© HelenStocker/iStock/Thinkstock

CHAPTER 8

Hospital Outpatient Prospective Payment System

LEARNING OUTCOMES

After reading this chapter, the student will be able to:

- Describe the role of Healthcare Common Procedure Coding System (HCPCS) codes, indicators, and Ambulatory Payment Classifications (APC) payment groups.
- Differentiate between the prospective payment systems for outpatient, home health, physician and nonphysician practitioners, and ambulatory surgical settings.
- Describe the responsibilities of the practitioners in each clinical setting.
- Define the basic language of the Medicare Prospective Payment Systems surrounding the Hospital Outpatient Prospective Payment System.

Introduction

The **Hospital Outpatient Prospective Payment System (OPPS)** has a set of rules and regulations separate from the delivery of care in the acute setting. Outpatient, home health, physician and nonphysician practitioners, and ambulatory surgery have rules and regulations related to billing. From the actual procedure to the coding to the billing, each site has unique and comprehensive requirements. It is essential for healthcare leaders to differentiate the settings and meet the site-specific regulations. In this chapter, we will discuss all components of OPPS, the home health prospective payment system (HH PPS), and resource-based relative value scale (RBRVS) for physician payments, which will help the student understand the many variables relative to payment in the outpatient setting.

Hospital Outpatient Prospective Payment System

History

The Social Security Act, as amended by the Balanced Budget Act (BBA) of 1997, authorized the Centers for Medicaid & Medicare

Services (CMS) to implement a Prospective Payment System for hospital outpatient services. These services included partial hospitalizations, services to beneficiaries who do not have Medicare Part A, Hepatitis B vaccines and certain services provided by Home Health Agencies (HHA), and various supplies provided to patients on **hospice care** for treatment of a nonrelated illness to their terminal diagnosis (CMS, 2012, p. 12).

The Balanced Budget Refinement Act of 1999 (BBRA) contains provisions that impact the development of the OPPS. The first item was to create a system under OPPS that would be budget neutral based on 1999 allowable amounts, maintain the agreed upon reduction in operating costs of 5.8%, and a reduction in capital costs of 10%. The OPPS payment rates, weights, and adjustments are required to be updated annually. In addition to these steps, it is required that an annual consultation with an expert provider panel to review payment groups, establish budget-neutral outlier adjustments adjusted to costs, allow transitional pass-through for additional costs for medical devices along with drugs and biologicals, payment for implantable devices, limit provider losses under OPPS by providing additional payments for community mental health centers (CMHCs) and cancer hospitals, and place a ceiling on the beneficiary coinsurance for services under OPPS not to exceed the inpatient hospital deductible (CMS, 2012, p. 13).

In addition to these revisions, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) introduced the accelerated reduction in a beneficiary's co-payment, increase in the market basket update in 2001, transitional corridor provision for transitional outpatient payments (TOPs), and a special transitional corridor provision for children's hospitals. Medicare will continue to pay for items such as clinical diagnostic laboratory services, prosthetics, and orthotics, take-home surgical and wound care dressings, chronic dialysis, mammogram screening, and outpatient rehabilitation services, and the 10 cancer hospitals are eligible for hold harmless payments under the TOPs.

OPPS applies to all hospital outpatient departments, except those that only provide Medicare Part B services to their inpatients; Critical Access Hospitals (CAHs); Indian Health Service hospitals; and hospitals located in American Samoa, Guam, Saipan, and the Virgin Islands. OPPS also applies to partial hospitalizations furnished by CMHCs and services provided by certain hospitals in Maryland that are paid under the Maryland waiver provision (CMS, 2012, p. 14).

Payment Status Indicators

An **OPPS payment status indicator** is assigned to every HCPCS code, and this indicator identifies whether the service identified by the HCPCS code is paid under OPPS. Moreover, this indicator identifies whether or not the payment is made separately or as a packaged payment. According to Casto (2018), the 10 types of indicators are Payment Status Indicator V that is for clinic or emergency departments, Payment Status Indicator T that represents a significant procedure and multiple reductions, Payment Status Indicator S that is for significant procedure that is not discounted when multiple procedures apply, Payment Status Indicator X that is for ancillary services, Payment Status Indicator K that is for non-pass-through drugs and non-implantable biological agents, such as therapeutic radiopharmaceuticals, Payment Status Indicator G that is for pass-through drugs or biologicals, Payment Status Indicator H that is for pass-through device categories, Payment Status Indicator P that is for partial hospitalizations, Payment Status Indicator R that is for blood and blood products, and Payment Status Indicator U that is for brachytherapy sources (Casto, 2018, p. 159). A full listing of Payment Status Indicators is available in Addendum D1 of the OPPS/ASC proposed final rules each year (**TABLE 8.1**).

TABLE 8.1 OPPS Payment Status Indicator

Payment Status Indicator	Description
G	Pass-through for drugs and biologicals
H	Pass-through for device categories
K	Non-pass-through drugs and non-implantable biological agents
P	Partial hospitalizations
R	Blood and blood products
S	Significant procedure that is not discounted with multiple procedures apply
T	Significant procedure and multiple reductions
U	Brachytherapy
V	Clinic or emergency department visits
X	Ancillary services

Ambulatory Payment Classification Groups

Each HCPCS code is assigned to only one APC. However, there can be an unlimited number of APCs per encounter for a single beneficiary. The number of APC assignments is based on the number of reimbursable procedures provided to that patient (Casto, 2018, p. 156). However, multiple surgical procedures performed on a patient on the same day are subject to a reduction or discount on the additional procedures.

All services that fall into an APC are similar in both the clinical aspect and resource consumption at the facility. The law requires that the median cost for the highest cost service in an APC may not be more than two times the median cost of the lowest cost service in the APC, which is referred to as the “2 times rule” (CMS, 2012, p. 15). Since the hospital cost reports determine the costs, the APC assignment of a service may change from year to year due to the change in costs and the “2 times rule.” Moreover, this will have an impact on billing and reimbursement for a facility.

Composite APCs

As with a Diagnosis-Related Group (DRG), an APC will provide a single payment for a comprehensive diagnostic treatment or service that may be reported with multiple HCPCS codes. When this takes place, a facility that provides services that fall into a Composite APC will be paid for all the services that have HCPCS codes that fall under the Composite APC. For example, Composite APC

8000 Cardiac Electrophysiologic Evaluation and Ablation Composite will cover at least 1 unit of current procedural terminology (CPT) code 93619 or 93620 and at least 1 unit of CPT code 93650 on the same date of service; or at least 1 unit of CPT codes 93653, 93654, or 93656 (no additional concurrent service codes required) (CMS, 2012, p. 15). There is no financial incentive to report these procedures together or separately, as the payment is almost identical either way. Hospitals should continue to follow the correct coding guidelines and report these services as supported by clinical documentation in the health record (Casto, 2018, p. 162).

Calculation of APC Payment Rates

Payment rates for APCs, outside of drugs and biologicals, are products of the relative weight of the APC and the OPPS conversion factor. The ultimate payment comes after the application of any adjustments for things such as multiple procedures or rural adjustments. Then, the wage index that applies to the area is factored in, and the payment is adjusted based on the rate of the location of the facility. The scaled relative weight is based on the median cost, including capital and operating costs, of all the services that are in a particular APC. These median costs are derived from the most recent filing of cost report data.

The process in which OPPS payment rates are determined is by hospital-specific cost-to-charge ratios (CCR) to convert the billed amount to a cost for each HCPC code billed. For most APCs, since they are single procedures, all of the procedures within a particular APC are used to find the median cost for the APC payment weight. If there is a Composite APC, then the calculations are a little different in that these are for multiple procedures that meet the criteria for the Composite APC payment. Then, the wage adjustment is calculated where it takes 60% of the total cost and adjusts it based on the wage adjustment for the area, and the other 40% is not adjusted. There are no token charges for devices, interrupted procedures, and no cost or full credit devices used to set the median cost for APCs. The median costs are then converted to a relative weight by dividing the median cost of the APC by the median cost for a Level 3 Hospital Clinic Visit APC. Then, the relative weights are scaled for budget neutrality, and it is ready for payment calculation. This next step is taking the relative weight and multiplying it by the conversion factor and any other adjustments, such as high cost of outlier payments and annual market basket update factors to come up with the APC payment.

Packaging

Packaged services under OPPS include items and services that are considered to be an essential or critical part of another service that is paid under the OPPS program. If the payment is for a packaged service, no other payments are made for the additional services or items. For example, routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure, so payment for these items are packaged into the APC payment for the surgical procedure (CMS, 2012, p. 20).

If there is a payment made for an OPPS APC that contained packaged services, a separate payment would not be made to the provider for those services. Healthcare facilities need to make sure that they are following Coding Clinic and Best Practices to ensure that all HCPCS codes are consistent in their descriptions, CPT codes, and CMS instructions along with correct coding principles for all charges to payers, regardless of whether the claim is a separate or a packaged claim.

Packaging Types Under the OPPS

There are different types of packaging for services under OPPS. The payment status indicators that will be referenced are "N," which

is not reimbursed under OPPS; "S," which is for significant procedures that do not involve multiple procedure reductions; "T," which is for surgical procedures where multiple procedure reductions apply; "V," which is for medical visits; and "X," which is for ancillary services.

There are unconditionally **packaged services** that a separate payment is never made on claims with a status indicator of "N." The next group is for status indicators STVX-packaged services. For the status indicator of S, T, V, and X, there is not an additional payment made to the provider. If there is an STVX-packaged claim, there cannot be another payment made for this packaged product. The "T"-packaged service is where a separate payment is made only if there is not another service reported for the same day that falls into the "T" status indicator. The T-packaged service is assigned the status indicator Q2. A service that is assigned a Composite APC is a significant component of a single **episode-of-care payment**. The facility only receives one payment through a Composite APC when there are multiple major separately identifiable services (CMS, 2012, p. 22).

Discounting

There are several areas where CMS takes a discount from a facility. One instance is a procedure where anesthesia is planned but then discontinued, as this type of service will have the facility receive 50% of the full OPPS payment. The discounting process goes on in that 50% of the full amount is paid if a procedure is used for which anesthesia is not planned. Then, multiple surgical procedures furnished during the same hospital stay will generate a payment based on the highest reimbursement. If there are multiple surgical procedures performed on a patient during the same operative session, then they will be discounted. The full amount is paid for the surgical procedure with the highest cost–weight, and 50% is paid for any other surgical procedure(s) that are performed at the same time.

Payment Adjustments

Payments under the OPPS structure are impacted by geographic differences in labor-related costs. In addition to the differences in labor-related costs, there are adjustments for rural hospitals, cancer hospitals, and outlier adjustments.

OPPS incorporates an outlier payment to make sure that all outpatient services with potentially significant costs do not pose an excessive financial risk to providers. A service or group of services that are billed become eligible for outlier payments when the CCR separately exceeds each relevant threshold.

Outlier payments are determined by calculating the cost-related portion of the OPPS line item, including all charges, such as pass-through devices, and multiplying this amount by the hospital's overall CCR and then determining whether the total cost for a service exceeds 1.75 times the OPPS payment, and if the cost for the service exceeds both thresholds, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment (CMS, 2012, p. 28).

To demonstrate the line item portion of packaged services and revenue codes, the cost of the claim is $100, and there are three APC payment amounts paid for OPPS services on the claim that are $200, $300, and $500 for a total payment of $1000. The first OPPS service line item will be allocated $20 or 20% of the total cost of the packaged services, as this line item accounts for 20% of the total payment on the claim. Then, the next line that is for $300 is allocated $30, and the third line is allocated $50, as it was 50% of the total cost of the packaged services (CMS, 2012, p. 29).

For a composite payment and pass-through device, the outlier payments are calculated as follows: the composite payment takes all costs and rolls them up into one line to establish a single cost for the Composite APC, and then, the packaged cost is allocated proportionately to the separate line items. For the pass-through device, the payment for

this device is added to the payment for the related procedures, less any offset, in determining if the procedure is eligible for an outlier payment.

OPPS Coinsurance

OPPS has frozen the outpatient hospital coinsurance at 20% of the national median charge for the services within each APC, but the coinsurance amount for an APC cannot be less than 20% of the APC payment rate. According to Casto (2018), CMS wanted to move to a PPS to ensure that beneficiary co-payment amounts from hospital to hospital would be consistent. Before this, Hospital A could charge $3000 for a colonoscopy, and the beneficiary would be responsible for $600, but if Hospital B charged $3500 for the same colonoscopy, the beneficiary would be responsible for $700 (Casto, 2018, p. 168).

The sequence for calculating a Medicare payment amount and coinsurance by applying the appropriate wage index adjustment to the payment for each APC group is as follows: subtract from the adjusted APC rate any deductible and multiply the adjusted APC payment (APC rate less deductible) by the program payment percentage or 80% (whichever is lower). Then, this amount is subtracted from the adjusted APC payment rate. If this amount is less than the inpatient deductible for the calendar year, the amount is the beneficiary's coinsurance amount. If the amount exceeds the deductible for the calendar year, the beneficiary coinsurance amount is limited to the inpatient hospital deductible amount and Medicare will pay the difference to the provider (CMS, 2012, p. 64).

Pass-Through Payments

The list of devices that are eligible for pass-through payments changes as new device categories are approved for pass-through payment status on an ongoing basis. The Medicare, Medicaid, and SCHIP BIPA of 2000 require establishing categories for purposes of determining transitional pass-through for devices. Each category is defined as a separate code in the C series, or occasionally, a code in another series of HCPCS (CMS, 2012, p. 85).

Devices that qualify may be billed using the currently active category codes for pass-through payments as long as they meet the definition of a device that qualifies it for this type of payment and is described by the long descriptor associated with a currently active pass-through device category HCPCS code and are described according to the definitions of terms and other general explanations issued by CMS (2012, p. 86).

Ultimately, the hospital is responsible for the content of the bills they present to Medicare. If hospital administrators have any questions regarding the appropriate coding processes, they can review the HCPCS codes available for the year of service in question. Many device manufacturers will make information available to hospitals with coding information for the devices that they manufacture, which can be helpful, but does not supersede federal requirements (CMS, 2012, p. 87).

New Technology

New technology APCs were created to allow procedures and services to enter OPPS quickly, even though their complete cost and payment information is not known. New technology APCs house modern procedures and services until enough data are collected to correctly place the new procedure in an existing APC or create a new APC. A procedure or service can remain in a new technology APC for an indefinite amount of time (Casto, 2018, p. 160).

Transitional Corridor Payments

The Medicare, Medicaid, and SCHIP BBRA of 1999 established transitional payments to limit providers' losses under the OPPS; the additional payments are for 3.5 years for CMHCs and most hospitals, and permanent for cancer

hospitals effective August 1, 2000. Section 405 of BIPA provides that children's hospitals are held harmless permanently, and some rural hospitals are held harmless for several years after the implementation of OPPS (CMS, 2012, p. 97).

Eligible facilities receive a quarterly interim hold harmless payment that provides additional reimbursement when the payment received under OPPS is less than the payment the facility would have received for the same services under the prior reasonable cost-based system in 1996 (Casto, 2018, p. 166). The payment is calculated by taking the OPPS reimbursement for the facility for the current quarter less the Pre-OPPS reimbursement, which will equal the hold harmless payment. If the OPPS payment exceeds the Pre-OPPS payment, there will be no hold harmless payment made to the facility.

Home Health Prospective Payment System

History

The **Home Health Prospective Payment System (HH PPS)** was initially mandated by law in the BBA of 1997. **Home healthcare** agencies provide skilled nursing care to patients who are considered to be homebound. The services that are provided are skilled nursing care, physical therapy, occupational therapy, speech therapy, social work, and home health aide services. Also, a nursing agency can provide durable medical equipment (DME) to their patients. To process claims for payment, an agency has two options. Most agencies submit claims electronically by using the electronic Health Insurance Portability, and Accountability Act (HIPAA) standard institutional claim transaction called 837I. The other option for some of the agencies is to submit a claim via the paper form CMS-1450, or otherwise known as UB-04.

Medicare beneficiaries have no cost sharing for home health services, except for a 20% coinsurance for any DME that is provided to the patient during the time the home health agency is servicing the patient. Since DME is covered under HH PPS, services are covered by Medicare Part A for nursing and Medicare Part B for DME. In the beginning, home care was established for short-term care for a patient who was discharged from an acute care facility. A registered nurse would open the case, and if the clinical need was present, a plan of care (POC) or certification would be created and sent to the patient's physician for signature. A home health physician, as well as a nonphysician practitioner (NPP) working with the certifying physician, can make these POCs after a patient's stay in an acute care facility or post-acute facility. The POC is for a 60-day time frame.

The certification must state that a face-to-face encounter took place within 90 days before the start of home care or within 30 days after the start of care. Then, the patient must be considered to be confined to their home environment and in need of intermittent care. A POC needs to be established and reviewed by a physician, and all services need to be furnished while under the care of a physician. The number of 60-day POCs are unlimited as long as the patient met the criteria for care from the agency.

Certifications, or POCs, must be completed at the time care is established or as soon as possible after the start of care. After the first POC, the physician must recertify services for the patient for each 60-day POC after that. The POC will identify how long the physician feels the patient will be in need of care from the home care agency.

Home care agencies are paid by an episode-of-care method of payment. This payment is considered to cover all services rendered to the patient during the current 60-day period or POC. This one payment will cover all skilled nursing, physical therapy, speech

therapy, home health aide services, medical social work services, and medical supplies that include nonroutine medical supplies, such as supplies that are needed to fulfill the orders from the physician and the particular needs of the patient as related to the POC.

Outcomes Assessment Information Set

Home health agencies collect data in the following six major domains (Casto, 2018, p. 222):

1. Sociodemographic
2. Environment
3. Support system
4. Health status
5. Functional status
6. Behavioral status

The data are collected at the following times:

1. Start of care (SOC)
2. Significant changes in condition (SCIC)
3. Transfer to an inpatient facility
4. Resumption of care (ROC) after inpatient hospitalization occurs
5. Discharge from the care of HHA
6. Death at home

Payment of Episodes

Typically, a split percentage payment is made to the home care agency. The payments consist of an initial payment and a final payment. The initial payment is in response to a **Request for Anticipated Payment (RAP)** and the final payment is in response to a submitted claim. The total of the RAP and the final payment will total 100% of the allowed payment for the episode (CMS, 2013b, p. 10).

There are multiple PPS for Medicare for different provider types. Each system operates differently and varies regarding how payments are made and how units are calculated. For the HH PPS program, the payments are for a 60-day period (or less) as the payment unit. The payment itself is not made entirely in advance, but the amount of the payment is known before the start of care. With HH PPS, the majority of the payment is made after the first visit is completed or delivered.

Case-mix is an underlying component of prospective payment. HH PPS is built on the prospective payment system, similar to how the inpatient prospective system works with the use of DRGs. In HH PPS, the resource groups are called home health resource groups (HHRGs) instead of DRGs. The 60-day POC payment is calculated, and there are case-mix adjustments identified through the patient assessment. The POC payment is adjusted through this case-mix process in that the adjusted payment is based on the elements of the Outcome and Assessment Information Set (OASIS) data set that includes the therapy visits throughout the episode. The number of therapy visits will be projected at the time the patient starts receiving services. The initial payment is based on the case-mix adjustment based on the Grouper software (CMS, 2013b, p. 11).

The 60-day episode-of-care payment is case-mix adjusted by using one of 153 HHRGs. These HHRGs are represented in the Health Insurance Prospective Payment System (HIPPS) codes and allow the HHRG to be reported more efficiently and include additional information for things such as payments for nonroutine supplies. There are five positions in this alphanumeric home health HIPPS codes and are described as follows:

1. The first position is for the grouping step that applies to the three domain scores that follow.
2. The second, third, and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system, and these characters are alphabetical only in HH PPS.
3. The fifth position indicates the severity group for nonroutine supplies.

Billing Process Under HH PPS

Home health agencies are required by Medicare to assess potential patients and reassess existing patients using the OASIS. The information is entered, formatted, and transmitted to state agencies and Haven software, which is available through CMS, supports the OASIS data and the transmission. The Haven software is not mandatory, and some home health agencies have chosen their own software applications for this purpose.

Grouper software determines the appropriate case-mix group for payment of an HH PPS 60-day episode from the results of an OASIS submission for a patient. This process groups everything into a CMS HIPPS. Grouper software will also output a Claims–OASIS Matching Key that will link the HIPPS code to a particular OASIS submission. Under HH PPS, both HIPPS code and the Claims–OASIS Matching Key will be entered on RAPs and claims. If an adjustment is made after the initial submission or the claim is rejected by the state agency, and a corrected claim is sent, the RAP and the final claim for the episode must be rebilled using the updated or correct HIPPS code (CMS, 2013b, p. 16).

Submitting a Request for Anticipated Payment

The home health agency can submit an RAP after the OASIS assessment is complete, export ready, or finalized for transmitting to the state, and after a physician's verbal orders for home care have been received and documented. Next, a POC is established and sent to the physician for signature. Finally, the first service visit has been completed by the home health agency (CMS, 2013b, p. 16).

Once an episode is opened on the common working file (CWF) with the processing of an RAP, all initial claims, subsequent claims or episodes, and transfer cases should be submitted as soon as possible after care is started to ensure being established as the primary home health agency for the patient/beneficiary. The initial RAP is submitted in a standard claim format. However, it is not treated as a home health claim and is not subject to many of the claims regulations. After submission for an RAP payment is made, the next submission will be a final bill or the bill at the end of the 60-day period. The home health agency cannot submit this claim until all services have been delivered and are completed. Home health claims must be submitted with the type of bill (TOB) 329. The HH PPS claim will include the elements submitted initially on the RAP and all other line item details for the entire episode. If the home health agency provided DME, oxygen, or prosthetics and orthotics, these services would be paid in addition to the episode of payment (CMS, 2013b, p. 17).

RAPs can be adjusted and/or canceled by the home health agency. An adjustment is submitted to correct any information that was submitted in error, and that may change the payment amount to the provider. A cancellation of a claim is used to change the beneficiary health insurance claim number (HICN) or the home health agency's provider number if it was submitted in error. The cancellation is due to the fact that if the beneficiary number is wrong, the patient who is being billed in error may cause a denial for the home health agency that might be starting up care. If the wrong home health agency number is transmitted, then the wrong agency will be receiving payment for care that they are not providing.

Transfer Cases

Transfer of a patient in home care is when a beneficiary chooses to change home health agencies during a 60-day period. By law, patients have the right to change or transfer from one home health agency to another home health agency. For this process to go smoothly, the receiving home health agency must submit an RAP with a transfer indicator

placed in the condition code field that will identify that an episode-of-care payment may already be open for the patient with another home health agency. Then, the receiving home health agency will document, in writing, that the patient has been informed that the initial home health agency will no longer be receiving Medicare payments on behalf of the patient and will no longer be the agency that will be delivering services after the transfer date.

The previously open episode will automatically be closed in the Medicare claims-processing system as of the date the patient begins service with the new home health agency. The payment will be prorated for the shortened length of care provided by the transferring agency that is less than 60 days. Sometimes, a patient may choose to transfer to another home health agency the day after the previous POC ends with the other home health agency. In this instance, the transferring agency may not have submitted the RAP for the upcoming 60-day POC and the home health agency that the patient is being serviced going forward will need to identify that their POC will be adjacent to the previous agency's POC. The agency that the patient has transferred to will need to educate the patient (and family or caregivers) that the previous agency will not be billing for services after the transfer/discharge date and that they will not be providing services after that date.

Discharge and Readmission

Discharge planning for a patient who receives service at a home health agency is when a patient completed the POC within the 60-day window, and all goals have been met on or by the 60th day, which will be considered a clean admission and discharge, as the home health agency has started the POC and submitted the RAP at the start of care and received payment and then delivered care up to the 60th day before discharging the patient on the 60th day and submitting their final bill. As perfect as this sounds, it is not always the case in home care. Sometimes, the patient can be discharged during the 60-day episode and then readmitted back to the same agency. In this case, the same agency cannot bill for another episode during the same 60-day period. The agency will need to have the first period prorated to reflect the time spent at the agency. Then, the new POC for the most recent admission will be a new episode for the home health agency once the first visit is delivered and completed. In situations where a patient is currently with a home health agency, and the patient is admitted to an inpatient facility, the servicing home health agency can discharge the patient if they feel that the patient will not return within the 60-day POC. At this point, the patient was discharged early in the POC; however, the agency will receive full payment. If the home health agency decides not to discharge the patient when the patient is sent to a hospital or skilled nursing facility, and the patient returns to the agency during the 60-day POC, the care will simply continue where the patient left off.

Partial Episode Payment

When a patient is discharged, readmitted, and transferred to the same agency in a 60-day period, it results in a shortened episode-of-care payment given by the agency. In this instance, the payment to the home health agency will need to be prorated for the shorter episode. These adjustments are called **Partial Episode Payments (PEP)**. This situation will occur when (CMS, 2013b, p. 20):

- A patient has been discharged and readmitted to home care within the same 60-day episode. This admission and discharge will be indicated by putting a Patient Discharge Status code of 06 on the final claim for the first part of the 60-day episode.
- A patient transfers to another home health agency during a 60-day episode. This encounter is also indicated with a Patient Discharge Status code of 06 on their final claim.

After January 1, 2008, the nonroutine supply (NRS) payment amount is also subject to this prorated PEP.

Low Utilization Payment

The normal episode-of-care payment covers a 60-day period. However, there are times that a shorter length of stay, or episode, is experienced for a patient. If a home health agency provides four visits or less in an episode, they will be paid a standardized per visit payment, instead of an episode payment for a 60-day period. Such payments, adjustments, and episodes themselves are called **Low Utilization Payment Adjustments (LUPAs)**.

On a LUPA claim, nonroutine supplies will not be reimbursed in addition to the per visit payment. The LUPA is made because the total annual supply payments are already calculated into all payment rates. Since home health agencies in such cases are likely to have received one split-percentage payment, which would likely be greater than the total LUPA payment, the difference between these visit payments and the payment already received will offset against future payments when the claim for the episode is received. If at a later date the patient receives five or more visits, the payments will be adjusted to an episode basis rather than a per visit basis (CMS, 2013b, p. 21).

If the home health agency anticipates that the episode-of-care payment will be four visits or less, they can elect not to submit an RAP at the start of care, which will help the agency avoid an adjustment, or recouping of funds, for receiving the initial payment and not exceeding four visits.

Therapy Thresholds

When the home health agency reports data on the episode for a patient in OASIS, the number of visits that are estimated will be verified from the line item detail on the claim form for the episode. The HH PPS adjusts the Medicare payment based on 3 therapy thresholds of 6, 14, or 20 visits being met. Due to the complexities of the payment system regarding therapies, the Pricer software in the Medicare claims-processing system will recode the claim based on the actual number of visits completed by the home health agency. Since the number of therapy visits provided can change the payment equation under the refined four-equation case-mix model, in some cases, it will change several positions in the HIPPS code. The electronic remittance advice (RA) will show the original code submitted on the claim at the beginning of the episode and the code used for payment to keep things identified for the home health agency (CMS, 2013b, p. 22).

Adjustment of Episode of Payment—Early and Late Episodes

HH PPS uses a four-equation case-mix model that recognizes and differentiates payment for early episodes-of-care that are the first or second episode in a sequence of adjacent covered episodes or any later episodes that are in the third episode and beyond in a sequence of adjacent covered episodes. An adjacent episode is one that is not separated by more than a 60-day period between claims.

Adjustment of Episode of Payment—Outlier Payments

HH PPS payment groups are based on averages of home care experience. When cases are considered to be outside the expected experience by involving an unusually high level of services in 60-day periods, Medicare will provide for extra or outlier payments in addition to the case-mix adjusted episode payment. Outlier payments can be a result of medically necessary high utilization of any or all of the service disciplines.

A claim is determined to be an outlier eligible claim if the number of visits of each discipline on the claim and each wage-adjusted

national standardized per visit rate for each discipline along with the sum of the episode payment and a wage-adjusted standard fixed loss threshold amount (CMS, 2013b, p. 24). Then, if the total product of the number of visits and the national standardized visit rate is greater than the case-mix specific payment amount plus the fixed loss threshold amount, a percentage of the difference may be payable to the home health agency. This amount will be a percentage of the amount that exceeds the case-mix payment and threshold. This outlier calculation is done automatically, and the home care agency does not need to submit anything to make a claim eligible. Because the outlier payment will show up on the electronic RA in a separate segment, the type of outlier does not need a long stay outlier payment because the number of continuous episodes-of-care for eligible beneficiaries is unlimited (CMS, 2013b, p. 25).

Home Health Prospective Payment System Consolidated Billing

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing of all home health services while a patient is under a POC for a home health agency that is authorized by a physician. The home health agency is considered to be overseeing the care for the patient, and any items or services are to be paid to a single home health agency overseeing the patient. The home health agency will be responsible for making payment to the other providers.

The types of service that are subject to the home health consolidated billing provision are skilled nursing care, home health aide services, physical therapy, speech–language pathology, occupational therapy, medical social services, routine and nonroutine medical supplies, medical services provided by an intern or resident-in-training of a hospital, and care for homebound patients involving equipment too cumbersome to take to the home (CMS, 2013b, p. 29). In some instances, a home health agency unaware of a vendor providing services either directly or under arrangement would not be responsible for payment to another provider when there was no knowledge of these services being rendered to the patient.

Under the Medicare Home Health Services Conditions of Participation: Patient Rights (42 CFR, §484.10 [c] [i]), the home health agency must advise the patient, in advance, of the disciplines (e.g., skilled nursing, physical therapy, or home health aide) that will furnish care and the frequency of visits proposed to be furnished. It is the responsibility of the home health agency to fully inform beneficiaries that all home health services, including therapies and supplies, will be provided by their primary home health agency (CMS, 2013b, p. 31).

In addition, under the Conditions of Participation: Patient Liability for Payment (42 CFR, §484.10[e]), home health agencies are responsible for advising the patient, in advance, about the extent to which payment is expected from Medicare or other sources, including the patient (CMS, 2013b, p. 31).

Responsibilities of Providers

Medicare makes payments to one home health agency under the consolidated billing process. With that in mind, it is the responsibility of the home health agency to determine if any other services or providers are in a patient's home before starting care with that patient. Therapy providers or suppliers can speak with the patient or caregivers to see if there are any providers of care presently giving care to the patient and document this in the medical record. This documentation does not shift any liability for payment to Medicare or the patient. Home health agencies can also check the CWF to see if any documentation exists showing that the patient is currently under the care of another agency.

Discharge Planning and Transfer Patients

Under the Medicare Conditions of Participation for Hospitals: Discharge Planning (42 CFR, §482.43 [b] [3] and [6]), hospitals must have a discharge process in place that applies to all patients and must include the evaluation or likelihood of the patient needing post-hospital services and of the availability of the services. The discharge planning evaluation must be present in the patient's medical record, and the hospital must discuss the planning process and evaluation with the patient and/or family members. In addition, under 42 CFR, §482.43 (c) (5), the patient and family or caregivers need to be counseled to prepare them to be able to handle post-acute care and 42 CFR, §482.43 (d) transfer or referral; the hospital must transfer or refer patients, along with the necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed for follow-up or ancillary care (CMS, 2013b, p. 33).

This process intends to make sure that not only the patient but the caregivers and family members are aware of which home health agency will be providing care for the patient and what services are going to be provided. Also, the hospital must give the patient freedom of choice to choose which agency that they would like to be transferred to after the hospital stay. The hospital must transfer all necessary information to the receiving agency to prepare for the admission of the patient.

Physician and Nonphysician Practitioners

A system that is designed for classifying health services based on the cost of furnishing physician services is called the RBRVS. This system is the federal government's payment system for physicians. RBRVS became effective on January 1, 1992. To avoid major disruptions to physicians' reimbursements, the RBRVS was gradually phased in, beginning in 1992 with full implementation by 1996 (Casto, 2018, p. 144).

A relative value scale permits comparisons of the resources needed or appropriate for various units of services. The relative value scale takes into account labor, skill, supplies, equipment, space, and other costs associated with each procedure or service in a physician's office (Casto, 2018, p. 145).

The structure of payment is based on a **relative value unit (RVU)** and has a geographic adjustment, and a conversion factor (CF). This system is based on the HCPCS, and each HCPCS/CPT code has been assigned an RVU. An RVU is defined as a unit of measure designed to permit comparison of the amount of resources required to perform various provider services by assigning weights to such factors as personnel time, level of skill, and sophistication of equipment required to render services to a patient (Casto, 2018, p. 141).

The fully implemented resource-based Medicare Physician Fee Schedule (MPFS) is calculated as follows:

$$\text{MPFS Amount} = \left[\left(\text{RVU}_w \times \text{GPCI}_w\right) + \left(\text{RVU}_{pe} \times \text{GPCI}_{pe}\right) + \left(\text{RVU}_m \times \text{GPCI}_m\right)\right] \times \text{CF}$$

- The RVU_w equals a relative value for physician work.
- The RVU_{pe} equals a relative value for practice expense.
- The RVU_m refers to a relative value for malpractice (MP).
- The GPCI_w is for physician work.
- The GPCI_{pe} is for practice expense.
- The GPCI_m is for MP.

The GPCI stands for **Geographic Practice Cost Indices**, which is the means in which each payment is adjusted based on the geography or payment locality. The last part of the equation is the CF. The CF is used in the computation of every MPFS amount. The current CF is $34.0230 (CMS, 2013a).

Work is the component that covers the physician's salary, which includes the work time that the physician spends working with the patient and the intensity in which that time is spent. The parts of intensity are mental effort and judgment, technical skill, physical effort, and psychological stress (Casto, 2018, p. 141).

Practice expense (PE) is the overhead and costs to operate the practice. CMS conducts a survey called the socioeconomic monitoring system (SMS) to obtain data to calculate the overhead costs of running a physician practice. The SMS includes six categories of costs. The first one is for clinical payroll that includes physician assistants, nurse practitioners but does not include the physician's payroll. The second expense category is administrative payroll, which covers the nonphysician administrative payroll for office managers and secretaries. The third category is for office expenses, which covers rent, mortgage, interest, depreciation, and utilities, such as telephone and electricity. The fourth category is for medical material and supply expenses that cover drugs, X-ray films, and disposable medical products. The fifth category is medical equipment expenses that include depreciation, leases, and rental for medical equipment. The sixth category is all other expenses that cover legal services, accounting, office management, professional association membership, and any professional expenses (Casto, 2018, p. 142).

The GPCI is an adjustment that adjusts for costs that vary in different parts of the country. This adjustment will take the relative differences in costs of a **market basket** of goods and normalize them to the area in which the practice is located.

The CF is an across-the-board multiplier that is a constant that applies to the entire calculation of a payment. The two categories that a physician can bill in are facility and nonfacility. For a facility setting, the physician is paid a facility rate in the inpatient hospital setting, outpatient hospital setting, emergency room setting, Medicare participating ambulatory surgical center, skilled nursing facility, ambulance (land or air), inpatient psychiatric facility, community mental health center, psychiatric residential treatment center, and comprehensive inpatient rehabilitation facility. A nonfacility setting is a pharmacy, school, homeless shelter, prison, office, home or private residence, group home, assisted living facility, mobile unit, temporary lodging, walk-in retail health clinic, urgent care facility, birthing center, nursing facility, custodial care facility, independent clinic, federally qualified health center, end-stage renal facility, rural health clinic, and independent laboratory, to name a few.

Ambulatory Surgical Center

History

Ambulatory surgical centers (ASCs) before 2008 handled specific surgical procedures under Medicare Part B. These procedures were those that generally did not exceed 90 minutes in length and did not require more than 4 hours of recovery time. Before 2008, Medicare did not pay an ASC for those procedures that required more than an ASC level of care. Beginning in January 2008, payment is made to ASCs under Medicare Part B for all surgical procedures, except those that CMS determines may pose a significant safety risk. Also, certain drugs and biologicals, OPPS pass-through devices, brachytherapy sources, and radiological procedures were covered at an ASC (CMS, 2010, p. 3).

In 2008, CMS started publishing updates to the list of procedures that an ASC can get paid for each year. This listing is also updated quarterly for new surgical procedures and covered ancillary services to establish payment indicators and payment rates for newly created

Level II HCPCS and Category III CPT codes. To be paid under this provision, a facility must be certified and must meet the requirements for ASC and accept Medicare's payment as payment in full for the services covered at an ASC. Certain other laboratory services or non-implantable DME may be performed when billed using the appropriate certified provider/supplier unique physician identification number (UPIN)/National Provider Identifier (NPI) (CMS, 2010, p. 4).

An ASC for Medicare is defined as an entity that operates exclusively to furnish outpatient surgical services. The ASC must have in effect an agreement with CMS in accordance with 42 CFR 416 subpart B. An ASC is either independent or operated by a hospital. A hospital-operated facility has the option of being considered by Medicare to be either an ASC or a provider-based department of a hospital (CMS, 2010, p. 4).

ASC Listing

ASC services are those surgical procedures that are identified by CMS and on a list that is updated annually. For surgical procedures not covered in ASCs, the related professional services may be billed by the rendering provider as Part B services, and the beneficiary is liable for the facility charges, which are not covered by Medicare.

Conclusion

The OPPS that started in 2000 has evolved into a complex prospective payment system. The outpatient environment includes outpatient services, home health, physician and NPP, and ambulatory surgical settings. Each area has a specific set of procedures and requirements to be compliant with regulations involving billing. Since 1992, the system that we call Medicare has evolved, and to remain competitive and continue to deliver quality patient care with a margin, the prospective payment system is needed to be understood by all levels of management and caregivers. This new way of reimbursing a healthcare facility has shifted the responsibility of profit and loss directly to the provider, much as the Inpatient Prospective Payment System has done on the acute care side. As hospitals continue to struggle with understanding this type of reimbursement, this chapter has introduced the many parts of the payment system, which will assist the healthcare professional in navigating through this payment system in the current state and future changes that may happen along the way.

References

Casto, A. B. (2018). *Principles of healthcare reimbursement* (6th ed.). Chicago, IL: AHIMA.

Centers for Medicare and Medicaid Services (CMS). (2010). Chapter 14: Ambulatory surgical centers. In *Medicare claims processing manual*. Retrieved from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf

Centers for Medicare and Medicaid Services (CMS). (2012). Chapter 4: Part B hospital (including inpatient hospital part B and OPPS). In *Medicare claims processing manual*. Retrieved from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

Centers for Medicare and Medicaid Services (CMS). (2013a). *CY 2013 Physician fee schedule final rule with comment period.* Retrieved from http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/physicianfeesched/

Centers for Medicare and Medicaid Services (CMS). (2013b). Chapter 10: Home health agency billing. In *Medicare claims processing manual*. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf