Management Briefs

THERESA RUIZ-LAW, BA
AANA Director of Managed Care and Reimbursement

Understanding the new Medicare Outpatient Prospective Payment System

Key words: Medicare, Outpatient Prospective Payment System.

Since the April 7, 2000 publication of the final rules, the new Medicare Outpatient Prospective Payment System (OPPS) has caused quite a stir in the healthcare industry, particularly within hospitals. As of August 1, 2000, the new Medicare OPPS applies to all outpatient hospital services, such as surgery, radiology, clinic, emergency room, chemotherapy, and partial hospitalization. Under OPPS, hospitals will be reimbursed for the use of their facilities and related services covering 8,000 outpatient procedures grouped together under 973 major ambulatory payment classification (APC) fee schedules. For CRNAs, anesthesia services and ancillary services within their scope of practice are still to be billed under Medicare Part B and are not affected by OPPS. There are, however, some exceptions to this general rule (see "Effect of OPPS on CRNAs working in hospitals"section).

A *prospective payment system* establishes a "fixed payment" rate for healthcare services, be it inpatient or outpatient. Each procedure is grouped or classified along with other similar services in which resource utilization (supplies, equipment and staff) and work involvement are similar. For inpatient care, these are diagnosis related groups (DRGs) and for outpatient hospital services, procedures are grouped into Ambulatory Payment Classifications (APCs). For freestanding ambulatory surgery centers (ASCs), payments for facility fees are bundled under 8 separate *ambulatory payment groups* (APGs) and are not subject to OPPS classifications.

Historical background

When the Medicare program was established, Medicare Part A payment for hospital services (inpatient) and facility use were based on the hospitals' reasonable costs or usual and customary charges for providing these services. Medicare Part A covers *inpatient hospital services,* such as semiprivate rooms or use of the operating room, meals, general nursing, blood, and other hospital services and supplies. It also covers skilled nursing facility (SNF) care, home healthcare, and hospice care. Medicare Part B, on the other hand, covers physicians' services or other covered healthcare practitioner services (except for routine examinations), *outpatient medical and surgical services and supplies,* diagnostic tests, and durable medical equipment (DME). Medicare Part B also covers clinical laboratory tests ordered by physicians, certain home healthcare services, vaccinations, and certain annual screening tests.

The Social Security Amendments of 1983 revised the cost-based payment for hospital inpatient services by establishing a prospective payment system (PPS) for acute hospital inpatient stays, effective Oct. 1, 1983. This established what

is known as the DRG payment system for inpatient services. However, Medicare outpatient services continued to be paid on a reasonable cost or customary charge basis.

To control the escalating costs of the Medicare program, the Balanced Budget Act (BBA) of 1997 and its refinements in 1999 (BBRA of 1999) mandated the implementation of an Outpatient Prospective Payment System. The new OPPS also allows for coverage of Medicare Part A services under Medicare Part B for beneficiaries whose Part A benefits have been exhausted.

Medicare beneficiaries have supported the passage of OPPS due to the fact that under this new system, Medicare patients would be able to predetermine their out-of-pocket expenses for outpatient services. Traditionally, Medicare patients would wait until they received their hospital bills to determine how much the hospitals have charged them for their outpatient services, and these charges varied from one healthcare setting to another.

Summary of OPPS regulations

Under the new OPPS, outpatient services and charges will be bundled into 973 APC payment categories. The Health Care Financing Administration (HCFA) contracted with 3M to determine how to classify more than 9,000 procedural codes into each of these payment groups, based on the similarity of the procedures and hospital resources utilized.

The OPPS applies to hospital outpatient departments, community mental health centers (CMHCs), and to some services provided by comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and services provided to hospice patients for the treatment of a nonterminal illness. The 10 cancer centers exempt from inpatient PPS are included in OPPS.

The APCs bundle the following into the payment groups: *anesthesia supplies (anesthetics and drugs), hospital outpatient and operating room supplies, certain drugs, hospital equipment, and the use of the recovery, emergency, and observation rooms.*

The following *services are included* within the scope of the hospital outpatient PPS:

- Services designated by the secretary of Health and Human Services—facility fees for *surgical procedures, radiology (including radiation therapy), clinic and emergency room visits, partial hospitalization for the mentally ill, surgical pathology, and cancer chemotherapy;*
- Certain *drugs, anesthetics, hospital supplies and equipment, nursing services, injections, implanted DME and diagnostic devices;*
- Certain services for patients who have exhausted their Part A benefits;
- Partial hospitalization services for CMHCs;
- Specific hospital outpatient services furnished to a beneficiary who is admitted to a Medicare-participating SNF, but who is not considered to be a SNF resident for purposes of SNF consolidated billing, with respect to those services that are beyond the scope of SNF comprehensive care plans;
- Certain preventive services furnished to healthy persons, eg, colorectal screening;
- Hospital outpatient PPS for certain medical and other health services when they are furnished by other providers, such as CORFS, and HHAs, or to hospice patients for the treatment of a nonterminal illness.

The OPPS *does not apply* to Indian Health Service or critical access hospitals (CAH). Moreover, outpatient services furnished by Maryland hospitals are under a waiver and will not be paid under this system.

The following services are *exempt* from OPPS and will continue to be paid under their own fee schedules:

- Physician and nonphysician practitioner (eg, CRNAs) services already paid under a physician fee schedule;
- Clinical diagnostic laboratory services paid under the laboratory fee schedules
- Nonimplantable DME, orthotics, prosthetics and prosthetic devices, prosthetic implants, and take-home surgical dressings paid under the DME point of service fee schedule;
- End-stage renal disease (ESRD) paid under the ESRD composite rate;
- Chronic dialysis (using the composite rate) — Note: Acute dialysis, eg, for poisoning, will be paid under OPPS;
- Drugs and supplies that are used within a dialysis session where payment is not included in the composite rate;
- Screening mammographies (based on the current payment limitation);
- Outpatient rehabilitation services (physical therapy including speech language pathology and occupational therapy) under the Medicare Physician Fee Schedule;
- Corneal tissue (paid on reasonable cost basis);

■ Hospital outpatient services furnished to SNF inpatients as part of his or her resident assessment or comprehensive care plan;

■ Services and procedures that require inpatient care;

■ Ambulance services, physical and occupational therapy, and speech/language services.

Highlights of OPPS provisions

The full extent of the impact of OPPS on the financial condition of hospitals has not been determined. Nevertheless, HCFA estimates that hospitals would see an average 4.6% increase in payments compared to their pre-PPS payments. The American Hospital Association, however, disagrees with this estimate due to the increases in the administrative costs in order to comply with OPPS and the uncertainty of the effect of this payment methodology, particularly the bundling of procedures and supplies which used to be billed separately. Hospital administrators and their financial departments have actually stated that they are experiencing serious cash flow problems because of the decreases and delay in payments resulting from OPPS.

Because of the fact that all outpatient services will be bundled into the APC groups, it is vital that both the billing departments and outpatient healthcare providers understand how to correctly record the services and supplies they have provided to the Medicare patient. With respect to issues directly related to CRNAs involved in the outpatient settings, some of the salient points of OPPS have been highlighted in the next section.

In order to facilitate the healthcare industry's transition process toward OPPS reimbursement, HCFA:

■ Allowed *outlier payments* to cover some of the additional costs of providing healthcare that exceeds established thresholds.

■ Will allow transitional corridor payments to limit hospital and CMHC losses under OPPS for a period of 3 ½ years. This means that for each year of this transitional period, hospitals/CMHC which incur a loss due to the difference between their pre-PPS amounts and the actual PPS amounts received, HCFA will continue to reimburse the facility up to its pre-PPS amounts.

■ Allowed transitional pass-through payments for the additional costs of new and current medical devices, drugs, and biological products for a period of at least 2 years, no more than 3 years.

■ Has determined that certain outpatient services (eg, diagnostic laboratory services, orthotics, prosthetics, etc.) will continue to be paid under their respective fee schedules.

■ Has designated certain procedures as "inpatient" only and will not pay for these procedures on an outpatient basis.

■ Will update the payment rates annually.

Billing and reimbursement changes

There are numerous billing and coding changes implemented by OPPS, which require the reengineering of the hospital billing procedures. Some of the highlights of OPPS to note are:

■ Multiple procedures performed during the same operative session will be discounted. The full amount is paid for the procedure with the highest relative weight, and 50% is paid to any other procedure(s) performed at the time.

■ Outpatient visits are categorized into 3 main "visit levels," the levels and resource utilization to be determined by each hospital.

■ Surgical procedures terminated after the patient is prepared for surgery but before anesthesia induction will be paid at 50% of the APC payment rate.

■ Sixty percent of the APC payments are considered labor-related and will be adjusted to reflect geographical differences in labor costs.

■ Hospitals would be required to use the Health Care Financing Administration common procedural collecting system (HCPCS) level 2 codes and procedural code modifiers, which include the American Medical Association's Current Procedural Terminology (CPT) codes and nonphysician services/supply codes to claim reimbursement.

■ Revenue codes are required on the UB-92 claim forms to indicate which area of the hospital provided the service/supplies.

■ Grouping of 31 CPT codes defining clinic and emergency room visits into 6 groups: namely, clinic visits (low, mid-level, and high-level) and emergency visits (low, mid-level, and high-level). Each hospital is responsible for mapping or setting appropriate policies for the correct determination of the visit level based on resource utilization.

Effect of OPPS on CRNAs working in hospitals

While the anesthesia technical component (equipment, drugs, and supplies) is bundled into the APC payments, the professional component ie, anesthesia services, pain management, ventilation management, nerve blocks, and other

services that are within the CRNA's scope of practice, are still billed under Medicare Part B. As stated in *Medicare Carrier's Manual* (Part 3, chapter 16, section H), Medicare describes payment for CRNA services as follows:

"Payment can be made for medical or surgical services furnished by nonmedically directed qualified anesthetists if they are allowed to furnish these services under state law. These services may include the insertion of Swan Ganz catheters, central venous pressure lines, pain management, emergency intubation, and the preanesthetic examination and evaluation of a patient who does not undergo surgery. Payment is determined under the physician fee schedule on the basis of the national physician fee schedule conversion factor, the geographic adjustment factor, and the resource-based relative value units for the medical or surgical service."

One of the major impacts of OPPS on CRNAs is that for outpatient surgical services, CRNAs (including all hospital clinical staff), would have to closely examine which of their services are reimbursed under Part A or Part B. Since the inception of direct reimbursement to CRNAs in 1989, CRNA services are most often billed under Medicare Part B. Moreover, diagnostic tests (except x-rays) performed for preoperative evaluations of patients, are still billed under the laboratory fee schedules. Surgical procedures performed by qualified providers also are billed separately under Medicare Part B and are subject to the global surgical procedure packaging rules.

Hospital-employed CRNAs who provide outpatient *nonanesthesia and ancillary services, which are not separately paid under Medicare Part B,* should bill for their services using the traditional cost-reporting method used by hospitals. For instance, nursing functions, nursing visits, routine injections (not pain management or nerve blocks), emergency room services, and observation services, should be billed using the appropriate APC category for that service. With the new OPPS system, both inpatient and outpatient services, including emergency department and critical care services will be paid under a fixed amount by Medicare Part A. One of the most significant impacts on CRNAs working in outpatient hospital settings would be that CRNAs will be asked to *document each and every item/service* they provided to the patient and to ensure that the hospital billing department captures each of these services and items for reimbursement.

Hospitals are struggling to understand which services are billable under Medicare Part A through APC groups and services billed under Medicare Part B. CRNAs can assist their hospital administrators in identifying what services they provide and the supplies they use to help them determine whether these services and supplies are billable under Part B or paid under OPPS as part of a bundled service. It also is important to understand that certain "new" drugs, supplies, or equipment used in the outpatient setting are reimbursable under the transitional pass-through provisions to ensure reimbursement for these items. A list of these "transitional devices and drugs" are available from the hospital's fiscal intermediary, or through the April 7, 2000 and November 13 *Federal Registers*. For other resources, see Table 1.

Table 1. Additional resources for the Medicare Outpatient Prospective Payment System

- For questions and answers about OPPS: http://www.hcfa.gov/medlearn/refopps.htm
- For additional information on OPPS: http://www.hcfa.gov/medicare/hospmain.htm
- The April 7, 2000 *Federal Register* and November 13, 2000 *Federal Register* contain the final rules and regulations of OPPS: http://www.access.gpo.gov/su_docs/aces/aces140.html

You also may contact your local Medicare Part A Fiscal Intermediary to sign up for one of their scheduled training courses on OPPS.

To illustrate the differences in payment for a surgical procedure based on where the procedure was performed, Table 2 provides a comparative illustration of the reimbursement for an epidural injection when performed in an outpatient hospital, freestanding ASC, and a physician office/clinic.

Note that the provider's professional fee (paid under Medicare Part B) is the same for both the hospital setting and ASC setting, but it is a bit higher in the clinic/physician setting. This is due to the fact that the resource-based relative value scale (RBRVS) for physicians performing the procedure in their clinic settings (nonhospital based) are allowed the full value of the practice expense costs, since they are not reimbursed separately for their facility costs.

The example in Table 2 shows that there is a financial incentive to provide epidural anesthesia in freestanding ASCs due to the amount of facility

Table 2. **Illustration of reimbursement for an epidural injection when performed in an outpatient hospital, free-standing ASC, and a physician office/clinic**

Procedure: CPT code 62310 single epidural injection (not included) neurolytic agent (local geographical price indexes not factored in)		
A. Hospital setting:		
Provider gets 2.59 x $36.6137 (conversion factor)	= $ 94.83	
Facility APC payment	= 176.49	
Total	$271.32	
B. Ambulatory surgical center (ASC) setting:		
Provider gets 2.59 x $36.6137 (conversion factor)	= $ 94.83	
Facility ASC payment	= 317.00	
Total:	$411.83	
C. Clinic (physician) setting:		
Provider gets 3.22 x $31.6137 (conversion factor)	= $101.80	
Note: No facility fee paid by Medicare		

reimbursement. This example also illustrates a potential shift in where certain healthcare procedures will be done due to payment differences by facility type. Eventually, HCFA will probably even out these payments to prevent any "patient dumping" or shifts in sites for certain healthcare procedures.

For more information

For questions regarding this article, please contact Theresa Ruiz-Law, BA, AANA director of Managed Care and Reimbursement at (847) 692-7050, ext. 3010, or email: truiz@aana.com.