Preparing for the Outpatient Prospective Payment System

Save to myBoK

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Are you ready for the outpatient prospective payment system? This special report tells you what you need to know. First, take a look at aspects of the new system that most directly affect HIM professionals. then, an expert offers advice on how to make aproactive transition to the new system.

Are you ready for the Outpatient Prospective Payment System (OPPS)? This new system, to be implemented on August 1, 2000, represents a total reform of the way Medicare pays hospitals for outpatient care. Since the publication of the final regulations on April 7, the industry has been preparing to implement this new system.[1] What aspects will most directly affect HIM professionals? This article tells you what you need to know.

To begin, here are a few key characteristics and features of the OPPS:

- the unit of payment is Ambulatory Payment Classifications (APCs), which are groups of outpatient services that are homogeneous both clinically and in terms of resource utilization. APCs play the same role in OPPS as DRGs do for the inpatient PPS
- assignment to an APC is primarily determined through the HCFA Common Procedure Coding System (HCPCS), which is composed of the American Medical Association CPT procedure codes plus codes for medical/surgical supplies and other services. Before OPPS, only a relatively small portion of Medicare outpatient payments were determined through the HCPCS codes. Under OPPS, virtually all of a hospital's Medicare outpatient payments are determined based on the HCPCS codes
- unlike DRGs, multiple APCs can be assigned to a claim
- for each APC, the hospital is paid a fixed prospective price
- a relatively complex set of edits and payment rules determine final APC payment. Under certain conditions, some APCs are not paid or are discounted
- payment edits and rules are based not only on the HCPCS codes on a claim, but also the HCPCS modifiers, revenue centers, service units, service date, condition codes, and type of bill
- OPPS payment edits not only alter APC payment but may also cause a claim to be returned to the hospital, suspended for medical review, rejected, or denied

The regulations establishing OPPS address all issues relating to Medicare payment of outpatient services, including beneficiary co-insurance, transitional pass-throughs, transitional corridors, unbundling of services, computation of payment weights, definition of provider-based status, volume control measures, and judicial review. This article will focus on only the aspects of OPPS that most directly affect the HIM professional and will not attempt to describe the entire regulation.

APC Development and Structure

The initial design and development of OPPS began in the early 1990s with the development of Ambulatory Patient Groups (APGs).[2] In 1994, Iowa Medicaid became the first major payer to implement an APG-based OPPS.[3] In September 1998, the Health Care Financing Administration (HCFA) published the proposed regulations for the Medicare OPPS.[4]

In the proposed regulations, the basis of payment was APCs, which are a modification of APGs resulting from the evaluation of newer and more comprehensive outpatient data. The proposed regulation generated approximately 10,500 comments with the majority of the comments on issues relating to the APCs.

In November 1999, the Balanced Budget Refinement Act of 1999 (BBRA 1999) made major changes to the proposed OPPS.[5] With respect to APCs, the BBRA 1999 limited the variation in resource use among procedures or services within an APC such that the highest-cost procedure or service within an APC could not be more than twice the cost of the lowest-cost procedure or service within the same APC. The one exception to this "two times" rule was for low-volume procedures or services.

As a result of the comments and the "two times" rule, the APCs in the proposed regulation were modified to have fewer codes and a narrower range of costs. In particular, because of the "two times" rule, some otherwise clinically homogeneous APCs were split into smaller groups.

In the evolution from APGs to proposed APCs to final APCs, several basic concepts have been consistent:

- **significant procedure, therapy, or service**—procedures, therapies, or services that are normally scheduled, constitute the reason for the visit, and dominate the time and resources expended during the visit (e.g., skin excision)
- **medical visit**—diagnostic, therapeutic, or consultative services provided to a patient by a healthcare professional that do not include a significant procedure, therapy, or service (e.g., emergency room visit for chest pain)
- **ancillary tests and procedures**—tests and procedures ordered to assist in patient diagnosis and treatment but not dominating the time and resources expended during the visit (e.g., chest X-ray)
- **incidental services**—services that are an integral part of or incidental to a medical visit or significant procedure, therapy, or service (e.g., range of motion measurement)
- **packaging**—the inclusion of certain costs into the payment amount for an APC (e.g., room charges)
- **multiple significant procedure discounting**—the reduction of the standard payment amount for an APC in order to recognize that the marginal cost of providing a second procedure to a patient during a single visit is less that the cost of providing the procedure by itself

"Comparing the Systems" summarizes the evolution of APGs to final APCs. In APGs all significant procedures, therapies, and services were subject to multiple significant procedure discounting. In APCs significant procedures, therapies, and services are divided into types "T" and "S" with multiple significant procedure discounting only applicable to type T procedures. In general, type T procedures are primarily surgical procedures. When multiple type T procedures occur on the same claim, the procedure with the highest payment amount is fully paid, and all other type T procedures are paid at 50 percent of the standard APC payment amount.

In the final APCs, 11 type T and four type S new technology APCs were added in order to pay for new technology for which there was no appropriate APC. In contrast to the standard APCs, the new technology APCs are based solely on cost and are not intended to be clinically homogeneous.

The definition of a medical visit has changed dramatically across the evolution of APGs to final APCs. The medical visit APGs were defined using only diagnoses. The proposed medical visit APCs were defined based on a combination of diagnoses and the HCPCS Evaluation and Management (E&M) codes.

The final medical visit APCs use only E&M codes and consist of three levels of clinic visits, three levels of emergency room visits, and a medical visit APC for interdisciplinary team conferences. The E&M code for critical care (99291) is assigned to a type S significant procedure APC. While the final medical visit APCs do not use diagnoses, the final regulation indicated that HCFA requires hospitals to provide accurate diagnosis coding and is assessing the possible future use of diagnoses in the medical visit APCs.

The APGs and the proposed APCs contained five and four chemotherapy groups, respectively. The BBRA 1999 requires for the initial two to three years of OPPS that orphan drugs (drugs that are intended for conditions that affect a limited number of

people), drugs and biologicals used in the treatment of cancer, radiopharmaceuticals, and new drugs and biologicals introduced after 1996 be paid on a pass-through basis. The pass-through amount is based on 95 percent of the average wholesale price of the drug or biological. There are 204 final APCs for pass-through drugs and biologicals. In addition to the drug and biological APCs that are elegible for pass-through payments, there are nine drug and biological APCs that are considered an ancillary service and paid a standard APC amount (e.g., streptokinase administered to an acute myocardical infarction patient for disolving a clot in the coronary artery). The payment amount for the drug and biological APCs is set at the lowest dose and the service units field on the claim is used to obtain appropriate payment for higher doses.

The APGs and proposed APCs did not contain APCs for devices. The BBRA 1999 requires that new medical devices with significant cost also be paid on a pass-through basis. The pass-through amount for devices is based on the hospital's cost for the device. The final APCs include 137 APCs for new medical devices.

There are four partial hospitalization APGs that reflect the reason for the hospitalization (i.e., substance abuse versus mental illness) and the extent of the hospitalization (i.e., full day versus half day). In the proposed regulations there was one APC for partial hospitalization based on a per diem rate, but the rules for assigning this APC were not defined. In the final regulations, the level and amount of services that constitute partial hospitalization are defined.

APC Payment Model

Not every service delivered by a hospital outpatient department is paid under OPPS.

Every HCPCS code is assigned one of the 13 status indicators contained in "APC Status Indicators." HCPCS codes with status indicators G, H, J, P, S, T, V, and X are assigned to an APC and are paid under OPPS. The subset of drugs, biologicals, and devices that are eligible for pass-through payments under OPPS are assigned to status indicators G, H, and J.

The remaining drugs, biologicals, and devices are assigned a status indicator of N along with other incidental services, which means that their cost is packaged into an APC with a status indicator of S, T, or V. Packaged incidental services include the use of operating and recovery room, anesthesia, medical/surgical supplies, observation, and various services such as venipuncture.

In the proposed regulation, corneal tissue acquisition, blood and blood products, casts, splints, immunosuppressive drugs, and certain high-cost drugs were packaged. The final regulation provides for separate payments for these services. However, observation and most drugs remain packaged, even though many comments urged separate payment for these services. Thus, the cost of observation is packaged into APC payments for emergency room visits.

Although incidental services are packaged and not paid separately, a hospital is still compensated for these services because the cost of the incidental services is incorporated into the payment amount of the type S, T, or V service with which the incidental service is associated. Services with status indicators of A and F are not paid under OPPS, but are paid by other methods such as a fee schedule. Services with a status indicator of C or E are not paid.

The assignment of the APC is, in general, straightforward. For the subset of HCPCS codes that have an APC assigned, each HCPCS code is mapped directly to an APC. The only exception is the APC for partial hospitalization. Partial hospitalization claims from hospitals are identified by the presence of condition code of 41 on the claim. Partial hospitalization claims are paid on a per diem basis and require that at least three mental health services, of which at least one is group psychotherapy, family psychotherapy, or extended individual psychotherapy, be provided for the partial hospitalization APC to be assigned.

Once the APCs are assigned to a claim, the basic payment computation under OPPS involves summing the payment amounts for each APC present on the claim. However, not all APCs are used to compute payment. While assigning APCs to a claim is straightforward, the determination of which APCs are used to compute payment is more complex.

How an APC is used in the computation of payment for a claim is highly conditional on the other APCs present on the claim, as well as the presence of certain modifiers, condition codes, and revenue centers. The rules for determining how APCs are used in the payment computation are contained in the Outpatient Code Editor (OCE).

Outpatient Code Editor

The OCE has been used by Medicare fiscal intermediaries (FIs) in the processing of Medicare outpatient claims since 1987.[6] The original OCE consisted of 14 edits that identified discrepancies or problems with data coded on a claim.

For example, one edit evaluated the consistency of the sex and the diagnoses on the claim. Thus, the OCE would flag a claim for a male with a diagnosis of uterine fibroma. All FIs used the OCE to edit claims, but the action and extent of follow-up that resulted from an OCE edit was determined by individual FIs.

With the implementation of the Medicare OPPS, the OCE has been greatly expanded,[7][8] The outpatient data on a UB-92 claim is organized as fixed header information, followed by up to 450 line items. The line items contain a description of each service rendered to the patient. The data from the UB-92 required to edit the claim and determine payment under OPPS are summarized in "Data Elements Required for Edits."

Not all line items will have a HCPCS code. However, every line item has a revenue center that describes the service. Currently, up to two modifiers are allowed with each HCPCS code. The charge field is used for payment-related adjustments, such as determination of outlier status. Payment under OPPS is primarily determined by the HCPCS code, HCPCS modifier, and service units. The other data elements are primarily used to edit the claim.

In general, the new OCE performs all functions that require specific reference to HCPCS codes, HCPCS modifiers, and ICD-9-CM diagnosis codes. Because these codes and modifiers are complex and annually updated, the centralization of the direct reference to these codes and modifiers in a single program reduces effort for the individual FIs and reduces the chance of inconsistent processing.

The new OCE performs four basic functions:

- editing the data on the claim for accuracy
- specifying the action the FI should take when specific edits occur
- assigning APCs to the claim
- determining payment-related conditions that require direct reference to HCPCS codes or modifiers (e.g., whether multiple significant procedure discounting applies to a line item)

Because the accuracy of the data coded on the claim directly determines the APC and the payment amount, the number of edits in the OCE has been greatly expanded. The initial release of the new OCE has 41 edits, and the number of edits is likely to grow over time. The original OCE focused solely on the presence or absence of specific edits and did not specify the action that should be taken when an edit occurred. When an OCE edit occurs, the FI can take one of six different actions:

- claim rejection—the provider can correct and resubmit the claim but cannot appeal the rejection
- claim denial—the provider cannot resubmit the claim, but can appeal the denial
- claim return to provider (RTP)—the provider can resubmit the claim once the problems are corrected
- claim suspension—the claim is not returned to the provider, but is not processed for payment until the FI makes a determination or obtains further information
- line item rejection—the claim is processed for payment with some line items rejected for payment. The line item can be corrected and resubmitted but cannot be appealed
- line item denial—the claim is processed for payment with some line items denied for payment. The line item cannot be resubmitted but can be appealed. The one exception is for ER visits in which a patient dies during a procedure categorized as an inpatient procedure. Under such circumstances, the claim can be resubmitted as an inpatient claim

Each edit in the OCE is associated with one of the six actions. Any individual claim could have multiple edits and, therefore, require multiple actions. The OCE identifies all applicable edits to allow the FI to address all problems with the claim

simultaneously and to minimize the need for the claim to be processed multiple times. A line item rejection or denial only affects the individual line item and not the processing of the other line items on the claim. "OCE Edits and Associated Actions," lists the 41 OCE edits and the actions that are associated with each one.

A denial or rejection is a more final action that limits the ability of the hospital to resubmit or appeal the claim. An RTP provides the hospital the most flexibility to correct and resubmit the claim. It can, however, create additional work and slow down bill processing, which hurts cash flow.

The initial actions in the OCE are largely RTP. Because it is anticipated that there will be an initial learning curve for hospitals associated with OPPS claims processing requirements, the RTP action was selected because it provides hospitals with maximum flexibility. However, over time, it is likely the action for some of the edits will be changed to deny or reject to reduce reprocessing.

The edits 1, 6, 22, 23, 25, 26, and 41 deal with the validity of the information used by the OCE. Because the OCE accepts claims that span more than one day, the dates on each line item must be accurate. If a claim spans more than one day, the OCE subdivides the claim into separate days.

All claims that span more than one calendar day are subdivided into multiple days, except claims for ER (identified by the presence of a revenue center code in the range 450-459) or observation (identified by the presence of revenue center code 762). Thus, claims for ER or observation visits are always treated as if they occurred on a single day. The OCE edits are applied independently to each calendar day on a claim.

The revenue center and modifier are checked to ensure that the code reported is valid. The condition code and type of bill, although used in some edits, are not checked for validity. Thus, an invalid modifier or revenue center automatically causes a claim to be returned to the provider, but an invalid condition code or type of bill will not.

In OPPS, the service units field is used to specify the number of times a specific service was delivered. Edit 15 checks to ensure that the service units are within reasonable limits (e.g., more than 10 finger amputations are not allowed). The service unit limits in edit 15 have initially been set very high, but will likely be made more restrictive over time.

If the HCPCS code for skin excision was listed with a service unit of two, the APC payment would be computed as twice the payment amount for a single skin excision (with applicable discounting and adjustments applied). Thus, the units field is critical from a payment accuracy and compliance perspective. In the OCE, a HCPCS code with a service unit of two is treated the same as two occurrences of the same HCPCS with a service unit of one.

Edits 2, 3, 7, and 8 relate to inconsistencies of age or sex and the diagnosis or procedures on the claim (e.g., an elderly pregnancy). Edits 9 to 14 relate to payment and coverage issues. Edits 5 and 28 relate to coding issues. Edit 28 identifies valid HCPCS codes that are not recognized by Medicare because an alternative code should be used to report the service (e.g., G0001 should be used to report routine venipuncture, not 36415).

Some procedure codes are inherently bilateral (e.g., 40701 primary bilateral cheiloplasty), while other codes are only considered bilateral if modifier -50 is present (e.g., 66920 cataract removal). If a code that would be considered bilateral if modifier -50 were present occurs two or more times on a claim without modifier -50, the claim is returned to the provider (edit 16). If there are multiple occurrences of an inherently bilateral procedure, or multiple occurrences of a bilateral procedure with modifier -50, all the line items with the bilateral procedure are rejected except one (edit 17).

Edits 19, 20, 39, and 40 implement the National Correct Coding Initiative (NCCI) edits, with the exception of the critical care and anesthesiology portions. The NCCI edits identify combinations of procedures that are mutually exclusive (e.g., 19180 Mastectomy, simple complete, and 19160 Mastectomy, partial) and combinations of procedures in which a procedure is a component of a comprehensive procedure (e.g., 69990, Use of operating microscope, is a component of 15757, Free skin flap with microvascular anastomosis).

In the above examples, the second listed mutually exclusive procedure (i.e., 19160) and the component procedure (i.e., 69990) are line item rejected. However, some NCCI edits are not applicable if an appropriate modifier is used. For example, if the modifiers LT and RT, which specify left and right side, are used with the mutually exclusive code pair 19180 and 19160, the code 19160 is not line item rejected. But because there are no modifiers that would override the comprehensive/component

procedure pair 15757 and 69990, 69990 is always line item rejected. If an NCCI edit occurs, the only consequence is that the mutually exclusive or component line item is denied or rejected. The rest of the claim is processed and paid.

Edit 18 identifies procedures that are not safe, appropriate, or considered to fall within the boundaries of acceptable medical practice if they are performed on other than a hospital inpatient basis. When an edit 18 inpatient procedure occurs, all line items on the day of the inpatient procedure are denied. If the claim is a multiple-day claim, only services on the day of the inpatient procedure are denied, and services on the other days are processed for payment. The designation of a procedure as inpatient does not preclude hospitals from providing it on an outpatient basis. It simply means that Medicare will not pay for the service if it is performed on an outpatient basis.

A modifier of 73 indicates that a procedure that required anesthesia was terminated prior to anesthesia. Modifier -52 (reduced services) indicates that a procedure that did not require anesthesia was terminated after the patient had been prepared for the procedure. Terminated procedures are discounted by 50 percent. If a bilateral procedure or a procedure with units greater than one is reported as terminated, edit 37 causes the claim to be returned to the hospital.

For some implantable devices, the cost of the device is not included in the implantation procedure, but is paid separately. Edit 38 identifies inconsistencies between the device implanted and the implantation procedure. The occurrence of edit 38 causes the claim to be returned to the hospital.

As incidental services are expected to be part of another procedure or service, a claim that has only incidental services is returned to the hospital (edit 27).

Edit 30 suspends for medical review partial hospitalization claims for which the mental health services provided were not as extensive as would be expected for a patient in a partial hospitalization program. Partial hospitalization claims usually cover a period of time (e.g., two weeks). Patients enrolled in a partial hospitalization program are expected to require services on an ongoing basis. Edits 32-34 suspend for medical review claims for which the number of days on which partial hospitalization services were provided were not as frequent as would be expected for a patient in a partial hospitalization program.

Hospital outpatient claims that are not for partial hospitalization (i.e., no condition code 41) could have a number of mental health services on the same day such that the sum of the individual payments for each service exceeds the partial hospitalization per diem. If this occurs, payment for the mental health services is limited to be equal to the partial hospitalization per diem. Edits 29, 31, 35, and 36 check the other aspects of partial hospitalization and mental health claims.

The E&M code portion of HCPCS is used to assign medical visit APCs. Any line item that has an E&M code is assigned the corresponding medical visit APC. However, under certain conditions, there is no additional payment associated with the medical visit APC.

If the medical visit APC occurs on a claim with a type T or S procedure APC, the medical visit is assumed to be associated with the procedure and there is no additional payment for the medical visit. Edit 21 identifies this condition and rejects the line item with the E&M code.

If the medical visit is unrelated to the type T or S procedure, the hospital can specify this by assigning a modifier of 25 to the E&M code. The presence of a modifier 25 results in payment for both the medical visit and the type T or S procedure.

Multiple medical visits can occur on the same day. Each medical visit is paid separately, as long as there are different revenue centers on the line items with the medical visit E&M codes. The revenue centers are used as means of identifying distinct services (e.g., ER versus clinic). If two or more medical visits on the same day have the same revenue center, then the hospital must use the condition code G0 in order to have all the medical visits paid separately.

Edit 42 applies to claims with multiple medical visits on the same day with the same revenue center without condition code G0. When edit 42 occurs, all medical visit line items that have the same revenue centers are rejected, except the line item with the highest medical APC payment amount.

The HCPCS E&M codes are the same as the American Medical Association CPT E&M codes. Thus, the HCPCS E&M codes represent different levels of physician effort and do not adequately describe facility resources. The final regulations require each hospital to have a system for mapping facility services provided to the different levels represented by the HCPCS E&M codes.

The *Federal Register* notes, "As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that it is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill."[9]

The level of the E&M code reported on the physician bill would not necessarily be expected to correspond to the level of E&M code reported on the hospital bill. The final regulations indicate that more definitive guidelines for hospital coding of E&M codes will be issued in the future.

As a result of the quarterly updates to the NCCI edits and the annual updates to HCPCS codes and diagnosis codes, the OCE is updated on a quarterly basis.

APC Payment

All line items that contain a HCPCS code which have a service indicator of G, H, J, P, S, T, V, or X are assigned an APC. The standard OPPS payment amount for a line item with an APC assigned is computed as the product of the payment amount corresponding to the assigned APC, any applicable discounting factor, and the service units. OPPS payment for the claim is then computed as the sum of the APC payment amounts across all line items that have not been line item denied or rejected by the OCE.

APCs with status indicators of G, H, or J are paid based on the transitional pass-through provisions of the BBRA 1999. In addition to OPPS payments, line items with a status indicator of A or F are paid by other methods. If hospital charges converted to cost for a claim exceed the OPPS payment (adjusted for pass-through payments) by more than 2.5 times (i.e., the outlier threshold) the hospital will receive an additional outlier payment equal to 75 percent of the cost above the outlier threshold.

Preparing for OPPS

Accurate and complete coding of HCPCS codes are essential for correct payment under OPPS and for meeting compliance requirements. Here are some things you can do to ensure your facility is prepared for OPPS:

- **Review HCPCS codes from your chargemaster.** Because HCPCS codes for some services (e.g., radiology) are usually automatically generated directly from the hospital chargemaster, HCPCS codes from the chargemaster should be reviewed for accuracy

- **Review HCPCS codes from superbills.** Since HCPCS codes for some services (e.g., clinic visits) are sometimes automatically generated directly from superbills, the HCPCS codes generated by the check-off categories on the superbills should be reviewed for accuracy

- **Review your process.** Consideration should be given to having all outpatient coding reviewed by the HIM department prior to claim submission. At minimum, high-cost visits, especially for the ER and same-day surgery units, should be coded directly by the HIM department

- **Sharpen HCPCS skills.** Make sure the HIM staff is trained in HCPCS codes and HCPCS modifiers. Coding tools such as HCPCS encoders should be available to help ensure accurate coding

- **Educate others.** Make sure you train physicians and any departments involved in the documentation or billing of outpatient claims on the requirements of OPPS
- **Standardize E&M coding.** Establish a consistent method of determining the different levels of HCPCS E&M codes

- **Pay attention to diagnosis coding.** Although diagnosis coding does not affect payment under OPPS, it is important for advance beneficiary notification of medical necessity for certain ancillary tests and procedures. Further, diagnoses may be used as a part of the APC definitions in the future. Therefore, the coding of diagnoses should receive the same attention as procedure coding

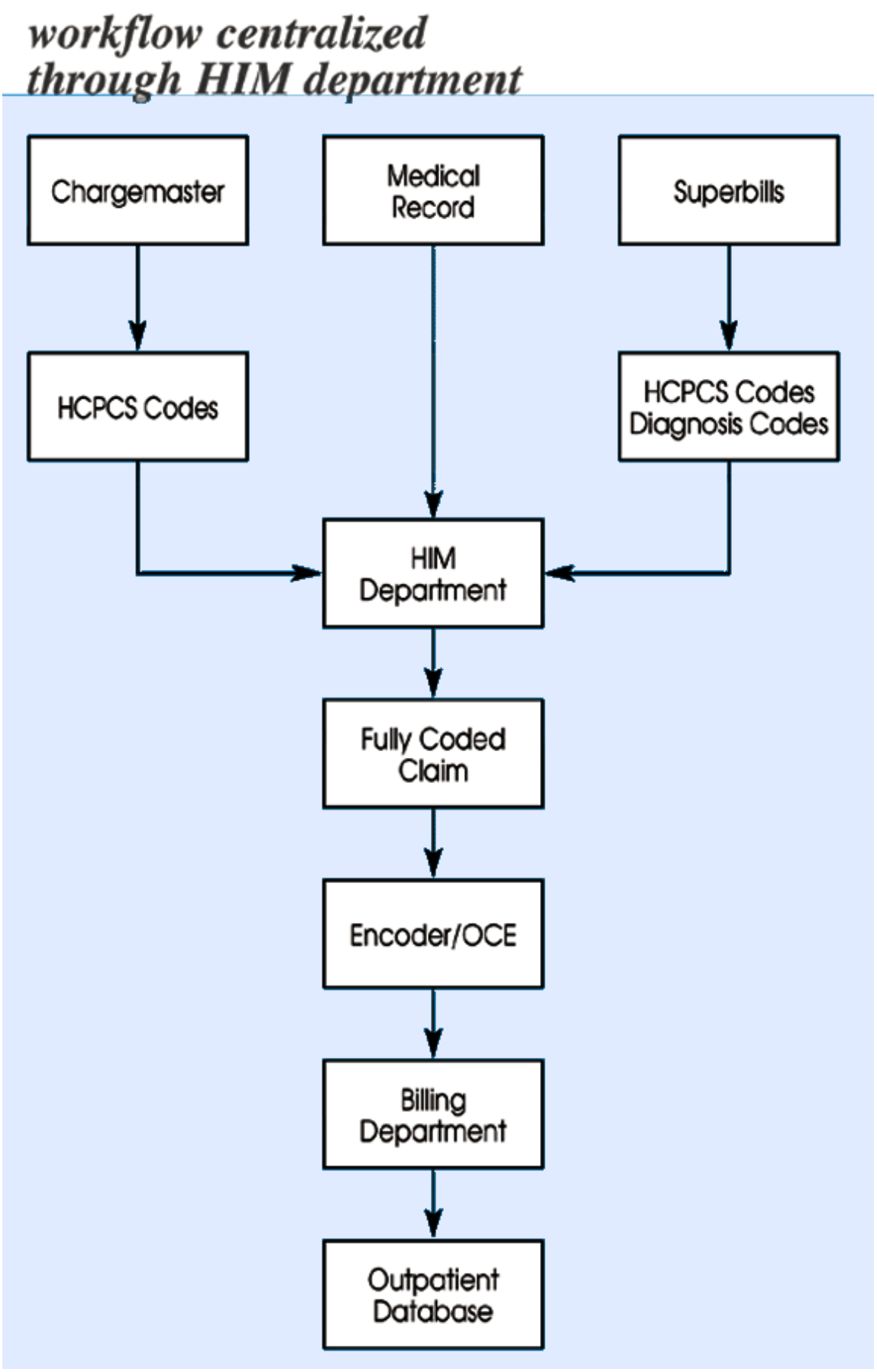
- **Check claims with the OCE.** Because claims that are denied, rejected, or returned to the hospital will result in lost revenue and cash flow delays, claims should be reviewed with the OCE before submission.

- **Watch the bottom line.** Create a comprehensive outpatient database that can generate product line APC-based profit and loss reports

- **Reconsider your workflow.** The ongoing production of complete, accurate, and timely outpatient claims can be accomplished through alternative workflows. The flow charts above show two different processes. One is a centralized workflow in which codes from the chargemaster and superbills are available at the time of coding from the medical record. In this workflow, the HIM department has access to all automatically generated codes, as well as access to the OCE during the process of finalizing the coding of the claim. In the second, noncentralized workflow, it is not possible to make the codes from the chargemaster and superbills available at the time of coding from the medical record. Codes from the HIM department are merged together with codes from the chargemaster and superbills, and then the OCE is applied to the complete complement of codes. Because the edits and payment rules in the OCE are highly dependent on the combination of codes present, it is essential that the OCE be applied to the full complement of codes before claim submission. If any OCE edits that will cause the claim to be denied, rejected or returned to the hospital are present, the HIM and patient accounting departments should resolve them before claim submission

The Medicare OPPS represents the most significant change in the method of hospital payment since the inception of the inpatient PPS. Correct payment is primarily determined by the accuracy and completeness of the coding of the HCPCS codes and HCPCS modifiers on the claim.

The adjudication process for an outpatient claim includes extensive edits and payment rules, which can result in loss of revenue and cash flow delays if a claim is not coded appropriately. Hospitals will need to establish a workflow that ensures that the coding on claims is accurate and complete and meets all the OPPS edits and payment rules. As with the inpatient PPS, the HIM department plays a central role in meeting these objectives.


workflow centralized through HIM department
Chargemaster
Medical Record
Superbills
HCPCS Codes
HCPCS Codes Diagnosis Codes
HIM Department
Fully Coded Claim
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Billing Department
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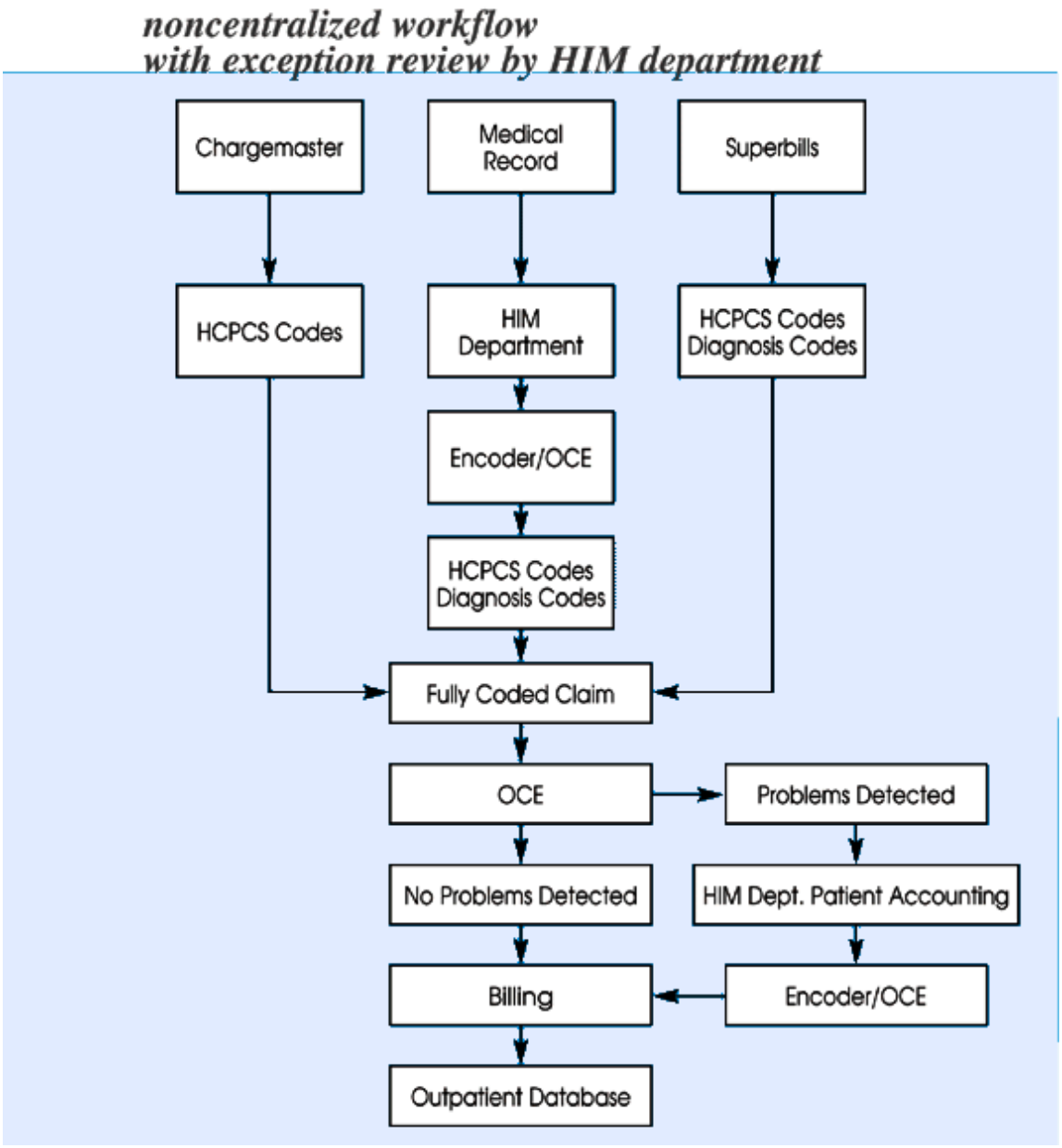

Notes

1. *Federal Register* 65, no 68. (April 7, 2000): 18438-18820.
2. Averill, R., N. Goldfield, M. Wynn, T. McGuire, R. Mullin, L. Gregg, and J. Bender. "Design and Evaluation of a Prospective Payment System for Ambulatory Care." *Health Care Financing Review* 15, no. 1, (1993): 71-100.
3. Vertrees, J., J. Pollatsek, K. Sheets, and M. Stark. "Developing an Outpatient Prospective Payment System Based on APGs for the Iowa Medicaid Program." *Journal of Ambulatory Care Management* 17, no. 4 (1994): 82-96.
4. *Federal Register* 63, no. 173 (September 8, 1998): 47552-48036.
5. Public Law 106-113.
6. *Outpatient Code Editor, Users Manual*. New Haven, CT: Health Systems International,1987.
7. Program Memorandum Intermediaries, Health Care Financing Administration, Transmittal No. A-00-21, April 2000.
8. "Outpatient Code Editor with Ambulatory Payment Classification Software." Software created by 3M Health Information Systems, Wallingford, CT, July 2000.
9. *Federal Register* 65, No. 68 (April 7, 2000): 18451.

Comparing the Systems

A number of changes took place in the development of the final APCs. Here we see the evolution of the system from APGs to final APCs.

	APGs	Prposed APCs	Finals APCs
Significant procedure, therapy, or service	135	134 Type T 46 Type S 180 Total	148 Type T 11 Type new technology 99 Type S 4 Type S new technology 262 Total
Medical visit	83 Diagnosis only	121 Diagnosis and E&M code	7 E&M code only
Drugs and biologicals	5 Chemotherapy only	4 Chemotherapy only	204 Pass through 46 Type S 180 Total Chemotherapy, orphan drugs, radiopharmaceuticals, new drugs, new biologicals
Devices	0	0	137 Pass through
Partial hospitalization Single	4 Full/half day substance abuse/ mental illness	1 Single per diem	1 Single per diem
Ancillary tests and procedures	53	40	39
Total	280	346	659

APC Status Indicators

Status Indicator	Service
A	Services that are paid under some other method, such as the physician fee schedule
C	Inpatient services that are not paid under OPPS
E	Services for which payment is not allowed under OPPS. In some instances, the service is not covered by Medicare. In other instances, Medicare does not use the code in question, but uses another code to describe the service

F Corneal tissue acquisition costs, which are paid separately

G A current drug or biological for which payment is made under the transitional pass-through

H A device for which payment is made under the transitional pass-through

J A new drug or biological for which payment is made under the transitional pass-through

N Services that are incidental, with payment packaged into an APC

P Services that are paid only in partial hospitalization programs

S Significant procedures, therapies, and services for which payment is allowed under OPPS but to which the multiple significant procedure discounting does not apply

T Surgical services for which payment is allowed under OPPS. Services with this payment indicator are the only services to which the multiple significant procedure discounting applies

V Medical visits for which payment is allowed under OPPS

X Ancillary services for which payment is allowed under OPPS

Data Elements Required for Edits

Data Elements	UB-92 Form locator	Location
From/through dates	6	Header
Age (birthdate)	14	Header
Sex	15	Header
Diagnoses	67-75	Header
Condition codes	24-30	Header
Type of bill	4	Header
HCPCS code	44	Line Item
Modifiers	44	Line Item
Line item service date	45	Line Item
Revenue center	42	Line Item
Service units	46	Line Item
Charge	47	Line Item

OCE Edits and Associated Actions

Edit	Description	Action
1	Invalid diagnosis code	RTP
2	Diagnosis and age conflict	RTP
3	Diagnosis and sex conflict	RTP
4	Not used	.
5	E-code as reason for visit	RTP
6	Invalid procedure code	RTP
7	Procedure and age conflict	RTP
8	Procedure and sex conflict	RTP
9	Noncovered service	Line item denial
10	Noncovered service submitted for verification of denial (condition code 21)	Claim denial
11	Noncovered service submitted for FI review(condition code 20)	Suspend
12	Questionable covered service	Suspend
13	Additional payment for service not provided by Medicare	Line item rejection
14	Code indicates a site of service not included in OPPS	RTP
15	Service unit out of range for procedure	RTP
16	Multiple bilateral procedures without modifier 50	RTP
17	Inappropriate specification of bilateral procedure	Line item rejection
18	Inpatient procedure	Claim denial
19	Mutually exclusive procedure that is not allowed even if appropriate modifier is present	Line item rejection
20	Component of a comprehensive procedure that is not allowed even if appropriate modifier is present	Line item rejection
21	Medical visit on same day as a type "T" or "S" procedure without modifier	Line item rejection
22	Invalid modifier	RTP
23	Invalid date	RTP
24	Date out of OCE range	Suspend
25	Invalid age	RTP
26	Invalid sex	RTP
27	Only incidental services reported	RTP
28	Code not recognized by Medicare; alternate code for same service available	RTP
29	Partial hospitalization service for non-mental health diagnosis	RTP
30	Insufficient services on day of partial hospitalization	RTP
31	Partial hospitalization on same day as ECT or type T procedure	Suspend
32	Partial hospitalization claim spans three or less days with insufficient services, or ECT or significant procedure on at least one of the days	Suspend
33	Partial hospitalization claim spans more than three days with insufficient number of days having mental health services	Suspend
34	Partial hospitalization claim spans more than three days with insufficient number of days meeting partial hospitalization criteria	Suspend

35	Only activity therapy and/or occupational therapy services provided	RTP
36	Extensive mental health services provided on day of ECT or significant procedure	Suspend
37	Terminated bilateral procedure or terminated procedure with units greater than one	RTP
38	Inconsistency between implanted device and implantation procedure	RTP
39	Mutually exclusive procedure that would be allowed if appropriate modifier were present	Line item rejection
40	Component of a comprehensive procedure that would be allowed if appropriate modifier were present	Line item rejection
41	Invalid revenue code	RTP
42	Multiple medical visits on same day with same revenue code without condition code G0	Line item rejection

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