Practical Tips

Medicare's Hospital Outpatient Prospective Payment System: OPPTS 101 (part 1 of 2)

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The Balanced Budget Act of 1997 granted authority to the Centers for Medicare and Medicaid Services (CMS) to establish a prospective payment system for hospital outpatient services. Further modifications were granted under the Balanced Budget Refinement Act of 1999. The main intent was to provide CMS with a system to better predict and manage program expenditures by assigning fixed payment amounts to groups of services similarly to the inpatient prospective payment system (based on Diagnosis-Related Groups).

The hospital outpatient prospective payment system (OPPS) in place today classifies all hospital outpatient services into Ambulatory Payment Classifications (APCs). Healthcare Common Procedure Coding System codes (HCPCS codes) are assigned to APCs by CMS, and these assignments are updated at least annually (HCPCS code sets include the full Current Procedural Terminology code set). The services assigned to any APC are considered by CMS to be clinically similar and similar in terms of the resources required to provide each service. Thus, one APC may be applied to numerous HCPCS codes, whereas any individual HCPCS code can be assigned to only one APC. Notably, many HCPCS codes are not assigned to any APC. Some are considered "packaged" into some other code, some are identified as appropriate only for the inpatient setting, and some are simply not considered by CMS to be payable under the OPPS. Thus, one must actually refer to the CMS files listing all HCPCS codes¹ in order to determine whether the service is paid. This will be noted on those CMS files (in addendum B) as the Status Indicator. Status Indicators for 2010 are shown in Table 1. A hospital may, depending on a variety of factors, be paid for more than one APC or for more than one occurrence of the same APC at any given encounter.

Who Is Subject to OPPTS?

Institutions that are licensed as hospitals are subject to the OPPS. These are referred to as providers by CMS (Table 2). In the simplest terms, entities subject to and eligible for payment under the OPPS system are those that bill for outpatient services using the CMS 1450 form (UB04). Nonprofit or for-profit status is irrelevant.

When the hospital outpatient services are provided outside the hospital's main facility, a determination of provider-based status must be made. The main criteria for receiving

this status center around issues of control of operations, physical proximity to the main provider location, and population served by the off-site facility as compared with the population served by the main facility. Many Medicare claims administrators offer forms for submission to attain provider-based status.²

OPPS Payment Structure

The payment amounts for each APC, updated at least annually, are established by CMS and are based on CMS's estimates of the costs associated with providing any of the services assigned to an APC. Costs are calculated using national, aggregate data from hospitals' claims and cost reports. Coinsurance amounts are set at 20% of the APC payment amount, and no coinsurance amount may be greater than the hospital inpatient deductible in that year. Payments for procedures (not drugs or devices) are adjusted for geographic wage variations, using CMS's annually updated wage index: 60% of the APC amount is multiplied by the wage index and added to the remaining 40% of the APC amount.

Because the methodology for setting payment rates is based on costs, the rates for any given HCPCS code can vary significantly from rates paid to physician practices (Table 3). In addition, many codes (both procedures and drugs) will be reimbursed in the practice setting but are not reimbursed in the hospital outpatient setting. Finally, drugs that are paid separately are generally paid either at average sales price plus 4% or average sales price plus 6% (see part 2 of this article for further detail).

Billing Under OPPTS

Hospitals may only bill for services that are provided at the hospital's expense. If the physicians are employed, those services may be billed by the hospital using the CMS 1500 claim form, and they will be paid under the Physician Fee Schedule for the applicable site of service. The rules for billing these professional services are identical to the rules for professional service billing in the physician practice setting.

Interestingly, when hospitals fall under OPPS, they do not bill using the APC codes. CMS requires line item billing using the HCPCS codes because HCPCS codes are frequently moved from one APC to another in the annual

Table 1. Status Indicators for 2010

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example, ambulance services; clinical diagnostic laboratory services; nonimplantable prosthetic and orthotic devices; EPO for ESRD patients; physical, occupational, and speech therapy; routine dialysis services for ESRD patients provided in a certified dialysis unit of a hospital; diagnostic mammography; screening mammography.	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS. Not subject to deductible or coinsurance.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF). An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient procedures.	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued codes.	Not paid under OPPS or any other Medicare payment system.
E	Items, codes, and services that are not covered by any Medicare outpatient benefit based on statutory exclusion; not covered by any Medicare outpatient benefit for reasons other than statutory exclusion; not recognized by Medicare for outpatient claims, but for which an alternate code for the same item or service may be available, and for which separate payment is not provided on outpatient claims.	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
F	Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines.	Not paid under OPPS. Paid at reasonable cost.
G	Pass-through drugs and biologicals.	Paid under OPPS; separate APC payment.
H	Pass-through device categories.	Separate cost-based pass-through payment; not subject to copayment.
K	Non-pass-through drugs and nonimplantable biologicals, including therapeutic radiopharmaceuticals.	Paid under OPPS; separate APC payment.
L	Influenza vaccine; pneumococcal pneumonia vaccine.	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and services not billable to the fiscal intermediary/MAC.	Not paid under OPPS.
N	Items and services packaged into APC rates.	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
P	Partial hospitalization.	Paid under OPPS; per diem APC payment.
Q1	STVX-packaged codes.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as an HCPCS code assigned status indicator "S," "T," "V," or "X" (2) In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T" (2) In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
R	Blood and blood products.	Paid under OPPS; separate APC payment.
S	Significant procedure, not discounted when multiple.	Paid under OPPS; separate APC payment.
T	Significant procedure, multiple reduction applies.	Paid under OPPS; separate APC payment.
U	Brachytherapy sources.	Paid under OPPS; separate APC payment.
V	Clinic or emergency department visit.	Paid under OPPS; separate APC payment.
X	Ancillary services.	Paid under OPPS; separate APC payment.
Y	Nonimplantable durable medical equipment.	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

Abbreviations: OPPS, outpatient prospective payment system; MAC, Medicare administrative contractor; EPO, epoetin alfa; ESRD, end-stage renal disease; APC, Ambulatory Payment Classification; CORF, comprehensive outpatient rehabilitation facility; CRNA, certified registered nurse anesthetist; HCPCS, Healthcare Common Procedure Coding System; DMERC, durable medical equipment regional carrier.

updates. The claims administrator receives the claims and applies the appropriate APC payment rates to the HCPCS codes. The specific rules for OPPS billing are similar but not identical to those for practices, with various edits regarding

allowable units of service, codes that may not be billed at the same encounter as other codes (component codes, mutually exclusive codes), and requirements regarding diagnosis codes.

Table 2. Hospital Provider Definition

Hospital Provider Definition (CMS Manual 100-01: Medicare General Information, Eligibility and Entitlement Manual)	
A hospital (other than psychiatric) means an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.	
Maintains clinical records on all patients.	
Has bylaws in effect with respect to its staff of physicians.	
Has a requirement that every patient must be under the care of a physician.	
Provides 24-h nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times.	
Has in effect a hospital utilization review plan.	
Is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing, and meets other health and safety requirements found necessary by the Secretary of Health and Human Services. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with exceptions specified in the law).	
Such an institution, if approved to participate as a hospital, may also be approved as a swing bed facility pursuant to demonstration authority or if the hospital is a rural hospital with less than 100 beds.	

Abbreviation: CMS, Centers for Medicare and Medicaid Services.

Hospitals have access to numerous codes that are not available to physician offices. Most of those are alphanumeric (one letter followed by numbers), and many are intended to allow hospitals to capture what was, before the OPPS, referred to as a “facility fee” (facility fees are no longer billable to Medicare – see part 2 of this article for further discussion). For example, when a multidisciplinary clinic is located at the hospital, code G0175 (payment before wage index adjustment in 2010 is \$113.44) may be billed for a scheduled interdisciplinary team conference that includes at least three team members (excluding patient care nursing staff) and that takes place with the patient present. This charge would be in addition to whatever professional fees may be billed by physicians for their evaluation and management services. Facility fees and visits will be discussed in greater detail in the second part of this article.

Hospital claims also differ from physician office claims in several ways. For example, there are condition codes, value codes, up to 28 ICD-9 diagnosis and procedure codes (which do not need to have pointers in the charge section), reason codes, and revenue codes.

Condition codes describe any conditions or events that apply to the billing period. For example, code 02 indicates employment-related illness/injury, and code 21 indicates

Table 3. Comparison of Selected 2010 Payment Rates

Code	Code Descriptions	OPPS	OFFICE
96360	IV, hydration; initial, 31 minutes to 1 hour (not for < 30 minutes)	75.69	53.76
96365	Ther IV, initial, up to 1 h	126.78	66.02
96368	Ther IV concurrent infusion (only 1 per encounter)	0.00	19.12
C8957	Ther IV; initiation of prolonged infusion (> 8 hours), requiring portable or implantable pump	219.96	0.00
96369	SQ infusion for therapy; initial, up to 1 hour, including pump set-up and establishment of SQ infusion site(s)	126.78	145.40
96372	Ther injection; subcutaneous or intramuscular	25.67	21.29
96374	Ther push, single or initial substance/drug	37.44	52.68
96379	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	25.67	0.00
96401	Chemotherapy SQ or IM nonhormonal antineoplastic	37.44	67.47
96402	Chemotherapy SQ or IM hormonal antineoplastic	37.44	35.00
96409	Chemotherapy push technique, single or initial substance/drug	126.78	107.15
96413	Chemotherapy IV up to 1 hour, single or initial substance/drug	219.96	139.99
96415	Chemotherapy IV technique; each additional hour	37.44	30.31
96416	Chemotherapy IV technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	219.96	153.34
96521	Refilling and maintenance of portable pump	126.78	123.39
J0881	Darbepoetin alfa, non-ESRD, 1 µg	2.826	2.880
J1100	Dexamethasone sodium phos, 1 mg	0.00	0.089
J1200	Diphenhydramine Hcl injection, 50 mg	0.00	0.797
J1750	Injectable iron dextran, 50 mg	12.388	12.626
J7050	Normal saline solution infuse, 250 mL	0.00	0.281
J9000	Doxorubicin Hcl injection, 10 mg	0.00	3.039
J9201	Gemcitabine Hcl injection, 200 mg	142.362	145.10
J9214	Interferon alfa-2b injection, 1 mil U	15.541	15.840
J9328	Temozolomide injection, 1 mg	4.899	4.899
J9263	Oxaliplatin, 0.5 mg	6.696	6.825

Abbreviations: IV, intravenous; Ther, therapeutic; SQ, subcutaneous; IM intramuscular; ESRD, end-stage renal disease; Hcl, hydrochloride.

that the bill is for denial notice. Value codes are used to report a variety of factors. Most relevant to oncology: when billing for growth factors, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Reason codes describe a patient's reason for the billed visit. The patient's reason for visit is required for all unscheduled outpatient visits for outpatient bills, documented with ICD-9 codes. Finally, revenue codes indicate which hospital department is associated with the billed line items. These codes are particularly important for the reimbursement of separately payable drugs; these must be billed with revenue code 636 or there is a risk of nonpayment.

Clearly there are some significant differences between Medicare's OPPOS and the Physician Fee Schedule, including complexities for billing and reimbursement for outpatient oncology

services. In the second part of this article we will explore those differences further, including questions around facility fees, 340B drug pricing, and operational challenges that can interfere with optimal financial performance for hospital-based outpatient infusion centers.

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Author's Disclosures of Potential Conflicts of Interest

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