MOUNTAIN STATE BLUE CROSS BLUE SHIELD

HOSPITAL OUTPATIENT BILLING AND REIMBURSEMENT GUIDE

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

TRADITIONAL/PPO/POS/FEP/STEEL

PROVIDER TRAINING MANUAL AND CHANGE DOCUMENTATION

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Section I. Overview of APC Based Payment Methods

This section provides overviews of the Medicare Outpatient Prospective Payment System (OPPS) that is based on the Ambulatory Payment Classification (APC) system and the use of the OPPS components in Mountain State Blue Cross Blue Shield (MSBCBS) APC based reimbursement methods for acute care hospital outpatient services.

Medicare APC Based OPPS

In response to the Federal law (BBA of 1997) enacted in 1997, the Center for Medicare and Medicaid services (CMS) implemented a new outpatient prospective payment system (OPPS) on August 1, 2000. This new payment system uses the Ambulatory Patient Classification (APC) system to classify and pay hospitals for outpatient services.

Since its inception, CMS has made, and continues to make, changes and refinements to APCs and the entire OPPS. These changes are made every calendar quarter, with the most significant changes occurring at the start of each calendar year. As required, updates to the OPPS are published in the Federal Register for public access.

The Medicare OPPS is designed to pay acute hospitals for most outpatient services. Hospitals must bill on a UB-04 or successor[1] claim form using CPT or HCPCS codes for all services, supplies and pharmaceuticals. Each line on a claim is evaluated for payment or non payment using various criteria. The outcome of the evaluation results in a Status Indicator assigned to each line. These Status Indicators determine the payment mechanism to be applied [reference **Appendix 1**].

Lines that are determined to be payable may be priced using multiple mechanisms.

- Certain CPT/HCPCS codes are designated to be paid an APC payment wherein the billed code has been mapped into a “grouping” of codes with similar costs. Components of the APC payment calculation include the following:
  - The grouper that classifies CPT/HCPCS codes into appropriate APC categories;
  - The Medicare relative weights assigned to each APC category;
  - The current National Medicare rate file inclusive of the conversion factor, hospital specific components such as wage indices and Outpatient Ratio of Cost to Charge (ORCC);

[1] reference updated January 2009

- The pricer mechanism that calculates the APC price (the conversion factor times weight) which is inclusive of packaged services;
- The applicable pricer determined outlier adjustment;
- Correct Coding Initiative (CCI) edits of the Outpatient Code Editor (OCE); and
- The recognition and application of appropriate modifiers.

- Lines that are not determined to receive APC payments are designated to be paid under alternative methods.
  - Certain codes (such as laboratory) are paid using the appropriate Medicare fee schedule.
  - Some lines are paid a fixed payment rate, such as an acquisition cost, using the ORCC.
  - Lines with Medicare outpatient mental health services are to be billed using a partial hospitalization provider number. MSBCBS will continue to reimburse Intensive Outpatient Services (IOP), the facility should continue to utilize the partial hospitalization provider number to also receive reimbursement for IOP services.

MSBCBS has implemented the use of factors or multipliers used to further adjust the Medicare calculated rates to a level of reimbursement that is appropriate for use with commercial products. Up to five (5) distinct factors may be utilized when calculating reimbursement; Overall Claim Percent (Single), ORCC, APC percent, Fee Schedule, and Pass Thru factors. After the calculation has occurred determining the reimbursement under Medicare, the appropriate factor is multiplied by this rate to determine the final MSBCBS commercial allowance.

Certain codes or lines are determined to receive no payment under the Medicare OPPS. Non-payment can be designated for reasons such as discontinued HCPCS codes, codes not recognized by Medicare, and other Medicare outpatient payment and benefit guidelines.

The most significant feature of the APC-based OPPS non-payment determination is the concept of packaging of services. The term packaging means that reimbursement for certain services or supplies is included in the payment for another procedure or service on the same claim. The payment rates for the services that include the packaged amounts have been increased to reflect the costs of the packaged claims. Since the start of the Medicare OPPS, CMS has moved more and more services[2] into a packaged status. The list of services[2] that are packaged is very extensive, and includes, for example, such things as inexpensive drugs (less than $60[1]), med/surg supplies, recovery room charges, costs to procure donor tissue (except corneal tissue), anesthesia, IV therapy and

[1] amount changed March 2008 and verified January 2009

many other similar supplies and services. Facilities are required to continue to bill for these services[1], but receive a zero payment for these lines.

The changes that CMS makes to APCs and OPPS occur quarterly with the most significant changes made at the start of each calendar year. In order to make these updates, CMS reviews changes in medical practice, changes in technology, new services, new cost data, and other information. The updates made on an annual basis include but are not limited to:

- updated hospital specific components such as wage indices and Outpatient Ratio of Cost to Charge [ORCC];
- residual payment component updates such as fee schedules;
- recalculated APC relative weights ;
- updates to the conversion factor ;
- updated definitions of APCs and status indicators ;
- added or deleted APC codes and status indicators ;
- updated outlier payment formula; and
- policy revisions including edits and coding criteria.

Updates made at the start of each calendar quarter throughout the year include but are not limited to:

- coding revisions;
- edit revisions;
- APC changes; and
- other payment or policy changes/updates.

NOTE: *All updates are implemented prospectively and retroactive adjustments are not applied.*[2]

MSBCBS APC Based Payment Methods

NOTE: *The basic issue of MSBCBS covered services determination has not been affected. MSBCBS APC based payment methods are reimbursement methodologies. The inclusion of any service, procedure or claim priced under these methods does not guarantee that it will be covered and paid. All MSBCBS coverage policies remain in effect.*

The MSBCBS APC based payment methods[3] are designed to use all of the features, values, and workings of the Medicare OPPS with the exception of select customized features. The RMCs are inclusive of the APC grouper and pricer, relative weights, applicable edits and quarterly updates. Prior to

[1] word changed January 2007
[2] sentence added February 2007
[3] words changed January 2007

implementation of any updates, MSBCBS evaluates the appropriateness of the new or revised components for potential modification.

Most of the customization for the MSBCBS APC based payment methods[2] takes place in the editing portion of the OCE.

- MSBCBS supports the Correct Coding Initiative (CCI) segment of the OCE and follows the Medicare decision rule for such edits.
- Medicare has also established edits to examine the type of patient and the procedures performed in order to determine coverage and clinical reasonableness for Medicare patients. MSBCBS, therefore, has evaluated the edits and made appropriate customizations for compliance with MSBCBS' facility contracts, subscriber benefits processing and medical management protocols as related to MSBCBS' Medicare Advantage and commercial products.
- In other instances, certain other edits are employed (turned on) by MSBCBS but the payment has been altered from the Medicare OPPS calculation. This is also a form of customized payment.
- Finally, certain edits have been discarded by Medicare and some installed but not activated. These have no effect on either Medicare or MSBCBS payment.

Each of these different types of edits are listed and discussed in detail in **Section II. MSBCBS Customization of APC based OPPS.**

In addition to the customization of certain edits, MSBCBS may also make changes to the grouper and pricer as deemed appropriate. The specifics of these changes can also be found in **Section II.**

Section II. MSBCBS Customization of APC Based OPPS

NOTE: *The basic issue of MSBCBS covered services determination has not been affected. MSBCBS APC based payment methods are reimbursement methodologies. The inclusion of any service, procedure or claim priced under these methods does not guarantee that it will be covered and paid. All MSBCBS coverage policies remain in effect.*

Customizations made to the Medicare OPPS in the creation of the MSBCBS APC based payment methods[1] may apply to any or all of the following components: the **edits**, the **grouper**, and the **pricer**.

1. Customization of Edits

The Outpatient Code Editor (OCE) contains validation edits that are used in processing the outpatient claims before the claim can be considered for payment. The major functions of the OCE are to 1) edit claims data and to identify the errors and the action to be taken and 2), most recently, assign an (APC) number, if applicable, to each service covered under OPPS and provide that information as input to the PRICER program. The APC classification, as the grouper component of OCE, is addressed in a separate section: **Customization of the Grouper.**

The edit validation logic is employed on the diagnosis, line or claim level. MSBCBS evaluates each edit to determine the appropriateness to MSBCBS processing, benefits, medical management and payment policies. The following describes the outcomes of that evaluation. Summaries by edit type and number are provided in **Appendices 2** and **3.**

Upfront MSBCBS UB Edits:
MSBCBS has adopted the National Uniform Billing Committee (NUBC) uniform billing and standard data set guidelines, commonly know as UB edits. These standards have been incorporated into MSBCBS' upfront claims processing system. When a claim is submitted, it must pass the UB edits in order to be processed through for payment. Claims that do not pass the UB[2] edits will be returned to provider. Medicare OCE edits 1, 2, 3, 8, 25, and 26 relating to invalid diagnosis code, diagnosis and age conflict, diagnosis and sex conflict, procedure and sex conflict, invalid age, and invalid sex edits have been determined to replicate the MSBCBS UB edits. *Therefore, these OCE edits will be turned off and will not edit as part of MSBCBS' APC based payment methods.*

[1] words changed January 2007
[2] reference added February 2007

Medicare Coverage Specific Edits:
Select edits have been deemed as coverage policy edits specific to Medicare. The OCE edits are 6, 9, 10, 11, 28, 45, 50, 62, 65, 66, 67, 68 and 83[1]: invalid HCPCS procedures, non-covered services, non-covered services submitted for verification of denial (condition code 21), non-covered services submitted for review (condition code 20), codes not recognized by Medicare, inpatient service is not separately payable, non covered by statutory exclusion, code not recognized by OPPS, revenue code not recognized by Medicare, code requires manual pricing, services provided prior to FDA approval, services provided prior to date of national coverage determination and services provided on or after the end date of NCD coverage[1].

*As noted at the start of this section, MSBCBS specific coverage policies will apply to member services and, as such, MSBCBS will not adopt these edits. MSBCBS will pay for such services via default pricing using an ORCC calculation (referenced in the **Customization of Pricer** section) if determined as covered under MSBCBS specific product benefits.*

Medicare Benefit Policy Edits[2]:
Certain edits are specific to Medicare Benefit policy. These include OCE edits 12, 49, and 69: questionable covered procedures, same day as inpatient procedure, and services provided outside of the approval period.

*As noted at the start of this section, MSBCBS specific coverage policies will apply to member services and, as such, MSBCBS will not adopt these edits. MSBCBS will pay for such services via default pricing using an ORCC calculation (referenced in the **Customization of Pricer** section) if determined as covered under MSBCBS specific product benefits.*

Inpatient Procedure Edits[2]:
Medicare has determined that certain services for Medicare patients should only be performed in an inpatient setting (Edit 18). The CPT/HCPCS codes designated for this edit are published and updated in the Federal Register. *[The current list is referenced in Federal Register/Vol.73, No.223, November 18, 2008, pages 68698-68702, Addendum E: CPT Codes That Are Paid Only as Inpatient Procedures for CY 2009.][3]*

Although most of these services are appropriate only for inpatients, there may be services that can be performed for non-Medicare patients on an outpatient basis under alternative medical management and payment policies. MSBCBS, therefore, has turned off the inpatient only edit.

[1] edit added January 2009
[2] word added January 2007
[3] reference updated January 2009

*Since there is no designated OPPS Medicare payment for these services, MSBCBS will pay for these services via default pricing using an ORCC calculation (referenced in the **Customization of Pricer** section).*

Billing/Coding Inconsistency Edits[1]:

a. There are billing/coding inconsistency edits that result in Medicare returning claims to providers for resubmission. These are OCE edits 5, 38, 41, 55, 60, 70, 73[2], and 79[3]: E codes as reasons for visits, inconsistencies between implanted devices and the implantation procedure, invalid revenue codes, services not reportable for this site of service, use of modifier CA with more that one procedure, and CA modifier that requires patient status code 20, and billing of blood and blood products[2,3].

MSBCBS will not follow this protocol in returning claims to providers. Instead, MSBCBS turns these edits off and processes the claim as submitted. Payment will be based on APCs, if available, or via default pricing using an ORCC calculation.

b. There are other OCE edits that check for billing and coding inconsistencies that have been evaluated for appropriateness to MSBCBS policies. These are OCE edits 15, 17, 21, 22, 23, 24, 27, 37, 42, 43, 44, 47, 48, 54, 58[4], 59, 71, 72, 74[4], 75 and 76[5], 77[6], 78[7] and 82[8]. They cover coding practice standards that edit such things as service units out of range for a specific procedure, inappropriate specifications of bilateral procedures, medical visits on the same day as a procedure without modifier 25, invalid HCPCS modifiers, invalid dates, dates out of the OCE range, terminated bilateral procedures or terminated procedures with units > 1, multiple medical visits on the same day, blood transfusion without specification of appropriate blood product, observation revenue code without observation HCPCS code, services not separately payable, revenue centers without requisite HCPCS, multiple codes for the same site of service, G0379 only allowed with payable G0378[4], clinical trials that require diagnosis code V70.7 as Other Than Primary diagnosis, claims that lack a required device code, and services not billable to the fiscal intermediary, units greater than one for bilateral procedure billed with modifier 50,[4] incorrect billing of modifier FB[5], trauma response critical care without revenue code 068x and

[1] word added January 2007
[2] edit 73 revised October 2008
[3] 79 added October 2008
[4] 58 and 74 added January 2007
[5] 75 and 76 added February 2007
[6] 77 added April 2007
[7] 78 added March 2008 and revised name January 2009
[8] 82 added January 2009

CPT 99291[5], claims that lack allowed procedure codes for coded devices[6], and claims that lack required radiolabeled products[7] and charges that exceed a token charge[8].

MSBCBS has determined that these are appropriate edits and will not pay for these types of services or procedures if edited for the applicable conditions noted above.

c. The Correct Coding Initiative (CCI) series of edits that look for combinations of CPT or HCPCS codes that are not separately payable except in certain circumstances are inherent in the OCE. These are OCE edits 19, 20, 39, and 40. This includes the mutually exclusive procedure edits and comprehensive procedure edits. Mutually exclusive codes represent procedures or services that could not reasonably be performed at the same session by the same provider on the same patient. A comprehensive code represents the major procedure or service when reported with another code; as such, one code is determined to contain a component of another code.

MSBCBS supports the Correct Coding Initiative (CCI) segment of the OCE and follows the Medicare decision rule for such edits. MSBCBS has determined that these are appropriate edits and will not pay for these types of services or procedures if edited for the applicable conditions noted above.

Observation Services[1]:
Medicare has changed its reimbursement policy many times over the history of OPPS. For CY 2008, Medicare has made another significant change in its method for paying for observation services. Medicare continues to require the use of the two G codes (G0378 and G0379) and all of the billing requirements except the diagnoses codes. The elimination of the restriction to only three diagnoses has caused MSBCBS to revise its methodology for integrating Medicare OPPS methodology with MSBCBS benefit coverage and payment policy.

Consequently, In order to effect this change in MSBCBS' payment for observation services, OCE edits 53 and 57 will now be applied in MSBCBS processing. Now that Medicare will cover all diagnoses, using edits 53 and 57 will allow MSBCBS to use the Medicare payment methodology. Further explanation on observation payment is referenced in the ***Customization of Pricer*** *section.*

Seven OCE edits have been associated with observation codes and services. OCE edits 44 and 58[2] are addressed under the above category for Billing/Coding

[1] first two paragraphs rewritten March 2008
[2] 58 added January 2007

Inconsistency edits. OCE edit 51 has not been activated by Medicare and OCE edits 52 and 56 have both been deleted by Medicare as a result of their dynamic policies regarding observation services. These are addressed in separate segments on terminated and inactive edits below.

Durable Medical Equipment (DME):
Under Medicare outpatient payment, hospitals must bill most durable medical equipment (DME) claims to the regional carrier (DMERC). Certain exempt claims are billed on a UB-04 or successor[1] form to the Fiscal Intermediary. OCE edit 61 applies to the DME billing restrictions and exceptions for Medicare rejection or pricing.

OCE edit 61 will remain on for MSBCBS processing. If this edit is triggered, the edit will activate the customized payment calculations referenced in the ***Customization of Pricer*** *section.*

Partial Hospitalization:
Claims for partial hospitalization services for Medicare are suspended or returned to provider according to OCE edits 29, 30, 32, 33, 34, 35, 46, 63, 64, 80[2] and 81[3].

MSBCBS allows the claim to edit through with no suspension or return to provider with the one exception noted below for outpatient mental health services.

The one feature of the Medicare OPPS that is not used by MSBCBS is partial hospitalization for outpatient mental health services. Facilities which provide outpatient mental health services must bill MSBCBS under a distinct and separate provider number from the acute number. If a claim is submitted to MSBCBS with condition code 41 by an acute provider under the MSBCBS APC based payment methods[4], it will be returned to the provider. Facilities should continue to bill partial hospitalization and IOP under the facility's partial hospitalization number. Should the facility not have a partial hospitalization number, please contact the Office of Provider Contracting and Reimbursement to establish a partial hospitalization provider number and negotiate a partial hospitalization per diem.

Not Applicable:
OCE edit 4, Medicare as secondary Payor Alert, is a situation that is only applicable to the Medicare OPPS.

[1] reference updated January 2009
[2] edit added October 2008
[3] edit added January 2009
[4] words changed January 2007

MSBCBS has turned this edit off since it is not applicable to the pricing components of the MSBCBS APC based payment methods[1].

Modifiers:
Certain OCE edits may be released with the appropriate use of modifiers. CCI edits 39 and 40 for mutually exclusive and comprehensive code pairings are the dominant segment of OCE that allows modifier usage as a release. Other OCE edits may also be impacted by modifiers.

MSBCBS accepts all approved facility modifiers and allows for appropriate release of edits within OCE guidelines.

Edits Deleted by Medicare:
Edits are deleted by Medicare based on continuing evaluation and updates to OPPS. To date, these include OCE edits 13, 14, 16, 31, 36, 52, and 56: separate payment for services not provided by Medicare, site of service not included in PPS, multiple bilateral procedures without modifier 50, partial hospitalization on same days as electroconvulsive therapy (ECT) or significant procedure, extensive mental health services provided on the day of electroconvulsive therapy or significant procedure, observation services not separately billable and observation service E&M criteria not met.

MSBCBS will not retain these edits and will consider them deleted.

Not Activated:
Some edits have not been activated in the current version of the OCE. These are OCE edits 7, and 51: procedure and age conflict, and overlapping observation periods.

MSBCBS will not activate these edits.

2. Customization of the Grouper

The APC grouper software, which is housed within the OCE software, is essentially used intact by the MSBCBS APC based payment methods. MSBCBS accepts the logic and decision rules for grouping the UB claim data elements into appropriate APCs.

MSBCBS reviews quarterly updates by Medicare for any new or revised APC logic and assignments for potential impacts to payment policies.

3. Customization of the Pricer

MSBCBS has made certain adjustments to the pricing components of OPPS. This customization falls into two types: 1) changes to payment calculations that are the result of customized edits and 2) additional pricing features that are required by MSBCBS payment policy.

ORCC Calculation:
Some of the edits that have been customized allow lines that are not paid by Medicare to be paid by MSBCBS. The payment for these lines involves what is called MSBCBS default pricing. It is calculated by multiplying the line charge times the hospital specific outpatient RCC (ORCC).

MSBCBS has also established ORCC as a default pricing mechanism to ensure provider payment in the case of delays in software updates in the processing system or to accommodate delays in customization or code updates.

The ORCC used in default pricing may or may not be the same as the ORCC used in calculating the Medicare pricing. The Hospitals will be notified of the CMS ORCC which is used in Medicare pricing and the Default ORCC which is used in default pricing.

Observation Services[1]:
Although MSBCBS will now more closely follow Medicare's payment policy for observation services, MSBCBS' policy will continue to be reflective of MSBCBS benefits, coverage and medical management. Generally, observation services are paid for up to 48 hours unless the claim also contains a line for a surgical service. The observation service line is, at that point, considered bundled with surgery and is not separately reimbursable.

Durable Medical Equipment (DME):
Under the MSBCBS APC based payment methods, determinations with respect to allowable DME services will be made in accordance with Health Plan's Medicare Advantage payment policies and product design. Where applicable, DME claims are to be billed on a UB-04 or successor form[2] to MSBCBS[1]. MSBCBS will pay for these claims using either a fee schedule or via the default pricing (ORCC) calculation if no fee exists. OCE edit 61 activates the

[1] paragraph rewritten March 2008
[2] reference updated January 2009

customized MSBCBS payment. The fee schedule used is the same fee schedule that is used by the regional carrier (DMERC).

Section III. MSBCBS APC Based Payment Fundamentals

This section provides a fundamental review of how a claim is priced under the MSBCBS APC based payment methods. The examples provided and the discussions below are assumptive of the inclusion of the MSBCBS customizations described in Section II.

As in the Medicare OPPS, hospitals must bill MSBCBS on a UB-04 or successor[1] claim form using CPT or HCPCS codes for all services, supplies and pharmaceuticals. Each line on the claim generally contains a charge amount, a HCPCS code, a revenue code, and units. The Outpatient Code Editor (OCE) edits the claims to identify errors and return a series of edit numbers. The OCE also assigns an APC number and returns additional information to be used by the Pricer logic.

Status Indicators:
The line level Status Indicator is one outcome of the OCE assignment process. These indicators identify if and how a HCPCS code is to be paid. A payment amount (including zero payment) is then calculated for each line on the claim. A summary listing and description of the current set of Status Indicators is contained in **Appendix 1**.

Status indicators ***A*** and ***Y*** indicate that the line was paid from a fee schedule. A number of different Medicare fee schedules are used, including ambulance, laboratory, DME and others.

Status indicators ***B, C, D, E, M*** and ***N*** indicate that no payment was made for the line. Each indicator reflects a distinct reason such as codes not recognized by Medicare, discontinued codes, non-covered services or services that are packaged into the payment covered by another APC payment line.

Status indicators ***F, G, H*** and ***L*** indicate that the payment was made at a fixed payment rate. This may be an acquisition cost or an additional payment not subject to adjustment factors such as the wage index.

Status indicator **P** indicates that payment was made on a per diem basis for partial hospitalization for mental health services. However, this status indicator is

[1] reference updated on January 2009

only used by Medicare OPPS and is not used by the MSBCBS APC payment methods [reference Section II].

Status indicator ***Q*** was added in 2006 and was split into Status indicators **Q1**, **Q2** and **Q3** in 2009. Sometimes these services are packaged and other times they are paid as a separate APC payment, depending on the services that are billed with them[1].

Status indicators ***K, S, T, V*** and ***X*** indicate that the line was paid according to an APC pricing calculation. The CPT/HCPCS code on the claim line is mapped to an APC code with an associated relative weight. The standard conversion factor (which is a unit price that is the same for every hospital) is then multiplied by this weight and the specific wage index of the submitting hospital to yield the base APC line payment. This base payment may be further adjusted for an outlier payment.

Status indicator ***T*** indicates that payment for more than one procedure would be subject to multiple procedure discounting.

Status indicator **R** for blood and blood products, was split out from Status Indicator K and is paid an APC payment[2].

Status Indicator **U** for all brachytherapy sources, was split out from Status Indicator K and is paid a charges adjusted to cost APC payment[1].

Other Components of Payment:
To accommodate MSBCBS concerns for group customer and individual members, the total payments for outpatient services for all MSBCBS APC based reimbursement methods are limited to a claim's total charges when calculated reimbursement exceeds those charges.

Recalibration of Factors:
MSBCBS will continue to utilize the *Rate Inflator Charge Increase for Outpatient Services, Fragmentation* section of the agreement as part of the OPPS methodology.

[1] status indicators added January 2009
[2] status indicators added January 2009

Claim Pricing Example[1]

Claim detail:

The following represents a claim for multiple services showing the APC-based method pricing for all service lines. The pricing, as noted above, is driven by the status indicator for each line. Only three codes have been mapped to an APC. The ***A*** indicator for the lab service shows that a fee has been used to price that line. The ***N*** indicator correctly shows no payment for the packaged service items.

Claim Line	CPT/HCPCS		APC	Status Indicator	Charges	Payment
1	78465	Cardiac Imaging	377	S	$2,107.00	$689.99
2	84484	Lab		A	$50.00	$12.17
3	71010	Radiology	260	X	$391.00	$39.85
4	36600	Blood		N	$8.00	$0.00
5	J3490	Drugs		N	$25.00	$0.00
6	93005	EKG	99	S	$259.00	$21.29
Total					$2,840.00	$763.30

Base APC Pricing Example:

In order to calculate the payment amount for the first line of this claim, the pricer software looks up the wage index for the hospital that submitted the claim. The pricer then adjusts the APC labor component, according to the following formula.

Hospital Specific Wage Index		.8568	
APC 377	**Status Indicator**	S	
	2008 Weight	11.8512	
2008 APC Conversion Factor (unit price)			$63.694
Line 1 APC Payment Calculation:			
	Conversion Factor	$63.694	
	APC 377 Weight	11.8512	
Base APC Amount [Conversion Factor x APC Weight]			$754.85
	Labor Portion Factor	0.60	
Labor Portion [Base Payment x Labor Factor]			$452.91
Wage Adjusted Labor Portion [Wage Index x Labor Portion]			$388.05
Non-Labor Portion [Base APC Amount - Labor Portion]			$301.94
Wage Adjusted APC Payment			**$689.99**
Multiply the APC Payment by the Facilities Designated APC Factor should the Hospital have an APC Factor			

[1] example updated for 2009 January 2009

Outlier Payment Example[1]:
The APC payment calculation also has a provision for a cost outlier payment based on annually updated criteria by Medicare. MSBCBS' APC based payment methods will follow those pricing criteria. The following shows how an outlier situation would alter the payment.

If the above claim had been submitted with a significantly higher charge on the first line for the heart imaging (or any other line that gets paid with an APC code), the claim would have had an amount added to the line's payment for a cost outlier. Cost outliers are calculated and paid at the ***line*** level.

Adjusted Claim detail for APC 377 Charges:

Claim Line	CPT/HCPCS	APC	Status Indicator	Charges	Payment	Proration of N Charges*	Allocation of N Charges**	Outlier Charges
1	78465	377	S	$8,000.00	$707.61	92.04%	$30.37	$8030.37
2	84484		A	$50.00	$12.17			
3	71010	260	X	$391.00	$39.85	5.18%	$1.71	$392.71
4	36600		**N**	**$8.00**	$0.00			
5	J3490		**N**	**$25.00**	$0.00			
6	93005	99	S	$259.00	$21.29	2.76%	$ .91	$259.91
Total				$8,733.00	$780.92	100.00%	$33.00	

* Based on the distribution of APC payment.
** Distribution of total N charges on claim.

Hospital Specific ORCC	0.3150
Outpatient Threshold Factor (OTF)	1.75
Outlier Payment Percentage OPP)	50%
Line cost (0.315*8030.37)	$2,529.57
Outlier Threshold Criteria:	
(1) 1.75*707.61	$1,238.32
(2) $1,800 + 707.61	$2,507.61

The formulae for determining and calculating a cost outlier payment are as follows:

2009 Outlier Threshold: Line cost must exceed both (1) OTF * Payment and (2) $1,800 + Payment
Outlier Threshold = 1.75 * APC payment amount
Outlier Payment Formula = [(Charges * ORCC) – (Outlier Threshold)] * OPP
Outlier Payment Calculation: [($8030.37*0.315) – (1238.32)] * .50 = **$645.62**

[1] updated to 2009 January 2009

Rosetta Stone
Outpatient Prospective Payment System (OPPS)
2009 Payment Status Indicators – Category Factor Hospitals

Appendix 1

A – Paid on fee schedule [Fee] CMS Fee Schedule x Fee Schedule Factor	**G – Pass-through drugs & biologicals** [APC including pass through amount] CMS Pass Thru Rate x Pass Thru Factor	**P – Partial hospitalization** [Medicare - Per diem APC payment] [MSBCBS – No pay] **Submit under separate Provider Number for Partial Hospitalization for reimbursement.	**T – Significant procedure; Multiple reduction applies** [APC] CMS APC Payment Rate x APC Factor
B – Codes not recognized by OPPS [Medicare – No Pay] [MSBCBS – Default] Charges x Default RCC	**H – Pass-through device categories ; and therapeutic radiopharmaceuticals** [Cost] Charges x CMS RCC x Cost Factor	**Q1 – STVX packaged codes** [No Pay] or [APC] CMS APC Payment Rate x APC Factor	**U – Brachytherapy sources** [APC] Charges x CMS RCC x Cost Factor
C – Inpatient only procedure [Medicare – No Pay] [MSBCBS – Default] Charges x Default RCC	**K – Non pass-through drugs and biologicals** [APC] CMS APC Payment Rate x APC Factor	**Q2 – T packaged codes** [No Pay] or [APC] CMS APC Payment Rate x APC Factor	**V – Clinic or Emergency Department visit** [APC] CMS APC Payment Rate x APC Factor
D – Discontinued codes [No Pay]	**L – Influenza vaccine; Pneumococcal Pneumonia vaccine** [Cost] Charges x CMS RCC x Cost Factor	**Q3 – Codes may be paid through a composite APC** [No Pay] or [APC] CMS APC Payment Rate x APC Factor	**X – Ancillary services** [APC] CMS APC Payment Rate x APC Factor
E – Non-covered service [MSBCBS – Default] Charges x Default RCC	**M – Items and services not billable to the Fiscal Intermediary** [Not paid under OPPS] [No Pay]	**R – Blood and blood products** [APC] CMS APC Payment Rate x APC Factor	**Y – Non-implantable Durable Medical Equipment** [Fee] CMS Fee Schedule x Fee Schedule Factor
F – Corneal tissue acquisition; certain CRNA services; Hepatitis B vaccines [Cost] Charges x CMS RCC x Cost Factor	**N – Packaged items and services** [No Pay]	**S – Significant procedure** [APC] CMS APC Payment Rate x APC Factor	

Updated by: OPCR
January 15, 2010
Source: Highmark

Rosetta Stone
Outpatient Prospective Payment System (OPPS)
2009 Payment Status Indicators – Single Factor Hospitals

Appendix 1

A – Paid on fee schedule [Fee] CMS Fee Schedule x Single Factor	**G – Pass-through drugs & biologicals** [APC including pass through amount] CMS Pass Thru Rate x Single Factor	**P – Partial hospitalization** [Medicare - Per diem APC payment] [MSBCBS – No pay] **Submit under separate Provider Number for Partial Hospitalization for reimbursement.	**T – Significant procedure; Multiple reduction applies** [APC] CMS APC Payment Rate x Single Factor
B – Codes not recognized by OPPS [Medicare – No Pay] [MSBCBS – Default] Charges x Default RCC X Single Factor	**H – Pass-through device categories ; and therapeutic radiopharmaceuticals** [Cost] Charges x CMS RCC x Single Factor	**Q1 – STVX packaged codes** [No Pay] or [APC] CMS APC Payment Rate x Single Factor	**U – Brachytherapy sources** [APC] Charges x CMS RCC x Single Factor
C – Inpatient only procedure [Medicare – No Pay] [MSBCBS – Default] Charges x Default RCC X Single Factor	**K – Non pass-through drugs and biologicals** [APC] CMS APC Payment Rate x Single Factor	**Q2 – T packaged codes** [No Pay] or [APC] CMS APC Payment Rate x Single Factor	**V – Clinic or Emergency Department visit** [APC] CMS APC Payment Rate x Single Factor
D – Discontinued codes [No Pay]	**L – Influenza vaccine; Pneumococcal Pneumonia vaccine** [Cost] Charges x CMS RCC x Single Factor	**Q3 – Codes may be paid through a composite APC** [No Pay] or [APC] CMS APC Payment Rate x Single Factor	**X – Ancillary services** [APC] CMS APC Payment Rate x Single Factor
E – Non-covered service [MSBCBS – Default] Charges x Default RCC X Single Factor	**M – Items and services not billable to the Fiscal Intermediary** [Not paid under OPPS] [No Pay]	**R – Blood and blood products** [APC] CMS APC Payment Rate x Single Factor	**Y – Non-implantable Durable Medical Equipment** [Fee] CMS Fee Schedule x Single Factor
F – Corneal tissue acquisition; certain CRNA services; Hepatitis B vaccines [Cost] Charges x CMS RCC x Single Factor	**N – Packaged items and services** [No Pay]	**S – Significant procedure** [APC] CMS APC Payment Rate x Single Factor	

Updated by: OPCR
January 15, 2010
Source: Highmark

Appendix 2

	MSBCBS APC					
	OCE EDIT SUMMARY					
Number of Edits	**General Edit Type**	**OCE EDIT #s**	**MSBCBS turns edit :**	**Does Medicare pay ?**	**Does MSBCBS pay ?**	**How MSBCBS pays**
6	Upfront MSBCBS UB edits	1,2,3,8,25,26	OFF	No	No	These OCE edits should never appear
1	Inpatient procedures	18	OFF	No	Yes	default price - Hospital specific RCC
3	Medicare benefit policy	12,49,69	OFF	No	Yes	default price - Hospital specific RCC
6	Billing/Coding Inconsistency	5,38,41,55,60,70,73,79	OFF	No	Yes	pay APC if possible,otherwise default price
3	Observation related	53,57,58	ON	No	No	
13	Medicare coverage specific edits	6,9,10,11,28,45,50,62, 65,66,67,68,83	ON	No	Yes	default price - Hospital specific RCC
25	Billing/Coding Inconsistency	15,17,19,20,21,22,23, 24,27,37,39,40,42,43, 44,47,48,54,59,71,72,74, 75, 76, 77,78,82	ON	No	No	
2	Medicare benefit policy	63,64	ON	No	No	
1	DME Fee Schedule	61	ON	Yes	Yes	fee schedule or default price if no fee
7	Edits deleted by Medicare	13,14,16,31,36,52,56	N/A			
7	Partial Hospitalization	29,30,32,33,34,35,46,80,81	N/A			
2	Not Activated	7,51	N/A			
1	Not Applicable	4	N/A			

Appendix 3

MSBCBS APC Payment Method: Edits, Pricer Return Codes and Other Components				
Decision Rules and Error Codes				
OCE EDIT #	**DESCRIPTION**	**MEDICARE REACTION**	**MSBCBS REACTION**	**COMMENTS**
1	Invalid Diagnosis Code	04 - RTP	Process claim	
2	Diagnosis and Age Conflict	04 - RTP	Process claim	
3	Diagnosis and Sex Conflict	04 - RTP	Process claim	
4	Medicare as Secondary Payor Alert	03 - Suspension	Process claim	
5	E-Code as Reason for Visit	04 - RTP	Process claim	
6	Invalid HCPCS Procedure	04 - RTP	Default Price	
7	Procedure and Age Conflict [Not Activated]	04 - RTP	Process claim	
8	Procedure and Sex Conflict	04 - RTP	Process claim	
9	Non-Covered Service	02 - Line Denial	Default Price	
10	Non-Covered Service Submitted for Verification of Denial (Cond Code 21)	06 - Claim Denial	Default Price	
11	Non-Covered Service Submitted for Review (Cond Code 20)	03 - Suspension	Default Price	
12	Questionable Covered Procedure	03 - Suspension	Process claim	
13	Separate Payment for Services Not Provided by Medicare	01 - Line Rejection	N/A	Medicare deleted this edit effective 01/01/06.
14	Site of Service Not Included in PPS	04 - RTP	N/A	Medicare deleted this edit effective 01/01/06.
15	Service Unit Out of Range for Procedure	04 - RTP	R6012	
16	Multiple Bilateral Procedures Without Modifier 50	04 - RTP	N/A	Medicare deleted this edit effective 10/1/05.
17	Inappropriate Specification of Bilateral Procedure	04 - RTP	R6014	
18	Inpatient Procedure	02 - Line Denial	Default Price	
19	Mutually Exclusive Procedure Not Allowed	01 - Line Rejection	R6016	
20	Code 2 of Column 1/Column 2 Correct Coding Edit Not Allowed	01 - Line Rejection	R6017	
21	Medical Visit on Same Day as Procedure Without Modifier 25	01 - Line Rejection	R6018	
22	Invalid HCPCS Modifier	04 - RTP	R6019	
23	Invalid Date	04 - RTP	R6020	

Appendix 3

OCE EDIT #	DESCRIPTION	MEDICARE REACTION	MSBCBS REACTION	COMMENTS
24	Date Out of OCE Range	03 - Suspension	N/A	This edit can never occur in the MSBCBS system because the date of service drives which reimbursement method to use
25	Invalid Age	04 - RTP	Process claim	
26	Invalid Sex	04 - RTP	Process claim	
27	Only Incidental Services Reported	05 - Claim Rejection Prior to 01/01/06 was 06 - Claim Denail	R6025	
28	Code Not Recognized by Medicare, Alternate Code for Same Service may be Available	04 - RTP	Default Price	
29	Partial Hospitalization Service for Non-Mental Health Diagnosis	04 - RTP	R6094	Partial Hospitalization claims cannot be billed under MSBCBS APC RMs
30	Insufficient Services on Day of Partial Hospitalization	03 - Suspension	R6094	Partial Hospitalization claims cannot be billed under MSBCBS APC RMs
31	Partial Hospitalization on Same Days as Electroconvulsive Therapy (ECT) or Significant Procedure (Type T)	03 - Suspension	N/A	Medicare deleted this edit effective 01/01/06.
32	Partial Hospitalization Claim Which Spans Three or Less Days and Has Insufficient Services or Has Electroconvulsive Therapy or Significant Procedure (Type T) on at Least One of the Days	03 - Suspension	R6094	Partial Hospitalization claims cannot be billed under MSBCBS APC RMs
33	Partial Hospitalization Claim Spans More Than Three Days, Insufficient Days With Mental Health Services	03 - Suspension	R6094	Partial Hospitalization claims cannot be billed under MSBCBS APC RMs
34	Partial Hospitalization Claim Spans More Than Three Days With Insufficient Number of Days Meeting Partial Hospitalization Criteria	03 - Suspension	R6094	Partial Hospitalization claims cannot be billed under MSBCBS APC RMs

Appendix 3

OCE EDIT #	DESCRIPTION	MEDICARE REACTION	MSBCBS REACTION	COMMENTS
35	Only Occupational Therapy Services Provided	04 - RTP	R6094	Partial Hospitalization claims cannot be billed under MSBCBS APC RMs
36	Extensive Mental Health Services Provided on the Day of Electroconvulsive Therapy or Significant Procedure	03 - Suspension	N/A	Medicare deleted this edit effective 01/01/06.
37	Terminated Bilateral Procedure or Terminated Procedure With Units >1	04 - RTP	R6035	
38	Inconsistency Between Implanted Device and Implantation Procedure	04 - RTP	Default Price	
39	Mutually Exclusive Procedure, Would Be Allowed With Appropriate Modifier	01 - Line Rejection	R6037	
40	Code 2 of Column 1/Column 2 Correct Coding Edit, Would Be Allowed With Appropriate Modifier	01 - Line Rejection	R6038	
41	Invalid Revenue Code	04 - RTP	Default Price	
42	Multiple Medical Visits on the Same Day, Same Revenue Code Without Condition Code GO	04 - RTP	R6040	
43	Blood Transfusion or Exchange Without Specification of Appropriate Blood Product	04 - RTP	R6041	
44	Obervation Room Revenue Code Without Observation HCPCS Code	04 - RTP	R6042	Follow Medicare edit to catch inappropriate HCPCS codes billed with RC 762.
45	Inpatient Service is Not Separately Payable	01 - Line Rejection	Default Price	
46	Partial Hospitalization Condition Code (41) Not Appropriate for Type of Bill	04 - RTP	R6094	
47	Service is Not Separately Payable	01 - Line Rejection	R6045	
48	Revenue Center Requires HCPCS	04 - RTP	R6046	
49	Same Date as Inpatient Procedure	02 - Line Denial	Process claim	
50	Non-Covered by Statutory Exclusion	01 - Line Rejection	Default Price	
51	Overlapping Observation Periods (not yet implemented)	04 - RTP	N/A	

Appendix 3

OCE EDIT #	DESCRIPTION	MEDICARE REACTION	MSBCBS REACTION	COMMENTS
52	Observation Services Not Separately Billable	04 - RTP	N/A	Medicare deleted this edit effective 01/01/06.
53	Observation Service Code Only Allowed on Bill Type 13X	01 - Line Rejection	Pay APC Rate prior to 01/01/2008; R6071 after 01/01/2008	
54	Multiple Codes for the Same Site of Service	04 - RTP	R6072	
55	Not Reportable for this Site of Service	04 - RTP	Default Price	
56	Observation Service E&M Criteria Not Met, Service Date Not 12/31 or 1/1	04 - RTP	N/A	Medicare deleted this edit effective 01/01/06.
57	Observation Service E&M Criteria Not Met, Service Date 12/31 or 1/1	03 - Claim Suspension	Pay APC Rate prior to 01/01/2008; R6075 after 01/01/2008	
58	G0379 Only Allowed With Payable G0378	04 - RTP	R6076	
59	Clinical Trial Requires Diagnosis Code V70.7 as Other Than Primary Diagnosis	04 - RTP	R6077	
60	Use of Modifier CA With More Than One Procedure is Not Allowed	04 - RTP	Default Price	
61	Service Can Only Be Billed to the DMERC	04 - RTP	Fee Schedule or Default Price	
62	Code Not Recognized by OPPS; Alternate Code May Be Available	04 - RTP	Default Price except for HCPCS codes 99217-99220 and 99234-99236 which will reject R6093	
63	Occupational Therapy Code Only Billed on Partial Hospitalization Claims	04 - RTP	R6082	
64	Activity Therapy Not Payable Outside the Partial Hospitalization Program	01 - Line Rejection	R6083	
65	Revenue Code Not Recognized by Medicare	01 - Line Rejection	Default Price	
66	Code Requires Manual Pricing	03 - Claim Suspension	Default Price	
67	Service Provided Prior to FDA Approval	01 - Line Rejection	Default Price	
68	Service Provided Prior to Date of National Coverage Determination	01 - Line Rejection	Default Price	

Appendix 3

OCE EDIT #	DESCRIPTION	MEDICARE REACTION	MSBCBS REACTION	COMMENTS
69	Service Provided Outside of Approval Period	01 - Line Rejection	Process claim	
70	CA Modifier Requires Patient Status Code 20	04 - RTP	Process claim	
71	Claim Lacks Required Device Code	04 - RTP	R6090	
72	Service Not Billable to Fiscal Intermediary	04 - RTP	R6091	
73	Billing of Blood and Blood Products	04 - RTP	Pay Default price prior to10/01/2008; Process claim after 10/01/2008	
74	Units Greater Than One for Bilateral Procedure Billed with Modifier 50	04 - RTP	R6097	
75	Incorrect Billing of Modifier FB	04 - RTP	R6098	
76	Trauma Response Critical Care Without Revenue Code 068X and CPT 99291	01 - Line Rejection	R6099	
77	Claim Lacks Allowed Procedure Code for Coded Device	04 - RTP	R6100	
78	Claim Lacks Required Radiopharmaceutical	04 - RTP	R6101	
79	Incorrect billing of revenue code with HCPCS Code	04 - RTP	Process claim	
80	Mental Health Code Not Approved for Partial Hospitalization Program	04 - RTP	R6094	
81	Mental Health not payable outside the partial hospitalization program	04 - RTP	R6094	Partial Hospitalization claims cannot be billed under MSBCBS APC RMs
82	Charge exceeds token charge	04 - RTP	R6106	
83	Service provided on or after the end date of NCD coverage	02 - Line Denial	Default Price	

PRICER RETURN CODE	DESCRIPTION	MEDICARE REACTION	MSBCBS REACTION	COMMENTS
9	Package Service	No pay	R6056	
10	Line Item Rejection From ACE	No pay	R6057	
11	Invalid Units for this Modifier	No pay	R6058	
12	Lab Panel Coding Error	No pay	R6059	

13	Ambulance Fee Schedule Item with no HCPCS	No pay	R6066	
OBSERVATION	**DESCRIPTION**	**MEDICARE REACTION**	**MSBCBS REACTION**	**COMMENTS**
	Observation Revenue Code Requires Appropriate HCPCS Procedure Code	N/A	R6401	
	Separate Payment will Not be Made for G0379	N/A	R6095	
OBSERVATION	**DESCRIPTION**	**MEDICARE REACTION**	**MSBCBS REACTION**	**COMMENTS**
EDIT 58	Appropriate HCPCS Codes must be Billed Together for Observation	04 - RTP	R6076	
	Only one Line should be billed for Observation with Appropriate Hours Represented in the Units Field	N/A	R6402	