

MOUNTAIN STATE BLUE CROSS BLUE SHIELD

HOSPITAL OUTPATIENT BILLING AND REIMBURSEMENT GUIDE

OUTPATIENT PROSPECTIVE PAYMENT
SYSTEM (OPPS)

TRADITIONAL/PPO/POS/FEP/STEEL



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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 Centers 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 all services to outpatients with only a very few exceptions.

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-92 or successor claim forms 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 (CMS RCC);
 - 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 CMS RCC.
- Lines that may not be paid under Original Medicare, but deemed appropriate services for non-Medicare patients (such as inpatient only procedures) under MSBCBS' commercial line of business may be priced using the Default RCC which is based off of the Hospital's current Outpatient Rate of Reimbursement.
- Lines with outpatient mental health services are to be billed using a partial hospitalization provider number. 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 number.

MSBCBS has implemented the use of factors, which are multipliers, used to adjust the Medicare rates of APC, Fee Schedule, Cost, and Pass Thru reimbursed services to make the payment acceptable for commercial products. MSBCBS has also implemented a Default RCC which is equivalent to the Hospital's current Outpatient Rate of Reimbursement. The appendices describe the application of the Default RCC in order to identify lines that will default price using the Default RCC.

Certain codes or lines are determined to receive no payment under the Medicare OPSS. 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 OPSS 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 OPSS, CMS has moved more and more services into a packaged status. The list of services that are packaged is very extensive, and includes, for example, such things as

inexpensive drugs (less than \$50), med/surg supplies, recovery room charges, costs to procure donor tissue (except corneal tissue), anesthesia, IV therapy and many other similar supplies and services. Facilities are required to continue to bill for these services, but receive a zero payment for these lines.

The changes that CMS makes to APCs and OPSS 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 [CMS RCC];
- 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.

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 reimbursement methods (RMs) are designed to use all of the features, values, and workings of the Medicare OPSS with the exception of select customized features. The RMs are inclusive of the APC grouper and pricer, relative weights, applicable edits and quarterly updates. Prior to 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 reimbursement methods 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 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 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 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 the MSBCBS' APC based payment methods.*

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 73: 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 billing of blood and blood products.

*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 the Default RCC calculation (referenced in the **Customization of Pricer** section) if determined as covered under MSBCBS specific product benefits.*

Medicare Benefit Policy Edits:

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 the Default RCC calculation (referenced in the **Customization of Pricer** section) if determined as covered under MSBCBS specific product benefits.*

Inpatient Procedure Edits¹:

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.71, No.226, November 24, 2006, pages 68154-68158, Addendum E: CPT Codes That Are Paid Only as Inpatient Procedures.]*

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.

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

Billing/Coding Inconsistency Edits:

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, and 70: 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 than one procedure, and CA modifier that requires patient status code 20.

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 the Default RCC 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, 59, 71, 72, 74, 75 and 76, and 77. 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, 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, incorrect billing of modifier FB, trauma response critical care without revenue code 068x and CPT 99291, and claims that lack allowed procedure codes for coded devices.

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:

Medicare has changed its reimbursement policy many times over the history of OPPOS. Currently, Medicare requires that hospitals use only two newly created G codes for both packaged and separately payable observation services. Payment policies for these observation codes have multiple restrictive criteria. The payment is restricted to three categories of diagnoses (chest pain, asthma, CHF) and for cases that stay in observation for eight hours or more. Additional restrictive coverage criteria may be applied.

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

*OCE edits 53 and 57 will not be applied in MSBCBS processing. This will enable the bypass of the Medicare payment policy and the appropriate payment under MSBCBS policy. Further explanation on observation payment is referenced in the **Customization of Pricer** section.*

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-92 or successor forms 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 and IOP:

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 and 64.

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 reimbursement methods, 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.

Not Applicable:

OCE edit 4, Medicare as secondary Payor Alert, is a situation that is only applicable to the Medicare OPPS.

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

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.

Default RCC 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 Default RCC which is equivalent to the Hospital's current Outpatient Rate of Reimbursement.

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

MSBCBS will not be using the CMS RCC established by CMS for these services. Instead, the current outpatient rates will be set as the Default RCC. By using the existing outpatient rates, MSBCBS will continue to utilize the *Rate Inflator Charge Increase for Outpatient Services, Fragmentation* section of the Hospital Agreement as part of the OPPS methodology.

Observation Services:

MSBCBS' policy for paying for observation services is distinct to MSBCBS benefits, coverage and medical management. Generally, observation services are paid for up to 24 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.

MSBCBS will price with the appropriate APC rate applied by the methodology for G0378. No pricing will be applied to G0379.

Durable Medical Equipment (DME):

Under the MSBCBS APC based payment methods, determinations with respect to allowable DME services will be made in accordance with payment policies and product design. Where applicable, DME claims are to be billed on a UB-92 or successor forms to MSBCBS. MSBCBS will pay for these claims using either a fee schedule or via the default pricing (Default RCC) calculation if no fee exists. OCE edit 61 activates the 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 OPPIs, hospitals must bill MSBCBS on a UB-92 or successor claim forms 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 only used by Medicare OPPIs and is not used by the MSBCBS APC payment methods [reference Section II].

Status indicator **Q** is for packaged services subject to separate payment under select criteria.

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 by the designated factor and/or for an outlier payment.

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

Recalibration of Factors:

MSBCBS will continue to use the *Rate Inflator Charge Increase for Outpatient Services, Fragmentation* section of the Hospital Agreement as part of the OPSS methodology.

Claim Pricing Example

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	\$365.28
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	\$438.59

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
2007 Weight	6.5012
2007 APC Conversion Factor (unit price)	\$61.468
Line 1 APC Payment Calculation:	
Conversion Factor	\$61.468
APC 377 Weight	6.5012
Base APC Amount [Conversion Factor x APC Weight]	\$399.62
Labor Portion Factor	0.60
Labor Portion [Base Payment x Labor Factor]	\$239.77
Wage Adjusted Labor Portion [Wage Index x Labor Portion]	\$205.43
Non-Labor Portion [Base APC Amount - Labor Portion]	\$159.85
Wage Adjusted APC Payment	\$365.28
Multiply the APC Payment by the Facilities Designated APC Factor	

Outlier Payment Example:

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	\$7,200.00	\$365.28	85.66%	\$28.27	\$7,228.27
2	84484		A	\$50.00	\$12.17			
3	71010	260	X	\$391.00	\$39.85	9.34%	\$3.08	\$394.08
4	36600		N	\$8.00	\$0.00			
5	J3490		N	\$25.00	\$0.00			
6	93005	99	S	\$259.00	\$21.29	4.99%	\$1.65	\$260.65
Total				\$7,933.00	\$438.59	100.00%	\$33.00	

* Based on the distribution of APC payment.

** Distribution of total N charges on claim.

Hospital Specific CMS RCC

Outpatient Threshold Factor (OTF)

Outlier Payment Percentage (OPP)

Line cost (0.315*7228.27) \$2,276.91

Outlier Threshold Criteria:

(1) 1.75*365.28 \$639.24

(2) \$1,825 + 365.28 \$2,190.28

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

2007 Outlier Threshold: Line cost must exceed both (1) OTF * Payment and (2) \$1,825 + Payment

Outlier Threshold = 1.75 * APC payment amount

Outlier Payment Formula = [(Charges * CMS RCC) – (Outlier Threshold)] * OPP

Outlier Payment Calculation: [(\$7228.27*0.315) – (639.24)] * .50 = **\$818.83**

Appendices

- **Appendix 1: Status Indicators**
- **Appendix 2: OCE Edit Summary**
- **Appendix 3: Edits and Pricer Return Codes**

Rosetta Stone
 Outpatient Prospective Payment System (OPPS):
 2007 Payment Status Indicators

**Hospital Specific Factors are used in the final payment calculation for commercial products.

<p>Status Indicator - A - Paid on fee schedule [Fee] CMS Fee Schedule x Fee Schedule Factor</p>	<p>Status Indicator – G - Pass-through drugs & biologicals [Pass Through] CMS Pass Thru Rate x Pass Thru Factor</p>	<p>Status Indicator – P-Partial hospitalization [Per diem APC payment] **Submit under separate Provider Number for Partial Hospitalization.</p>
<p>Status Indicator - B-Codes not recognized under OPSS [Medicare – No Pay] [MSBCBS – Default] Charges x Default RCC</p>	<p>Status Indicator - H-Pass-through devices; Brachytherapy sources; Radiopharmaceuticals [Pass Through] Charges x CMS RCC X Pass Thru Factor</p>	<p>Status Indicator - S-Significant service [APC] CMS APC Payment Rate x APC Factor</p>
<p>Status Indicator - C-Inpatient only procedure [Medicare – No Pay] [MSBCBS – Default] Charges x Default RCC</p>	<p>Status Indicator - K-Non pass-through drugs & biologicals; Radiopharmaceuticals [APC] CMS APC Payment Rate x APC Factor</p>	<p>Status Indicator - T-Significant procedure; Multiple reduction applies [APC] CMS APC Payment Rate x APC Factor</p>
<p>Status Indicator - D-Discontinued codes [No Pay]</p>	<p>Status Indicator - L-Influenza vaccine; Pneumococcal Pneumonia vaccine [Cost] Charges x CMS RCC x Cost Factor</p>	<p>Status Indicator - V-Clinic or Emergency Department visit [APC] CMS APC Payment Rate x APC Factor</p>
<p>Status Indicator - E-Non-covered service [Medicare – No Pay] [MSBCBS – Default] Charges x Default RCC</p>	<p>Status Indicator - M-Items and services not billable to the Fiscal Intermediary [No Pay]</p>	<p>Status Indicator - Y-Non-implantable Durable Medical Equipment [Fee] CMS Fee Schedule x Fee Schedule Factor</p>
<p>Status Indicator - F-Corneal tissue acquisition; certain CRNA services; Hepatitis B vaccines [Cost] Charges x CMS RCC x Cost Factor</p>	<p>Status Indicator - N-Packaged items and services [No Pay] Status Indicator - Q-Packaged services subject to separate payment under certain criteria</p>	<p>Status Indicator - X-Ancillary service [APC] CMS APC Payment Rate x APC Factor</p>

CMS Addendum B supplies APC Payment Rate and Pass Thru Payment Rate
 CMS Fee Schedule supplies fees for codes that are paid using a fee schedule

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					
1	Inpatient procedures	18	OFF	No	Yes	default price - Hospital specific Default RCC				
3	Medicare benefit policy	12,49,69	OFF	No	Yes	default price - Hospital specific Default RCC				
6	Billing/Coding Inconsistency	5,38,41,55,60,70	OFF	No	Yes	pay APC if possible,otherwise default price				
2	Observation related	53,57	OFF	No	Yes	pay applicable APC except w surg (-0- pay)				
1	Observation related	58	ON	No	No					
13	Medicare coverage specific edits	6,9,10,11,28,45,50,62,65,66,67,68,73	ON	No	Yes	default price - Hospital specific Default RCC				
24	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	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	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	Potential Submission Error - Line No Pay	
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	Potential Submission Error - Line No Pay	
18	Inpatient Procedure	02 - Line Denial	Default Price	
19	Mutually Exclusive Procedure Not Allowed	01 - Line Rejection	Potential Submission Error - Line No Pay	
20	Code 2 of Column 1/Column 2 Correct Coding Edit Not Allowed	01 - Line Rejection	Potential Submission Error - Line No Pay	
21	Medical Visit on Same Day as Procedure Without Modifier 25	01 - Line Rejection	Potential Submission Error - Line No Pay	
22	Invalid HCPCS Modifier	04 - RTP	Potential Submission Error - Line No Pay	

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
23	Invalid Date	04 - RTP	Potential Submission Error - Line No Pay	
24	Date Out of OCE Range	03 - Suspension		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 Code Not Recognized by Medicare, Alternate Code for Same Service may be Available	05 - Claim Rejection Prior to 01/01/06 was 06 - Claim Denial	Potential Submission Error - Line No Pay	
28		04 - RTP	Default Price	
29	Partial Hospitalization Service for Non-Mental Health Diagnosis	04 - RTP	Potential Submission Error - Line No Pay	Partial Hospitalization claims cannot be billed under MSBCBS APC methodology
30	Insufficient Services on Day of Partial Hospitalization	03 - Suspension	Potential Submission Error - Line No Pay	Partial Hospitalization claims cannot be billed under MSBCBS APC methodology
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	Potential Submission Error - Line No Pay	Partial Hospitalization claims cannot be billed under MSBCBS APC methodology
33	Partial Hospitalization Claim Spans More Than Three Days, Insufficient Days With Mental Health Services	03 - Suspension	Potential Submission Error - Line No Pay	Partial Hospitalization claims cannot be billed under MSBCBS OPSS methodology

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	
34	Partial Hospitalization Claim Spans More Than Three Days With Insufficient Number of Days Meeting Partial Hospitalization Criteria	03 - Suspension	Potential Submission Error - Line No Pay	Partial Hospitalization claims cannot be billed under MSBCBS OPPS methodology
35	Only Occupational Therapy Services Provided	04 - RTP	Potential Submission Error - Line No Pay	Partial Hospitalization claims cannot be billed under MSBCBS OPPS methodology
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	Potential Submission Error - Line No Pay	
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	Potential Submission Error - Line No Pay	
40	Code 2 of Column 1/Column 2 Correct Coding Edit, Would Be Allowed With Appropriate Modifier	01 - Line Rejection	Potential Submission Error - Line No Pay	
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	Potential Submission Error - Line No Pay	
43	Blood Transfusion or Exchange Without Specification of Appropriate Blood Product	04 - RTP	Potential Submission Error - Line No Pay	
44	Observation Room Revenue Code Without Observation HCPCS Code	04 - RTP	Potential Submission Error - Line No Pay	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	Potential Submission Error - Line No Pay	
47	Service is Not Separately Payable	01 - Line Rejection	Potential Submission Error - Line No Pay	

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
48	Revenue Center Requires HCPCS	04 - RTP	Potential Submission Error - Line No Pay	
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	
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	
54	Multiple Codes for the Same Site of Service	04 - RTP	Potential Submission Error - Line No Pay	
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	
58	G0379 Only Allowed With Payable G0378	04 - RTP	Potential Submission Error - Line No Pay	
59	Clinical Trial Requires Diagnosis Code V70.7 as Other Than Primary Diagnosis	04 - RTP	Potential Submission Error - Line No Pay	
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)	
63	Occupational Therapy Code Only Billed on Partial Hospitalization Claims	04 - RTP	Potential Submission Error - Line No Pay	
64	Activity Therapy Not Payable Outside the Partial Hospitalization Program	01 - Line Rejection	Potential Submission Error - Line No Pay	

