

OUTPATIENT **P**ROSPECTIVE

PAYMENT **S**YSTEM

2003 UPDATE

FACILITATOR GUIDE

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**OUTPATIENT PROSPECTIVE PAYMENT
SYSTEM
2003 UPDATE**

LESSON PLAN

LESSON PLAN FOR 2003 UPDATE TO THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

PURPOSE:

This class will assist providers and Medicare fiscal intermediaries (FI) with the information needed to successfully implement the 2003 changes made to the Outpatient Prospective Payment System (OPPS).

EXPECTED LENGTH OF TIME:

2 hours

MATERIALS AND EQUIPMENT:

- ❑ Facilitator Guide for the 2003 Update to the Outpatient Prospective Payment System
- ❑ Computer*
- ❑ Projector*
- ❑ Projection screen (preferable, but not required)
- ❑ PowerPoint presentation
- ❑ Pre-test
- ❑ Observation Flowchart (One per participant)
- ❑ How to Use the OPPS Calculator handout (One per participant)
- ❑ Post-test

* See Miscellaneous Notes/Helpful Hints

OBJECTIVES:

- After completion of this class, providers will have the 2003 updated OPPS knowledge required in order to file claims more accurately.

SUGGESTED APPROACH:

- Step 1:** Set up computer and projector, including projection of PowerPoint slides onto screen or wall.
- Step 2:** Administer pre-test.
- Step 3:** Distribute the Observation Flowchart and Instructions on using the OPPS Calculator.
- Step 4:** Use the PowerPoint to instruct providers on updates to OPPS. Talking points are provided to ensure consistency with each of your training sessions.
- Answer questions as they arise.
 - Refer to the Observation Flowchart handout when observation services are discussed.
 - Explain how to use the OPPS calculator. (Refer to the handout on the OPPS calculator).

Step 5: Administer Post-test.

MISCELLANEOUS NOTES/HELPFUL HINTS:

- A light colored wall may be used as an alternative to a projection screen.
- An overhead and transparencies of the PowerPoint may be used in lieu of a computer and projector.
- Talking points are not intended for distribution to providers, rather they are an educational tool for FIs to use to guide their training sessions.

**OUTPATIENT PROSPECTIVE PAYMENT
SYSTEM
2003 UPDATE**

**POWERPOINT PRESENTATION
WITH TALKING POINTS**

Insert PowerPoint presentation with talking points here.

**OUTPATIENT PROSPECTIVE PAYMENT
SYSTEM
2003 UPDATE**

POWERPOINT NOTES PAGES

Slide 1- Title Screen

Since the inception of OPPS in 2000, the Centers for Medicare and Medicaid Services has continued to make updates and improvements to this payment methodology. 2003 is no exception. The November 1, 2002, Final Rule made several changes to OPPS that may have an impact on providers. During today's workshop, we will address the 2003 OPPS Updates. During today's workshop, we will address how the following agenda topics are affected . . .

SLIDE 2- AGENDA

Our agenda today is divided into five segments, covering the major 2003 OPPS changes:

- First, Inpatient-Only Procedures
- Second, Observation
- Third, Pass-Through Payments
- Fourth, Miscellaneous Issues
- and finally, Other Payment Issues

SLIDE 3- INPATIENT-ONLY PROCEDURES

SLIDE 4- INPATIENT-ONLY PROCEDURES CRITERIA

Anyone interested in having a particular code or group of codes on the inpatient list reviewed for payment under OPPS can submit a request to CMS. The request should include supporting information and data to demonstrate that the code meets these five criteria:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes already removed from the inpatient list.
- The procedure is being performed in numerous hospitals on an outpatient basis, and
- The procedure can be appropriately and safely performed in an Ambulatory Surgery Center and is on the list of approved ASC procedures or proposed by CMS for addition to the ASC list.

In addition to these requirements, CMS requests that submitted evidence include operative reports of actual cases and peer-reviewed medical literature, to demonstrate that the procedure is being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals.

Additionally, you might include community medical standards and practice as well as physician comments, outcome data, and post-procedure care data to reinforce the point. To ensure beneficiary confidentiality, providers should be sure that no beneficiary identifying information is submitted with their documentation.

SLIDE 5- INPATIENT-ONLY PROCEDURES

Addendum E of the November 1, 2002, Federal Register, pages 67012-67038 contains an updated Inpatient-Only procedure list.

Inpatient-only procedures are identified by a C status indicator.

SLIDE 6- INPATIENT-ONLY PROCEDURES

To receive Medicare payment in situations where an “inpatient-only” procedure is performed on an outpatient on an emergency basis, the hospital may do one of the following:

- Admit the patient, and submit an inpatient claim for payment under the inpatient PPS.
- Admit the patient, then transfer to an appropriate facility, and submit a claim for a per diem DRG rate.

SLIDE 7- DEATH OF A BENEFICIARY

CMS created new rules for billing when a patient has an inpatient-only procedure performed before he has been formally admitted as an inpatient and then dies while in surgery.

Hospitals should use the CA modifier, which was effective January 1, 2003, to bill inpatient-only procedures, identified with a C status indicator, that are performed on an outpatient who dies. The following four conditions must apply in order to use it:

- First, the patient’s status is outpatient.
- Second, the patient has an emergent, life-threatening condition.
- Third, a procedure on the inpatient-only list is performed to resuscitate or stabilize the patient.

- Fourth, the patient dies without being admitted as an inpatient.

If these conditions are met, payment for a service on a claim that has the same date of service as the inpatient-only HCPCS code and the CA modifier is made under APC 977. Separate payment is not allowed for other services furnished on the same date. Payment is not allowed for the inpatient procedure.

SLIDE 8- DEATH OF A BENEFICIARY

Many hospitals have questions about how to bill when a beneficiary dies when his/her status is outpatient.

If a patient dies in the emergency department and the patient's status is outpatient, the hospital should bill for payment under OPPS for the services that were furnished. If the emergency department or other physician orders the patient to the operating room for a surgical procedure and the patient dies in surgery, payment will be based on the status of the patient:

- If the patient was admitted as an inpatient, the hospital should submit a claim for payment under the hospital inpatient PPS (a DRG-based payment).
- If the patient was not admitted as an inpatient and no inpatient-only procedure was performed, the hospital should bill for payment under OPPS for the furnished services.
- If the patient was not admitted as an inpatient and an inpatient-only procedure was performed, the hospital should bill for payment under OPPS for the services that were furnished on that date using a CA modifier on the claim with the inpatient-only procedure code.

SLIDE 9- CLAIM EXAMPLE USING CA MODIFIER

Let's review a claim example with the CA modifier—

In this example, the hospital submitted a claim to its Intermediary using a 131 type of bill because the services were provided to an outpatient. The status in field locator 22 is 20 because the patient expired. The inpatient-only procedure code with the CA modifier is reported in field locator 44 of the UB-92.

Remember Medicare does not make payment for procedures on the inpatient list when they are performed on a hospital outpatient. A lump sum payment of \$1,125 is made for any other services furnished in addition to and on the same date of service as the procedure with the CA modifier.

SLIDE 10- INPATIENT-ONLY RECAP

CMS removed certain surgical procedures from the inpatient-only list. The codes are listed in the November 1, 2002, Final Rule.

If you want to request the removal of any remaining inpatient-only codes, you will find the address and documentation requirements in the November 1, 2002, Final Rule.

When a patient is ordered to the operating room for a surgical procedure and the patient dies during surgery, the payment is based on the status of the patient. When an inpatient-only procedure is performed as an emergency on an outpatient that dies, the hospital may use a CA modifier to receive payment for services related to the inpatient-only procedure under APC 977 if all requirements are met for its use.

SLIDE 11- OBSERVATION**SLIDE 12- OBSERVATION SERVICES**

In general, payment for observation is packaged. Effective April 1, 2002, new provisions were made that allow separate payment for outpatient observation under certain conditions.

Separate payment is provided for observation when a patient has one of three conditions: either chest pain, asthma, or congestive heart failure. Hospitals should use HCPCS code G0244. Payment is made under APC 0339.

The provision also requires an evaluation and management (E/M) on the day before or the day of the observation admission.

SLIDE 13- OBSERVATION SERVICES

There are diagnostic testing requirements that must be met in order to separately bill for outpatient observation services:

- For a diagnosis of chest pain the hospital must perform at least two sets of cardiac enzymes (either two CPK or two troponin) and two sequential electrocardiograms.
- For a diagnosis of asthma, a breathing capacity test or a pulse oximetry must be performed. The pulse oximetry codes are treated as packaged services under OPSS but must be reported if G0244 is billed.

- For a diagnosis of congestive heart failure, a chest x-ray, an electrocardiogram, and a pulse oximetry must all be performed as a part of the observation.

Although no separate payment is made for packaged codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry. This helps to establish whether the observation services for congestive heart failure or asthma diagnoses meet the criteria for separate payment.

SLIDE 14- OBSERVATION SERVICES

Not only are the appropriate diagnostic tests required; but, the patient must spend a minimum of 8 hours and a maximum of 48 hours in outpatient observation.

SLIDE 15- MULTIPLE OBSERVATION SERVICES

Hospitals may bill more than one period of observation on a single claim.

Each observation period must be paired with a separate E/M visit, and modifier-25 must be used with the E/M visit for payment using G0244.

It's important to remember that if multiple observations are provided, the criteria for each observation must be met to receive payment for each. If there are multiple observation periods for the same diagnosis, each of the required diagnostic tests must be performed multiple times, as required for the diagnosis.

SLIDE 16- DIRECT ADMISSION HCPCS CODES

Two new HCPCS codes have been created to bill for direct admissions to observation-- G0263 and G0264.

A direct admission is defined as an admission that occurs when a physician in the community refers a patient to the hospital for observation bypassing the clinic or emergency department.

Both of these new codes should be reported with revenue code 0762.

G0263 is used with code G0244 when a patient is admitted directly to observation and meets the requirements for separately payable observation. G0263 should be billed with modifier 25 for the initial nursing assessment. This code replaces the E/M required for G0244 and has an N status indicator because payment is packaged into G0244.

The second code G0264 is used to bill for patients who are directly admitted to observation but do not meet the requirements for separately payable observation. Therefore, hospitals should report G0264 but not G0244 on the claim. G0264 is assigned to APC 600 and is paid the same amount as a low-level clinic visit.

SLIDE 17- OBSERVATION SERVICES G0263

Let's look at a claim example for a direct admission to observation when the requirements for separately payable observation stay are met:

In this example, the patient's diagnosis is 786.50, unspecified chest pain. This diagnosis meets the requirements for a separately payable observation stay.

In field locator 44, the hospital reported G0263 with modifier 25, because the patient was directly admitted to observation. (*Remember, G0263 replaces the E/M service required for separately payable observation*).

The hospital also reported G0244 in field locator 44 because this claim meets the requirements for a separately payable observation stay. CPT codes 82550 and 930051 indicate that the patient had the required diagnostic tests performed for a patient with chest pain.

In field locator 46, 22 units are reported indicating the patient was in observation for 22 hours.

SLIDE 18- OBSERVATION SERVICES G0264

Now, let's look at a claim example for a direct admission that does not meet the requirements for a separately payable observation stay:

In this example, the patient's diagnosis is 4800, pneumonia. In field locator 46, 18 units are reported indicating the patient was in observation for 18 hours.

The hospital reported G0264 in field locator 44 because the patient was directly admitted to observation from the physician's office. However, G0244 is not coded on the claim in field locator 44 because the requirements for a separately payable observation stay were not met. (*The patient did not have one of the required diagnoses, nor were the required diagnostic tests completed*).

Therefore, payment for this service will be made under APC 0600.

SLIDE 19- OBSERVATION FLOWCHART

The following flowcharts will walk through three common scenarios providers frequently encounter when billing for observation services.

The flowcharts will demonstrate the observation criteria and assist in determining the correct billing in each situation.

SLIDE 20- QUESTIONS TO DETERMINE OPERATIONS BILLING- SCENARIO 1

In this first scenario, the patient has one of the required diagnoses for: CHF, asthma, or chest pain, and a direct admission to observation was made.

The first question to ask is: Were the required diagnostic tests performed? If not, payment for observation is packaged and should be billed using HCPCS G0264.

If the diagnostic tests were performed, the second question to ask is: Was the patient in observation between 8 and 48 hours?

If not, payment for observation is packaged and HCPCS G0264 should be billed.

If the patient was in observation between 8 and 48 hours, the required diagnostic tests were performed, and the patient was directly admitted to observation, the hospital should bill HCPCS GO244 and GO263 with modifier-25.

SLIDE 21- QUESTIONS TO DETERMINE OPERATIONS BILLING- SCENARIO 2

In this second scenario, the patient has one of the required diagnoses for: CHF, asthma or chest pain, and the patient was not directly admitted for observation.

The first question to ask: Were the required diagnostic tests performed?

If not, observation is packaged.

If the required diagnostic tests were performed, the next question to ask: Was the patient in observation between 8 and 48 hours?

If not, observation is packaged.

If the patient was in observation the required length of time, the next question: Was the required E/M service provided?

If not, observation is packaged.

If an E/M service was provided, the patient was in observation the required length of time, and the required tests were performed, the hospital should bill HCPCS G0244 and the appropriate HCPCS with modifier-25.

SLIDE 22- QUESTIONS TO DETERMINE OPERATIONS BILLING- SCENARIO 3

In this last example, the patient has a diagnosis other than CHF, asthma, or chest pain.

If a patient has a diagnosis other than congestive heart failure, asthma, or chest pain, and is not a direct admission, the observation is packaged.

If a patient has a diagnosis other than congestive heart failure, asthma, or chest pain, and is a direct admission: the observation is packaged, and HCPCS G0264 should be billed.

SLIDE 23- INTRAVENOUS INFUSION THERAPY

HCPCS code G0258 for infusion therapy was deleted from OPPS effective January 1, 2003. There is a 90-day grace period for this code. If G0258 is used after March 31, 2003, OCE will return claims to the provider for correction.

Providers should use Q0081 for infusion therapy started in the emergency department, clinic, or observation area if the infusion continues during the observation stay.

In the past, Medicare payment rules denied payment for G0244 if a service with a T status indicator was performed the day before, the day of, or the day after observation care. This caused observation claims reported with HCPCS codes G0244 and Q0081 to be denied. (*Q0081 has a T status indicator*). The OCE logic has been modified to allow payment for G0244 when Q0081 is reported on the claim because patients in observation may require intravenous infusions of fluid.

Effective for services furnished on or after April 1, 2002, OCE will allow payment for HCPCS code G0244 when billed with Q0081.

Hospitals who did not receive payment for observation services because they billed for them along with Q0081 may resubmit claims that were denied for services furnished on or after April 1, 2002.

SLIDE 24- OBSERVATION SERVICES RECAP

Separately payable observation is billed in hourly increments for a minimum of 8 hours, up to a maximum of 48 hours. The number of hours in observation should

be listed as the number of units in field locator 46 of the corresponding line on the UB-92.

For observation to be covered by Medicare, the patient must be under the care of a physician, and the medical record must include documentation identifying how the patient would benefit from observation care along with an acceptable diagnosis.

A diagnosis of chest pain, asthma, or congestive heart failure must be listed on the claim as the primary or secondary diagnosis. A list of acceptable diagnoses may be found in Program Memorandum CR 2503, Section V.

Documentation in the medical record must include the admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

SLIDE 25- PASS-THROUGH

SLIDE 26- EXPIRED PASS-THROUGH DEVICES

Effective January 1, 2003, many items that were initially identified as pass-through items under OPPS will no longer receive this type of payment. CMS now has adequate information to place these items in an APC group. For a list of the expired items please refer to CR 2503.

The expired device categories should now be reported using the appropriate revenue code. Remember, a HCPCS code is not required because these items are now packaged under OPPS. Although a device may no longer be eligible for pass-through payment and may no longer have a reportable HCPCS code, it is essential that hospitals continue to include a charge on the claim for any device they furnish to a patient.

There will not be a 90-day grace period for expiring device codes. If the expired code is reported for services rendered after December 31, 2002, the OCE will return the claim to the provider for correction. Hospitals should resubmit the charge for the device either without a HCPCS code, or with a current HCPCS code.

SLIDE 27- NEW PASS-THROUGH DEVICE CODES

There are a total of nine pass-through device categories in effect for 2003, including four new pass-through items have been added– C1884, C2614, C2632, and C1814.

SLIDE 28- REMAINING PASS-THROUGH DEVICE CATEGORIES

New pass-through device categories may be added or removed quarterly; therefore, FIs are encouraged to monitor CMS Program Memoranda for updates to the categories. C 1814 was ended effective April 1, 2003, via a future Program Memorandum.

If a device is described by one of the existing device categories but is packaged as a component of a system, only the device that meets the pass-through criteria would be eligible for pass-through payment under the appropriate category.

SLIDE 29- EXPIRED PASS-THROUGH DRUGS

Unlike expiring pass-through device categories, when pass-through drugs expire, they have a 90-day grace period in which they may continue to be reported. The last day of the grace period is March 31, 2003.

A comprehensive list of pass-through drugs as well as expiring pass-through drugs can be found in Program Memorandum CR 2503.

SLIDE 30- EXPIRED DRUG CHART EXAMPLE

The codes listed in the left column titled—Old HCPCS—were retired December 31, 2002; however, because of the 90-day grace period that hospitals have for reporting the new 2003 HCPCS, these codes remain in effect for hospital outpatient billing for drugs furnished through March 31, 2003.

Beginning April 1, the expired codes are no longer reportable on OPPS claims because the codes will be replaced with new codes indicated in the right column titled – New HCPCS Code--. They will be reportable under OPPS.

There are some codes with an asterisk in the APC field. This means the drug is packaged.

SLIDE 31- DRUG ISSUES

Certain drugs are such an important component of a procedure or treatment that they are considered packaged supplies under the APC for the particular procedure or treatment.

Hospitals may not separately bill beneficiaries for packaged items, except for the co-payment that applies to the APC. Drugs treated as supplies should be reported under the appropriate revenue code.

Some drugs are not directly related to a procedure or treatment, and are not considered packaged supplies. For example, a drug would not be considered a supply if it is given to a patient for his/her continued use at home after leaving the hospital or in situations where a patient has surgery and needs daily insulin or anti-hypertensive medication.

Once a drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, hospitals are encouraged to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded along with the amount administered. In the event that a drug is ordered and reconstituted by the hospital's pharmacy, but never actually administered to the patient, payment may not be made under OPSS.

Drugs with status indicator of K require detailed coding. The appropriate HCPCS code along with revenue code 0636 should be reported. When drugs with status indicator N are used, they are packaged and do not require a HCPCS, but the appropriate revenue code must be reported.

Hospitals should report charges for packaged drugs with the procedure or service being provided. The costs of the packaged drugs are used to calculate the hospital's outlier and transitional corridor payments, and they are used in the annual update of APC payment rates.

SLIDE 32- HEPATITIS, INFLUENZA, AND PNEUMOCOCCAL VACCINES

Effective for claims with dates of service on or after January 1, 2003, payment for the influenza and pneumococcal vaccines will be based on provider type.

Hospitals and home health agencies will be paid on reasonable cost.

Comprehensive Outpatient Rehabilitation Facilities (CORFs) will be paid based on the lower of the charges or 95 percent of the average wholesale price for the vaccine and the Medicare Physician Fee Schedule for the administration of the vaccine.

System changes for these new requirements will not be installed by the standard system maintainers until July 2003. If claims are received before the release, they will be suspended until the updates are made. If other services were furnished in addition to the vaccines, affected providers may choose to submit their claims without the charges for the vaccines and then adjust their claims at a later date to add the charges once the updates have been released.

Interest will be paid on held claims and condition code 15 will be added by the FI to indicate that the claims were clean claims impacted by a CMS processing delay.

SLIDE 33- PASS-THROUGH RECAP

SLIDE 34- MISCELLANEOUS ISSUES

SLIDE 35- PARTIAL HOSPITALIZATION PROGRAM (PHP)

Addendum B of the November 1, 2002 Final Rule lists codes that may be used to bill for PHP services. However, the Final Rule does not identify all covered HCPCS codes that may be billed for PHP patients. This list is expected to be revised in the 2004 update.

PHP claims should be submitted with condition code 41 to indicate PHP services are being provided.

For calendar year 2003, CMS decided hospitals and Community Mental Health Centers should not bill the carrier for the professional services furnished by Clinical Social Workers. Instead, they should continue to bill their Intermediary.

Payment for CSW services is included in the PHP's per diem amount.

SLIDE 36- PHP CLAIM EXAMPLE

Let's look at a claim example for a PHP:

In this example, the hospital filed a claim to its intermediary using bill type 133 because it is for an outpatient who is receiving continuous care. Condition code 41 is required in field locator 24 when billing for PHP services. Occurrence code 44 is reported in field locator 32 to indicate the date that occupational therapy (OT) began. Occurrence code 17 is reported, indicating the date the outpatient OT plan was established or last reviewed. Occurrence code 11 indicates the date of the onset of symptoms or illness. Value code 51 reported in field locator 39 indicates the number of cumulative OT services.

SLIDE 37- WOUND CARE PROCEDURES

CPT Code 97601 is a physical therapy service for wound care and is not paid under OPSS. Instead, this service is paid based on the Medicare Physician Fee Schedule.

CPT Code 97602 is a wound care service that is packaged under OPPS.

Effective January 1, 2003:

- When code 97602 is the only service provided it may be billed with outpatient visit code 99211, and payment will be packaged into the payment for code 99211.

- When code 97601 or code 97602 and a clinic or emergency department visit is billed on the same day, the clinic or emergency visit must be separately identifiable for payment to be made.

Code 97601 is not paid under OPPS.

Code 97602 is a packaged OPPS service.

When code 97602 is the only service provided, bill with code 99211.

The visit must be separately identifiable when code 97601 or code 97602 is billed on the same day.

SLIDE 38- EAR WAX REMOVAL HCPCS CODE

Hospitals performing ear wax removal for a beneficiary on the same day as audiologic function testing (CPT codes 92553 through 92598, except for non-covered codes 92559 and 92560) should use G0268 to report ear wax removal.

Reporting G0268 indicates that a physician removed the ear wax at a separate encounter from the audiologic function testing. If 69210 is reported on the claim, a CCI edit will deny payment for G0268.

SLIDE 39- PROSTATE BRACHYTHERAPY HCPCS CODES

Two new codes have been created to report prostate brachytherapy.

These codes include payment for transperitoneal placement of needles and/or catheters into the prostate, cystourethroscopy, radioelement application, and implanted brachytherapy sources. Therefore, hospitals should not report CPT codes 55859 and 77776-77778 in addition to either of the G codes. Hospitals should not separately report any HCPCS for brachytherapy sources in addition to one of the G codes.

Hospitals should report only one G code for this service. As with other procedure codes, post-operative recovery, and/or observation are packaged into payment for the procedure. Other services provided during the performance of prostate

brachytherapy (e.g. intraoperative ultrasound, laboratory testing, diagnostic services) are separately payable and should be separately reported.

Hospitals should not use codes G0256 and G0261 to report prostate brachytherapy that does not utilize implantable sources (e. g. remote afterloading high-intensity brachytherapy). Remote afterloading high-intensity brachytherapy should be reported with the use of the appropriate CPT codes.

SLIDE 40- SACROILIAC JOINT INJECTION HCPCS CODES

CPT code 27096, Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid, describes two distinct procedures: one used with diagnostic procedures and the other therapeutic. To make reporting and payment for both procedures described by CPT code 27096 more efficient, two new codes (G0259 or G0260) were created.

Hospitals should bill using G0259 if providing diagnostic injections. If a therapeutic injection is performed, hospitals should bill using G0260.

Payment for G0259 is packaged because it is used to report diagnostic injections; the status indicator is N.

G0260 is separately payable because it is used to report therapeutic injections; the status indicator is T.

SLIDE 41- ARTHROSCOPIC PROCEDURES OF THE KNEE

This is an add-on code and should be added to the knee arthroscopy code for the major procedure being performed. Report this code only once per extra compartment, even if both chondroplasty, loose body removal, and foreign body removal are performed. The code may be reported twice (or with a unit of two) if the physician performs these procedures in two compartments in addition to the compartment where the main procedure was performed.

This code should only be reported when the physician spends at least 15 minutes in the additional compartment performing the procedure. It should not be reported if the reason for performing the procedure is due to a problem caused by the arthroscopic procedure itself. This code is to be used when a procedure is performed in the lateral, medial, or patellar compartments in addition to the main procedure. The new code, G0289, is a packaged service under OPSS.

SLIDE 42- DRUG-ELUTING STENT HCPCS CODES

Two temporary HCPCS codes were created for drug-eluting coronary stents. The codes will be effective April 1, 2003, for services furnished on or after April 1, pending FDA approval.

- G0290 and G0291 will be effective based on the approval date.
- Payment will be made based on APC 0104 until further notice.

If FDA approval is not granted by April 1, 2003:

- A new effective date will be announced by Program Memoranda.

SLIDE 43- RADIOPHARMACEUTICAL BIODISTRIBUTION CODES

Zevalin was removed as a pass-through drug because it is neither a drug nor a biological. Two codes were created to report the use of Zevalin:

- G0273 should be used to report the diagnostic administration of Zevalin. It is paid under APC 718 and includes all scans.
- G0274 should be used for therapeutic administration of Zevalin. It is paid under APC 725.

The purpose of the scanning is to ensure that the biodistribution of Zevalin is normal, thus decreasing the risk of toxic effects from administration of a therapeutic dose of Zevalin. The published criteria for determining appropriate biodistribution involve making a qualitative comparison of isotope uptake in several organ systems between the two scans. Therefore, these scans cannot be read in isolation, and the code should only be reported once no matter how many scans are performed.

The infusion of Rituxumab prior to the administration of Zevalin is separately payable.

SLIDE 44- CLINICAL TRIALS

Three new G codes were created for clinical trials under OPPS: G0292, G0293, and G0294.

These new G codes were created for hospitals to report clinical trial services furnished in hospital outpatient departments.

G0292 should be billed when experimental drugs are administered as part of a

Medicare-qualifying clinical trial. This code provides payment for the covered services associated with the administration of drugs as part of a clinical trial. Its APC is 0708.

G codes G0293 & G0294 should be used to bill for procedures performed as part of a qualifying clinical trial.

The APC for G0293 is 0710, and the APC for G0294 is 0707.

The status indicator for all three codes is S. This means they are significant procedures and are not discounted when multiple procedures are performed. All three of these clinical trial HCPCS codes are for OPPS use only.

SLIDE 45- IMMUNOSUPPRESSIVE DRUGS

Effective January 1, 2003 Intermediaries may no longer pay hospitals for immunosuppressive drugs furnished to beneficiaries for use in the home.

Immunosuppressives are paid under OPPS when furnished in the hospital to a registered hospital outpatient.

To receive payment for immunosuppressive drugs that the hospital furnishes to beneficiaries for their use at home, the hospital must bill the durable medical equipment regional carrier, or DMERC.

Hospitals that have a DMERC supplier number must use it to file claims to the DMERC for immunosuppressive drugs.

If a hospital does not have a DMERC supplier number, they must complete an enrollment application and receive a supplier number prior to submitting claims.

Hospitals must file claims to the DMERC using the CMS-1500 claim form rather than the UB92.

To obtain an enrollment application form, a hospital may choose one of the following options:

SLIDE 46- DMERC ENROLLMENT APPLICATION

Contact the NSC and request an application form, called a CMS 855-S. The NSC toll free Service Center Phone Number is (866) 238-9652.

Or, visit the CMS Web site and download the enrollment application.

The hospital should complete the application and return it to the NSC.

To expedite the enrollment process, the provider should attach a cover letter to the DMERC application including the name of the hospital's current Intermediary, and the hospital's Medicare provider number.

The NSC will issue supplier numbers retroactive up to 90-days but not effective before January 1, 2003.

SLIDE 47- CMS-1500 CLAIM FORM

This claim example is the CMS-1500, which must be completed for claim submission to the DMERC.

Key issues in completing the CMS-1500 are:

Item 11 should be "None" if Medicare is primary.

SLIDE 48- CMS-1500 CLAIM FORM

Item 21 indicates the patient's diagnosis, which in this case is kidney transplant.

Item 24A indicates the date of service from date only.

Item 24B indicates the place of service, which is 12 in this instance as the immunosuppressive drugs are to be used in the patient's home.

Item 24D indicates the drug ordered by the physician by HCPCS code.

Item 24G indicates the numbers of units provided, which is 210.

Item 27 indicates assignment, as BIPA 2000 mandates mandatory assignment on drugs.

Item 29 should be left blank.

Item 33 lists the supplier's name, address, telephone number, and PIN# -- NSC supplier number.

For more details on completion of the CMS-1500, please contact the appropriate DMERC.

SLIDE 49- STEREOTACTIC BREAST BIOPSY

Report stereotactic breast biopsy using the appropriate HCPCS code. Radiological or ultrasound guidance for the biopsy should be reported separately using the appropriate HCPCS code.

For example, a patient receives ultrasound guidance, and a liver biopsy. The hospital should bill 76942 for the ultrasound and 47000 for the liver biopsy.

SLIDE 50- RADIATION THERAPY

To bill codes ranging from CPT codes 77407 through 77416, the hospital must add the radiation delivered to each treatment area. Select the appropriate CPT code based on the sum total of radiation provided.

CPT codes 77401 through 77416 should be reported with only one service unit per date of service for each patient. Only one of these codes may be reported per date of service:

- Codes 77402 through 77406 describe treatment delivery for a single treatment area.
- Codes 77407 through 77411 describe treatment delivery to two treatment areas.

SLIDE 51- DIALYSIS

A new HCPCS code was created to allow hospitals not certified as an ESRD facility to bill the intermediary for ESRD patients who receive dialysis in the outpatient hospital setting. This new code is assigned to APC 170.

Hospitals that do not have a certified dialysis facility may receive payment for outpatient dialysis services furnished to ESRD patients under the following circumstances:

1. Dialysis performed following or in connection with a vascular access procedure.

It is important to note when these services are performed on beneficiaries in a covered Skilled Nursing Facility Part A stay, they are not separately payable because of Skilled Nursing Facility consolidated billing edits. In the future, CMS will issue separate instructions to address edit changes that will be made to pay for this dialysis service.

2. Dialysis performed following treatment for an unrelated medical emergency. For example, a patient goes to the emergency room for chest pain and misses a

regularly scheduled dialysis treatment that cannot be rescheduled.

3. Emergency dialysis. In the past, hospitals had to admit these patients to receive payment, which often resulted in inappropriate inpatient admissions.

SLIDE 52- DIALYSIS

Hospitals should use the appropriate revenue code for the site of service when billing G0257. *For example, if the dialysis services were performed in the emergency room, the hospital should use revenue code 450.*

Units should be listed as the number of dialysis treatments provided corresponding with the date(s) of service.

CMS will monitor the use of G0257 to ensure that certified ESRD facilities are not using this code, and that Medicare is not billed for the same patients repeatedly. This would indicate routine dialysis.

Also, the hospital performing non-routine dialysis should notify the ESRD provider that the patient received dialysis services in the hospital outpatient department. The hospital and dialysis facility should work together in providing adequate documentation. The ESRD facility will continue to be responsible for ensuring continuity of care.

SLIDE 53- DIALYSIS CLAIM EXAMPLE

In this example, the hospital filed a claim to their intermediary using bill type 131, indicating outpatient admission through discharge. This patient went to the emergency department with pneumonia. While in the ER, the patient required dialysis.

The hospital billed with HCPCS code G0257 for one unit and used revenue code 450 because the dialysis was provided in the ER.

SLIDE 54- LOW OSMOLAR CONTRAST MATERIAL

Medicare payment for ionic and non-ionic contrast media, including low osmolar contrast material (LOCM), is packaged into the APC payment for the related diagnostic procedure.

For LOCM furnished on or after January 1, 2003, hospitals that are subject to OPSS should bill for LOCM one of two ways:

1. Include the charge for LOCM in the charge for the diagnostic procedure.

2. Bill for LOCM as a separate charge using one of the following two revenue codes:

SLIDE 55- LOW OSMOLAR CONTRAST MATERIAL

Hospitals must not use HCPCS codes A4644, A4645, or A4646 to bill for LOCM furnished on or after January 1, 2003. Claims submitted with these HCPCS codes will be returned to the hospital.

Non-OPPS hospitals must follow billing instructions in §443.C.3f and §443.C.3g of the Medicare Hospital Manual and §3631.C.3f and §3631.C.3g of the Medicare Intermediary Manual.

SLIDE 56- PAYMENT

SLIDE 57- CALCULATING APC PAYMENT WEIGHTS

There are 2 components in updating APC's for 2003 – the weights and the rates. I'll explain the updates in weights first.

The new APC weights for CY 2003 were calculated using claims data from the period of April 1, 2001, through March 31, 2002. This was the most recent charge data available and therefore is the most accurate. Claims data from this period was then matched to the cost reports they corresponded to. The APC relative weights were based on median costs for the APC services in these cost reports. By law, the APC weights are reviewed at least annually.

The highlights of how CMS calculated these weights are:

Billed charges from the claims data were converted to cost. This was done using the most recently available cost report. Once the charges were converted to cost, they were aggregated to the procedure or visit level. As mentioned before, a hospital's cost to charge ratio is computed by taking the costs from the cost report and dividing by the charges. Then, current charges are applied to this ratio of cost to charges in order to determine the estimate of current costs.

Using the median APC costs, the relative payment weight was calculated for each APC. APC 0601 was the beginning point. This APC is one of the most frequently performed services in hospital outpatient settings. It's a mid-level clinic visit. All relative payment rates were scaled to this APC. APC 0601 was assigned a relative weight of 1.00 and then further reduced by a budget neutrality factor of .969. Each median cost for the other APCs was divided by the median cost for APC 0601. The median cost for APC 0601, using the claims data retrieval previously described, was determined to be \$57.56.

If you would like to take a look at the APCs and their relative weights, they are located in the Addendum A of the Final Rule.

SLIDE 58- CALCULATING APC PAYMENT RATES

Now that we've discussed how the weights were recalculated, let's look at the APC rates. The APC rates were updated for inflation and other adjustments using the conversion factor update.

The conversion factor for 2002 was \$50.904. This was increased for 2003 to take into account the market basket increase for FY 2003, which was 3.5 percent.

This was further adjusted for budget neutrality and an adjustment for pass-through payment changes. The final conversion factor for 2003 was established as \$52.151.

SLIDE 59- PASS-THROUGH DRUG AND DEVICE PAYMENTS

Let's look at pass-through calculations:

Because the calculations are done differently, we'll go over both calculations with you. Let's take a look at the device payment calculation first, and then the drug payment calculation.

Pass-through drugs and devices continue to be reimbursed as they were in 2002. Pass-through devices are reimbursed on reasonable cost and pass-through drugs are reimbursed on 95 percent of the average wholesale price (AWP).

There is a break for providers in 2003 for pass-through device categories and drugs. The pro-rata reduction for pass-through device categories and drugs that was in effect for 2002 has been eliminated for 2003.

The APCs that have device offset amounts for 2003 and the offset amounts are published in Table 11 of the 2003 OPPTS Final Rule. The offset adjustment is applied only when a pass-through device is billed with one of the APCs listed in Table 11.

One big difference between payments for pass-through drugs and pass-through devices is that pass-through device calculations include an offset that the drugs calculation doesn't include. The reasonable cost of the new device is reduced by the amount included in the APC for the procedure that reflects the payment for the old device.

SLIDE 60- PRO RATA DEDUCTION

The Act limits the total projected amount of transitional pass-through payments for a given year to an applicable percentage. If the projected payments for the year are above this percentage, a pro rata reduction to the rates will have to be made.

For 2003, this percentage is 2.5 percent. The estimate before CY 2003 determined that projected pass-through payments would be less than this percentage; therefore, there will be no pro rata reduction to the pass-through payments in 2003.

SLIDE 61- PASS-THROUGH DEVICE CALCULATION

In this example we have APC 83. The pass-through device category associated with this APC in our example is Embolization Protective System (C1884).

The offset amount per Table 11 for this APC is \$802.06. Normally, this amount would be wage adjusted, but for ease in this example, we will use a wage factor of 1.0.

The payment rate for APC 83 is \$2,710.57 and the coinsurance amount is \$542.11.

Both of the payment rate and the coinsurance amounts can be found in Addendum A of the Final Rule.

SLIDE 62- PASS-THROUGH DEVICE CALCULATION

In this example, the cost to charge ratio is 50 percent and is used to convert the billed charges of \$2,400 to \$1,200 in costs.

SLIDE 63- PASS-THROUGH DEVICE CALCULATION

The device cost reduced by the offset is computed by taking the \$1200.00 converted device costs minus the offset amount from table 11 of \$802.06. The net amount is \$397.94.

The Medicare program payment (before wage adjustments for APC 83) is computed by subtracting the coinsurance amount of \$542.11 from the payment rate of \$2,710.57 or \$2,168.46.

SLIDE 64- PASS-THROUGH DEVICE CALCULATION

The total payment to the hospital for APC 83 and the associated pass-through device is determined by adding the Medicare program payment of \$2,168.46, plus the coinsurance amount of \$542.11, plus the transitional pass-through amount for the device of \$397.94. The total payment to the hospital is \$3,108.51.

SLIDE 65- PASS-THROUGH DRUG CALCULATION

Now, let's review an example using a pass-through drug:

In this example, we have APC 9120, a drug injection. The payment rate for this is \$175.16 and the coinsurance amount is \$26.18. The total amount paid by Medicare will be \$175.16 minus \$26.18 or \$148.98.

SLIDE 66- PASS-THROUGH DRUG CALCULATION

- The payment rate of \$175.16 is allocated between the non pass-through portion and the pass-through portion.
- The non pass-through portion is computed by multiplying 5 times the coinsurance rate of \$26.18 or \$130.90.
- The pass-through portion is the payment rate of \$175.16 minus the non pass-through portion of \$130.90 or \$44.26.

SLIDE 67- ORPHAN DRUGS

Vaccines and orphan drugs have changes to their reimbursement as well. Orphan drugs are generally expensive and used very little. Prior to Jan 1, 2003, all orphan drugs were reimbursed under OPSS through APCs. For four orphan drugs, reimbursement under the Final Rule for 2003 is on a reasonable cost basis. The four orphan drugs are billed under HCPCS J1785, J0205, J0256, and J9300. They will all have a status indicator of "F" which indicates reimbursement under reasonable costs.

Flu and Pneumonia Vaccines were treated similarly to these four orphan drugs. However, reimbursement is now based on provider type. Hospitals and HHA reimbursement will be paid on reasonable cost effective January 1, 2003. CORF reimbursement for vaccines will be paid based on the lower of the charges or 95 percent of the average wholesale price for the vaccine and on the Medicare Physician Fee Schedule for the administration of the vaccine.

SLIDE 68- 2003 OUTLIER PAYMENT UPDATES

Outlier payments are additional payments under OPSS to account for high-cost services. Charges on the claim are converted to costs through a cost to charge ratio. This is then compared to a certain threshold set by CMS to see if the service qualifies for outliers. For CY 2003, the threshold is 2.75 times OPSS payment.

The payment for the outlier will be 45 percent of the excess between the cost and this threshold. In 2002 the threshold was 3.5 times the payments and the payment percentage was 50 percent. So, in 2003 it's easier for high-cost services to qualify for outliers, but the outlier payout percentage has decreased.

SLIDE 69- OPSS OUTLIER COMPUTATION

Let's look at how outliers are calculated via the OPSS calculator:

In this example, we have Hospital XYZ. On XYZ's claim, it filed \$1,000 charges for APC 0001 and \$2,000 charges for APC 0002. The cost to charge ratio for this hospital based on cost-report information is 50 percent. Charges for APC 0001 are converted to costs of \$ 500.

The cost of packaged items related to APC 0001 is \$27.78. Charges for APC 0002 are converted to costs of \$ 1,000.00. The cost of packaged items related to APC 0002 are \$222.22. These costs are then compared to the threshold. The threshold is determined by multiplying the payment on the claim by 2.75.

In our example, the payment for APC 0001 is \$50.00. \$50.00 is multiplied by 2.75 to determine the threshold amount. The difference between this amount and the cost on the claim is \$390.28. This amount is then paid at 45 percent, or \$175.63.

For APC 0002, the threshold is \$1,100.00, and the total costs are \$1,222.22. The amount of costs over the threshold is \$122.22. This amount is paid at 45 percent or \$55.00.

Outliers under OPSS are computed on an APC-by-APC basis rather than on a claim-by-claim basis.

***Note: The OPSS calculator is available on the CMS MedLearn Website.*

SLIDE 70- TOPS 2003 CALCULATION

We can also use the OPPS calculator to look at the **TOPS** payments. TOPS payments are not calculated on a claim-by-claim basis, but on a monthly basis. If we look at all the claims data that was paid in one month, we can determine the

TOPS amount that should be paid. TOPS are payments under OPPS to help hospitals transition to the new payment system.

The formula for 2003 has also reduced the amount of TOPS payments that hospitals will receive. The basis for the TOPS payments is: if the provider is getting paid less under OPPS than prior to OPPS (also known as the Pre-BBA amount), it will receive an additional payment. If a provider's OPPS payments are greater than its Pre-BBA payments, it will not receive an additional payment. The formula that is used to compute TOPS looks at the ratio of OPPS payments to pre-BBA payments. The new formula for 2003 is:

- OPPS payments are divided by Pre-BBA Payments.
- If the OPPS payment compared to Pre-BBA payment is greater or equal to 90 percent and less than 100 percent, the TOPS payment is 60 percent of the difference between the two, then paid at 85 percent in the interim. This 85 percent is to help avoid overpaying the provider because TOPS payments are subject to final settlement on the cost report.
- If the OPPS payment compared to Pre-BBA payment is less than 90 percent, the TOPS payment is 6 percent of the Pre-BBA payment, then paid at 85 percent in the interim.

SLIDE 71- TOPS 2003 CALCULATION

Let's take a look at a TOPS example for 2003:

Using our calculator, you can see Hospital XYZ's total monthly charges are \$10,000. The provider's cost-to-charge ratio is 50 percent. The total OPPS payment, including coinsurance and deductibles, is \$2,000.

Charges of \$10,000 are converted to cost using the 50 percent cost-to-charge ratio, resulting in \$5,000. This cost is then converted to payments by multiplying the estimated costs by the payment-to-cost ratio of 80 percent.

The payment-to-cost ratio is another variable used in computing TOPS payments. The payment-to-cost ratio is computed by and keyed into the system by the FI. This total of \$4,000 is the Pre-BBA payment amount.

The total OPSS payment of \$2,000 is divided by the Pre-BBA payment amount of \$4,000. This results in a ratio of 50 percent. Since this amount is less than 90 percent, the TOPS payment is calculated by multiplying 6 percent by the Pre-BBA payment of \$4,000, resulting in \$240. The interim TOPS payment is paid at 85 percent of this, or \$204.

SLIDE 72- APC CALCULATOR

Using the OPSS calculator, let's take a quick look at how a basic APC is calculated.

In this example, we're calculating payment for APC 0001 – the first APC in Addendum A of the Final Rule.

Each APC has an assigned status indicator in Addendum A. The status indicator explains how the APC is paid under OPSS. In OPSS, multiple discounting is often used when more than one APC is billed on the same claim.

In multiple discounting, the APC with the highest weight is generally paid at 100 percent and the other APCs are paid at 50 percent.

For this APC, the status indicator is "S" which shows that this APC is a significant procedure under OPSS, and multiple discounting does not apply. Therefore, this APC will be paid at 100 percent regardless if other APCs are billed on the claim.

The payment rate for APC 0001 is \$19.71. The national unadjusted co-payment amount is \$7.09. These are both listed in Addendum A of the Final Rule.

The wage index for our sample provider is .9122. (By the way, wage indexes for OPSS 2003 are based on the inpatient hospital wage indexes for FY 2003.)

You can now see that the APC payment rate must be split between labor and non-labor portion in order to apply the wage index to the labor portion. The split for 2003 is 60 percent labor and 40 percent non-labor, which is the same as last year.

This calculator computes the program payment percentage and the co-payment percentage. The co-payment and program payment is then calculated.

The coinsurance amount, in addition to being limited to 55 percent of the APC rate, is also limited to the inpatient hospital deductible amount, which is \$840 for 2003.

SLIDE 73- PAYMENT RECAP

The weights were recalibrated based on claims charge data that were converted to cost. The 2003 rates were updated using a conversion factor. The increase in the conversion factor takes into account the change in rates from 2002 to 2003 due to inflation, budget neutrality, and other adjustments.

We learned about OPPS outlier computation changes for 2003. Remember, outliers are additional payments for high-cost services that are computed on a line item basis on the claim.

Remember, TOPS are additional payments issued if the provider's payments under OPPS are less than they would have been pre-BBA. These payments are computed on a monthly basis and help hospitals transition to the new payment system. TOPS will end for most providers after calendar year 2003.

Another important fact to remember is that the co-payment amount for an APC is limited to a maximum of 55 percent of the APC rate—just like last year—and also by the inpatient hospital deductible amount for 2003, which is \$840.

The OPPS calculator tool is located on the CMS MedLearn Web site (www.cms.hhs.gov/medlearn). Providers may download and use it to calculate OPPS rates.

**OUTPATIENT PROSPECTIVE PAYMENT
SYSTEM
2003 UPDATE**

TRAINING TOOLS

INSTRUCTIONS FOR USING THE OPPTS CALCULATOR

The OPPTS calculator is a tool that can be used to calculate payment, outlier payments, or monthly TOPS. The calculator is available on the CMS website at www.CMS.HHS.gov/medlearn.

To Compute Payment

To use the OPPTS calculator to compute payment under OPPTS, first access the APC Calculation Worksheet.

1. Type in all items indicated in red, which is the provider name, provider number, number of beds and MSA code.
2. Type in the APC number from Addenda A in the November 1, 2002 Final Rule.
3. Type in the wage index for the hospital (NOT in red).
4. Type in the discount percent.
5. Type in any deductible amounts.

To Compute Outlier Payment

The OPPTS calculator can also be used to compute outlier payments. The instructions to use the OPPTS calculator to compute outliers are as follows:

1. The provider name and provider number are filled in from the information entered in the Outlier Worksheet.
2. Type in the total charges under each APC heading.
3. Type cost-to-charge ratio.
4. Type OPPTS program payment for each APC.
5. Type in charges for packaged items.
6. Type in payments from the claim for APC1 and APC2.

To Compute Monthly TOPS

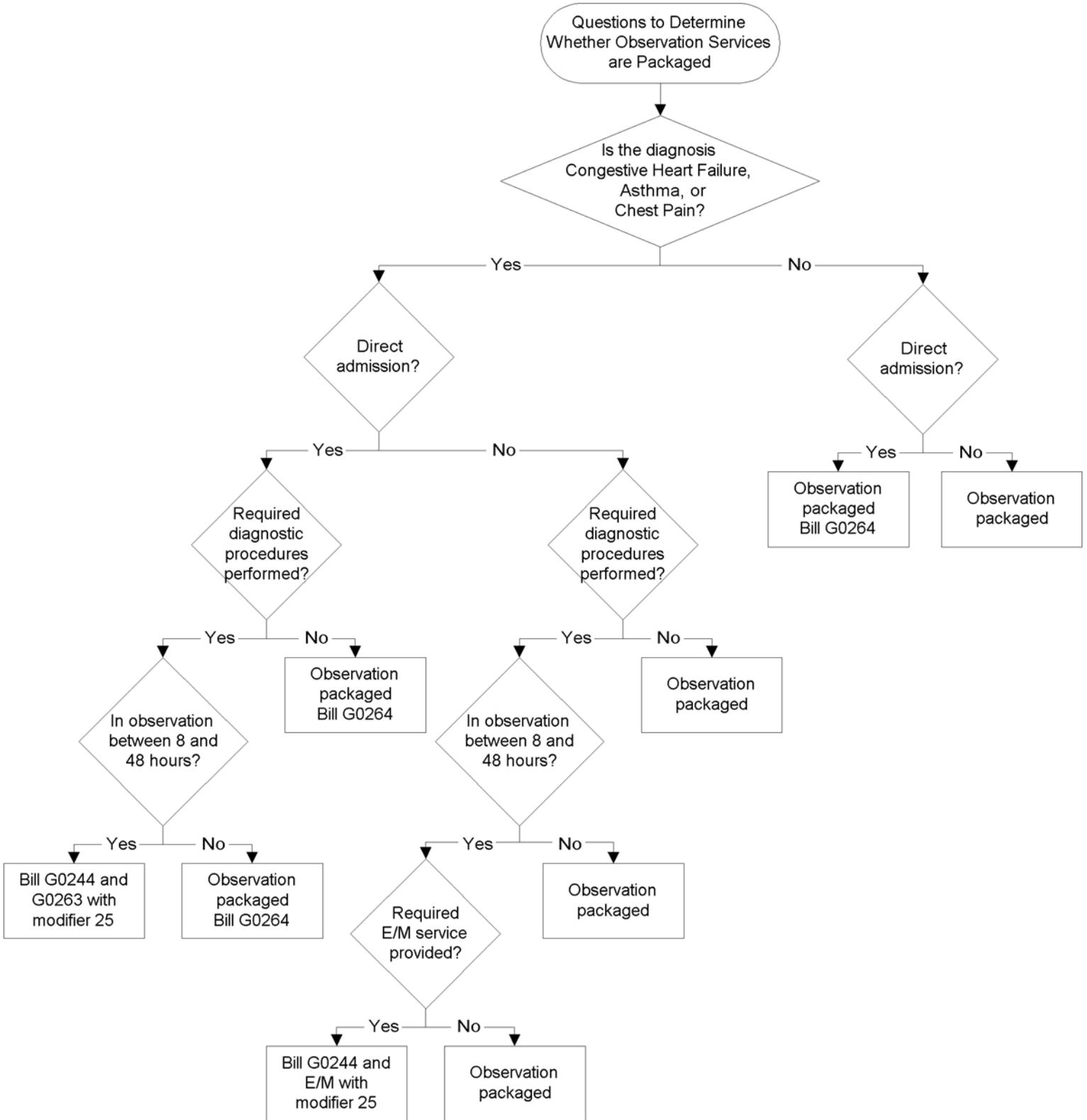
The OPPTS calculator can also be used to compute monthly TOPS under OPPTS. The instructions to use the OPPTS calculator to compute TOPS are as follows:

1. Type in the charges for all covered OPPTS services for the month on the TOPS worksheet.
2. Type the outpatient cost-to-charge ratio.
3. Type the payment-to-cost ratio.
4. Type the total OPPTS program payment including coinsurance and deductible amounts for the month.

Sample page of the OPPS Calculator:

	A	B	C	D	E	F	G	H	I	J	K
1	APC Calculation Spreadsheet										
2											
3	Provider Name										
4	Provider Number										
5	Number of Beds (If calculating TOPS)										
6	MSA Code (Per Provider Specific File)										
7	Effective 1/1/03										
8	File Name: M:\screim\scrate\PPS spreadsheets\11-1-03 opps.xls										
9											
10											
11	APC Number (Addendum A)				1						
12	APC Payment Rate Per Federal Register				19.71	#N/A	#N/A	#N/A	#N/A		
13	APC National Coinsurance per FR				7.09	#N/A	#N/A	#N/A	#N/A		
14	Relative Weight				0.3779	#N/A	#N/A	#N/A	#N/A		
15	Wage Index for hospital (Per November 1, 2002 Federal Register)				#N/A	#N/A	#N/A	#N/A	#N/A		
16	Status Indicator				S	#N/A	#N/A	#N/A	#N/A		
17	Discount										
18	<i>(if status indicator is T, the discount is 100%</i>										
19	<i>for APC with highest relative weight and all other APC will be 50%)</i>										
20											
21	Adjusted APC Payment:										
22	1. APC Payment Rate				0.00	#N/A	#N/A	#N/A	#N/A		
23	2. Labor Percentage				0.60	0.60	0.60	0.60	0.60		
24	3. Labor Portion				0.00	#N/A	#N/A	#N/A	#N/A		
25	(line 1 x line 2)										
26	4. Non Labor Portion				0.00	#N/A	#N/A	#N/A	#N/A		
27	(line 1 - line 3)										
28	5. Wage adjusted Labor				#N/A	#N/A	#N/A	#N/A	#N/A		
29	(line 3 x wage index)										
30	6. Adjusted APC Payment				#N/A	#N/A	#N/A	#N/A	#N/A		
31	(line 4 + line 5)										
32											
33	Program Payment Percentage:										
34	1. APC Payment Rate				19.71	#N/A	#N/A	#N/A	#N/A		
35	2. APC Unadjusted Coinsurance				7.09	#N/A	#N/A	#N/A	#N/A		
36	3. Difference in line 1 - line 2				12.62	#N/A	#N/A	#N/A	#N/A		
37	4. Program Payment Percentage				0.64	#N/A	#N/A	#N/A	#N/A		
38	(line 3/line 1)										
39	5. Coinsurance Percentage				0.36	#N/A	#N/A	#N/A	#N/A		
40											
41											
42											
43											
44	Calculation of Coinsurance:										
45	1. Adjusted APC Payment Rate				#N/A	#N/A	#N/A	#N/A	#N/A		
46	2. Subtract Applicable Deductible*					0.00	0.00	0.00	0.00	\$0.00	
47	3. APC payment less Deductible				#N/A	#N/A	#N/A	#N/A	#N/A		
48	4. Program Payment Percentage				0.64	#N/A	#N/A	#N/A	#N/A		
49	5. Prelim Medicare Payment Amt				#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
50	(line 3 x line 4)										
51	6. Coinsurance Amount				#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
52	(line 3 - line 5) limit to \$840										
53											
54	*Deductible is applied from the lowest program payment percentage to the highest not to exceed \$100.										
55											
56											

Observation Flow Chart:



2003 UPDATE TO OPPTS WORKSHOP PRE-TEST QUESTIONS

1. Which of the following is not a criterion used in determining inpatient-only procedures?
- A. The procedure is performed in numerous hospitals on an outpatient basis.
 - B. The simplest procedure described by the code may be performed in most outpatient departments.
 - C. Most outpatient departments are equipped to provide the services to the Medicare population.
 - D. The procedure is often performed on an emergency basis.
 - E. The procedure can be appropriately and safely performed in an Ambulatory Surgical Center (ASC). The procedure must also be on the list of approved ASC procedures or proposed by CMS for addition to the ASC list.

The correct answer is D.

2. If a surgical procedure on the inpatient-only list is performed on an emergency basis on an outpatient basis, and the patient is admitted as an inpatient the patient must be admitted as an inpatient. When this occurs, what documentation is required?
- A. Documentation showing the procedure was medically necessary
 - B. If the patient was admitted and transferred to another facility, that the transfer was medically necessary
 - C. Documentation that the surgical procedure was actually performed
 - D. Physician orders to admit
 - E. All of the above

The correct answer is E.

3. Effective January 1, 2003, when a surgical procedure on the inpatient-only list is performed emergently on a patient that dies before he/she can be admitted, payment can be made for the surgical procedure if modifier _____ is used.

The correct answer is CA.

4. True or False? Observation services are always packaged services.

The correct answer is False.

5. True or False? Observation services may be paid if the patient has a diagnosis of congestive heart failure, asthma or chest pain?

The correct answer is True.

6. Direct admissions to observation may be paid if the beneficiary meets the requirements for covered observation services. If these requirements are met, which two HCPCS codes should be billed? Choose two:
- A. G0263
 - B. G0244
 - C. G0264
 - D. Q0081
 - E. 99281

The correct answers are A and B.

7. True or False? Although a device may no longer be eligible for pass-through payment and may no longer have a reportable HCPCS code, must hospitals continue to include a charge on the claim (either as part of the charge for the procedure or as a separate charge billed under a device revenue code) for any device they furnish to a patient?

The correct answer is True.

8. True or False? Does Medicare pay for unused portions of a drug under OPPS?

The correct answer is True.

9. If you provide a 30-day supply of immunosuppressive drugs to a patient upon discharge following a transplant, where do you file the claim?

- A. To the fiscal intermediary.
- B. To the durable medical equipment regional carrier.

The correct answer is B.

10. True or False? CMS will pay for services associated with clinical trials for routine costs.

The correct answer is True.

2003 UPDATE TO OPPTS WORKSHOP POST-TEST QUESTIONS

1. Which of the following is not a criterion used in determining inpatient-only procedures?
- A. The procedure is performed in numerous hospitals on an outpatient basis.
 - B. The simplest procedure described by the code may be performed in most outpatient departments.
 - C. Most outpatient departments are equipped to provide the services to the Medicare population.
 - D. The procedure is often performed on an emergency basis.
 - E. The procedure can be appropriately and safely performed in an Ambulatory Surgical Center (ASC). The procedure must also be on the list of approved ASC procedures or proposed by CMS for addition to the ASC list.

The correct answer is D.

2. If a surgical procedure on the inpatient-only list is performed on an emergency basis on an outpatient basis, and the patient is admitted as an inpatient the patient must be admitted as an inpatient. When this occurs, what documentation is required?
- A. Documentation showing the procedure was medically necessary
 - B. If the patient was admitted and transferred to another facility, that the transfer was medically necessary
 - C. Documentation that the surgical procedure was actually performed
 - D. Physician orders to admit
 - E. All of the above

The correct answer is E.

3. Effective January 1, 2003, when a surgical procedure on the inpatient-only list is performed emergently on a patient that dies before he/she can be admitted, payment can be made for the surgical procedure if modifier _____ is used.

The correct answer is CA.

4. True or False? Observation services are always packaged services.

The correct answer is False.

5. True or False? Observation services may be paid if the patient has a diagnosis of congestive heart failure, asthma or chest pain?

The correct answer is True.

6. Direct admissions to observation may be paid if the beneficiary meets the requirements for covered observation services. If these requirements are met, which two HCPCS codes should be billed? Pick two:

- A. G0263
- B. G0244
- C. G0264
- D. Q0081
- E. 99281

The correct answers are A and B.

7. True or False? Although a device may no longer be eligible for pass-through payment and may no longer have a reportable HCPCS code, must hospitals continue to include a charge on the claim (either as part of the charge for the procedure or as a separate charge billed under a device revenue code) for any device they furnish to a patient?

The correct answer is True.

8. True or False? Does Medicare pay for unused portions of a drug under OPSS?

The correct answer is True.

9. If you provide a 30-day supply of immunosuppressive drugs to a patient upon discharge following a transplant, where do you file the claim?

- A. To the fiscal intermediary.
- B. To the durable medical equipment regional carrier.

The correct answer is B.

10. True or False? CMS will pay for services associated with clinical trials for routine costs.

The correct answer is True.