New APCs and More: Changes to the Outpatient Prospective Payment System

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The Outpatient Prospective Payment System (OPPS) went into effect on August 1, 2000. However, as a result of continuing comments from hospitals and the initial experience with the operation of the system, HCFA has made some substantial changes to OPPS. These changes fall into three categories:

- modifications to the definition of the APCs
- policy changes that affect the claims adjudication process or payment computation
- modifications to the edits in the Outpatient Code Editor (OCE).

The article "Preparing for the Outpatient Prospective Payment System" in the July-August 2000 *Journal of AHIMA* summarized the key features of OPPS that affect HIM professionals. This article assumes the reader is familiar with the content of that article and focuses on summarizing the changes to OPPS.

Modifications to the APCs

Effective October 1, 2000, 286 new APCs were added, increasing the number of APCs from 659 to 945. "Modifications to APCs," summarizes the changes. Most of the changes were made to APCs for drugs and biologicals and devices. Sixteen drug and biological APCs that met the criteria to be paid on a pass-through basis were added, and one was deleted.

Modifications to APCs

	Modifications to August APCs		October APCs	
Significant procedure, therapy, or services	No Change		148 11 99 4 262	Type T Type T New Technology Type S Type S New Technology Total
Medical Visit	No Change		7	
Drugs and biologicals	Added Deleted Added Changed	16 1 7 1	Pass-through Pass-through Ancillary Ancillary Pass-through	220 15 235	Pass-through Ancillary Total
Devices	Added Deleted Created	250 2 11	Pass-through Pass-through Ancillary new device technology	385 11 396	Pass-through Ancillary Total
Partial hospitalization	No Change		1		
Ancillary tests and procedure	Added	5	44		
Total	Net addition of 286		945		

Drug and biological APCs categorized as ancillary are paid a standard APC amount and are not paid on a pass-through basis. Seven ancillary APCs for drugs and biologicals were added, and one ancillary drug and biological APC was changed to a pass-through. These new ancillary drug and biological APCs related primarily to blood products.

For devices that meet the criteria to be paid on a pass-through basis, 250 additional APCs were created, and two were deleted. In addition, 11 ancillary new device technology APCs were created. Devices that do not meet the criteria to be eligible for pass-through payment but for which HCFA has decided to pay separately are assigned to one of the 11 ancillary new device technology APCs. The new device technology APCs are based solely on cost, and the devices assigned to the new device technology APCs are not intended to be clinically similar. Five ancillary test and procedure APCs related to laboratory services were also added.

Policy Modifications

In the August release of the OCE, claims for ER or observation visits were treated as if they occurred on a single day. For example, if an ER visit spanned two days, the number of occurrences of a service across both days were added together for the purpose of applying the OPPS payment rules and OCE edits. This policy created problems for batch bills that contained an ER or observation service. The policy was modified so that ER and observation claims that span more than one calendar day are subdivided into multiple days, and the OPPS payment rules and OCE edits are applied independently to each calendar day on the claim. For example, the units edit is now applied independently to the services on each calendar day of an ER visit, whereas in the August release of the OCE, services across all days on the claim were summed together before applying the units edit.

If more than one bilateral type T or S procedure was performed, the discounting rules limited payment to a single bilateral procedure. This policy has been changed in the October OCE release to allow full payment for multiple type S bilateral procedures (primarily bilateral radiological procedures).

The rules for partial hospitalization require that at least three services associated with partial hospitalization (e.g., group therapy) be provided on each day of partial hospitalization. In the October release of the OCE, services identified as associated with partial hospitalization were expanded to include partial hospitalization program services (code G0172).

In addition to the above changes, the use of modifier -25 was clarified. Modifier -25 assigned to an E/M code means that if the code occurs on the same day as a type T or S procedure, the medical visit was a service distinct from the procedure and both the medical visit and procedure are paid. For services performed in the emergency room, a question was raised as to whether the medical evaluation preceding the decision to perform a procedure in the ER would always constitute a distinct service and therefore should be re-ported with an E/M code with modifier -25. In Program Memorandum A-00-40, HCFA stated, "Medicare requires that modifier -25 always be appended to the emergency department (ED) E/M code (99281-99285) when provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s)."

Thus, in the ER, the medical services provided in conjunction with a procedure can be reported with the appropriate E/M code with modifier -25. This is not necessarily true for other sites of service, such as same-day surgery units in which medical services provided in conjunction with the procedure would not usually constitute a distinct service and would not be reportable using modifier -25.

OCE Edit Modifications

Two new edits were added to the October release of the OCE. The Medicare secondary payer edit suspends claims that have trauma diagnoses for the fiscal intermediary to review the claims to check if another insurer should be the primary payer. The second new edit returns to the provider any claims with a transfusion or blood product exchange procedure in which there are no HCPCS codes specifying the blood product provided.

The underlying logic of several of the OCE edits was modified for the October OCE release, as summarized in "OCE Edit Modifications." The content of the knowledge files that underlie each edit were updated for the October OCE release. For example, the units file (edit 15) was updated to make the units limits more restrictive and clinically meaningful. The NCCI file (edits 19, 20, 39, 40) was updated from version 6.2 to version 6.3. In the August OCE, the NCCI edits were modified to exclude critical care and anesthesiology. In the October OCE, the NCCI exclusions were expanded to encompass E/M codes

and mental health visit codes. In addition, minor clarifications were made to the logic of some of the edits primarily directed at supporting the workflow requirements of the fiscal intermediaries. For example, the procedure and age conflict edit (edit 7) was modified not to be issued when the age was invalid. The October release of the OCE also included the update to the ICD-9-CM diagnoses codes and HCPCS codes that were effective October 1, 2000.

OCE Edit Modifications

Edit	August OCE	October OCE
10/11	A claim with a noncovered service submitted for verification of denial (condition code 21)or for F1 review (condition code 20) is denied or suspended	Edits 10 and 11 were modified to deny or suspend a claim bsed solely on presence of these condition codes. A noncovered service need not be present for the edit to apply
13	HCPCS codes for which separate payment is not provided by Medicare are line item rejected	Edit 13 was expanded to apply to line items that do not have a HCPCS code but have a revenue center for which separate payment is not provided by Medicare
14	HCPCS codes that indicate a site of service not included in OPPS are returned to the provider	Edit 14 modified to be conditional on the type of bill
17	Multiple occurrences of a bilateral procedure results in all of the line items except one with the bilateral procedure being rejected	Claim is returned to provider if bilateral procedure occurs multiple times
27	Claims with only incidental services (no APCs) are returned to the provider	Edit 27 was modified not to occur in a non-OPPS service is present on the claim
42	Multiple occurrences of an E/M code with the same revenue center on a claim without condition code G0 result in all except one of the line items with the E/M code being rejected	Claim is returned to provider if an E/M code with the same revenue center occurs multiple times on a claim without condition code G0

Retroactive Modifications

Each update of the OCE software used by the fiscal intermediaries contains all previous versions of the OCE. Based on the "from" date on the claim, the OCE software selects the correct version of the OCE to apply to the claim. This feature of the OCE software allows HCFA to make retroactive changes to a prior release of the OCE software. With the exception of the new APCs, new ICD-9-CM diagnosis codes, new HCPCS codes, new edits, and NCCI update, HCFA has made all other OCE modifications in the October release of the OCE retroactive to the August release. This means that the fiscal intermediaries will reprocess all claims from the August to September time period that are affected by the retroactive revisions to the August OCE.

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