OPPS & HSCRC Compatibility

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HFMA HSCRC Workshop

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Objectives

- Understand the differences between OPPS and HSCRC reimbursement methodology
- Understand what information provided for OPPS providers is and is not applicable to Maryland hospitals
- Understand how the CDM should be maintained to meet HSCRC Special Audit Procedures

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Outpatient Prospective Payment System (OPPS)

- Excludes Maryland hospitals
- Hospitals are paid a set amount of money to provide certain outpatient services to people with Medicare
- Payments are determined by APC (Ambulatory Payment Classification) at a federal level, and do not vary by resource
- Payments may be defined at a comprehensive level (i.e. paid at the primary procedure including ancillaries, supplies and drugs)
- Guidance is provided at least quarterly, with annual payment updates

Health Services Cost Review Commission (HSCRC)

- Includes Maryland hospitals
- Outpatient services are paid at a unit of measure defined by the HSCRC (e.g. minutes, days, RVU)
  - Refer to Section 700. Appendix D and/or Section 200. Chart of Accounts
- The rate of that unit of measure is determined at a local level on an annual basis (i.e. rate order)
- Rules for “bundling” are defined within the HSCRC Accounting Manual (e.g. supplies and drugs)
- The HSCRC Accounting Manual is not updated regularly to keep course with coding and charge capture rules

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Quick Comparison

Component	OPPS	HSCRC
Applicable Providers	PPS Hospitals	Maryland Hospitals
Payment Rate	Ambulatory Payment Classification (APC)	94% of Charges
Charging Methodology	Hospital Defined	Regulated – Unit of Measure
Coding	AMA/CMS	AMA/CMS
Coding Edits	I-OCE	I-OCE with Maryland flag "Y"
Bundling	Refers to payment at a comprehensive level	Refers to inclusion of routine items in standard unit of measure
References	Federal Register & Appendices, OPPS Quarterly Updates, Transmittals, Bulletins	HSCRC Accounting Manual

Epidural Steroid Injection

performed in Diagnostic Radiology (RAD)

Component	Code	Units	OPPS			HSCRC		
			APC	SI	Payment	RVU	Unit Rate	Payment (94%)
Procedure	CPT 62310	1	207	T	$669.91	24	$19.51	$440.15
Radiologic Guidance	CPT 77003	1		N	Inc			
Supplies	RC272	1		N	Inc			$45.00
Drugs	RC250	2		N	Inc			$3.00
Total Estimated Reimbursement					**$669.91**			**$488.15**

Outpatient Observation

Component	Code	Units	OPPS			HSCRC		
			APC	SI	Payment	RVU	Unit Rate	Payment (94%)
ED Visit	CPT 99284	1	615	Q3	$293.71	12	$31.18	$351.71
EKG	CPT 93005	1		N	Inc	12	$3.41	$38.46
Troponin	CPT 84484	1		N	Inc	25	$2.14	$50.29
CMP	CPT 80053	1		N	Inc	15	$2.14	$30.17
PT	CPT 85610	1		N	Inc	8	$2.14	$16.09
PTT	CPT 85730	1		N	Inc	8	$2.14	$16.09
CK	CPT 82550	1		N	Inc	6	$2.14	$12.07
CK-MB	CPT 82553	1		N	Inc	15	$2.14	$30.17
Chest X-Ray 2 View	CPT 71020	1	260	Q3	$57.35	3	$34.66	$97.74
Observation	HCPCS G0378	9		N	Inc	9	$68.59	$580.27
Supplies	RC272	3		N	Inc			$100.00
Drugs	RC250	2		N	Inc			$50.00
Total Estimated Reimbursement			8009		$1,199.00			$1,373.08

Single Chamber Pacemaker Insertion

performed in IRC

Component	Code	Units	OPPS			HSCRC		
			APC	SI	Payment	RVU	Unit Rate	Payment (94%)
Procedure	CPT 33206	1	89	T	$8,790.30	90	$61.78	$5,226.59
Implants	HCPCS C1786	1		N	Inc			$4,600.00
	HCPCS C1779	1		N	Inc			$1,200.00
Supplies	RC272	1		N	Inc			$150.00
Drugs	RC250	1		N	Inc			$15.00
Chest X-Ray 1 View	CPT 71010	1	260	Q3	$57.35	2	$34.66	$65.16
Recovery >6 hrs		1		N	Inc	1	$491.51	$462.02
Total Estimated Reimbursement					**$8,847.65**			**$11,718.77**

True or False?

Medicare OPPS rules for bundling apply to Maryland hospitals.

FALSE.

OPPS bundling is specific to determining the APC payment rate. Items, procedures and services are indicated as bundled by status indicator “N” and/or status indicators for composite rate APCs (e.g. Q3).

True or False?

Some Medicare OPPS APC status indicators apply to Maryland hospitals.

TRUE.

OPPS APC status indicators are utilized for Maryland hospital claims processing to identify excluded (“E”) and inpatient only procedures (“C”).

APC status indicators are provided annually in the Federal Register as Addendum B.

True or False?

Services and procedures with an OPPS APC status indicator of “N” indicates that the service or procedure should not be captured, coded or charged.

FALSE.

OPPS bundling is specific to determining the APC payment rate. This is not the same as coding bundling.

True or False?

Maryland hospitals are excluded from National Correct Coding Initiative Edits (NCCI).

FALSE.

Maryland hospitals are held to industry coding guidelines for mutually exclusive codes and unbundling of procedures.

Within the NCCI Edits, the Outpatient Code Editor (OCE) edits also reside. OCE edits are flagged for applicability to Maryland (Non-OPPS) hospitals.

Example NCCI Edit – *Breast Biopsy*

Reporting of components included in comprehensive procedure code or reporting of deleted codes.

Component	CPT/ HCPCS	Description	Comment
Procedure	19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), **when performed**, and imaging of the biopsy specimen, **when performed**, percutaneous; first lesion, including stereotactic guidance	Comprehensive Procedure
Imaging	~~77031~~	~~Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation~~	Deleted Code. Included in comprehesive procedure.
Clip Placement	~~19295~~	~~Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)~~	Deleted Code. Included in comprehesive procedure.
Specimen X-Ray	76098	Radiological examination, surgical specimen	Do not report separately (unbundling)

Maryland Applicable OCE Edits - *Highlights*

Edit #	Description	Non OPPS Hosp.	Disposition
12	Questionable covered service	Y	Suspend
17	Inappropriate specification of bilateral procedure (see Appendix A)	Y	RTP
22	Invalid modifier	Y	RTP
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	Y	Line item reject
50	Non-covered under any Medicare outpatient benefit, based on statutory exclusion	Y	RTP
53	Codes G0378 and G0379 only allowed with bill type 13x or 85x	Y*	Line item reject
54	Multiple codes for the same service	Y	RTP
68	Service provided prior to date of National Coverage Determination (NCD) approval	Y	Line item denial
72	Service not billable to the Fiscal Intermediary/Medicare Administrative Contractor	Y	RTP
83	Service provided on or after effective date of NCD non-coverage	Y	Line item denial
96	Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion.	Y	Line item denial

Maryland Applicable OCE Edits

Appendix F(b) – OCE Edits Applied by Non-OPPS Hospital Bill Type [OPPS flag = 2]

Row #	Provider/Bill Types	Edits Applied (by edit number)	APC buffer
1	12X or 14X with condition code 41, and OPPS flag = 2	46	Buffer not completed
2	12X or 14X without condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 53, 54, 61, 65, 67-69, 72, 83.	Buffer not completed
3	13X with condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 54, 61, 65, 67-69, 72, 83.	Buffer not completed
4	13X without condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 54, 61, 65, 67-69, 72, 83.	Buffer not completed
5	85X, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 22, 23, 25, 26, 28, 41, 50, 54, 61, 65, 67-69, 72, 74, 83.	Buffer not completed
6	83X, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 53, 54, 61, 65, 67-69, 72, 83.	Buffer completed

FLOW CHART ROWS ARE IN HIERARCHICAL ORDER.

Notes:

1) Edit 10, and edits 23 and 24 for **From/Through** dates, are not dependent on Appendix F.
2) If edit 23 is not applied, the lowest service (or **From**) date is substituted for invalid dates and processing continues.
3) Edit 22 is bypassed if revenue code is 540
4) Bypass edit 72 if bill type is 85X and HCPCS with SI = M is submitted with revenue code 096x, 097x or 098x.
5) 83X bill type is invalid for IOCE effective for dates of service on or after 1/1/08 (IOCE v9.0).

https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/IntegOCEspecsV150_508.pdf

True or False?

Guidance provided on updates to the OPPS does not apply to Maryland hospitals.

FALSE.

Guidance provided may include the addition or clarification of Medicare coverage, documentation and coding requirements.

Not all guidance is specific to payment rates and reimbursement methodology.

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CY2014 Update to the OPPS

Highlight	Applicable to Maryland Hospitals?
Single HCPCS (G0463) for Clinic Visits	**YES.** The Single HCPCS is to be reported for claims processing. Maryland hospitals continue to report RVUs based on Clinical Care Time. While a single HCPCS will be reported for Medicare, charge amounts are expected
Reporting of HCPCS (C-Code) for application of skin substitutes, distinguishing the application of low and high cost skin substitutes	**NO**. The HCPCS (C-Codes) were developed as a means to determine a final APC payment amount. Claims will edit under OCE Edit 87. The OCE Edit is not flagged as applicable to Non-OPPS Hospitals.
Discontinued Device to Procedure, and Radiopharmceutical to Procedure Edits for Claims Processing	**NO.** The edits did not apply to Maryland hospitals when active. However, the use of the edits within most claim scrubbers is a valuable charge capture audit tool.
Certain outpatient laboratory testing (excluding molecular pathology) will be bundled into the primary service or procedure, when not reported as a laboratory only claim (Bill type 14X)	**NO.** This is an OPPS APC bundling rule. Maryland hospitals should continue to report and be reimbursed separately for laboratory testing performed, whether a laboratory only claim or not.
Certain supplies, drugs and radiopharmaceuticals will be bundled (packaged) into the payment of the service or procedure performed.	**NO**. Maryland hospitals should continue to separately report and be reimbursed for supplies and drugs where the HSCRC indicates these items are not included in the standard unit of measure.

Reporting of Outpatient Services

- Begins with the Charge Description Master (CDM)
- The “menu” of available items, services and procedures within the hospital
- Common fields define the department of use, description, the unit of measure, coding and gross charge

CDM	CDM Description	UB REV CODE	CPT/ HCPCS	RVU	RATE CENTER	UOS	GROSS CHARGE
1234567891	EMG 1 EXTR W/NERVE COND	922	95885	20	EEG	1	$103.00

HSCRC Expectations of the CDM

- Standard Unit of Measure
  - Appendix D/Chart of Accounts
  - By Report methodology
- Accuracy in Coding
  - Current to calendar year
- Regular Review and Maintenance
  - Special Audit Procedures

Special Audit Procedures

- Memo to CFOs, May 2012
- Specific to expectations of charge master reviews
- Prompted by a Legislative audit indicating inaccuracies in RVU assignment
- Inaccuracies in RVUs directly affects data for analysis
- Hospitals were directed to establish procedures to review the CDM, at least annually
- Attestations from the CFO are required under Special Audit Procedures to confirm there are processes in place
- CDMs are subject to audit

Common CDM Pitfalls in Maryland

- Inaccuracies in CPT/HCPCS code assignment
- Mis-mappings to appropriate HSCRC rate center
- Hard-coding of modifiers -59 and -91
- Unbundling of supplies in HSCRC rate centers where supplies are included in the standard unit of measure
- Inaccuracies in RVU assignment
  - Most commonly due to By Report
    - Example on following slide
- Assuming a clean CDM = clean charge capture

Example of Inaccuracy in RVU Assignment

CDM	CDM Description	CPT/ HCPCS	RVU	RATE CENTER
1234567891	EMG 1 EXTR W/NERVE COND	95885	24	EEG

From Appendix D:

NEUROMUSCULAR (Con'd)

		Unit Value
95829	Electro-corticogram at surgery (independent procedure)	BR+
95831	Muscle testing, manual, extremity (excluding hand) or trunk, with report, by physician (independent procedure)	6.4
95832	hand (with or without comparison with normal side)	8.0
95833	total evaluation of body excluding hands)	26.0
95834	including hands	30.0
95842	Electro testing reaction of degeneration; chronaxy; galvanic/tetanus ratio; one or more extremities, one or more methods; per hour	20.0
95845	Strength duration curve, per nerve	9.8
95851	Range of motion measurements and report, each extremity (excluding hand)(independent procedure)	8.0
95852	hand (with or without comparison with normal side)	8.0
98587	Tensilon test for myasthenia gravis	10.0
95858	with electromyographic recording	RNE
95860	Electromyography, one extremity and related paraspinal areas	20.0
95861	two extremities and related paraspinal areas	36.0
95863	three extremities and related paraspinal areas	44.0
95864	four extremities and related paraspinal areas	52.0
95867	cranial nerve supplied muscles, unilateral bilateral	RNE
	limited study of specific muscles, e.g., external anal sphincter, thoratic spinal muscles, etc.	BR+

Recommendations for CDM Maintenance

- Document Policies and Procedures
  - New Items and Services
  - Revisions
  - Review for Coding Updates
    - Quarterly
    - Annually
  - Determination of RVUs (By Report)
- Outline Roles and Responsibilities
- Utilize Up to Date Resources and Materials
- Independent Review
  - every 3 years

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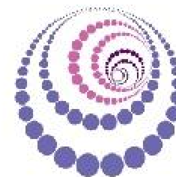
Presentation Complete



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