

Outpatient Prospective Payment System (OPPS) Project



Understanding Ambulatory Payment Classification (APC)



Purpose and Objectives

After this presentation, you will have a better understanding of OPPS and the tools you will need to bill successfully.

Agenda

- Key Terms
- How APC pricing works
- Coding, Billing and Edits
- Claim walk-through
- Changes to the Remittance Advice
- Resources
- Wrap-up

Key Terms

- **APC (Ambulatory Payment Classification)**
 - OPSS is more commonly known by its grouping methodology, Ambulatory Payment Classifications, or APCs.
 - An APC is assigned to each CPT/HCPCS code that represents a service paid under OPSS.
 - APCs are applied to the full range of ambulatory services, including same day surgery, hospital ER and outpatient clinics.
 - Each APC has a pre-established prospective payment amount associated with it. In essence, APCs are a line-level fee schedule by procedure code.
 - The APC assigned to each CPT/HCPCS may be found on the new APC-based fee schedule, which will be posted to the EqualityCare website.

Key Terms

- **Outpatient Code Editor (OCE)**

The OCE software was developed for the implementation of the Medicare OPPS. The two main functions of the OCE are to identify errors and assign APCs. In addition, the software performs the following functions when processing a claim:

- Edits a claim for accuracy
- Assigns status indicators
- Determines if packaging is applicable
- Applies discount factors, if applicable

Key Terms

- **Status Indicators**

- The OCE assigns each CPT/HCPCS code a letter that signifies whether EqualityCare covers the service and how it will be reimbursed (e.g., APC-based fee or percent of charge.)
- The indicator also helps in determining whether policy rules, such as packaging and discounting apply.
- The status indicators used by EqualityCare are based on the ones used by Medicare, with additional EqualityCare-specific indicators that, at times, override Medicare's.

Medicare Status Indicators Used by EqualityCare

Status Code	Description	Comments	Charge Cap
C	Inpatient Procedure	Not covered in an outpatient setting	N/A
D	Discontinued Code	Not covered	N/A
F	Corneal Tissue	Paid a percentage of charges using a hospital-specific or statewide cost-to-charge ratio	N/A
G	Pass-through drugs, biologicals and radiopharmaceutical agents	Paid an APC-based fee that includes a pass-through amount	No
H	(1) Pass-through device categories (2) Brachytherapy sources	Paid a percentage of charges using a hospital-specific or statewide cost-to-charge ratio	N/A
K	Non-pass-through drugs, biologicals and radiopharmaceutical agents	Paid an APC-based fee	No

Medicare Status Indicators Used by EqualityCare

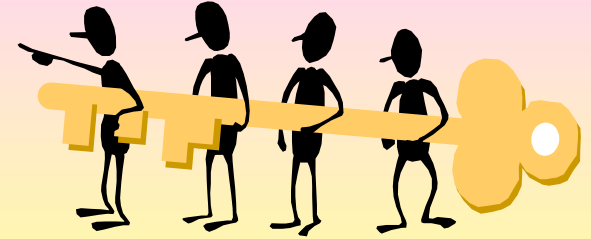
Status Code	Description	Comments	Charge Cap
N	Items and services packaged into APC rates	Paid zero (payment is packaged into other services)	N/A
S	Significant procedure (not subject to multiple procedure discounting)	Paid an APC-based fee	No
T	Significant procedure (subject to multiple procedure discounting)	Paid an APC-based fee	No
V	Clinic or emergency department visit	Paid an APC-based fee	No
Y	Non-implantable durable medical equipment (DME)	Not covered under OPPS	N/A
X	Ancillary services	Paid an APC-based fee	No

EqualityCare-Specific Status Indicators

Status Code	Description	Comments	Charge Cap
1	Not Covered	Not Covered	N/A
2	Percentage of charges	Paid a percentage of charges using a hospital-specific or statewide cost-to-charge ratio	N/A
3	Other fee schedules	Exceptions to APC-based fees, including lab services, screening and diagnostic mammography, therapy services (physical, occupational and speech), immunizations, vaccines, supplies, etc. These services will be paid using current fee schedules.	<u>YES</u>

The status indicator assigned to each CPT/HCPCS may be found on the new APC-based fee schedule, which will be posted to the EqualityCare website.

Key Terms



- **Charge Cap**

- A charge cap is a limit on reimbursement for a CPT/HCPCS code based on the provider's submitted charge.
- For example, EqualityCare reimburses \$34.66 for CPT code 80050 (general health panel.) If a provider submits a claim for a general health panel, but only bills \$32.00 EqualityCare will “cap” the reimbursement at \$32.00 even though the fee schedule allots \$34.66.

Key Terms

- **Charge Cap (cont.)**

- This concept changes slightly under OPPS:

- ❖ If the CPT/HCPCS code is assigned Status Indicator 3 (Other Fee Schedule), the charge cap still applies.
- ❖ If the CPT/HCPCS code is assigned Status Indicators G, K, S, T, V or X, the charge cap does not apply. EqualityCare will reimburse the full APC-based fee, rather than limiting it to the provider's submitted charge.

Exception: If the submitted charge is zero, EqualityCare will pay zero.

Key Terms

- **Pass-through Payments**

- Pass-through payments are transitional payments established by Medicare for new drugs, biologicals, radiopharmaceutical agents, and medical devices. It is a temporary way to pay for these items until Medicare determines whether the cost continues to be paid separately or is packaged into an existing APC-based fee.
- Drugs and devices having a status indicator of G and H receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. The fee is either the APC-based fee or a percentage of charges.

Key Terms

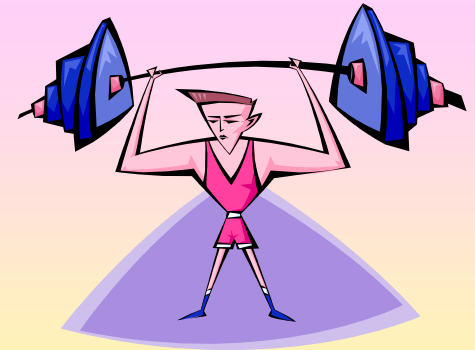
- **Packaged Services**

- Services having a status indicator of N are considered packaged or bundled into other services. The costs of these services are allocated to the APC, but are not paid separately.
- The relative weights for surgical, medical and other types of visits were developed to reflect packaged services in the APC-based fee.



Questions?

Key Terms



- **Relative Weight**

- Each APC is assigned a relative weight, which plays a key role in calculating the APC-based fee.
- The relative weight represents the relative effort required to perform a specific procedure.
- EqualityCare has chosen to adopt Medicare's relative weights for each APC.
- The relative weight for each CPT/HCPCS may be found on the new APC-based fee schedule, which will be posted to the EqualityCare website.

Key Terms

- **Conversion Factor**

- The conversion factor is a standard dollar amount that is multiplied by the relative weight to obtain the APC-based fee for CPT/HCPCS codes.
- For this first year, EqualityCare will be reviewing the conversion factor quarterly, thereafter, EqualityCare will review the conversion factor annually.

Key Terms

- **Discount Formulas**

- There are 8 discount formulas that affect pricing. They are applied based on the presence of specific modifiers (50 and 73) or multiple procedures with a status indicator of T.
- The corresponding formula number (1-8) will appear on the remittance advice (RA) next to the line item. This number can be cross-referenced to the list of discount formulas on the EqualityCare website.

Discount Formulas

Discount Formula Number	Applies to Status Indicator	Description	% of APC-based Fee Paid
1	G, K, S, V, X	No discount applied	100%
2	T	Procedure with the highest relative weight	*100%
3	T	Discontinued procedure (modifier 73) with highest relative weight	*50%
4	T	Bilateral procedure (modifier 50) with highest relative weight	*150%
5	T	Subsequent procedures	50%
6	T	Subsequent discontinued procedures (modifier 73)	*25%
7	T	Subsequent bilateral procedures (modifier 50)	*75%
8	G, K, S, V, X	Bilateral procedure with modifier 50	150%

*When units billed are greater than 1, the percentage of the APC-based fee will decrease. Using discount formula number 2 for example, 1 unit = 100%, 2 units = 75%, 3 units = 66%, etc.

Discount Formula Examples

One Procedure with Status Indicator T

Date of Service	Procedure	Status Indicator	Relative Weight	Modifier	Unit	Discount Formula Number
7/1/05	27380	T	20.2046		1	2 → 100%

One procedure with status indicator T pays 100% of the APC-based fee.

Two Procedures with Status Indicator T

Date of Service	Procedure	Status Indicator	Relative Weight	Modifier	Unit	Discount Formula Number
7/1/05	27380	T	20.2046		1	2 → 100%
7/1/05	25530	T	1.8527		1	5 → 50%

The procedure with the highest relative weight pays 100% of the APC-based fee. The remaining procedures pay 50% of the APC-based fee.

Discount Formula Examples

One Bilateral Procedure w/o Modifier 50

Date of Service	Procedure	Status Indicator	Relative Weight	Modifier	Unit	Discount Formula Number
7/1/05	27380	T	20.2046		1	2 → 100%

This procedure was not performed bilaterally and, therefore, only pays 100% of the APC-based fee.

One Bilateral Procedure w/Modifier 50

Date of Service	Procedure	Status Indicator	Relative Weight	Modifier	Unit	Discount Formula Number
7/1/05	27380	T	20.2046	50	1	4 → 150%

A procedure performed bilaterally (signified by modifier 50) pays 150% of the APC-based fee.

Discount Formula Examples

Two Bilateral Procedures w/Modifier 50

Date of Service	Procedure	Status Indicator	Relative Weight	Modifier	Unit	Discount Formula Number
7/1/05	27380	T	20.2046	50	1	4 → 150%
7/1/05	25530	T	1.8527	50	1	7 → 75%

The bilateral procedure with the highest relative weight pays 150% of the APC-based fee. The remaining bilateral procedures pay 75% of the APC-based fee.

Discount Formula Examples

One Discontinued Procedure (Modifier 73)

Date of Service	Procedure	Status Indicator	Relative Weight	Modifier	Unit	Discount Formula Number
7/1/05	27380	T	20.2046	73	1	3 → 50%

A discontinued procedure pays 50% of the APC-based fee.

Two Discontinued Procedures (Modifier 73)

Date of Service	Procedure	Status Indicator	Relative Weight	Modifier	Unit	Discount Formula Number
7/1/05	27380	T	20.2046	73	1	3 → 50%
7/1/05	25530	T	1.8527	73	1	6 → 25%

The discontinued procedure with the highest relative weight pays 50% of the APC-based fee. The remaining discontinued procedures pay 25% of the APC-based fee.

How APC Pricing Works

Each APC-based fee is the product of a relative weight (RW) times a conversion factor (CF) times a discount formula (DF) times the number of paid units.



$$\text{APC-based Fee} = \text{RW} \times \text{CF} \times \text{DF} \times \text{Paid Units}$$

How APC Pricing Works

Using the formula, an example of an APC-based fee for a chest x-ray (CPT 71010, APC 00260, Status Indicator X) is:

RW x CF x DF x Paid Units = APC-based Fee

0.7698 (RW) x \$45.83 (CF) x 1 (DF) x 1 (Paid Unit) = \$35.28





Coding, Billing and Edits

What Does this Mean to You?



Coding, Billing and Edits

Line Item Date of Service

- No more than one date of service per line item.

Span Billing

- Hospitals may continue to include services for more than one day on a single claim, when each service is listed on a separate line with a single date of service.

Coding, Billing and Edits

Recording Detailed ICD-9 Diagnosis Codes

- Diagnosis codes must be recorded to the greatest level of specificity using the fourth and fifth digit when required by the ICD-9-CM. For example diagnosis code 540, acute appendicitis, requires an additional digit (540.0, 540.1 or 540.9)
- A claim will deny if:
 - A diagnosis code does not have the required fourth or fifth digit; or
 - The principal diagnosis field is blank; or
 - There are no diagnosis codes entered on the claim.

Coding, Billing and Edits

Recording Detailed CPT/HCPCS Codes

- Payment calculations under OPPS are dependent on CPT/HCPCS codes. This is why most revenue codes now require a CPT/HCPCS code.
- Although some revenue codes do not require a CPT/HCPCS code, hospitals are encouraged to use them as the presence of certain codes (e.g., high cost drugs and supplies) may positively impact payment.
- Hospitals are responsible for ensuring the accuracy of revenue codes, CPT/HCPCS codes and units.
- Bill proper units as it applies to the specific CPT/HCPCS codes.

Coding, Billing and Edits

Bill Types

- The only bill types acceptable on outpatient hospital claims are 12X, 13X, 14X or 85X.

Services on Same Day

- All services provided to an EqualityCare client by a hospital on the same day must be billed on a single claim.

Exception: This requirement does not apply when a claim for a reference lab (bill type 14X) is billed in conjunction with a claim for an outpatient hospital (bill type 12X, 13X or 85X.)

Coding, Billing and Edits

Modifiers

- The significance of modifiers increases under OPPS.
- Modifiers add clarification and specificity to CPT/HCPCS codes.
- Failure to use them or use of an incorrect modifier may adversely affect payment for some outpatient services.

Allowed Modifiers / Services Paid by APC-based Fee

Level I (CPT) Modifiers				Level II (HCPCS) Modifiers						
25	50	73	91	CA	E1	FA	GA	LC	RC	TA
27	52	74			E2	F1	GG	LD	RT	T1
	58	76			E3	F2	GH	LT		T2
	59	77			E4	F3	GZ			T3
		78				F4				T4
		79				F5				T5
						F6				T6
						F7				T7
						F8				T8
						F9				T9

Allowed Modifiers / Services Paid by Fee Schedule (Status Indicator 3)

Level I (CPT) Modifiers				Level II (HCPCS) Modifiers			
						GG	TC
						GH	
						GN	
						GO	
						GP	

Key Modifiers - 25

- Significant, separately identifiable E/M service by the same physician on the same day.
- Used with E/M codes 92002 – 92014, 99201 – 99499, G0175 and G0264.
- Required when one or more procedures with a status indicator of T or S occur on the same day as the E/M code.

Key Modifiers - 50

- Used to report bilateral procedures performed at the same operative session.
- If a procedure is performed bilaterally, bill the CPT/HCPCS code on one line with a 50 modifier.
- Do not use if the CPT/HCPCS code is inherently bilateral.

Patient Status Code

- This field will be **required** with dates of service starting July 1, 2005.
- An up-to-date list of patient status codes may be found on the EqualityCare website, in the UB-92 Manual issued by the Wyoming Hospital Association or in the UB-92 Editor.

Condition Codes

- Include condition codes as appropriate per the National Uniform Billing Committee (NUBC.)
- In particular, condition code G0 (distinct medical visit) is required when multiple medical visits occurred on the same day with the same revenue code.
- **Do not use condition code 21** (service submitted for verification of denial.) It will trigger an automatic denial of the entire claim.

Observations

- Under OPPS, hospitals are required to bill for observation in one of two ways:
 - As packaged services (the observation is included in the relative weights for other APC-based fees); or
 - As a separately payable APC-based fee when certain conditions are met for congestive heart failure (CHF), asthma, chest pain and obstetric complications.

Observations

- The qualifying diagnosis must be listed as either the admitting or principle diagnosis code.
- The observation is billed using revenue code 0762 (observation room) and the appropriate procedure code:
 - Procedure codes 99217-99220, 99234-99236, G0244, G0263 and G0264 are valid for CHF, asthma and chest pain observations.
 - Procedure codes 99217-99220, 99234-99236 and G0264 are valid for obstetric complication observations.

Observations

- For obstetric complications, 1 unit equals 1 hour. An 8-hour minimum observation (8 units) is required for a separately payable APC-based fee.
- For CHF, asthma and chest pain, the unit of measure and minimum requirements depend on the CPT/HCPCS code. HCPCS code G0244 is billed in hours (1 unit = 1 hour) and requires an 8-hour minimum for payment, while CPT code 99218 is billed per day (1 unit = 1 day) and has no minimum requirement.

Observations

- Each observation must be paired with a unique E/M visit, critical care visit, or with HCPCS code G0263 (direct admission from the physician's office.) The E/M or critical care visit is required the day before or day of observation.
- If an E/M visit occurs the same day as a procedure with a status indicator of S or T, it must have a 25 modifier.

Inpatient-only Procedures

- EqualityCare has chosen to adopt Medicare's list of inpatient-only procedures, provided EqualityCare covers the service.
- A complete list of inpatient-only procedures may be found on the EqualityCare website.

New Edits

- With the implementation of OPPS, EqualityCare will institute a series of new claim edits.
- For example, some of the new edits will check for:
 - Mutually exclusive procedures on the same date of service
 - Components of a comprehensive procedure billed separately on the same date of service
 - Inappropriate specification of bilateral procedures
 - Invalid or inappropriate modifiers
 - Improperly billed observations (e.g., do not meet minimum hours, do not have a qualifying diagnosis, etc.)
 - Missing or invalid patient status code

The full list of new claim edits will be available on the EqualityCare website.

Line Item Denials & Claim Denials

- A claim will not necessarily be denied if an edit causes a line item to deny.
- When a hospital is able to correct a line item that has denied, the hospital should submit an adjustment to ACS. The claims processing system will then re-price the entire claim and adjust payment as appropriate.

Remember: The filing limit for adjustments is 6 months from the date the claim was paid.

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Questions?

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Example of Outpatient Hospital Claim Paid by APC

This claim covers a single day on which two surgical procedures were performed along with some ancillary and lab services.

Claim as Submitted by Hospital					Claim as Paid by APC				
Line	Revenue Code	Proc	Charge	Units	APC	Status Indicator	Allowed	Paid	Discount Formula
1	0258		\$134.00	4		N=Packaged	\$0.00	\$0.00	
2	0259		\$459.00	84		N=Packaged	\$0.00	\$0.00	
3	0300	80050	\$32.00	1		3=Fee Schedule	\$34.66	\$32.00	
4	0300	82247	\$10.00	1		3=Fee Schedule	\$6.62	\$6.62	
5	0310	88302	\$28.00	1	00342	X=Ancillary	\$9.48	\$9.48	1 → 100%
6	0360	47562	\$951.00	1	00131	T=Significant	\$1959.35	\$1959.35	2 → 100%
7	0360	44970	\$951.00	1	00131	T=Significant	\$979.68	\$979.68	5 → 50%
8	0370		\$648.00	103		N=Packaged	\$0.00	\$0.00	
9	0636	J0330	\$20.00	1		N=Packaged	\$0.00	\$0.00	

Changes to the Remittance Advice

- New Allowed Charge Source Codes (Column on the RA labeled 'S')
 - Allowed Charge Source 5 = APC-based Fee
 - Allowed Charge Source 6 = Packaged (Paid Zero)
- New RA Fields
 - APC = Ambulatory Payment Classification assigned to the CPT/HCPCS code
 - DIS FML = the discount formula applied
- Change to WRITE OFF column
 - If the line was paid by APC and the "PAID BY MCAID" is greater than the "BILLED AMT," then the "WRITE OFF" will be negative.

Changes to the Remittance Advice

REMITTANCE ADVICE

TO: GENERAL HOSPITAL

R. A. NO.: 0000001

DATE PAID: 07/06/05 PROVIDER NUMBER: 123456700 PAGE: 1

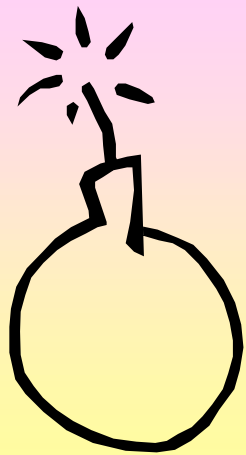
TRANS-CONTROL-NUMBER	BILLED	OTHER	PAID BY	COPAY	WRITE	DIS
1ST-LAST DATE PROC/MOD REV UNITS AMT.	INS.	MCAID	AMT	OFF	S PLAN FEE APC FML	

* * * CLAIM TYPE: OUTPATIENT

* * * CLAIM STATUS: PAID

ORIGINAL CLAIMS:

* MOUSE	M MICKEY	RECIP ID:	0699999999	PATIENT ACCT #:	ABCDEFG
	0-05185-22-100-0001-00		3233.00	0.00	2987.13 0.00 245.87
LI: 001	07/01/05 07/01/05	0258	4	134.00	0.00 0.00 0.00 134.00 6 MCAD M01
LI: 002	07/01/05 07/01/05	0259	84	459.00	0.00 0.00 0.00 459.00 6 MCAD M01
LI: 003	07/01/05 07/01/05 80050	0300	1	32.00	0.00 32.00 0.00 0.00 B MCAD M01
LI: 004	07/01/05 07/01/05 82247	0300	1	10.00	0.00 6.62 0.00 3.38 F MCAD M01
LI: 005	07/01/05 07/01/05 88302	0310	1	28.00	0.00 9.48 0.00 18.52 5 MCAD M01 00342 1
LI: 006	07/01/05 07/01/05 47562	0360	1	951.00	0.00 1959.35 0.00 -1008.35 5 MCAD M01 00131 2
LI: 007	07/01/05 07/01/05 44970	0360	1	951.00	0.00 979.68 0.00 -28.68 5 MCAD M01 00131 5
LI: 008	07/01/05 07/01/05	0370	103	648.00	0.00 0.00 0.00 648.00 6 MCAD M01
LI: 009	07/01/05 07/01/05 J0330	0636	1	20.00	0.00 0.00 0.00 20.00 6 MCAD M01



Questions?



Resources for More Information

- Hospitals will continue to be informed of billing changes through provider bulletins and the EqualityCare website.
- Address of the EqualityCare website:
<http://wyequalitycare.acs-inc.com>

Resources for More Information

- **Address for Claims and Adjustments:**

Claims

ACS, Inc.

P.O. Box 547

Cheyenne, WY 82003-0547

- **Address for Correspondence:**

Provider Relations Unit

ACS, Inc.

P.O. Box 667

Cheyenne, WY 82003-0667

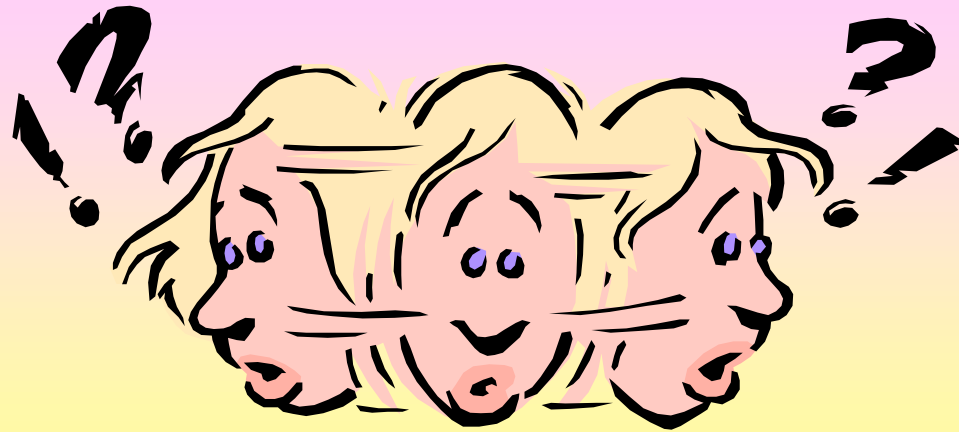
- **Telephone Numbers for Provider Relations**

Inside Cheyenne – (307) 772 – 8401

Outside Cheyenne – (800) 251 – 1268

Fax (307) 772 – 8405





Questions?