Hospital Medicare
Outpatient
Reimbursement

March 13, 2007
Medicare Outpatient Reimbursement

- History
- Overview of Ambulatory Payment Classifications (APCs)
- How CMS determines reimbursement amounts
- Calculating payments
- Calendar 2007 updates
- OPPS Billing Compliance
  - Compliance challenges
  - General and specific compliance concerns
History of Medicare Outpatient Reimbursement

- Ambulatory payment classifications (APCs) became effective August 1, 2000
- Prior to APCs hospitals were reimbursed cost of a blend of cost and fee schedule amounts
- Some services still paid at cost or fee schedule
Overview of APCs

► Rates are based on national payment amounts adjusted for geographic wage differences
► Covers supplies and services integrally related to performing the service
► Certain drugs, biologicals and devices qualify for separate reimbursement
► Clinical lab, ambulance and certain therapies are excluded from APCs
  ▪ Paid on a fee schedule
► Additional payments are made for outliers in certain circumstances
How CMS Determines Reimbursement Amounts

- National Conversion Factor established by CMS
  - Takes into account:
    - Group weights
    - Volume of services in each group
    - Expenditure target
    - Adjusted as needed to ensure budget neutrality

- Each APC has an assigned weight
  - Derived from median hospital costs of the services in the group relative to the median hospital cost for a mid-level clinic visit
  - Mid-level clinic visit chosen because it is one of the most frequently performed service in the outpatient setting
  - Based on hospital cost reports

- Wage adjustment factor
  - Based on area wage index specific to geographic area
Calculating the Total Payment Amount

- The APC Weight is applied to the APC Conversion Factor.
- The wage index adjustment is applied to the labor related portion of the APC group.
- The wage adjusted labor portion is added to the non-labor portion.
- This calculates the total payment due the provided, the Medicare/beneficiary split is determined by the National Co-payment Amount.
## Sample APC Payment Calculation

### Calendar Year 2006

<table>
<thead>
<tr>
<th></th>
<th>CT Scan - Body</th>
<th>Ultrasound</th>
<th>Minor Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Revenue Code</td>
<td>352</td>
<td>402</td>
<td>361</td>
</tr>
<tr>
<td>2 CPT code</td>
<td>71250</td>
<td>76770</td>
<td>20610</td>
</tr>
<tr>
<td>3 APC that CPT maps to</td>
<td>0332</td>
<td>0266</td>
<td>0204</td>
</tr>
<tr>
<td>4 APC Conversion Factor</td>
<td>$ 59.5110</td>
<td>$ 59.5110</td>
<td>$ 59.5110</td>
</tr>
<tr>
<td>5 APC Weight</td>
<td>3.1608</td>
<td>1.5883</td>
<td>2.2667</td>
</tr>
<tr>
<td>6 Number of units</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>7 Unadjusted APC Payment Amount</td>
<td>$ 188.10</td>
<td>$ 94.52</td>
<td>$ 134.89</td>
</tr>
<tr>
<td>8 Labor portion</td>
<td>0.60</td>
<td>0.60</td>
<td>0.60</td>
</tr>
<tr>
<td>9 Unadjusted wage portion</td>
<td>112.86</td>
<td>56.71</td>
<td>80.94</td>
</tr>
<tr>
<td>10 Wage Index</td>
<td>1.1551</td>
<td>1.1551</td>
<td>1.1551</td>
</tr>
<tr>
<td>11 Wage adjusted portion</td>
<td>130.37</td>
<td>65.51</td>
<td>93.49</td>
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<tr>
<td>12 Non-wage portion</td>
<td>75.24</td>
<td>37.81</td>
<td>53.96</td>
</tr>
<tr>
<td>13 Total payment amount *</td>
<td>$ 205.61</td>
<td>$ 103.32</td>
<td>$ 147.45</td>
</tr>
</tbody>
</table>

* Medicare/beneficiary portion is dependent on the National Copay Amount
Calendar Year 2007 Update

Highlights

► Conversion factor increasing from $59.511 to $61.551

► Outlier payments
  ▪ Final dollar threshold is $1,825
  ▪ Outlier payment to be made at 50% of the amount by which the cost of furnishing services exceeds 1.75 times the APC amount

► Devices
  ▪ Reduced payment rates when a device is replaced without cost (recalls), beneficiary coinsurance also reduced

► Drug and Biologicals
  ▪ Paid at 106 percent of average sales price
  ▪ Radiopharmaceuticals paid at hospital specific cost to charge ratio

► E/M services
  ▪ New APCs implemented for evaluation and management
OPPS Billing Compliance

► Challenges
► General Concerns
► OPPS Specific Concerns
► The Near Future
Compliance Challenges

► Keeping Current
  - New Regulations, National, and Local Coverage Determinations
  - Changes to Regulations, National and Local Coverage Determinations
  - Probe Findings, Alerts, and Bulletins
  - OIG Work Plan, Reports, and Publications
  - List-Serves, Conferences, and Trade Publications

► Identifying What is Relevant
  - Regulatory Updates Process

► Identifying and Educating Appropriate Staff
Compliance Challenges

► Monitoring
  ▪ Evaluating *Your* Risk Areas (Annually)
    ► Performing *Your* Risk Assessment
    ► Evaluating Internal Audit’s Findings
    ► Reviewing The OIG Work Plan
    ► New Systems, New Regulations, and New Vendors
    ► Articles in the Trade Press
    ► Findings from CMS, FI, Carrier, MAC, and Other Payers
    ► Allegations Received
    ► Soliciting Requests
Compliance Challenges

► Monitoring

  ▪ Assuring That *Your* Process Controls are Functioning
    ▶ Establishing *Your* Work Plan
    ▶ Conducting Reviews, Interviews, and Monitors
    ▶ Checking-in (Quarterly)
    ▶ Producing Findings / Rating Them
    ▶ Reporting Your Findings
    ▶ Acting Upon Your Findings
    ▶ Following Up on Significant Findings
Compliance Challenges

► Accessibility
  - Can Issues Reach You?
  - Will Issues Reach You?

► Documentation
  - Thoughts and Considerations
  - Guidance
  - Research
  - Work Product
General Compliance Concerns

▶ Policies & Procedures
  ▪ In its Various Compliance Program Guidance Publications, the OIG Recommends Policies and Procedures for an Effective Program:
    ▶ Billing Standards of Conduct (on future slides)
    ▶ Employee Educational Requirements
    ▶ Risk Areas (Fraud, Abuse and Waste)
    ▶ Integrity of Information
    ▶ Resolution of Ambiguities
    ▶ Coding
General Compliance Concerns

► Documentation and Coding
  ▪ Assignment of Codes
  ▪ Billing Only for Services Documented
  ▪ Billing Only for Services That are Medically Necessary
  ▪ Following the National Correct Coding Initiatives
  ▪ Proper Use of Modifiers
    ► -25 Significant, separately identifiable Evaluation and Management Service by the same physician on the same day of the procedure or other service
    ► -57 Decision for surgery
    ► -59 Distinct procedural service
General Compliance Concerns

Charge Capture and the Charge Description Master

- New, Edited, and Deleted CPT/HCPCS Codes
- Tighter Implementation Deadlines (01/01 vs. 04/01)
- AMA CPT vs. CMS HCPCS Requirements
- Education
General Compliance Concerns

- Medicare as Secondary Payer
- Charges on a Fee Schedule / Not OPPS
  - Ambulance Services
  - Screening & Diagnostic Mammography
  - End Stage Renal Disease / Chronic Kidney Failure
  - Professional Services
  - Clinical Laboratory
  - Durable Medical Equipment / Prosthetic and Orthotics
  - Outpatient Skilled Nursing Facility Services
  - Organ and Corneal Tissue Acquisition Costs
  - Others...
Specific Compliance Concerns

► Outpatient Services Treated as Inpatient Services Rules
  ▪ Outpatient Services Followed by an Admission Before Midnight of the Following Day
  ▪ Preadmission Diagnostic Services (Revenue Code)
  ▪ Preadmission Non-Diagnostic Services (Diagnosis)

► Are you holding claims long enough to prevent inappropriate billing?
► Late charge process?
Specific Compliance Concerns

- Duplicate Billing
  - New Processes
  - Redundant Processes / Shadow Systems

- Bundled Services
  - Use of Individual Codes Rather Than Aggregate Codes (Lab: BMP, CMP, HFP)

- Inpatient-Only List

- Charges Covered by Research / Clinical Trials
Specific Compliance Concerns

► Facility Evaluation & Management Leveling
  - No Guidance from CMS Other than to Develop Your Own System and Follow It

► Provider-Based Clinics
  - Ability to Charge a Facility Fee and Professional Fee

► Observation Services
  - Requires a Directed Order to Admit to Observation
  - Not for Routine, Post-Surgical Recovery
  - Condition Code 44 (Inpatient to Observation)

► Partial Hospitalization Program
  - Used by Outpatient Psych Facilities
  - Stringent Documentation / Care Requirements
Specific Compliance Concerns

- Pass-Through Payments for Drugs, Biologicals, Devices, and New Technologies

- Outlier Payments
  - For Unusually Costly Services
  - 1.75x Over APC Payment and Dollar Threshold

- Resolution of Overpayments
  - Often Result from MSP or Duplicate Billing Issues
  - Quarterly Credit Balance Report to Medicare
  - Reimburse within 60 Days
Future Compliance Concerns

- **Medically Unlikely Edits (v2 on 04/01/2007)**
  - No Published MUE List
  - Monitor Return to Provider Errors

- **Services Performed Outside of the US**
  - Tele-Radiology Services (for example)
  - No Facility or Professional Payment Made
  - Implementation Date: 04/02/2007
  - Retro-effective Date: 11/13/2006

- Thursday in April – Next CMS Hospital Forum
- Tuesday; April 17, 2007 Next CMS Provider Forum
Future Compliance Concerns

► Medicare Administrative Contractor Conversion
  ▪ Coordination Between Fiscal Intermediaries and Carriers
  ▪ Consolidation of Local Coverage Determinations
  ▪ Standardization of Systems

► Data Mining
  ▪ Expect More of It
  ▪ With Increased Accuracy
  ▪ Sharing of Medicare Findings with Medicaid Integrity Program

► Research / Clinical Trials Billing

► FY08 CMS OPPS Proposed / Final Rule
Resources

► Hospital Outpatient Prospective Payment System and CY 2007 Payment rates; Final Rule, November 24, 2006 *Federal Register*

► Office of the Inspector General

- **Compliance Program Guidance for Hospitals** (February 23, 1998)
- **Supplemental Compliance Program Guidance for Hospitals** (January 27, 2005)
- **Compliance Program Guidance for Third-Party Medical Billing Companies** (December 18, 1998)
Contact US

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