Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-00-09 **Date: MARCH 2000**

This PM is informational only. Specific contractor claims processing instructions will follow.

CHANGE REQUEST 1012

SUBJECT: Hospital Outpatient Services Prospective Payment System (PPS) Background
Section 1833(t) of the Social Security Act (the Act) as added to the Act by §4523 of the Balanced Budget Act of 1997, authorizes HCFA to implement a prospective payment system (PPS) for hospital outpatient services including Part B services furnished to inpatients who have no Part A coverage. The law also includes coverage of partial hospitalization services furnished by community mental health centers (CMHCs) under the new PPS. On November 29, 1999 President Clinton signed new legislation which incorporates the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) that contains a number of major provisions that affect the development of a hospital outpatient PPS. These provisions, in part, --:

- Extend the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs (which was due to sunset on December 31, 1999) through the first date the PPS is implemented;
- Require annual updating of the PPS payment weights, rates, payment adjustments and groups;
- Require annual consultation with an expert provider advisory panel in the review and updating of payment groups;
- Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all services included on the submitted outpatient bill for services furnished before January 1, 2002 and thereafter based on the individual services billed using the appropriate department-specific cost-charge ratio for each services;
- Provide transitional pass-throughs for the additional costs of new and current medical services, drugs, and biologicals for at least 2 years but not more than 3 years;
- Include under the PPS payment for implantable devices including DME, prosthetics and those used in diagnostic testing;
- Establish transitional payments to limit hospitals' losses under the PPS; the additional payments are 3 years for most hospitals and low volume rural hospitals (no more than or equal to 100 beds), and permanent for the 10 cancer hospitals; and,
- Limit beneficiary copays for services paid under the PPS to the inpatient hospital deductible.

The Secretary has the authority under §1833(t) of the Act to determine which services are included under the PPS (with the exception of ambulance services and physical, occupational, and speech therapies, for which fee schedules are or have been separately created). We will continue to pay for chronic renal dialysis using the composite rate and for most laboratory services, surgical dressings, orthotics, and nonimplantable DME and prosthetics on their respective fee schedules. Acute dialysis, e.g., for poisoning, will be paid under the PPS.

The 10 cancer centers exempt from inpatient PPS will come under the outpatient PPS system on July 1, 2000. Certain hospital outpatient services furnished by Maryland hospitals are under a PPS waiver and will not be paid under this system. Critical access hospitals will also be excluded from this system and will continue to be paid on a cost basis.

Effective Dates

The implementation date for the outpatient prospective payment system is July 1, 2000. The editing with the revised Outpatient Code Editor (OCE) will begin July 1, 2000.

Payment Groups

The PPS will consist of groups of services known as Ambulatory Payment Classification (APCs) groups. Services within an APC are similar clinically and require similar resource use. APCs require no changes in coding or billing forms. Discounting of multiple surgical procedures performed during the same operative session will apply. Payment for multiple APCs is possible for a given patient on a given day.

APC Payment Rates

In keeping with the statutory requirements, an APC's relative weight is calculated based on the median cost (operating and capital) of the services included in the group using calendar year 1996 hospital outpatient claims and the most recent cost report.

Coinsurance

Under current law, coinsurance for hospital outpatient services is based on 20 percent of the hospital's billed charges. PPS freezes coinsurance at 20 percent of the national median charge for each APC (wage adjusted for the hospital's geographic area). As the total payment to the hospital increases each year based on market basket updates, the present or *frozen* coinsurance amount will become a smaller portion of the total payment, until coinsurance represents 20 percent of the total payment. Once coinsurance becomes 20 percent of the payment amount, the annual updates will also increase coinsurance so that it continues to account for 20 percent of the total payment. As previously stated the coinsurance for a service paid under the PPS cannot exceed the inpatient deductible amount.

A hospital or CMHC may elect to reduce its copayment to no less than 20 percent of the total Medicare payment (for any individual or all services) and advertise these reduced rates. This election is made yearly and cannot be changed during the year.

We will specify at a later date how hospitals and CMHCs will elect coinsurance and how you will handle contacts with insurers with whom you have trading partnership agreement/Medigap insurance.

HCFA Common Procedure Coding System (HCPCS)

Section 9343(g) of the Omnibus Budget Reconciliation Act (OBRA) of 1986 requires hospitals to report claims for outpatient services using HCPCS coding. HCPCS includes CPT-4 codes. In preparation for outpatient prospective payment, revisions to this requirement include:

--Editing date of service for every line where a HCPCS code is reported on hospital outpatient bills.

--Redefining the reporting of service units for hospital outpatient services.

Specific instructions addressing line item dates of service and changes to service units, were released in the Medicare Intermediary Manual Transmittal #1787 and Hospital Manual Transmittal #747. Systems testing of these new requirements will begin April 1, 2000.

Outpatient Code Editor (OCE)

OCE will be run in FI contractor systems for dates of service on or after July 1, 2000. The OCE will be modified in preparation of hospital outpatient PPS. There will be two main functions of the OCE--setting a series of flags that will be used by the outpatient PRICER program in the determination of payment (e.g., flag to indicate which procedures are discounted); and editing of claims to identify errors. In general, the OCE should perform all functions that require specific reference to HCPCS codes, HCPCS modifiers and ICD-CM diagnosis codes. Since HCPCS codes, HCPCS modifiers and ICD-9-CM codes are complex and annually updated, the centralization of the direct reference to these codes and modifiers in a single program will reduce effort for you and reduce the chance of inconsistent editing.

A number of Correct Coding Initiative (CCI) edits and unit edits will be included in the OCE. These edits will be similar to those developed for carrier processing. OCE will produce additional error messages which will indicate the HCPCS codes which have failed the CCI or unit edits and must be denied by you. This will require line item denial capability.

Specific instructions regarding the modified OCE will be issued in a separate PM.

Modifiers

The use of modifiers is an integral part of the Outpatient PPS payment process. Modifiers add clarification and specificity to procedures and assist in promoting claims processing accuracy. Providers must begin using modifiers April 1, 2000. Modifiers are addressed in the MIM, Transmittal 1729 and the Medicare Hospital Manual (HCFA Pub. 10), Transmittal 726.

Specific instructions addressing the use of modifiers in the outpatient hospital setting are outlined in CR 937, PM-A-99-41: Clarification of Modifier Usage in Reporting Outpatient Hospital Services , released September 24, 1999.

Outpatient Pricer

HCFA developed software will determine the APC line item price based on several data sources:

--National APC amounts
--Outpatient Provider Specific File
--HCPCS
--Wage indices by MSA
--Multiple surgical procedure discounts

Hospital Outpatient Partial Hospitalization Services

Partial Hospitalization services provided in the hospital outpatient department or in a CMHC will be paid under the hospital outpatient PPS based on a per diem. Sections 3651 and 3661 of the Part A Intermediary Manual, Part 3 have been updated to provide coding changes necessary for proper payment under this system in July 2000.

These coding changes will be effective April 1, 2000.

Medical Review

Follow medical review guidelines in Chapter 6, §11 of the Program Integrity Manual for instructions regarding the medical review of hospital outpatient claims. For medical review instructions regarding hospital outpatient partial hospitalization services, please refer to medical review guidelines in PM A-99-39 released in September 1999.

Billing Instructions

We will provide you with additional information to make the necessary FI and standard systems changes. CWF and Standard Systems history will be expanded April 1, 2000. The outpatient history will include new data elements in CWF (i.e., provider-specific coinsurance, deductible, APC price discount indicator, payment amount, and line item dates of service).

! Standard systems and you will maintain responsibility for the creation of an Outpatient Provider Specific File which will include the following:

--NPI Number;
--Provider Number;
--Effective Date;
--Actual Geographic Location-MSA;
--Wage Index Location-MSA;
--Change Code for Wage Index Classifications;
--Standardized Amount Location-MSA;
--Intermediary Number;
--Cost of Living Adjustment; and
--Waiver Indicator.

! Standard Systems must:

--Extract the necessary data elements for pricing based on the status indicator:

-Provider Specific File data;
-Units;
-HCPCS/Modifiers;
-APC;
-Status payment indicator;
-OCE output;
-Line item date of service; and
-Primary diagnosis code
-Other necessary OCE output.

--Forward the trailer to the outpatient PRICER based upon the status indicator.
--Process new and revised error messages produced by OCE; and
--Integrate the outpatient PRICER into claims processing.

--After the outpatient PRICER returns the line item APC price, and coinsurance and claim deductible and outlier information, you and the Standard Systems must accept the information and pass it on as they do now, and calculate the final payment to the provider.

--Complete pricing of other line items.

--Disseminate remittance advice notice with payment to the outpatient provider.

--Disseminate Medicare Summary Notice or Explanation of Medicare Benefits to Medicare beneficiary.

--Complete any other necessary claims processing changes.

We are also looking at how to work with the insurance industry to notify them of when a hospital has elected a lower copay for a specific APC.

You were provided UB92 electronic file specifications.

This Program Memorandum (PM) may be discarded July 1, 2001.

The *effective date* for this PM is July 1, 2000.

The *implementation date* for this PM is July 1, 2000.

For further information concerning this PM , contact your HCFA regional office.

These instructions should be implemented within your current operating budget.