

**PAYING PROVIDERS BASED ON MEDICARE:
“HOW ARE THOSE FEES CALCULATED?”**

National PACE Association Annual Conference

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Introductions

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Outline

- > Medicare Physician Fee Schedule
- > Clinical Laboratory Fee Schedule
- > DME/POS Fee Schedule
- > Other Fee Schedules
- > Hospital Payment Rates
- > Ambulatory Surgery Centers

MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

Calculating Medicare Physician Non-Facility Fees

- > The formula for calculating 2008 MPFS Non-Facility payment amount is as follows:

$((\text{Work RVU} * \text{Budget Neutrality Adjustor (0.8806)})$
 $(\text{round product to two decimal places}) * \text{Work}$
 $\text{GPCI}) +$

$(\text{Non-Facility PE RVU} * \text{PE GPCI}) +$

$(\text{MP RVU} * \text{MP GPCI})] *$

Conversion Factor

Components of the MPFS

- > Procedure Codes
- > Relative Value Units (“RVUs”)
- > Geographic Practice Cost Indices (“GPCIs”)
- > Conversion Factor (“CF”)
- > Modifiers
- > Place of Service

Procedure Codes: CPT and HCPCS Codes

- > There are two subsystems with HCPCS:
 - o Level I of the HCPCS is comprised of CPT (Current Procedural Terminology) codes.
 - o Level II consists of codes typically referred to as the “HCPCS” codes.

Procedure Codes: CPT Codes

- > Include descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.
- > Consist of five numeric digits (e.g., 99212).
- > Are maintained by the American Medical Association (AMA).

Procedure Codes: HCPCS Codes

- > Are maintained by CMS.
- > Are used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).
- > Are also referred to as “alpha-numeric codes” because they consist of a single alphabetical letter followed by 4 numeric digits (e.g., J0010).

Relative Value Units (RVUs)

- > Work RVUs - reflect the relative levels of time and intensity associated with furnishing a physician service.
- > Practice Expense (PE) RVUs - reflect the costs of maintaining a practice such as renting office space, buying supplies and equipment, and staff costs.
- > Malpractice RVUs - reflect the resources physicians actually expend to acquire professional liability insurance.

GPCIs

- > Are used to account for geographic variations in the costs of practicing medicine in different areas within the country.
- > Adjustments that are applied to each of the three relative values used in calculating a physician payment.

GPCIs – an example

Addendum E - 2008** Geographic Practice Cost Indices by State and Medicare Locality					
			2008 GPCIs		
Carrier	Locality	Locality name	Work	PE	MP
00805	01	Northern NJ	1.057	1.225	1.038
00805	99	Rest of New Jersey	1.042	1.124	1.038
00521	05	New Mexico	1.000	0.888	0.989
00803	01	Manhattan, NY	1.064	1.299	1.243
00803	02	NYC Suburbs/Long I., NY	1.051	1.286	1.493
00803	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.983
14330	04	Queens, NY	1.032	1.235	1.449
00801	99	Rest of New York	1.000	0.919	0.544
00522	00	Oklahoma	1.000	0.853	0.503
00835	01	Portland, OR	1.002	1.037	0.453
00835	99	Rest of Oregon	1.000	0.926	0.453
00865	01	Metropolitan Philadelphia, PA	1.016	1.102	1.492
00865	99	Rest of Pennsylvania	1.000	0.914	0.938

Conversion Factors (CF)

- > Are updated on an annual basis according to a formula specified by statute.
- > Are based on the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compare to a target rate (the Sustainable Growth Rate (SGR)).

Conversion Factors by Year

Calendar Year	Conversion Factor	Change from Prior Year
2002	36.1992	-
2003 (eff 3/1/03)	36.7856	1.6199%
2004	37.3374	1.5000%
2005	37.8975	1.5001%
2006	37.8975	0.0000%
2007	37.8975	0.0000%
2008	38.0870	0.5000%
Proposed for 2009	38.5060	1.1000%

Original proposed change for 7/1/08 - 12/31/08	34.0862	-10.0569%
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Modifiers

- > Are used to submit additional information regarding the service provided.
- > Most have policy impacts, while a few have direct fee impact:
 - o 26 – professional service only
 - o TC – technical service only
 - o 00 – global service

Sample of Other Modifier Codes

Code	Description
50	Bilateral Procedure
51	Multiple Procedures
55	Postoperative Management Only
56	Preoperative Management Only
80	Assistant Surgeon

Place of Service (POS) codes

- > Are two-digit codes used to indicate the setting in which a service was provided.
- > CMS maintains POS codes used throughout the health care industry.

Sample POS Codes

Code	Description
11	Office
13	Assisted Living Facility
14	Group Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
32	Nursing Facility

Calculating Physician Non-Facility Fees

- > The formula for calculating 2008 MPFS Non-Facility payment amount is as follows:

$((\text{Work RVU} * \text{Budget Neutrality Adjustor (0.8806)})$
 $(\text{round product to two decimal places}) * \text{Work}$
 $\text{GPCI}) +$

$(\text{Non-Facility PE RVU} * \text{PE GPCI}) +$

$(\text{MP RVU} * \text{MP GPCI})] *$

Conversion Factor

Calculating Physician Facility Fees

> The formula for calculating 2008 MPFS Facility payment amount is as follows:

$((\text{Work RVU} * \text{Budget Neutrality Adjustor (0.8806)})$
 $(\text{round product to two decimal places}) * \text{Work}$
 $\text{GPCI}) +$

$(\text{Facility PE RVU} * \text{PE GPCI}) +$

$(\text{MP RVU} * \text{MP GPCI})] *$

Conversion Factor

Sample MPFS Calculations – Part I

HCPCS	Mod	Description	Work RVU	Budget Neutrality (BN)	Work RVU * BN	Round to 2 digits	Work GPCI	Work RVU * Work GPCI
99211	00	Office/outpatient visit, est	0.17	0.8806	0.1497	0.15	1.00	0.15
99212	00	Office/outpatient visit, est	0.45	0.8806	0.3963	0.40	1.00	0.40
99213	00	Office/outpatient visit, est	0.92	0.8806	0.8102	0.81	1.00	0.81
99214	00	Office/outpatient visit, est	1.42	0.8806	1.2505	1.25	1.00	1.25
99215	00	Office/outpatient visit, est	2.00	0.8806	1.7612	1.76	1.00	1.76
71010	00	Chest x-ray	0.18	0.8806	0.1585	0.16	1.00	0.16
71010	26	Chest x-ray	0.18	0.8806	0.1585	0.16	1.00	0.16
71010	TC	Chest x-ray	0.00	0.8806	0.0000	0.00	1.00	0.00
80050	00	General health panel	0.00	0.8806	0.0000	0.00	1.00	0.00
80051	00	Electrolyte panel	0.00	0.8806	0.0000	0.00	1.00	0.00
80053	00	Comprehen metabolic pan	0.00	0.8806	0.0000	0.00	1.00	0.00
90471	00	Immunization admin	0.17	0.8806	0.1497	0.15	1.00	0.15
90658	00	Flu vaccine, 3 yrs & >, im	0.00	0.8806	0.0000	0.00	1.00	0.00

Sample MPFS Calculations – Part 2

HCPCS	Mod	Description	Non-Facility Practice Expense RVU	Practice Expense GPCI	Non-Facility Practice Expense RVU * GPCI	Facility Practice Expense RVU	Practice Expense GPCI	Facility Practice Expense RVU * GPCI
99211	00	Office/outpatient visit, est	0.36	1.00	0.36	0.06	1.00	0.06
99212	00	Office/outpatient visit, est	0.55	1.00	0.55	0.15	1.00	0.15
99213	00	Office/outpatient visit, est	0.73	1.00	0.73	0.26	1.00	0.26
99214	00	Office/outpatient visit, est	1.06	1.00	1.06	0.42	1.00	0.42
99215	00	Office/outpatient visit, est	1.35	1.00	1.35	0.63	1.00	0.63
71010	00	Chest x-ray	0.48	1.00	0.48	0.48	1.00	0.48
71010	26	Chest x-ray	0.06	1.00	0.06	0.06	1.00	0.06
71010	TC	Chest x-ray	0.42	1.00	0.42	0.42	1.00	0.42
80050	00	General health panel	0.00	1.00	0.00	0.00	1.00	0.00
80051	00	Electrolyte panel	0.00	1.00	0.00	0.00	1.00	0.00
80053	00	Comprehen metabolic pan	0.00	1.00	0.00	0.00	1.00	0.00
90471	00	Immunization admin	0.38	1.00	0.38	0.38	1.00	0.38
90658	00	Flu vaccine, 3 yrs & >, im	0.00	1.00	0.00	0.00	1.00	0.00

Sample MPFS Calculations – Part 3

HCPCS	Mod	Description	Malpractice RVU	Malpractice GPCI	Malpractice RVU * GPCI
99211	00	Office/outpatient visit, est	0.01	1.00	0.01
99212	00	Office/outpatient visit, est	0.03	1.00	0.03
99213	00	Office/outpatient visit, est	0.03	1.00	0.03
99214	00	Office/outpatient visit, est	0.05	1.00	0.05
99215	00	Office/outpatient visit, est	0.08	1.00	0.08
71010	00	Chest x-ray	0.03	1.00	0.03
71010	26	Chest x-ray	0.01	1.00	0.01
71010	TC	Chest x-ray	0.02	1.00	0.02
80050	00	General health panel	0.00	1.00	0.00
80051	00	Electrolyte panel	0.00	1.00	0.00
80053	00	Comprehen metabolic pan	0.00	1.00	0.00
90471	00	Immunization admin	0.01	1.00	0.01
90658	00	Flu vaccine, 3 yrs & >, im	0.00	1.00	0.00

Sample MPFS Calculations – Part 4

HCPCS	Mod	Description	Total of Non-Facility RVU * GPCI	Total of Facility RVU * GPCI	Conversion Factor	2008 Medicare National Non-Facility Fee	2008 Medicare National Facility Fee
99211	00	Office/outpatient visit, est	0.52	0.22	38.09	\$19.81	\$4.36
99212	00	Office/outpatient visit, est	0.98	0.58	38.09	\$37.33	\$21.65
99213	00	Office/outpatient visit, est	1.57	1.10	38.09	\$59.80	\$65.78
99214	00	Office/outpatient visit, est	2.36	1.72	38.09	\$89.89	\$154.60
99215	00	Office/outpatient visit, est	3.19	2.47	38.09	\$121.50	\$300.10
71010	00	Chest x-ray	0.67	0.67	38.09	\$25.52	\$17.10
71010	26	Chest x-ray	0.23	0.23	38.09	\$8.76	\$2.01
71010	TC	Chest x-ray	0.44	0.44	38.09	\$16.76	\$7.37
80050	00	General health panel	0.00	0.00	38.09	\$0.00	\$0.00
80051	00	Electrolyte panel	0.00	0.00	38.09	\$0.00	\$0.00
80053	00	Comprehen metabolic pan	0.00	0.00	38.09	\$0.00	\$0.00
90471	00	Immunization admin	0.54	0.54	38.09	\$20.57	\$11.11
90658	00	Flu vaccine, 3 yrs & >, im	0.00	0.00	38.09	\$0.00	\$0.00

CLINICAL LAB FEE SCHEDULE

CLINICAL LAB

Clinical Laboratory Fee Schedule

- > Are developed in accordance with Section 1833(h) of the Social Security Act.
- > Fees are paid under Medicare Part B when they are furnished in a Medicare participating laboratory and ordered by a physician or qualified non-physician practitioner who is treating the patient.

CLINICAL LAB

Sample of the Clinical Lab Fee Schedule

2008 Clinical Diagnostic Laboratory							
Fee Schedule							
12/13/2007							
			NY1	NY2	PA	NY3	
		National	00801	00803	00865	14330	Short
HCP	Modifier	Limit	Loc 00	Loc 00	Loc 00	Loc 00	Desc
36415	00	\$0.00	\$3.00	\$3.00	\$3.00	\$3.00	Routine venipuncture
78267	00	\$10.98	\$10.98	\$10.98	\$10.98	\$10.98	Breath tst attain/anal c-14
78268	00	\$94.11	\$94.11	\$94.11	\$60.66	\$94.11	Breath test analysis, c-14
80047	00	\$0.00	\$30.29	\$18.70	\$30.51	\$18.70	Metabolic panel ionized ca
80048	00	\$11.83	\$11.20	\$8.93	\$11.83	\$8.93	Metabolic panel total ca
80051	00	\$9.80	\$8.93	\$7.45	\$9.80	\$7.45	Electrolyte panel
80053	00	\$14.77	\$14.77	\$13.36	\$14.77	\$13.36	Comprehen metabolic panel
80061	QW	\$0.00	\$18.72	\$18.72	\$18.72	\$18.72	Lipid panel
80061	00	\$0.00	\$18.72	\$18.72	\$18.72	\$18.72	Lipid panel
80069	00	\$12.13	\$12.13	\$11.20	\$12.13	\$11.20	Renal function panel
80074	00	\$0.00	\$66.54	\$66.54	\$66.54	\$66.54	Acute hepatitis panel
80076	00	\$11.42	\$11.20	\$8.93	\$11.42	\$8.93	Hepatic function panel
80100	00	\$20.32	\$20.32	\$20.32	\$20.32	\$20.32	Drug screen, qualitate/multi
80101	QW	\$19.24	\$19.24	\$19.24	\$19.24	\$7.04	Drug screen, single
80101	00	\$19.24	\$19.24	\$19.24	\$19.24	\$7.04	Drug screen, single
80102	00	\$18.51	\$18.51	\$18.51	\$18.51	\$8.76	Drug confirmation
80150	00	\$21.06	\$21.06	\$21.06	\$21.06	\$21.06	Assay of amikacin

**DURABLE MEDICAL EQUIPMENT
& PROSTHETICS, ORTHOTICS
AND SUPPLIES (DME/POS)
FEE SCHEDULE**

DME/POS Fee Schedule

- > Mandated by section 4062 of the Omnibus Budget Reconciliation Act (OBRA) of 1987, with some modifications afterwards.
- > Services include:
 - Durable medical equipment (DME);
 - Prosthetics and orthotics (P&O);
 - Parenteral and enteral nutrition (PEN);
 - Surgical dressings; and
 - Therapeutic shoes and inserts.
- > Includes fees for most HCPCS codes.

DME/POS

Sample of the DME/POS Fee Schedule

HCPCS	Mod	Description	Ceiling	Floor	CA	NY	OR
A4216	00	Sterile water/saline, 10 ml	\$0.45	\$0.38	\$0.45	\$0.41	\$0.38
A4259	00	Lancets per box	\$0.00	\$0.00	\$12.06	\$12.06	\$12.06
E0100	NU	Cane adjust/fixed with tip	\$21.07	\$17.91	\$19.99	\$21.07	\$20.72
E0148	NU	Heavyduty walker no wheels	\$127.05	\$107.99	\$127.05	\$127.05	\$127.05
E0148	RR	Heavyduty walker no wheels	\$12.72	\$10.81	\$12.72	\$12.72	\$12.72
E0148	UE	Heavyduty walker no wheels	\$95.28	\$80.99	\$95.28	\$95.28	\$95.28
L1902	00	Afo ankle gauntlet	\$85.82	\$64.37	\$73.76	\$84.24	\$78.92
L1904	00	Afo molded ankle gauntlet	\$505.56	\$379.17	\$505.56	\$392.12	\$379.17
Q0480	00	Driver pneumatic vad, rep	\$92,712.63	\$69,534.47	\$75,952.87	\$75,952.87	\$75,952.87

Resources

> Key Web sites:

- o <http://www.cms.hhs.gov/home/medicare.asp>
- o <http://www.cms.hhs.gov/PhysicianFeeSched/>
- o <http://www.cms.hhs.gov/PfsLookup/>
- o <http://www.cms.hhs.gov/ClinicalLabFeeSched/>
- o <http://www.cms.hhs.gov/DMEPOSFeeSched/>

OTHER CMS NON-HOSPITAL FEE SCHEDULES

Other CMS Fee for Service Payments

- > Ambulance <http://www.cms.hhs.gov/AmbulanceFeeSchedule/>
- > ESRD <http://www.cms.hhs.gov/PCPricer>
- > Home Health
- > Hospice
- > Long Term Care Hospital
- > Medicare Part B Drugs (J Codes)
- > Inpatient Psychiatric Hospital
- > Inpatient Rehabilitation
- > Skilled Nursing Facility

HOSPITAL INPATIENT PAYMENTS: DRGS

Diagnosis-Related Groups (DRGs)

- > Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.
- > This payment system is referred to as the Inpatient Prospective Payment System (IPPS).

Modifications to the DRG Model

- > The original objective of DRGs was to develop a patient classification system that related types of patients treated to the resources they consumed.
- > An updated version of the DRG model was adopted by CMS effective 10/1/07.
 - o Version #25, otherwise known as the “MS DRGs”, created 745 new severity-adjusted DRGs to replace the current 538.

HOSPITAL INPATIENT

Key Variations between DRGs and MS-DRGs

DRGs	MS-DRGs (effective 10/1/07)
25 MDCs and 538 DRGs.	25 MDCs and 745 MS-DRGs.
Each case was categorized into a DRG based on diagnosis and was assigned a payment weight based on the average resources used to treat Medicare patients in that DRG.	Cases are categorized based on not only the principal diagnosis, but also the severity of the patient's illness.
0-17 years of age is a consideration for a condition for a DRG assignment.	0-17 years of age is NOT a consideration for a condition for a DRG assignment (in most cases).
190 Transfer DRGs including 10 special pay transfer DRGs.	263 Transfer MS-DRGs which include 21 special pay transfer MS-DRGs.

HOSPITAL INPATIENT

Key Variations between DRGs and MS-DRGs

DRGs	MS-DRGs										
<p>CC – Complication/Comorbidity MCV – Major Cardiovascular diagnosis</p> <ul style="list-style-type: none"> • 115 DRGs are single or split based on “with CC”, “with MCV” or “without MCV/CC” • 3,326 CCs 	<p>CC – Complication/Comorbidity MCC – Major Complication/Comorbidity</p> <ul style="list-style-type: none"> • Revised list that eliminates some previous CCs, adds new ones, and adds/carves out a new list for conditions that are considered MCCs. • MS-DRGs have 3 levels of severity: <ul style="list-style-type: none"> ○ With MCC ○ With CC ○ With non-CC • 2,583 CCs 										
<p>Current Average Case Percentage</p> <table> <tr> <td>CC</td> <td>78%</td> </tr> <tr> <td>Non-CC</td> <td>22%</td> </tr> </table>	CC	78%	Non-CC	22%	<p>Current Average Case Percentage</p> <table> <tr> <td>MCC</td> <td>22%</td> </tr> <tr> <td>CC</td> <td>37%</td> </tr> <tr> <td>Non-CC</td> <td>41%</td> </tr> </table>	MCC	22%	CC	37%	Non-CC	41%
CC	78%										
Non-CC	22%										
MCC	22%										
CC	37%										
Non-CC	41%										

Calculating a DRG Rate

- > Hospitals submit key data (e.g., patient name, date of birth, facility, place of service, diagnosis code(s) and procedure code(s)).
- > Under the IPPS, each case is categorized into a DRG.
- > Each DRG has a payment weight assigned to it, which is based on the “average resources” used to treat Medicare patients in that DRG.

Calculating a DRG Rate (continued)

- > Several adjustments can be made to the base DRG rate:
 - Wage index;
 - Indirect Medical Education (IME);
 - Disproportionate Share (DSH);
 - Cost Outliers; and
 - Transfer Adjustments (in and out).

PACE-Specific Adjustments

> IME

- PACE programs follow the same payment rules as Medicare Advantage plans when a member of the plan receives care at a non-contracted provider.
- PACE and Medicare Advantage plans are not required to pay the IME portion of payment to non-contracted hospitals.

PACE-Specific Adjustments

> DSH

- DSH amounts are included in the capitation rates that PACE and Medicare Advantage organizations are paid.
- PACE and Medicare Advantage plans therefore must pass this payment on to non-contracted providers.

HOSPITAL INPATIENT

DRG Payment Rates – for Medicare

```
INDRV085.exe - COBOL Text Window
      INPAT PRICER 2008.5 PSF 08/04 <DISCHRG 10/2007-9/2008>
PROVIDER> 390111 HOSPITAL OF UNIV OF PENNSYLVANIA      PROU TYPE> 00 CEN-DIV> 2
EFF DATE> 20080201

      * OPERATING AMOUNTS *
PATIENT ID>000-00-0000A      O-FSP> $4,934.06      DRG WGT> 00.9308
      DRG> 124      O-HSP> $.00      GM ALOS> 03.9
      ADMIT DATE> 08/03/2008      O-OUTLR> $.00      AM ALOS> 05.3
      DISCH DATE> 08/04/2008      O-DSH> $633.04      WAGED SIZE> LARGE-URB
      FY BEG DATE> 07/01/2007      O-IME> $2,098.08      WAGED INDX> 01.0892
      LEN OF STAY> 001      * CAPITAL AMOUNTS *      PR WAGED INDX> 00.0000
      OUTLIER DAYS> 000      C-FSP> $420.57      GEO/STD CBSA> 37964/37964
      TRANSFER ADJ> 0.00000 NO      C-HSP> $.00      RECL CBSA> 37964 NO
      CHARGES AMT> $20,000.00      C-OUTLR> $.00      OPER/CAP CCR> 0.164/0.010
      PASS THRU AMT + $.00      C-DSH> $25.11      NAT LABOR> 3478.45
      NEW TECH AMT + $.00      C-IME> $147.90      NAT NLABOR> 1512.15
      TOT OPER AMT + $7,665.18      C-EXCEPT> $.00      NAT FSP AMT> $5,300.88
      TOT CAPI AMT + $593.58      C-OLD-HH> $.00      INT/BED RATIO> 0.9662
      *** TOTAL AMT = $8,258.76      CMI CPD AMT> $5,045.77
      PAY CODE> B
      *****> 00 CALCULATED AS FULL DRG PAYMENT
DRG DSC> OTHER DISORDERS OF THE EYE W MCC
MDC DSC> DISEASES & DISORDERS OF THE EYE
-----
U = VIEW THIS PROU  A = ADD PROU  B = CHANGE BILL  R = PRT REPORT  Q = QUIT  ENTER>
```

HOSPITAL INPATIENT

DRG Payment Rates - without IME

```
INDRV085.exe - COBOL Text Window
INPAT PRICER 2008.5 PSF 08/04 <DISCHRG 10/2007-9/2008>
PROVIDER> 390111 HOSPITAL OF UNIV OF PENNSYLVANIA   PROV TYPE> 00 CEN-DIU> 2
EFF DATE> 20080201

PATIENT ID> 000-00-0000A
DRG> 124
ADMIT DATE> 08/03/2008
DISCH DATE> 08/04/2008
FY BEG DATE> 07/01/2007
LEN OF STAY> 001
OUTLIER DAYS> 000
TRANSFER ADJ> 0.00000 NO
CHARGES AMT> $20,000.00
PASS THRU AMT + $ .00
NEW TECH AMT + $ .00
TOT OPER AMT + $5,567.10
TOT CAPI AMT + $593.58
*** TOTAL AMT = $6,160.68

* OPERATING AMOUNTS *
O-FSP> $4,934.06
O-HSP> $ .00
O-OUTLR> $ .00
O-DSH> $633.04
O-IME> $ .00

* CAPITAL AMOUNTS *
C-FSP> $420.57
C-HSP> $ .00
C-OUTLR> $ .00
C-DSH> $25.11
C-IME> $147.90
C-EXCEPT> $ .00
C-OLD-HH> $ .00

DRG WGT> 00.9308
GM ALOS> 03.9
AM ALOS> 05.3
WAGED SIZE> LARGE-URB
WAGED INDX> 01.0892
PR WAGED INDX> 00.0000
GEO/STD CBSA> 37964/37964
RECL CBSA> 37964 NO
OPER/CAP CCR> 0.164/0.010
NAT LABOR> 3478.45
NAT NLABOR> 1512.15
NAT FSP AMT> $5,300.88
INT/BED RATIO> 0.9662
CMI CPD AMT> $5,045.77
PAY CODE> B

****> HMO CLAIM> 00 CALCULATED AS FULL DRG PAYMENT
DRG DSC> OTHER DISORDERS OF THE EYE W MCC
MDC DSC> DISEASES & DISORDERS OF THE EYE

-----
U = VIEW THIS PROV A = ADD PROV B = CHANGE BILL R = PRT REPORT Q = QUIT ENTER>
```

HOSPITAL INPATIENT

DRG Payment Rates – Transfer In

```
INDRV085.exe - COBOL Text Window
      INPAT PRICER 2008.5 PSF 08/04 <DISCHRG 10/2007-9/2008>
PROVIDER> 390111 HOSPITAL OF UNIV OF PENNSYLVANIA   PROU TYPE> 00 CEN-DIU> 2
EFF DATE> 20080201

      * OPERATING AMOUNTS *
PATIENT0 ID>000-00-0000A
      0-FSP> $2,530.28
      DRG> 124      0-HSP> $.00
      ADMIT DATE> 08/03/2008      0-OUTLR> $.00
      DISCH DATE> 08/04/2008      0-DSH> $324.63
      FY BEG DATE> 07/01/2007      0-IME> $.00
      LEN OF STAY> 001
      * CAPITAL AMOUNTS *
      OUTLIER DAYS> 000      C-FSP> $215.68
      TRANSFER ADJ> 0.51282 REU=03      C-HSP> $.00
      CHARGES AMT> $20,000.00      C-OUTLR> $.00
      PASS THRU AMT + $.00      C-DSH> $12.88
      NEW TECH AMT + $.00      C-IME> $75.85
      TOT OPER AMT + $2,854.91      C-EXCEPT> $.00
      TOT CAPI AMT + $304.41      C-OLD-HH> $.00
      *** TOTAL AMT = $3,159.32

      DRG WGT> 00.9308
      GM ALOS> 03.9
      AM ALOS> 05.3
      WAGED SIZE> LARGE-URB
      WAGED INDX> 01.0892
      PR WAGED INDX> 00.0000
      GEO/STD CBSA> 37964/37964
      RECL CBSA> 37964 NO
      OPER/CAP CCR> 0.164/0.010
      NAT LABOR> 3478.45
      NAT NLABOR> 1512.15
      NAT FSP AMT> $5,300.88
      INT/BED RATIO> 0.9662
      CMI CPD AMT> $5,045.77
      PAY CODE> B

      ***** HMO CLAIM> 03 XFER CALC PERDIEM BASIS ADJUSTED OR FULL DRG
DRG DSC> OTHER DISORDERS OF THE EYE W MCC
MDC DSC> DISEASES & DISORDERS OF THE EYE

-----
U = VIEW THIS PROU  A = ADD PROU  B = CHANGE BILL  R = PRT REPORT  Q = QUIT  ENTER>
```

HOSPITAL INPATIENT

DRG Payment Rates – Transfer Out

```

INDRV085.exe - COBOL Text Window
      INPAT PRICER 2008.5 PSF 08/04 <DISCHRG 10/2007-9/2008>
PROVIDER> 390111 HOSPITAL OF UNIV OF PENNSYLVANIA      PROV TYPE> 00 CEN-DIU> 2
EFF DATE> 20080201

      * OPERATING AMOUNTS *
PATIENT# ID>000-00-0000A      O-FSP> $4,934.06      DRG WGT> 00.9308
      DRG> 124      O-HSP> $.00      GM ALOS> 03.9
      ADMIT DATE> 08/03/2008      O-OUTLR> $.00      AM ALOS> 05.3
      DISCH DATE> 08/04/2008      O-DSH> $633.04      WAGED SIZE> LARGE-URB
      FY BEG DATE> 07/01/2007      O-IME> $.00      WAGED INDX> 01.0892
      LEN OF STAY> 001      PR WAGED INDX> 00.0000
      OUTLIER DAYS> 000      * CAPITAL AMOUNTS *      GEO/STD CBSA> 37964/37964
      TRANSFER ADJ> 0.00000 NO      C-FSP> $420.57      RECL CBSA> 37964 NO
      CHARGES AMT> $20,000.00      C-HSP> $.00      OPER/CAP CCR> 0.164/0.010
      PASS THRU AMT + $.00      C-OUTLR> $.00      NAT LABOR> 3478.45
      NEW TECH AMT + $.00      C-DSH> $25.11      NAT NLABOR> 1512.15
      TOT OPER AMT + $5,567.10      C-IME> $147.90      NAT FSP AMT> $5,300.88
      TOT CAPI AMT + $593.58      C-EXCEPT> $.00      INT/BED RATIO> 0.9662
      *** TOTAL AMT = $6,160.68      C-OLD-HH> $.00      CMI CPD AMT> $5,045.77
      PAY CODE> B
      *****> HMO CLAIM> 00 CALCULATED AS FULL DRG PAYMENT
DRG DSC> OTHER DISORDERS OF THE EYE W MCC
MDC DSC> DISEASES & DISORDERS OF THE EYE

-----
J = VIEW THIS PROV A = ADD PROV B = CHANGE BILL R = PRT REPORT Q = QUIT ENTER>
  
```

HOSPITAL OUTPATIENT: OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

HOSPITAL OUTPATIENT

Outpatient Prospective Payment System (OPPS)

- > Section 4523 of the Balanced Budget Act of 1997 (BBA) provides authority for CMS to implement a prospective payment system (PPS) under Medicare for hospital outpatient services.
- > The provisions of this section were further modified by sections 201 and 202 of the Balanced Budget Refinement Act of 1999 (BBRA).

HOSPITAL OUTPATIENT

The following services are excluded from OPPS, and are separately payable:

- > Physician, Nurse Practitioner, Certified Nurse-Midwife, Physician Assistant, Qualified Clinical Psychologists, Clinical Social Workers and others
- > Dialysis services furnished to end-stage renal disease (ESRD) patients
- > Ambulance services
- > Diagnostic services and other diagnostic tests
- > Radiology and radiation therapy
- > Cancer chemotherapy
- > And more...

HOSPITAL OUTPATIENT

Non-physician or other health care provider's portion of the following services are included within the scope of OPPTS:

- > Surgical procedures, clinic visits and emergency department visits
- > Diagnostic services and other diagnostic tests
- > Surgical pathology
- > Partial hospitalization
- > Psychiatric services
- > And more...

Ambulatory Payment Classification

- > All services paid under OPPS are classified into groups called Ambulatory Payment Classifications or “APCs”.
 - Services in each APC are similar clinically and in terms of the resources they require;
 - A payment rate is established for each APC; and
 - Unlike DRGs, depending on the services provided, hospitals may be paid for more than one APC for an encounter.

HOSPITAL OUTPATIENT

Computing an APC Payment Rate

APC GROUP INFORMATION: INTEGUMENTARY SYSTEM

CPT Code	Description	Coverage	Effective Date of Changes	Source	APC Group	APC Status	Payment Rate	National Adjusted Copay
10021	Fna w/o image		01/01/08	FR 11/27/07	0002	T	\$70.68	\$14.14
▲ 10022	Fna w/image	?	01/01/08	FR 11/27/07	0004	T	\$275.60	\$55.12
▲ 10040	Acne surgery	?	01/01/08	FR 11/27/07	0013	T	\$50.51	\$10.10
10060	Drainage of skin abscess		01/01/08	FR 11/27/07	0006	T	\$89.59	\$17.92
10061	Drainage of skin abscess		01/01/08	FR 11/27/07	0006	T	\$89.59	\$17.92
10080	Drainage of pilonidal cyst		01/01/08	FR 11/27/07	0006	T	\$89.59	\$17.92
10081	Drainage of pilonidal cyst		01/01/08	FR 11/27/07	0007	T	\$736.26	\$147.25
10120	Remove foreign body		01/01/08	FR 11/27/07	0006	T	\$89.59	\$17.92
10121	Remove foreign body		01/01/08	FR 11/27/07	0021	T	\$1,025.48	\$219.48

HOSPITAL OUTPATIENT

Computing an APC Payment Rate

Steps for Computing the Labor-Adjusted Medicare Program Payment and the Beneficiary Copayment

Step 1 (adjusted labor component of rate)

National APC group payment rate	\$100
x Standardized labor-related portion	x 0.60
= National labor component of rate	= \$60
x CMS wage index	x 1.1
= Adjusted labor component of rate	= \$66

Step 2 (unadjusted non-labor component of rate)

National APC group payment rate	\$100
x Standardized non-labor-related portion	x 0.40
= Unadjusted nonlabor component of rate	= \$40

Step 3 (labor-adjusted APC payment rate)

Adjusted labor component of rate	\$66
+ Unadjusted nonlabor component of rate	+ \$40
= Labor-adjusted APC payment rate	= \$106

Step 4 (Medicare program payment amount)

Labor-adjusted APC payment rate	\$106
- Deductible (if applicable)	\$0
x Lower of 80% or the APC group's Medicare program payment %	x 75%
= Medicare program payment amount	= \$79.50

Step 5 (APC copayment amount)

Labor-adjusted APC payment rate	\$106
- Deductible (if applicable)	- \$0
- Medicare program payment amount	- \$79.50
= Beneficiary copayment amount	= \$26.50

Source: Medicare Program; "Prospective Payment System for Hospital Outpatient Services," Final Rule with Comment Period, *Federal Register*, April 7, 2000

HOSPITAL OUTPATIENT OPPS Wage Index

APC Table 3. Wage Index Adjustments for Hospitals

CBSA Code	Urban Area (Constituent Counties)	OPPS Wage Index	CBSA Code	Urban Area (Constituent Counties)	OPPS Wage Index
42644	¹ Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1363	45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9028
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9704	45300	¹ Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9171
43100	² Sheboygan, WI Sheboygan County, WI	0.9684	45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.8824
43300	Sherman-Denison, TX Grayson County, TX	0.8531	45500	² Texarkana, TX- ² Texarkana, AR (TX Hospitals) Miller County, AR Bowie County, TX	0.8198
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8552	45500	Texarkana, TX- ² Texarkana, AR (AR Hospitals) Miller County, AR Bowie County, TX	0.7782
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9083			
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD	0.9554			

AMBULATORY SURGERY CENTER: ASC PAYMENT RATES

ASC

ASC Payment Rate

- > The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to revise the ASC payment system no later than January 1, 2008.
- > Hospitals must report CPT/HCPCS codes.
- > The hospital is paid based on the procedure(s) completed. There is a complex formula for calculating the actual payment to the hospital.

ASC

ASC Payment Rules

- > Providers are paid the lesser of their actual charge versus the standard ASC payment rate.
- > Certain services have a cap on the payment rates. Payments can not exceed the MPFS non-facility practice expense amount for:
 - Surgical procedures that are commonly performed in physicians' offices; and
 - Technical components of covered ancillary radiology procedures.

ASC Payment Rates

21825		Outpatient Billing Expert					
CPT/ HCPCS	Description	Subject to Discount	Effective Date	Source	ASC Payment Indicator	ASC Payment Rate	ASC Copayment
21825	Treat sternum fracture		01/01/08	FR 11/27/07	C5		
21899	Neck/chest surgery procedure		01/01/08	FR 11/27/07	U5		
21920	Biopsy soft tissue of back	Y	01/01/08	FR 11/27/07	P3	\$131.50	\$26.30
21925	Biopsy soft tissue of back	Y	01/01/08	FR 11/27/07	A2	\$552.99	\$110.60
21930	Remove lesion, back or flank	Y	01/01/08	FR 11/27/07	A2	\$552.99	\$110.60
21935	Remove tumor, back	Y	01/01/08	FR 11/27/07	A2	\$600.99	\$120.20
22010- 22015	I&d, p-spine		01/01/08	FR 11/27/07	C5		
22100- 22101	Remove part of vertebra		01/01/08	FR 11/27/07	X5		
22102	Remove part, lumbar vertebra	Y	01/01/08	FR 11/27/07	G2	\$1,936.42	\$387.28

CMS Payment Indicator	Explanation Indicator
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
C5	OPPS inpatient-only procedure
E5	Not covered by Medicare

APC and ASC Payment Rules

> Key Web sites:

- o <http://www.cms.hhs.gov/HospitalOutpatientPPS/>
- o <http://www.cms.hhs.gov/ASCPayment/>

> Other resources:

- o Ingenix Outpatient Billing Expert and the OPSS Manager

Questions and Answers