPT) code 72149). The contrast utilized during the MRI is an iron-based magnetic resonance contrast agent that is reported with CPT code Q9953. Under OPPS packaging, the contrast medium is considered a supportive service and is included in the reimbursement for the MRI of the lumbar spine. A separate payment is not made for the contrast agent.

(continued)

Service	CPT Code	APC	Reimbursement (2020)
MRI lumbar spine with contrast	72149	APC 5572	$381.85
Iron-based magnetic resonance contrast agent	Q9953	No APC	Packaged ($0.00)

Source: CMS 2020a.

Various levels of packaging are executed under OPPS, some of which are activated based on combinations of services performed during the encounter.

Bundling takes a predetermined set of services that, when performed together during an encounter, result in the reimbursement for all services being combined into one payment amount. Examples of bundling include critical care services, imaging, and mental health services. Example 7.2 illustrates bundling in OPPS.

Example 7.2

A patient is seen by her primary care physician for continued neck and back pain. The physician orders MRIs to be performed at the cervical, thoracic, and lumbar regions. The MRI of each region is an individual component (in other words, cervical, thoracic, and lumbar). When these three components are provided during the same encounter, the payment for the components is combined into one APC.

APC	Components	Reimbursement (2020)
8007 – MRI and MRA without Contrast Composite	• 72141, MRI cervical • 72146, MRI thoracic • 72148, MRI lumbar	$543.18

Source: CMS 2020b.

This example shows how the component procedures are bundled together into one service. Most bundling occurs within component APCs, which will be discussed in the next section of this text.

The APC system is a partially packaged system. Services or items, such as recovery room, anesthesia, and some pharmaceuticals, are packaged or bundled into a single payment. Although most ancillary and supportive services are packaged or bundled, other services are not, which is why this system is partially packaged as opposed to fully packaged, like inpatient prospective payment system (IPPS). For the inpatient setting, it is easier to predict which resources a patient will consume for a given clinical issue. However, in the outpatient setting, treatment pathways vary greatly from patient to patient, making it much more difficult to determine the resources that will be consumed for a clinical issue. Therefore, a partially packaged system was created to provide adequate reimbursement and to allow the treatment flexibility that is needed to appropriately care for patients in the outpatient setting. The implication of the partially packaged nature of the OPPS is that each claim may be assigned more than one APC, while in the fully packaged IPPS, each claim is assigned only one Medicare severity-diagnosis related group (MS-DRG).

Although OPPS has been a partially packaged system since its inception in 2000, CMS has been moving toward a fully packaged case-rate system over the past several years. Each year, CMS has increased packaging of ancillary and supportive services, which were previously payable separately. The OPPS packages payments for multiple and interrelated items and services to promote effective and efficient care in the following ways:

- Encourage hospitals to provide efficient care and to manage resources with maximum flexibility
- Incentivize hospitals to choose the most cost-efficient option when a variety of devices, drugs, items, and supplies could be utilized to meet the patient's needs
- Encourage hospitals to effectively negotiate with manufacturers and suppliers to reduce the purchase price for supplies and items
- Influence hospitals to establish protocols to ensure the necessary services are provided, but scrutinize practitioner orders to maximize the efficient use of hospital resources (CMS 2017, 52390)

Each year, CMS continues to examine payment for services under OPPS to determine if further services can be packaged. CMS's goal is to advance the OPPS into a fully packaged case-rate system.

Payment Status Indicators

OPPS requires that facilities use Healthcare Common Procedure Coding System (HCPCS) codes to report

Table 7.1. **Payment status indicators for 2020**

Payment Status Indicator	Reimbursement Method	Procedure or Service Example
A	Fee schedule payment	Ambulance, separately payable clinical diagnostic laboratory, physical, occupational, and speech therapy, prosthetics, orthotics, diagnostic mammogram, and screening mammogram
B	Not reimbursed under OPPS	Service not appropriate for Part B claim
C	Not reimbursed under OPPS	Inpatient-only services
D	Not reimbursed under OPPS	Code is discontinued
E1	Not reimbursed under OPPS	Not covered by any Medicare outpatient benefit category, is statutorily excluded by Medicare, or is not reasonable and necessary
E2	Not reimbursed under OPPS	Items and services for which pricing information and claims data are not available
F	Reasonable cost payment	Acquisition of corneal tissue, certain certified registered nurse anesthetist (CRNA) services, and hepatitis B vaccines
G	APC Payment	Pass-through drugs and biologicals
H	Reasonable cost payment	Pass-through device categories No copayment
J1	Comprehensive APC payment	All services are packaged with the primary J1 service except services with SI F, G, H, L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; self-administered drugs; all preventive services; and certain Part B inpatient services
J2	Services may be paid through a comprehensive APC payment	All services on the claim are packaged into a single payment for specific combinations of services except services with SI F, G, H, L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; self-administered drugs; all preventive services; and certain Part B inpatient services Packaged APC payment if billed on the same claim as an HCPCS code assigned status indicator J1
K	APC payment	Non-pass-through drugs and nonimplantable biologicals, including therapeutic radiopharmaceuticals
L	Reasonable cost payment	Influenza and pneumococcal pneumonia immunizations No copayment or deductible amount
M	Not reimbursed under OPPS	Services not billable to the Medicare administrative contractor (MAC) Pharmacy dispensing fee, chemo assessment of nausea, pain, fatigue, and such
N	Packaged payment	Payment is packaged into payment for other services
P	Per diem APC payment	Partial hospitalization
Q1	Conditional APC payment	STV conditionally packaged services. Packaged on same claim as a code with S, T or V
Q2	Conditional APC payment	T conditionally packaged services. Packaged on same claim as a code with T
Q3	Composite APC payment	Services that may be paid through a composite APC
Q4	Conditional APC payment	Conditionally packaged laboratory tests. Packaged on same claim as a code with SI J1, J2, S, T, V, Q1, Q2, or Q3 If not packaged, SI is A and service is paid via the Clinical Lab Fee Schedule
R	APC payment	Blood and blood products
S	APC payment	Procedure or service, multiple procedure reduction does not apply
T	APC payment	Procedure or service, multiple procedure reduction applies
U	APC payment	Brachytherapy sources
V	APC payment	Clinic or emergency department visits
Y	Not reimbursed under OPPS	Nonimplanted durable medical equipment (DME) that must be billed directly to the DME MAC

Source: Adapted from CMS 2019.

services and procedures performed and items and supplies provided for beneficiaries. Each code in HCPCS has been assigned a **payment status indicator (SI)**. The SI is a code that establishes how a service, procedure, or item is paid in OPPS (for example, fee schedule, APC, reasonable cost, not paid). Table 7.1 provides a listing of the SI codes and their definitions for 2020.

Interpreting SIs is the foundation of determining OPPS reimbursement. SIs are assigned to all HCPCS codes. HCPCS codes are displayed in Addendum B of the OPPS final rule. Addendum B is updated quarterly and is available on the CMS website. Since multiple HCPCS codes are reported for a single encounter, there will be multiple SIs per claim. Due to the extensive amount of packaging utilized in OPPS, all of the SIs for an encounter must be critically examined together to determine the reimbursement outcome for the claim. To assist with the complex packaging executed under OPPS, individuals can use the **Outpatient Code Editor (OCE)** from CMS. In addition to editing the claim for billing requirements, the OCE performs the packaging and bundling logic of OPPS. The output is the final APC and reimbursement determinations for an encounter. The desktop version of the OCE can be downloaded from the CMS website under the "Medicare" tab. The editing component of the OCE is discussed further in chapter 13 of this text, "Revenue Compliance."

Each HCPCS code is assigned to one and only one APC group, and that group is assigned an SI. The APC assignment for a procedure or service does not change based on the patient's medical condition or the severity of illness. There may be an unlimited number of APCs per encounter for a single patient. The number of APC assignments is based on the number of covered procedures or services provided for that patient.

Each APC contains a title, SI, relative weight, national unadjusted payment amount, national unadjusted copayment amount, and a code range. These components are shown in figure 7.1.

The relative weight is a measure of the resource intensity of a procedure or service. The **national unadjusted payment** amount is the product of the conversion factor (CF) multiplied by the relative weight, unadjusted for geographic differences. This is the unadjusted amount a hospital will receive for a procedure or service in that APC. The national unadjusted payment amount is divided into two components: Medicare facility amount and beneficiary copayment amount. Both the Medicare facility component and the beneficiary copayment components are adjusted for differences in wage indexes. This is the only adjustment made to APC payment rates to account for differences among hospitals. Sixty percent of the facility amount is wage index adjusted. The wage index amount for the facility location based on core-based statistical area (CBSA) is determined in the IPPS update for the corresponding rate year.

Figure 7.1. **APC components**

APC 5021 Title: Level 1 Type A ED Visits	
Payment Status Indicator	$69.62
Relative Weight	0.8617
National Unadjusted Payment Amount	$68.66
National Unadjusted Copayment Amount	N/A
Minimum Copayment Amount	$13.93
HCPCS Procedure Code(s) 99281 Emergency Department Visit	

Source: CMS 2020b.

Payment Status Reimbursement Methods

To understand how an encounter is reimbursed under OPPS, the various categories of SI must be correctly applied. However, when determining encounter reimbursement, each category cannot be assessed in isolation. Instead, all SIs must be used in combination to correctly determine reimbursement under OPPS. There are nine SI reimbursement methods currently used in the OPPS:

- APC payment
- Per diem APC payment
- Comprehensive APC (C-APC) payment
- Conditional APC payment
- Composite APC payment
- Packaged payment
- Fee schedule payment
- Reasonable cost payment
- Services not reimbursed under OPPS

In the sections that follow, each of the SI reimbursement methods is discussed in detail.

APC Payment: SIs G, K, R, S, T, U, and V

There are seven SIs in the APC payment reimbursement methods. They represent services or procedures that are reimbursed by prospective payment methodology through APCs. Below are the SIs and their descriptions:

- G: Pass-through drugs and biologicals
- K: Non-pass-through drugs and nonimplantable biologicals, including radiopharmaceuticals
- R: Blood and blood products
- S: Significant procedures for which multiple procedure reduction does not apply
- T: Surgical procedures for which multiple procedure reduction applies
- U: Brachytherapy services
- V: Clinic and emergency department visits

When services with one of these SIs are performed, associated ancillary and supportive items are packaged into the payment for the service. Example 7.3 illustrates OPPS reimbursement for APC payment SIs.

Example 7.3

A patient is seen for wound care after she fell and sustained a scalp laceration. During the wound care visit the physician treated her for wound dehiscence (split wound) (CPT code 12020). The physician gave the patient an injection of lidocaine to numb the area prior to starting the closure procedure. The injection of lidocaine and supplies required to perform the closure are packaged into the payment for the procedure. Only the service with SI T, the simple closure, is payable separately.

CPT code and/or Service Description	SI	APC	Reimbursement
99282 – Closure of split wound	T	5053	$497.02
J2001 – Lidocaine injection	N (packaged)	0000	$0.00
Supplies and drugs reported without HCPCS Codes	Packaged	0000	$0.00

Source: CMS 2020a.

Multiple surgical procedures with payment status indicator T performed during the same operative session are discounted. Discounting is a reimbursement policy where the highest-weighted procedure is fully reimbursed and all other procedures with payment status indicator T are reimbursed at 50 percent. This reduction is made to account for resource saving that hospitals experience by performing multiple procedures together. For example, operating room surgical instruments are prepped only once, anesthesia is administered once, and the recovery room is used once for all the procedures performed.

Although many services assigned to these APC payment SIs are payable separately in most circumstances, they can be packaged with C-APCs, which are discussed later in this section. The one exception is pass-through drugs and biologicals (SI G), which are exempt from packaging policies. A **pass-through** is a high-cost supply that is reimbursed under a different reimbursement methodology than other supplies. The pass-through policy for drugs, biologicals, and devices is discussed in the "Provisions of OPPS" section later in this chapter.

Within the APC payment SI category are new technology APCs. New technology APCs are a special group of APCs created to allow new procedures and services to enter OPPS quickly, even though their complete cost and payment information is not known. New technology APCs house modern procedures and services until enough data are collected to properly place the new procedure in an existing APC or to create a new APC for the service or procedure. A procedure or service can remain in a new technology APC for an indefinite amount of time. The APC system contains 82 new technology APCs. Forty-one groups have SI S and are not subject to multiple-procedure discounting. The remaining 41 groups have SI T and are subject to the multiple-procedure discount provision. Placement into new technology APCs is based on cost bands. For example, APC 1491, New Technology–Level IA, contains procedures that have an average cost of $0 to $10. The payment for the group is $5.

Per Diem APC Payment: SI P

Partial hospitalization program (PHP) is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care to patients who have an acute mental illness (CMS 2004, 50543). Partial hospitalization may be provided

by hospital outpatient departments and Medicare-certified community mental health centers (CMHCs). Patients who receive psychiatric services and who have a diagnosis of an acute mental health disorder are grouped into APC 5853, partial hospitalization (three or more services) for CMHCs or APC 5863, partial hospitalization (three or more services) for hospital-based PHPs. The unit of service for partial hospitalization is one day. Therefore, the APC payment rate for APCs 5853 and 5863 is based on a per diem amount. For 2020, the APC payment rate for APC 5853 is $124.30, of which $24.86 is the beneficiary copayment amount. The APC payment rate for APC 5863 is $238.66, of which $47.74 is the beneficiary copayment amount (CMS 2020b).

Comprehensive APC Payment: SIs J1 and J2

With the goal of moving toward a fully packaged outpatient PPS, CMS created C-APCs. C-APCs are all-inclusive APC categories where a primary procedure is identified for the encounter and then most other procedures, services, and supplies are packaged into the C-APC payment amount. Services that are packaged are adjunctive, integral, ancillary, supportive, or dependent services that are provided to support the primary service (CMS 2017, 52363). C-APCs were first introduced in 2015. Since that time, the number of C-APCs has grown from 25 to 66 in 2020. Figure 7.2 is an example of a claim that includes a C-APC.

In this example (figure 7.2), code 26607 is assigned as the primary service and, therefore, is assigned as the C-APC for the encounter. Even though code 26720 has an SI T and is often separately payable, here, the service is packaged because it is part of a C-APC encounter. This is shown after final adjudication by the SI changing from T to N.

For some encounters there will be more than one C-APC. However, there can only be one primary service for the encounter. CMS provides a ranking of C-APC procedures each year in Addendum J of the final rule. Whichever procedure is ranked highest is deemed the primary C-APC for the encounter. All other J1 procedures are then packaged.

There is one caveat to C-APCs. Some combinations of procedures are costlier than others. Therefore, CMS developed the C-APC complexity adjustment. The complexity adjustment allows for a higher payment when established criteria are met.

Figure 7.2. **Example of C-APC encounter**

Claim Services with SI Information from Addendum B (2020)		
CPT Code	Description	SI (from Addendum B, before packaging logic)
26607	Closed treatment of metacarpal fracture	J1 (C-APC)
26720	Closed treatment of phalangeal shaft fracture	T (Surgical procedure; discount applies)
99284	Emergency department visit	J2 (C-APC)
73120	X-ray hand	Q1 (Conditionally packaged)

Claim Services with Final APCs		
CPT Code	APC with description	SI (after adjudication)
26607	5113, Level 3 Musculoskeletal Procedures	J1 – C-APC
26720	0000, No APC	N - packaged
99284	0000, No APC	N - packaged
73120	0000, No APC	N – packaged

Source: CMS 2020a.

Conditional APC Payment: SIs Q1, Q2, and Q4

Conditional APC payment services are assigned SIs Q1, Q2, and Q4. These services are conditionally packaged only when certain criteria are met. There are three types of conditionally packaged services. First are Q1 or STV-packaged items. When an ancillary service with SI Q1 is reported on the same encounter as a service with an SI of S, T, or V, then the ancillary service is packaged. But if the ancillary service is performed without any service with an SI of S, T, or V, then payment is provided for the ancillary service. The example provided in figure 7.3 illustrates how Q1 packaging is executed.

In this example (figure 7.3), Claim 1 shows how the ankle x-ray is packaged when it is performed during the same encounter as the ankle strapping. When performed independent of another procedure, as shown in Claim 2, the x-ray is reimbursed separately and the SI changes from Q1 to S.

The second type of conditional packaging is Q2 or T-packaged codes. The concept is like the STV-packaged codes, but only SI T affects whether the ancillary service is separately paid or not. Example 7.4 illustrates conditional packing in OPPS.

Figure 7.3. **Example of SI Q1 packaging**

Claim Services with SI Information from Addendum B (2020)		
CPT Code	Description	SI (from Addendum B, before packaging logic)
29540	Strapping of ankle/foot	T
73610	X-ray ankle	Q1
Claim 1 – Services with Final APC		
CPT Code	APC with description	SI (after adjudication)
29540	5101, Level 1 Strapping and Cast Application	T – surgical procedure
73610	0000, No APC	N – packaged
Claim 2 – Only radiology service provided, no strapping performed – Final APC		
CPT Code	APC with description	SI (after adjudication)
73610	5521, Level 1 Imaging without Contrast	S

Source: CMS 2020a.

Example 7.4

A patient is admitted to the emergency department for a possible hip dislocation. A hip x-ray with contrast is performed and shows a hip dislocation. Therefore, treatment is provided to return the hip to proper alignment. The hip x-ray is assigned SI Q2. The dislocation treatment is assigned SI T. Because the hip x-ray is conditionally packaged and performed with a T procedure, payment is only made for dislocation treatment.

Conditionally packaged laboratory tests are the third type and are assigned SI Q4. Laboratory tests are packaged if billed on the same claim as SIs J1, J2, S, T, V, Q1, Q2, or Q3. Laboratory services are packaged most of the time in OPPS. However, if the laboratory service is present on a claim without one of the designated SIs, then the service is SI A and is reimbursed via the Medicare Clinical Lab Fee Schedule (CLFS).

Composite APC Payment: SI Q3

Composite APCs are created by bundling individual components of a larger service into one payment group. Composite APCs are formed by grouping services that are always performed together into a single payment. Currently, there are eight composite APCs included in OPPS; they are listed in table 7.2.

Each composite APC includes parameters for when the composite APC will be assigned rather than individual APC assignments for each component. APC 8004, Ultrasound, composite is activated when more than one of the designated ultrasound procedures are reported for the same encounter. The services included in table 7.3 are included in the ultrasound composite. Example 7.5 shows a composite APC in action.

Table 7.2. **Composite APCs for 2020**

APC Number	APC Title
5041	Critical Care
5045	Trauma Response with Critical Care
8004	Ultrasound
8005	CT and CTA without Contrast
8006	CT and CTA with Contrast
8007	MRI and MRA without Contrast
8008	MRI and MRA with Contrast
8010	Mental Health Services

Source: CMS 2019.

Table 7.3. **APC 8004, ultrasound composite**

CPT Code	Code Description
76700	Ultrasound exam of abdomen, complete
76705	Ultrasound exam of abdomen, limited
76770	Ultrasound, retroperitoneal, complete
76776	Ultrasound, transplanted kidney, with Doppler
76831	Saline infusion sonohysterography (SIS)
76856	Ultrasound exam of pelvis, complete
76857	Ultrasound exam of pelvis, limited
76981	Ultrasound, elastography; parenchyma
76982	Ultrasound, elastography; first target lesion

Source: CMS 2019.

Example 7.5

A patient with abdominal and pelvic pain is sent to radiology to receive several ultrasound services. The physician has ordered ultrasounds of the abdomen, retroperitoneal, and pelvis at the local hospital. Because all the radiology services performed for this patient are part of composite APC 8004, the facility will receive one APC payment for all three services.

Code with description	SI	APC	Reimbursement
76700, ultrasound exam of abdomen, complete	Q3	8004	$307.72
76770, ultrasound of retroperitoneal, complete	Q3		
76856, ultrasound of pelvis, complete	Q3		

Source: CMS 2020b.

Packaged Payment: SI N

As discussed earlier in this section, the use of packaging and bundling is a major component of the OPPS. To identify procedures, services, and supplies that have been packaged into the cost and reimbursement for APC services with which they are most often performed, SI N is assigned. These items are always packaged. It is important to note that these services are covered under OPPS, but a separate payment is not provided for the individual service or supply. Examples of packaged services that are assigned SI N are provided in table 7.4.

As you can see from the packaged service listing, anesthesia services, add-on procedures (except drug administration add-ons), and vaccinations are all packaged in OPPS. To identify all packaged services by CPT code, examine the most current Addendum B located on the "Hospital Outpatient PPS" page on the CMS website. Additionally, any OPPS services and supplies that do not have an HCPCS code are packaged.

Table 7.4. **Sample of packaged services with SI N in OPPS**

00102	Anesthesia repair of cleft lip
11045	Debridement of subcutaneous tissue add-on
23350	Injection for shoulder x-ray
35500	Harvest vein for bypass
49568	Hernia repair with mesh
58110	Biopsy done with colposcopy add-on
64832	Repair nerve add-on
90632	Hepatitis vaccine adult intramuscular

Source: CMS 2020b.

Fee Schedule Payment: SI A

Services such as ambulance transportation, physical therapy, and mammography are reimbursed based on a fee schedule amount. Various fee schedules are used for the reimbursement rates. For example, the Medicare Physician Fee Schedule (MPFS) is used for the physical therapy payments. Fee schedule amounts are exempt from many of the OPPS adjustments and provisions. For example, fee schedule reimbursement rates are not wage index adjusted via the OPPS methodology because the fee schedule amount has already been adjusted for geographical differences.

Reasonable Cost Payment: SIs F, H, and L

There is a small subset of services and supplies that are reimbursed at reasonable cost. In the cost-based payment calculation, the hospital-specific outpatient CCR is utilized. Reasonable cost is calculated by multiplying the charge for the service times the CCR developed from cost report statistics.

Not Reimbursed under OPPS: SIs B, C, D, E1, E2, M, and Y

There are numerous procedures, services, and supplies that are not reimbursed under OPPS. There are services that are statutorily excluded from the Medicare benefit package, procedures that are not reasonable or necessary, and services that are not appropriate for the outpatient setting.

SI C is used for inpatient-only (IPO) procedures. Because Level I HCPCS codes (CPT codes) were originally designed to report physician services in all healthcare settings, the coding system contains codes for inpatient and outpatient procedures. OPPS covers only outpatient services. Each year, CMS reviews claims data and determines which procedures are IPO procedures and creates the IPO list. All procedures on the IPO list are assigned SI C. To move off the IPO list, a procedure must be performed in outpatient settings at least 60 percent of the time. To be reimbursed, procedures with SI C must be provided to Medicare beneficiaries in an inpatient setting, and payment is made under the IPPS.

Check Your Understanding 7.1

1. Define packaging and bundling as they pertain to OPPS.
2. List a way that packaging promotes effective and efficient care.
3. Match the SI to APC category.

a. Q3	1. APC payment
b. K	2. C-APC
c. J1	3. Composite APC payment
d. Q4	4. Conditional APC payment

4. A claim is produced for an outpatient ambulatory surgery encounter. There are three codes on the claim. One code has SI J1, the second code has SI T, and the third code has SI S. Which codes are separately payable and which are packaged?
5. Describe discounting as it applies to payment SI T.

OPPS Provisions

The OPPS uses provisions to provide additional payments for high-cost items and unusual admissions that historically have added significant cost to patient care. Without the additional payments associated with these provisions, it may not be feasible for hospital outpatient facilities to provide all services to Medicare beneficiaries. OPPS has numerous provisions, which include the following:

- Interrupted services
- High-cost outlier
- Rural hospital adjustment
- Cancer hospital adjustment
- Pass-through payment policy

Each of the OPPS provisions and the related payment adjustments is discussed in detail in the sections that follow.

Interrupted Services

Interrupted services are reported with modifiers. When modifiers are applied to the surgical codes, a reduction in payment may be applied. Procedures reported with modifier -73, surgery discontinued for a patient who has been prepared for surgery (that requires anesthesia) and taken to the operating room but before the administration of anesthesia, will be reduced by 50 percent. A procedure reported with modifier -74, surgery discontinued after administration of anesthesia or initiation of the procedure, will be reimbursed at 100 percent of the APC rate. Procedures and services that do not require anesthesia but that are reduced or discontinued at the physician's discretion should be reported with modifier -52. For these procedures, the payment rate will be reduced by 50 percent.

High-Cost Outlier

This provision is intended to provide financial assistance for unusually high-cost services. The outlier provision is based on the cost of individual services rather than the cost for the entire encounter (all services). Therefore, there may be multiple outlier calculations per claim. The equations for case qualification and additional payment levels are adjusted each year. Medicare limits the percentage of total payments that can be attributed to outlier payments to one percent. There are two types of outlier calculations: one for CMHCs' partial hospitalization services and one for all other facilities and services.

Rural Hospital Adjustment

Public Law 108-173, better known as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, allowed for a payment adjustment to be applied for rural hospitals if warranted after study. CMS presented the results of its study in the 2006 final rule. Regression analysis showed that overall, the cost of treating Medicare beneficiaries at rural hospitals was only 2.4 percent greater than at urban hospitals and did not warrant an adjustment. However, further analysis showed that the cost to rural **sole-community hospitals (SCHs)** was 7.1 percent greater than that of urban hospitals. SCHs are hospitals that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of patient hospital services reasonably available to Medicare beneficiaries in a geographic area. SCH status is determined by the Secretary of the Department of Health and Human Services. Because the cost at SCHs is significantly higher than the cost at other facilities, an adjustment is warranted. Therefore, beginning in 2006 OPPS, a rural adjustment of 7.1

percent was provided to SCHs, including essential access community hospitals (EACHs).

Cancer Hospital Adjustment

The Affordable Care Act of 2010 (Public Law 111-148) provides for an adjustment to dedicated cancer hospitals to address the higher costs incurred by this type of facility. CMS first proposed an adjustment in the 2011 proposed rule, but the proposed methodology was disputed by many in the healthcare community. One of the major issues with the proposed methodology was that the copayment amounts for beneficiaries would be significantly higher at the cancer hospitals. Based on the numerous comments received by CMS, the proposed methodology was not adopted.

In the 2012 final rule, a new methodology was adopted by CMS for the cancer hospital adjustment. This methodology allows for aggregate payments to be made to each cancer hospital at cost report settlement rather than at the APC level on each claim. This allows the adjustment to be provided to the cancer hospitals without negatively impacting the beneficiary copayments.

The adjustment is facility specific. CMS compares each facility's payment-to-cost ratio (PCR) with the target PCR based on the PCR for OPPS hospitals for the given year.

Pass-through Payment Policy

Pass-throughs are exceptions to the Medicare PPSs. These exceptions exist for high-cost supplies. Pass-throughs are not included in the packaging component of PPS and are passed through to other payment mechanisms that attempt to adjust for the high cost of items. Therefore, pass-throughs minimize the negative financial effect of combining all services into one lump-sum payment. Pass-throughs occur in both IPPS and OPPS.

Drugs, biological agents, and devices qualify for pass-through status if they were not being paid for as a hospital outpatient drug as of December 31, 1996, and their cost is "not insignificant" in relation to the OPPS payment for the procedures or services associated with their use (CMS 2004, 50502). The pass-through status application process is described on the CMS website (CMS 2020c).

Pass-through device APCs (SI H) are paid on a reasonable cost basis less the device offset amount. The device offset amount is the portion of the payment amount that CMS has determined is associated with the cost of the device (CMS 2004, 50501). This amount is deducted from the pass-through payment because it is already reimbursed as part of the surgical APC payment.

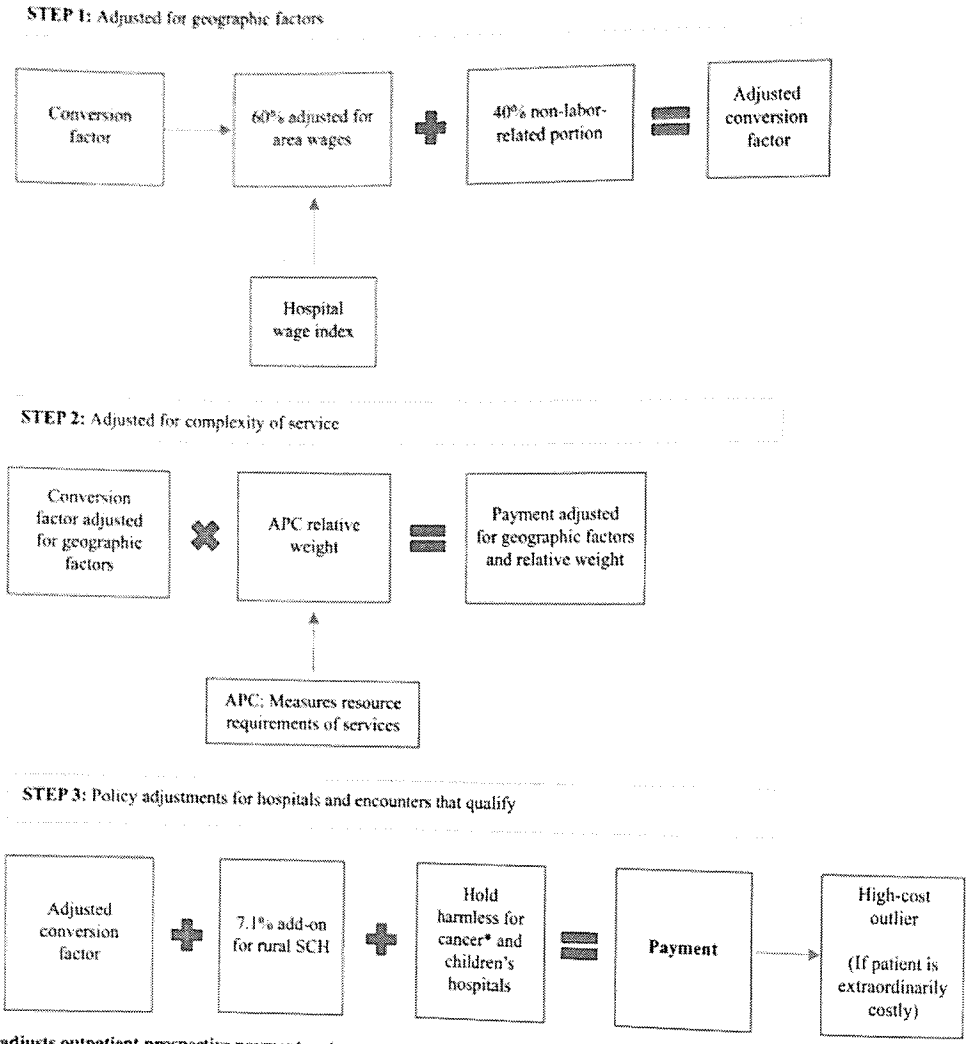
OPPS Payment Workflow

Hospitals submit a claim to Medicare for payment. Claims are sent electronically to the designated Medicare administrative contractor (MAC). Each claim contains visit information, patient information, facility information, detailed charges by procedure code, and diagnosis codes. The MAC performs an audit of the claim to ensure the claim contains complete and accurate information based on the edits found in the OCE. The OCE is discussed in greater detail in chapter 13, "Revenue Compliance." During the editing process, APCs are assigned using grouper software as appropriate, based on the HCPCS codes submitted. The foundation of OPPS payment is displayed in figure 7.4.

The OPPS payment calculation uses a CF to convert the APC relative weight into a dollar amount. A **conversion factor (CF)** is a national dollar multiplier that sets the allowance for the relative values. During step one, the CF is adjusted to account for geographic differences. The CF for 2020 is $80.78 (CMS 2020a). Pricer software, released by CMS, completes the steps necessary to calculate the claim payment, including applying the OPPS provisions. When the payment steps are completed, payment is made to the facility, and the data from the encounter is included in the national claims history file. The outpatient standard analytical file and the OPPS file, extracted from the national claims history file, are used for statistical analysis and research. Figure 7.5 provides an example of a simple payment calculation for a Level II emergency department visit provided in a facility with a wage index of 0.9775.

Figure 7.6 provides an example of a more complex calculation for a shoulder repair surgery performed in a facility with a wage index of 0.9775. This example highlights the use of packaging through C-APCs. Prior to adjudication, codes 23430, 29824, and 93005 are eligible for separate APC payments (Addendum B SI). However, using the C-APC logic associated with SI

Figure 7.4. **Foundation of hospital OPPS**



***Medicare adjusts outpatient prospective payment system payment rates for 11 cancer hospitals so the payment-to-cost ratio (PCR) for each cancer hospital is equal to the average PCR for all hospitals.**
Source: MedPAC 2019.

J1, only one procedure can be the primary procedure for the encounter. According to the C-APC hierarchy, code 23430 is indicated as the primary C-APC for this encounter. All other procedures, because of their SI, are then packaged into the payment for the primary procedure. Their SI changes from the Addendum B SI to the Final SI of N (packaged). The result is payment for APC 5114 (CPT code 23430).

OPPS is one of the more complex payment systems used by Medicare. It is also one of the few payment systems without a value based program component. Currently, organizations that provide hospital outpatient services only participate in the Hospital Quality Reporting program as discussed in the first sections of chapter 5, "Medicare Hospital Acute Inpatient Payment System."

Figure 7.5. **Example of simple calculation of OPPS payment**

2020 CF	Wage index adjustment	CPT Code	Addendum B SI	APC	APC RW	Final SI (after adjudication)	Reimbursement
$80.78	(80.78 × .60 × 0.9775) + (80.78 × 0.40) 47.38 + 32.31 79.69 79.69 × 1.5838 = 126.22	99282	V	5022	1.5838	V	$122.98

Source: CMS 2020a.

Figure 7.6. **Example of complex calculation of OPPS Payment**

2020 CF	Wage index adjustment	CPT Code	Addendum B SI	APC	APC RW	Final SI (after adjudication)	Reimbursement
$80.78	(80.78 × .60 × 0.9775) + (80.78 × 0.40) 47.38 + 32.31 79.69 79.69 × 74.0404 = 5,900.28	23430	J1	5114	74.0404	J1	$5,531.14
$78.64	$77.58	29824	J1	5113	33.8823	N	$0
$78.64	$77.58	29826	N	0000	0.000	N	$0
$78.64	$77.58	93005	Q1	5733	0.6809	N	$0
					Total Reimbursement for Encounter		**$5,531.14**

Source: CMS 2020a.

Patient Connection

It's September, and it's time for Malakai to get his flu and pneumonia vaccines. Malakai goes to the flu shot clinic at Memorial Hospital to receive his shots. The flu shot clinic makes it easy for Medicare beneficiaries because no appointment is necessary; walk-ins can arrive between 10 a.m. and 3 p.m. to be vaccinated. The claim submitted for Malakai's visit includes the following charges:

42 REV CD	43 DESCRIPTION	44 HCPCS/ RATE/	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES
0771	Admin influenza virus vaccine	G0008	9/12/2x	1	100 00
0771	Admin pneumococcal vaccine	G0009	9/12/2x	1	100 00
0636	Influenza virus vaccine, IM	90662	9/12/2x	1	75 00
0636	Pneumococcal polysaccharide vaccine, IM	90732	9/12/2x	1	125 00

Let's calculate the reimbursement for this encounter. Using OPPS Addendum B, we identify that the APC for both code G0008 and G0009 is 5691, which has an unadjusted payment rate of $38.11. Further, the copayment amount is $0. The payment SI for APC 5691 is S. Codes 90662 and 90732 both have the SI of L and are not assigned to APCs. Referencing table 7.1, let's determine which lines are separately payable and which lines, if any, are packaged or bundled.

The payment SI for APC 5691 is S. HCPCS codes with payment SI S are paid via the APC rate. Further, S represents procedures or services for which the multiple procedure reduction does not apply. But remember, to determine bundling we must consider all payment SIs for the claim. So, let's look at payment SI L for the vaccines. HCPCS codes with payment SI L are paid via reasonable cost methodology. To calculate reasonable cost, the facility charge is multiplied by the facility CCR, which for Memorial Hospital is 0.35. Further, table 7.1 indicates that the beneficiary does not have to pay a deductible amount or copayment amount for the influenza and pneumococcal vaccines. According to table 7.1, no

(continued)

Patient Connection *(continued)*

packaging or bundling is involved when only payment SIs S and L are included on a claim.

But before we finalize reimbursement, we need to wage index adjust the payment rate for APC 5691. The wage index amount for Memorial Hospital is 1.0014. The wage index adjustment calculation is as follows:

($38.11 × 0.60 × 1.0014) + ($38.11 × 0.40)

The wage index adjustment payment amount is $38.14. Remember that when the wage index amount is greater than 1.0, the payment rate will be higher after it is wage index adjusted. Pulling all our information together, we can calculate the final reimbursement. The reimbursement rates are as follows:

- $38.14 for code G0008
- $38.14 for code G0009
- $26.25 for code 90662 [$75 × 0.35 (hospital CCR)]
- $43.75 for code 90732 [$125 × 0.35 (hospital CCR)]

The total payment to Memorial Hospital equals $146.28 ($38.14 + $38.14 + $26.25 + $43.75). However, Malakai owes nothing. These vaccines are provided to Medicare beneficiaries free of deductible and cost sharing.

Chapter 7 Review Quiz

1. Which reimbursement methodologies are used in OPPS?
2. Which SI is used to identify services that are packaged?
3. Which SIs are used to identify services that are paid using a reasonable cost-based methodology?
   a. F, T, S
   b. H, P, L
   c. J1, L, M
   d. F, H, L
4. Which of the following SIs is the highest ranked SI and causes all other services to be packaged on a claim?
   a. T
   b. S
   c. J1
   d. J2
5. Which classification system is used in OPPS to combine procedures or services that are clinically comparable and have similar resource use together into groups?
6. Which type of service includes an APC per diem methodology that includes payment for all services provided on a single day of service under OPPS?
   a. Clinic visits
   b. Partial hospitalization
   c. Emergency department visits
   d. Same-day surgery
7. Which type of APCs did CMS establish in order to support access for Medicare beneficiaries to receive new and innovative drugs, biologicals, and devices in the hospital outpatient setting?
8. Comprehensive APCs (C-APCs) have SIs J1 and J2. They are CMS's first step in moving OPPS from a partially packaged system to a _____ packaged system.
9. What is the purpose of the cancer hospital adjustment provision?
10. Why do sole-community hospitals receive a rural hospital adjustment under OPPS?

References

CMS (Centers for Medicare and Medicaid Services). 2020a. Addendum B, April 2020 Correction. https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatient ppsaddendum-and-addendum-b-updates/april-2020-correction.

CMS (Centers for Medicare and Medicaid Services). 2020b. Addendum A, January 2020 Correction. https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatient ppsaddendum-and-addendum-b-updates/january-2020-correction.

CMS (Centers for Medicare and Medicaid Services). 2020c. "Pass-through Payment Status and New Technology Ambulatory Payment Classification (APC)." https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.

CMS (Centers for Medicare and Medicaid Services). CMS. 2019. Medicare program: Changes to hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; revisions of organ procurement organizations conditions of coverage; prior authorization process and requirement for certain covered outpatient department services; potential changes to the laboratory date of service policy; changes to grandfathered children's hospitals-within-hospitals;

notice of closure of two teaching hospitals and opportunity to apply for available slots. *Federal Register* 84(218):61142–61492.

CMS (Centers for Medicare and Medicaid Services). 2017. Medicare program; Hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; Final rule with comment period. *Federal Register* 82(217):52356–52637.

CMS (Centers for Medicare and Medicaid Services). 2007. Medicare program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 payment rates, ambulatory surgical center payment system and CY 2008 payment rates, hospital inpatient prospective payment system and FY 2008 rates and payments for graduate medical education for affiliated teaching hospitals in certain emergency situations. *Federal Register* 72(227):66610.

CMS (Centers for Medicare and Medicaid Services). 2004. Medicare program; Proposed changes to the Hospital Outpatient Prospective Payment System and calendar year 2005 payment rates; Proposed rule. *Federal Register* 69(157):50447–50546.

MedPAC (Medicare Payment Advisory Commission). 2019. Payment Basics: Outpatient Hospital Services Payment System. http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_opd_final_sec.pdf?sfvrsn=0.