



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 7: Medicare Outpatient Payment Systems

- I. Overview of the Outpatient Prospective Payment System (OPPS)
 - A. OPPS applies to most, but not all, hospitals.
 1. Hospitals that are not paid under OPPS include certain Maryland hospitals and Critical Access Hospitals¹. <42 C.F.R. 419.20>
 - B. OPPS pays for most, but not all, covered hospital outpatient services, and specified hospital inpatient services. <42 C.F.R. 419.21(a) and (b); 42 C.F.R. 414.5>

Services not paid under OPPS

- Physician and professional services furnished by specified NPPs – MPFS
- Services in non-excepted off-campus provider-based departments – MPFS
- Outpatient therapy (PT, OT, and ST) – MPFS
- Certain durable medical equipment, prosthetics, orthotics – DME Fee Schedule
- Certain clinical diagnostic laboratory services – CLFS
- Telehealth Originating Site Fee - MPFS
- Services and supplies furnished to ESRD patients – to the ESRD provider
- Services and supplies furnished to SNF patients – to the SNF

C. OPPS Addendum B

1. The OPPS is HCPCS code driven. Addendum B is a master list of all HCPCS codes and identifies the payment system or payment status for each code and the payment amount under OPPS, if applicable.
 - a. Selected pages from the current Addendum B are included in the Supplement to these materials.

¹ Critical Access Hospitals must be located in rural areas and generally be 35 miles from another like hospital. They have a maximum of 25 beds and an average length of stay of no more than 96 hours.

2. Addendum B is published with the OPPS Final Rule each year and updated quarterly.

Link: OPSS – Regulations and Notices under Medicare-Related Sites - Hospital

3. The Addendum B quarterly updates do not generally change payment rates established in the OPSS Final Rule with the exception of updating drug payment rates to the new quarterly Average Sales Price (ASP). The quarterly update may also add new HCPCS codes and rates, e.g., for new pass-through drugs.

Link: OPSS – Addendum A&B under Medicare-Related Sites - Hospital

D. Status Indicators

1. Each HCPCS code is assigned a Status Indicator in Addendum B to indicate the payment system or payment status for the code. <Medicare Claims Processing Manual, Chapter 4 § 10.1.1>
2. The key for the Status Indicators is published as Addendum D1 to the OPSS final rule each year. Handout 13 is Addendum D1.

Caution: The fact a HCPCS code is assigned a payable Status Indicator does not mean the item or service is covered under Medicare. The Status Indicator simply indicates how the item or service will be paid if the service meets coverage requirements.

E. Ambulatory Payment Classifications (“APCs”)

1. APCs are outpatient payment groups (similar to inpatient DRGs) that set a single payment rate for a group of HCPCS codes that are clinically similar and have comparable resource use. <42 C.F.R. 419.31(a)>

Each OPSS payable HCPCS code maps to an APC and all HCPCS codes mapped to the same APC have the same payment rate.

2. Addendum A is the master list of APCs and is published with the OPSS Final Rule each year and updated on a quarterly basis.
 - a. The current Addendum A is included in the Supplement to these materials.

Case Study 1

Facts: A Medicare patient presented to a hospital-based clinic for an incision and drainage of a complicated skin abscess (10061). What is the APC for this procedure?

Modified Facts: If the procedure had instead involved removal of a foreign body (10120), what is the APC for this procedure? What is the payment difference between incision and drainage of the skin abscess and the foreign body removal?

Modified Facts: If the procedure was performed by a salaried physician employed by the hospital, will payment for APC 5052 include payment for the physician's professional services?

II. Comprehensive APCs (C-APCs)

- A. C-APCs are special APCs that provide for a single encounter-based payment for most services rendered during a single encounter reported together on the same claim.

Services excluded from the C-APC payment and paid separately:

- Ambulance Services
- Preventative services
- Screening and diagnostic mammography
- Pass-through (new) drugs, biologicals, and devices
- Brachytherapy seeds and sources
- Therapy under a therapy plan of care, billed on a separate facility claim, discussed below
- Cost based services (vaccines, corneal tissue, certain rural CRNA services)
- Procedure codes assigned to New Technology APCs
- Drugs or biologicals reported with C9399 (Unclassified drugs or biologicals)
- Specified COVID-19 Treatments, from November 2, 2020, through the end of the COVID-19 Public Health Emergency, discussed below

Note: Non-covered services, including self-administered drugs, are also excluded.

1. Therapy Services provided with C-APCs

- a. Therapy services provided under a therapy plan of care and billed on a separate monthly facility claim are excluded from the C-APC payment and paid separately. <79 Fed. Reg. 66800, 80 Fed. Reg. 70326-327; Medicare Claims Processing Manual, Chapter 4 § 10.2.4>
- b. Therapy services provided during the perioperative period that are not part of a therapy plan of care are included in the C-APC for the procedure. <79 Fed. Reg. 66800, 83 Fed. Reg. 58838; Medicare Claims Processing Manual, Chapter 4 § 10.2.4>
 - i. Therapy services that are not part of a plan of care and are packaged to a C-APC may be reported in one of two ways:
 - a) Under revenue code 940 (Other Therapeutic Services) with no HCPCS code; or
 - b) Under the appropriate therapy revenue code with a therapy HCPCS code and all required modifiers and occurrence codes. <Medicare Claims Processing Manual, Chapter 4 § 10.2.4>

B. There are three types of C-APCs:

1. HCPCS codes with status indicator J1 trigger surgical C-APCs, discussed below.
2. HCPCS codes with status indicator J2 trigger the Observation C-APC, discussed in a later module.
3. Inpatient only procedures reported with modifier -CA are paid under a special C-APC, discussed in a later module.

C. Surgical Comprehensive APCs (C-APCs)

1. Table 2 of the CY2024 OPPS Final Rule contains a list of the 71 finalized surgical C-APCs grouped in their Clinical Families, along with the observation and inpatient only C-APCs. Table 2 is included in the materials behind the outline. <88 Fed. Reg. 81563>
2. There are 3,110 primary procedures that drive the assignment of a surgical C-APC. These primary procedures are assigned status indicator J1. <January 2024 IOCE Quarterly Data Files, Report-Table, Data_CAPC (Supplement)>

3. The list of HCPCS codes triggering a surgical C-APC is published in Addendum J of the OPPS Final Rule each year and updated quarterly in the IOCE Quarterly Data Files, Report-Table folder, “Data_CAPC” available on the IOCE homepage. The current list is included in the Supplement to these materials.

Link: OCE Quarterly Files – Specifications and Report Tables under Medicare-Related Sites – Hospital

4. Steps to determine assignment of a surgical C-APC
 - a. Step 1: Identify the primary procedure
 - i. Look up all status indicator J1 procedures on the C-APC Rankings table (IOCE Quarterly Data Files, Report-Table folder, “Data_CAPC”) and determine the highest-ranking procedure (i.e., lowest number in the rank column). This procedure is considered the primary procedure and will control assignment of the C-APC. <IOCE Specifications, Section 6.6.1 C, 6.6.1.1, 6.6.3 (Supplement)>
 - ii. If multiple units of the primary procedure are reported or the primary procedure is reported with modifier 50, the units are reduced to one and the modifier ignored for purposes of paying a single C-APC payment. <See IOCE Specifications, Section 6.6.1 D, 6.6.3 (Supplement)>
 - b. Step 2: Determine if the case potentially qualifies for complexity adjustment
 - i. If there is a “1” in the “COMPLEXITY_ADJUSTMENT” column on the C-APC Rankings (“Data_CAPC”) table, the case potentially qualifies for complexity adjustment. Go to Step 3.
 - ii. If there is a “0” in the “COMPLEXITY_ADJUSTMENT” column, denoting the code is not eligible for complexity adjustment, no further steps are taken and the C-APC for the primary procedure determined in Step 1 is assigned.
 - c. Step 3: Determine if a complexity adjustment applies.
 - i. Look up the primary procedure in the CODE1 column on the Complexity Adjustment Pairs table (IOCE Quarterly Data Files, Report-Table folder, “Map_CAPC”). If a code reported on the claim is listed in the CODE2 column next to the primary procedure code, the case will qualify for a complexity adjustment and the applicable C-APC will be increased by one level as designated in the “APC” column on the table. <IOCE Specifications, Section 6.6.1.1, 6.6.3 (Supplement)>

- ii. Multiple units of a primary procedure code or the primary procedure code reported with modifier -50 may qualify for complexity adjustment if the primary procedure code is repeated in the CODE2 column. <See *IOCE Specifications*, Section 6.6.3 (Supplement)>
- iii. The Complexity Adjustment Pairs table is updated quarterly and is available in the IOCE Quarterly Data Files, Report-Table folder, “MAP_CAPC” on the IOCE homepage. The current table is included in the Supplement to these materials.

5. Handout 14 contains a table with Comprehensive APC assignment examples.

III. Composite APCs

- A. Composite APCs are special APCs that provide for a single payment when multiple outpatient services, coded with specified HCPCS codes, are reported together on the same claim.
- B. HCPCS codes with status indicator Q3 have been assigned to Composite APCs. Addendum M to the OPSS Final Rule identifies the Composite APC for each code assigned status indicator Q3. Addendum M is included in the materials behind the outline.
- C. There are three types of Composite APCs:
 - 1. Imaging Family Composite APCs (APCs 8004-8008), discussed in a later module.
 - 2. Critical Care Composite APCs (APCs 5041, 5045), discussed in a later module.
 - 3. Daily Mental Health Composite APC (APC 8010), discussed in a later module.
- D. If the criteria for composite payment are met, the status indicator Q3 HCPCS codes are packaged into payment for the composite APC and are not paid separately. <See *IOCE Specifications*, Section 6.5 (Supplement); OPSS Addendum D1>
- E. If the criteria for composite payment are not met, the status indicator Q3 HCPCS code is paid according to its single code APC assignment specified on Addendum M. <See *IOCE Specifications*, Section 6.5 (Supplement); OPSS Addendum D1>

IV. Packaged Services under OPPS

- A. Packaged services are covered services that are separately reportable but are not separately payable. Payment for packaged services is included in other separately payable services, whether or not they are clinically related.

Caution: Even though no separate payment is made from Medicare for packaged services, it is not appropriate to bill the patient for them because CMS considers payment for them to be included in payment for other paid items on the claim.

- B. Although separate payment is not made for packaged services, the costs of those services are used for outlier calculations and future rate setting. Hospitals should report appropriate HCPCS codes, based on coding instructions from CPT and CMS, and charges for all packaged services they provide to ensure the costs for those services are accounted for appropriately. <Medicare Claims Processing Manual, Chapter 4 § 10.4 A>

- C. There are four types of packaged services:

1. Services identified by Status Indicator N are always packaged and never received separate payment. <OPPS Addendum D1>

Examples: hourly observation, supplies, most drug, including diagnostic drugs

2. Services identified by Status Indicator Q1 are packaged if another service with Status Indicator J1 (C-APC), S (significant service), T (surgical service), or V (visit) is reported on the same claim. <OPPS Addendum D1>

- a. Status Indicator Q1 services are only paid separately if no Status Indicator J1, S, T, or V service is reported on the same claim. <OPPS Addendum D1>

Examples: minor procedures, x-rays, EKGs, pathology, blood bank

3. Services identified by Status Indicator Q2 are packaged if another service with Status Indicator J1 (C-APC) or T (surgical service) is reported on the same claim. <OPPS Addendum D1>

- a. Status Indicator Q2 services are only paid separately if no Status Indicator J1 or T service is reported on the same claim. <OPPS Addendum D1>

Examples: add-on procedures and diagnostic components of surgeries

4. Laboratory services identified by Status Indicator Q4 are packaged if another service with Status Indicator J1, J2, S, T, V, Q1, Q2, or Q3 is reported on the same claim. <OPPS Addendum D1>
 - a. Status Indicator Q4 laboratory services are paid separately under the CLFS only if no other OPPS payable service appears on the same claim. Packaging of laboratory services is discussed in a later module.

Examples: clinical lab, except molecular pathology and preventative labs

D. Conditional Packaging Rules

1. Status Indicator Q1 or Q2 Codes Reported with Q3 Codes
 - a. If a status indicator Q1 code is reported on the same day as any Q3 code, the Q1 code is always packaged because all Q3 codes have status indicators S or V assigned to their standard APCs. <See *IOCE Specifications*, Section 6.4.1 (Supplement); OPPS Addendum B and D1>
 - b. If a status indicator Q2 code is reported on the same day as any Q3 code, the Q2 code is not subject to packaging because no Q3 code is assigned status indicator T. <See *IOCE Specifications*, Section 6.4.1 (Supplement); OPPS Addendum B and D1>
2. Status Indicator Q1 or Q2 Paid Separately
 - a. If not packaged, services with status indicator Q1 or Q2 are paid separately under their standard APC and status indicator. <See *IOCE Specifications*, Section 6.4.1 (Supplement); OPPS Addendum D1>
 - i. The standard status indicator for a Q1 or Q2 code can be verified by looking up the APC (from Addendum B) on Addendum A.
 - b. If a service with status indicator Q1 or Q2 is paid separately, the service units are reduced to one and a single unit is paid. <See *IOCE Specifications*, Section 6.4.1 (Supplement)>
 - c. If a service with status indicator Q1 or Q2 is paid separately and is reported with modifier 50 (bilateral procedure), the modifier is ignored. <See *IOCE Specifications*, Section 6.4.1 (Supplement)>
 - d. If more than one Q1 or Q2 code is reported, and no code is reported that triggers packaging, payment is made for the highest paying Q1 or Q2 code

and all other Q1 and Q2 codes are packaged. <See *IOCE Specifications*, Section 6.4.1 (Supplement); *Medicare Claims Processing Manual*, Chapter 4 § 10.4 C>

3. Handout 15 is a table with packaging examples.

Case Study 2

Facts: A Medicare patient received an x-ray of the lower spine while bending (72120) followed by a contrast x-ray (myelography) of the lower spine (72265). These two services are the only services the patient receives that day. Will Medicare pay separately for these two procedures? If not, which procedure will be paid?

V. OPPS Payment

1. The national “unadjusted” payment rate for each HCPCS code, published in Addendum B, is equal to the relative weight for the HCPCS code multiplied by a national OPPS “conversion factor.” <42 C.F.R. 419.32(c); 88 Fed. Reg. 81591>
2. There are two national OPPS “conversion factors” established by CMS annually and published in the OPPS Final Rule each year:
 - a. For 2024, the “full market basket” conversion factor is \$87.382. <88 Fed. Reg. 81583>
 - i. The full market basket conversion factor is used for hospitals who meet Hospital Outpatient Quality Data Reporting Program requirements.
 - b. For 2024, the “reduced market basket” conversion factor is \$85.687. <88 Fed. Reg. 82012>
 - i. Hospitals that fail to meet the quality reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program receive approximately 2% reduction (.9806) in their payment rate for services with status indicators J1, J2, P, Q1, Q2, Q3, R, S, T, U, and V. <88 Fed. Reg. 82011>
 - a) The Hospital Outpatient Quality Reporting (OQR) Program - Annual Payment Update (APU) Determinations list is posted on the QualityNet.org website.

Link: QualityNet Main Page under Medicare-Related Sites - General

B. Calculating the hospital specific payment rate for each HCPCS code

2. Step 1: Determine the national unadjusted payment rate.

- a. The national payment rate published in Addendum B is the “full” national unadjusted payment rate for hospitals meeting the Hospital OQR Program requirements. <88 Fed. Reg. 81591>
- b. For hospitals not meeting the Hospital OQR Program requirements, the payment rate published in Addendum B for services with status indicators “J1”, “J2”, “P”, “Q1”, “Q2”, “Q3”, “Q4”, “R”, “S”, “T”, “U”, or “V” is multiplied by .9806 to arrive at the “reduced” national unadjusted payment rate. <88 Fed. Reg. 81591, 82011>

3. Step 2: Adjust the national rate by the hospital’s wage index

- a. The applicable national “unadjusted” payment rate is adjusted to reflect geographic differences in labor costs as reflected by the wage index published in the IPPS Final Rule for the hospital’s locality. <42 C.F.R. 419.43(a) through 419.43(c); 88 Fed. Reg. 81592>
 - i. The wage index used for the calendar year is the wage index for the applicable fiscal year, i.e., the FY2024 wage index applies to OPPS services in CY2024. <88 Fed. Reg. 81592>
- b. Overview of the wage index

The wage index is a ratio of average hourly hospital wage-related costs in a given labor market area relative to the national average hourly wage-related costs for all IPPS hospitals.

- If the wage related costs are less than the national average, the wage index for the geographic area will be less than 1.0.
 - For example, the lowest wage index is 0.7121 for rural Alabama
- If the wage related costs are more than the national average, the wage index for the geographic area will be more than 1.0.
 - For example, the highest wage index is 1.8911 for Vallejo, CA

c. Wage Index Tables

- i. Table 3 to the IPPS Final Rule provides the wage indices for rural and urban areas by Core Based Statistical Area (CBSA).

Link: [IPPS – FY2024 Final Rule Home Page under Medicare-Related Sites – Hospital](#)

- a) CMS publishes a data file with a crosswalk between counties and their CBSAs. The FY2024 “County to CBSA Crosswalk File” is included in the Supplement to these materials.
- b) Hospitals located in an urban area, designated by a five-digit CBSA, receive the urban wage index.
- c) Hospitals not located in an urban area (i.e., designated as rural on the crosswalk file) receive the rural wage index for their state, indicated by a two-digit CBSA.
- d) Hospitals that have been reclassified to a different CBSA receive the “reclassified wage index” for the urban or rural CBSA to which they have been reclassified.

The Medicare Geographic Classification Review Board (MGCRB) considers applications for geographic reclassification. Applications for reclassifications effective for FY2024 were due September 1, 2022.

d. Special Wage Index Provisions

i. Wage Index Rural Floor

- a) The wage index for an urban area may not be lower than the statewide rural wage index for that state. <88 Fed. Reg. 58971>

ii. Frontier Wage Index Floor

- a) Montana, Nevada, North Dakota, South Dakota and Wyoming are classified as frontier states for wage index purposes and are subject to a frontier wage index floor of 1.0000. <88 Fed. Reg. 58977, Table 3 IPPS Final Rule>

- 1) The Nevada statewide rural wage index is 1.2372 for FY2024 which exceeds the Frontier Wage Index Floor. This results in application of the Rural Wage Index Floor rather than the Frontier State Wage Index Floor for the state of Nevada.

iii. Temporary Policy to Address Wage Index Disparities

- a) For four years, beginning in FY2020, hospitals with a wage index value below the 25th percentile of all hospitals will have their wage index increased by half the difference between the otherwise applicable wage index and the 25th percentile. <88 Fed. Reg. 58978>

- 1) The 25th percentile wage index value across all hospitals for FY2024 is 0.8667. <88 Fed. Reg. 58978>
- 2) This policy is designed to allow lower wage index hospitals an opportunity to increase their wages and thereby increase their wage index. <88 Fed. Reg. 58978>

iv. Cap on the decrease in wage index

- a) There is a 5 percent cap on any decrease to a hospital's wage index from its wage index in the prior fiscal year, regardless of the circumstances causing the decline. A hospital's wage index will not be less than 95% of its final wage index for the prior fiscal year. <88 Fed. Reg. 58980>
- e. The wage index is only applied to 60% of the unadjusted payment rate, which CMS estimates to be the labor-related costs. <Medicare Claims Processing Manual, Chapter 4 §§ 10.8, 30.2, 88 Fed. Reg. 81592>

Example: The national allowable for an APC is \$100 and the wage index for the hospital's area is .90.

$$\text{Hospital Specific Payment} = \$40 + (\$60 \times .90) = \$94$$

- f. The wage index adjustment is applicable to services with status indicators J1, J2, P, Q1, Q2, Q3, S, T, and V. <87 Fed. Reg. 71791>
- i. Services with status indicator R and U are not subject to wage index adjustment. <88 Fed. Reg. 81591>

III. Outpatient Deductibles and Coinsurance

- A. The Part B deductible for 2024 is \$240 per year. <88 Fed. Reg. 71562>
- B. The Part B coinsurance is typically 20%. <Medicare Claims Processing Manual, Chapter 4 § 30>

Three APCs have a coinsurance of higher than 20% due to a transitional calculation from the beginning of the OPSS. A table with affected APCs and their coinsurance percentage is included in the materials behind the outline.

- C. The coinsurance amount for any single APC, including the coinsurance for associated drugs, biologicals and blood products, may not exceed the inpatient deductible for the applicable year (\$1632 for CY2024). <42 C.F.R. 419.41(c)(4)(i)>

1. The coinsurance cap is first applied to the procedural APC, then to the blood product and finally distributed across the payable drug and biological APCs in relationship to their payment amounts. <Medicare Claims Processing Manual, Transmittal 3602>
2. See examples of how this calculation is made in an excerpt from *Medicare Claims Processing Manual Transmittal 3602* included in the materials behind the outline.

- D. The coinsurance amount is calculated based on the payment rate prior to outlier adjustment. <42 C.F.R. 419.41(c)(4)(iv)>
- E. There is no deductible or coinsurance for the Initial Preventative Physical Exam or for preventative services that are covered by Medicare and recommended with a grade A or B by the United States Preventative Services Task Force. <Medicare Claims Processing Manual, Chapter 18 § 1.3>
1. A complete table of preventative services and whether they are subject to deductible and coinsurance is published in the *Medicare Claims Processing Manual*, Chapter 18 § 1.2.>
- F. Handout 16 is an example of the calculation of the Medicare OPPS payment rate and coinsurance.

IV. Outliers

- A. Outlier payments are made when the cost of a given outpatient service exceeds a certain “outlier threshold.” <42 C.F.R. 419.43(d)>
1. The outlier calculation is made for each separately payable line on the claim. <Medicare Claims Processing Manual, Chapter 4 §§ 10.7.1, 50.4>
 2. Outlier payment is not made for services or items with status indicators G (pass-through drugs), K (non-pass-through drugs), or H (pass-through devices). <Medicare Claims Processing Manual, Chapter 4 § 50.4>
- B. Determining If a Service Qualifies for Outlier Payment
1. For purposes of determining whether a service qualifies for outlier payment, the hospital’s costs must exceed both:
 - a. The “outlier cost threshold”, determined by multiplying 1.75 times the wage index adjusted allowable; and
 - b. The “fixed-dollar threshold”, determined by adding \$7,750 to the wage index adjusted allowable. <88 Fed. Reg. 81591>

2. Determining Cost

- a. For purposes of outlier calculations, cost is determined by multiplying covered charges by the hospital's outpatient cost-to-charge ratio (CCR).
 - i. Covered charges are determined for each separately payable line by allocating the packaged services on the claim across the payable lines based on the percent of payment for the line compared to total payment for the claim. <Medicare Claims Processing Manual, Chapter 4 §§ 10.7.1, 50.4>
 - a) If more than one status indicator S or T procedure is reported, and one or more of them have a charge less than \$1.01, the charges for all S or T procedures are summed and then allocated across the S and T lines in proportion to the percent of payment for the line compared to the total payment for the claim. <Medicare Claims Processing Manual, Chapter 4 §§ 10.7.1, 50.4>
 - ii. Each provider has an outpatient CCR separate from their inpatient CCR. <Medicare Claims Processing Manual, Chapter 4 § 10.11.1>
 - iii. The outpatient CCR used for outlier calculations is based on the most recent "full year cost reporting period" – may be either "final settled" or "tentatively settled." <Medicare Claims Processing Manual, Chapter 4 § 10.11.3>
 - iv. The MAC must make changes to the CCR used for a hospital in the Outpatient Provider Specific File within 30 days of calculation of a change to the CCR (i.e., from a reopened cost report). <Medicare Claims Processing Manual, Chapter 4 § 10.11.11>

C. Calculating Outpatient Outlier Payments

The formula for the outlier payment amount:

$(\text{Cost} - \text{Outlier Payment Threshold}) \times \text{Outlier Payment Percentage}$

- Outlier Payment Threshold = 1.75 X the wage index adjusted allowable
- Outlier Payment Percentage = 50%

1. Handout 16 is an example of the basic Medicare OPDS outlier calculation.

D. Outpatient Outlier Reconciliation

1. As part of the cost report settlement process, the MAC will re-compute outpatient outlier payments using the hospital's actual CCR from the cost report for that year if:
 - a. The CMS central office and regional office approves the reconciliation; and
 - b. The overall outpatient ancillary CCR for the cost reporting period varies by plus or minus 10% from the CCR used to calculate the outlier payment; and
 - c. The total outpatient outlier payments for the year exceed \$500,000.
<Medicare Claims Processing Manual, Chapter 4 § 10.7.2.1>
2. Any recomputed outlier overpayments or underpayments are subject to interest.
<Medicare Claims Processing Manual, Chapter 4 § 10.7.2.3, 42 C.F.R. 419.43(d)(6)(ii)>

V. Rural Sole Community Hospital Adjustment

- A. Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) receive a 7.1% upward payment adjustment. <88 Fed. Reg. 81586, Medicare Claims Processing Transmittal 10541>
 1. The adjustment does not apply to:
 - a. Drugs and biologicals that are paid under a separate APC;
 - b. Devices paid under the pass-through payment policy; and
 - c. Items paid at charges adjusted to cost by application of a hospital-specific cost-to-charge ratio. <42 C.F.R. 419.43(g)(4)>
 2. The adjustment is applied before calculation of copayments, which means that the adjustment will increase the patient's copayment liability. <42 C.F.R. 419.43(g)(5)>
 3. The adjustment is applied before calculation of any outlier payments. <42 C.F.R. 419.43(g)(6)>
- B. To be considered "rural" and receive the adjustment, a SCH must be either:
 1. Physically located in a rural area; or
 2. Reclassified as rural for purposes of the wage index. <42 C.F.R. 419.43(g)(1)(ii)>

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A Medicare patient presented to a hospital-based clinic for an incision and drainage of a complicated skin abscess (10061). What is the APC for this procedure?

Analysis: The APC on Addendum B for HCPCS code 10061 is 5052. <42 C.F.R. 419.22(a); OPPS Addendum>

Modified Facts: If the procedure had instead involved removal of a foreign body (10120), what is the APC for this procedure? What is the payment difference between incision and drainage of the skin abscess and the foreign body removal?

Analysis: The APC on Addendum B for HCPCS code 10120 is 5052. There is no difference in payment between the two procedures because both procedures have the same APC. <42 C.F.R. 419.22(a); OPPS Addendum>

Modified Facts: If the procedure was performed by a salaried physician employed by the hospital, will payment for APC 5052 include payment for the physician's professional services?

Analysis: No, physician services are excluded from payment under OPPS. <42 C.F.R. 419.22(a); OPPS Addendum B>

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Case Study 2

Facts: A Medicare patient received an x-ray of the lower spine while bending (72120) followed by a contrast x-ray (myelography) of the lower spine (72265). These two services are the only services the patient receives that day. Will Medicare pay separately for these two procedures? If not, which procedure will be paid?

Analysis: CPT code 72120 has status indicator Q1 and payment rate \$104.75. CPT code 72265 has status indicator Q2 and payment rate \$762.88. When more than one code with status indicators Q1 or Q2 is reported, without another separately payable service, only the highest paying code will trigger payment on the claim. CPT code 72265 has the highest rate and will be paid separately at \$762.88; CPT code 72120 will be packaged. <42 C.F.R. 419.22(a); OPPS Addendum B>

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TABLE 2: FINAL CY 2024 C-APCs

C-APC	CY 2024 APC Group Title	Clinical Family	New C-APC
5072	Level 2 Excision/Biopsy/Incision and Drainage	EBIDX	
5073	Level 3 Excision/Biopsy/Incision and Drainage	EBIDX	
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	BREAS	
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	BREAS	
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	BREAS	
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	BREAS	
5112	Level 2 Musculoskeletal Procedures	ORTHO	
5113	Level 3 Musculoskeletal Procedures	ORTHO	
5114	Level 4 Musculoskeletal Procedures	ORTHO	
5115	Level 5 Musculoskeletal Procedures	ORTHO	
5116	Level 6 Musculoskeletal Procedures	ORTHO	
5153	Level 3 Airway Endoscopy	AENDO	
5154	Level 4 Airway Endoscopy	AENDO	
5155	Level 5 Airway Endoscopy	AENDO	
5163	Level 3 ENT Procedures	ENTXX	
5164	Level 4 ENT Procedures	ENTXX	
5165	Level 5 ENT Procedures	ENTXX	
5166	Cochlear Implant Procedure	COCHL	
5182	Level 2 Vascular Procedures	VASCX	
5183	Level 3 Vascular Procedures	VASCX	
5184	Level 4 Vascular Procedures	VASCX	
5191	Level 1 Endovascular Procedures	EVASC	
5192	Level 2 Endovascular Procedures	EVASC	
5193	Level 3 Endovascular Procedures	EVASC	
5194	Level 4 Endovascular Procedures	EVASC	
5200	Implantation Wireless PA Pressure Monitor	WPMXX	
5211	Level 1 Electrophysiologic Procedures	EPHYS	
5212	Level 2 Electrophysiologic Procedures	EPHYS	
5213	Level 3 Electrophysiologic Procedures	EPHYS	
5222	Level 2 Pacemaker and Similar Procedures	AICDP	
5223	Level 3 Pacemaker and Similar Procedures	AICDP	
5224	Level 4 Pacemaker and Similar Procedures	AICDP	
5231	Level 1 ICD and Similar Procedures	AICDP	
5232	Level 2 ICD and Similar Procedures	AICDP	
5244	Level 4 Blood Product Exchange and Related Services	SCTXX	
5302	Level 2 Upper GI Procedures	GIXXX	
5303	Level 3 Upper GI Procedures	GIXXX	

C-APC	CY 2024 APC Group Title	Clinical Family	New C-APC
5313	Level 3 Lower GI Procedures	GIXXX	
5331	Complex GI Procedures	GIXXX	
5341	Level 1 Abdominal/Peritoneal/Biliary and Related Procedures	GIXXX	
5342	Level 2 Abdominal/Peritoneal/Biliary and Related Procedures	GIXXX	*
5361	Level 1 Laparoscopy and Related Services	LAPXX	
5362	Level 2 Laparoscopy and Related Services	LAPXX	
5372	Level 2 Urology and Related Services	UROXX	
5373	Level 3 Urology and Related Services	UROXX	
5374	Level 4 Urology and Related Services	UROXX	
5375	Level 5 Urology and Related Services	UROXX	
5376	Level 6 Urology and Related Services	UROXX	
5377	Level 7 Urology and Related Services	UROXX	
5378	Level 8 Urology and Related Services	UROXX	
5414	Level 4 Gynecologic Procedures	GYNXX	
5415	Level 5 Gynecologic Procedures	GYNXX	
5416	Level 6 Gynecologic Procedures	GYNXX	
5431	Level 1 Nerve Procedures	NERVE	
5432	Level 2 Nerve Procedures	NERVE	
5461	Level 1 Neurostimulator and Related Procedures	NSTIM	
5462	Level 2 Neurostimulator and Related Procedures	NSTIM	
5463	Level 3 Neurostimulator and Related Procedures	NSTIM	
5464	Level 4 Neurostimulator and Related Procedures	NSTIM	
5465	Level 5 Neurostimulator and Related Procedures	NSTIM	
5471	Implantation of Drug Infusion Device	PUMPS	
5491	Level 1 Intraocular Procedures	INEYE	
5492	Level 2 Intraocular Procedures	INEYE	
5493	Level 3 Intraocular Procedures	INEYE	
5494	Level 4 Intraocular Procedures	INEYE	
5495	Level 5 Intraocular Procedures	INEYE	
5496	Level 6 Intraocular Procedures	INEYE	*
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	
5627	Level 7 Radiation Therapy	RADTX	
5881	Ancillary Outpatient Services When Patient Dies	N/A	
8011	Comprehensive Observation Services	N/A	

HCPCS Code	Short Descriptor	SI	Single Code APC Assignment	Composite APC Assignment	Composite APC
71045	X-ray exam chest 1 view	Q3	5521	5041, 5045	Critical Care
71046	X-ray exam chest 2 views	Q3	5521	5041, 5045	Critical Care
92953	Temporary external pacing	Q3	5781	5041, 5045	Critical Care
94002	Vent mgmt inpat init day	Q3	5801	5041, 5045	Critical Care
94003	Vent mgmt inpat subq day	Q3	5801	5041, 5045	Critical Care
94662	Neg press ventilation cnp	Q3	5801	5041, 5045	Critical Care
94762	Measure blood oxygen level	Q3	5721	5041, 5045	Critical Care
76700	Us exam abdom complete	Q3	5522	8004	Ultrasound
76705	Echo exam of abdomen	Q3	5522	8004	Ultrasound
76770	Us exam abdo back wall comp	Q3	5522	8004	Ultrasound
76776	Us exam k transpl w/doppler	Q3	5522	8004	Ultrasound
76831	Echo exam uterus	Q3	5523	8004	Ultrasound
76856	Us exam pelvic complete	Q3	5522	8004	Ultrasound
76857	Us exam pelvic limited	Q3	5522	8004	Ultrasound
76981	Use parenchyma	Q3	5522	8004	Ultrasound
76982	Use 1st target lesion	Q3	5522	8004	Ultrasound
0633T	Ct breast w/3d uni c-	Q3	5522	8005	CT/CTA
0636T	Ct breast w/3d bi c-	Q3	5523	8005	CT/CTA
70450	Ct head/brain w/o dye	Q3	5522	8005 or 8006	CT/CTA
70480	Ct orbit/ear/fossa w/o dye	Q3	5522	8005 or 8006	CT/CTA
70486	Ct maxillofacial w/o dye	Q3	5522	8005 or 8006	CT/CTA
70490	Ct soft tissue neck w/o dye	Q3	5522	8005 or 8006	CT/CTA
71250	Ct thorax dx c-	Q3	5522	8005 or 8006	CT/CTA
72125	Ct neck spine w/o dye	Q3	5522	8005 or 8006	CT/CTA
72128	Ct chest spine w/o dye	Q3	5522	8005 or 8006	CT/CTA
72131	Ct lumbar spine w/o dye	Q3	5522	8005 or 8006	CT/CTA
72192	Ct pelvis w/o dye	Q3	5522	8005 or 8006	CT/CTA
73200	Ct upper extremity w/o dye	Q3	5522	8005 or 8006	CT/CTA
73700	Ct lower extremity w/o dye	Q3	5522	8005 or 8006	CT/CTA
74150	Ct abdomen w/o dye	Q3	5522	8005 or 8006	CT/CTA
74176	Ct abd & pelvis w/o contrast	Q3	5523	8005 or 8006	CT/CTA
74261	Ct colonography dx	Q3	5522	8005 or 8006	CT/CTA
0634T	Ct breast w/3d uni c+	Q3	5571	8006	CT/CTA
0635T	Ct breast w/3d uni c-/c+	Q3	5571	8006	CT/CTA
0637T	Ct breast w/3d bi c+	Q3	5572	8006	CT/CTA
0638T	Ct breast w/3d bi c-/c+	Q3	5572	8006	CT/CTA
70460	Ct head/brain w/dye	Q3	5571	8006	CT/CTA
70470	Ct head/brain w/o & w/dye	Q3	5571	8006	CT/CTA
70481	Ct orbit/ear/fossa w/dye	Q3	5571	8006	CT/CTA
70482	Ct orbit/ear/fossa w/o&w/dye	Q3	5571	8006	CT/CTA
70487	Ct maxillofacial w/dye	Q3	5571	8006	CT/CTA
70488	Ct maxillofacial w/o & w/dye	Q3	5571	8006	CT/CTA

HCPCS Code	Short Descriptor	SI	Single Code APC Assignment	Composite APC Assignment	Composite APC
70491	Ct soft tissue neck w/dye	Q3	5571	8006	CT/CTA
70492	Ct sft tsue nck w/o & w/dye	Q3	5571	8006	CT/CTA
70496	Ct angiography head	Q3	5571	8006	CT/CTA
70498	Ct angiography neck	Q3	5571	8006	CT/CTA
71260	Ct thorax dx c+	Q3	5571	8006	CT/CTA
71270	Ct thorax dx c-/c+	Q3	5571	8006	CT/CTA
71275	Ct angiography chest	Q3	5571	8006	CT/CTA
72126	Ct neck spine w/dye	Q3	5572	8006	CT/CTA
72127	Ct neck spine w/o & w/dye	Q3	5571	8006	CT/CTA
72129	Ct chest spine w/dye	Q3	5571	8006	CT/CTA
72130	Ct chest spine w/o & w/dye	Q3	5571	8006	CT/CTA
72132	Ct lumbar spine w/dye	Q3	5572	8006	CT/CTA
72133	Ct lumbar spine w/o & w/dye	Q3	5571	8006	CT/CTA
72191	Ct angiograph pelv w/o&w/dye	Q3	5571	8006	CT/CTA
72193	Ct pelvis w/dye	Q3	5571	8006	CT/CTA
72194	Ct pelvis w/o & w/dye	Q3	5571	8006	CT/CTA
73201	Ct upper extremity w/dye	Q3	5572	8006	CT/CTA
73202	Ct uppr extremity w/o&w/dye	Q3	5571	8006	CT/CTA
73206	Ct angio upr extrm w/o&w/dye	Q3	5571	8006	CT/CTA
73701	Ct lower extremity w/dye	Q3	5571	8006	CT/CTA
73702	Ct lwr extremity w/o&w/dye	Q3	5571	8006	CT/CTA
73706	Ct angio lwr extr w/o&w/dye	Q3	5571	8006	CT/CTA
74160	Ct abdomen w/dye	Q3	5571	8006	CT/CTA
74170	Ct abdomen w/o & w/dye	Q3	5571	8006	CT/CTA
74175	Ct angio abdom w/o & w/dye	Q3	5571	8006	CT/CTA
74177	Ct abd & pelv w/contrast	Q3	5572	8006	CT/CTA
74178	Ct abd & pelv 1/> regns	Q3	5572	8006	CT/CTA
74262	Ct colonography dx w/dye	Q3	5571	8006	CT/CTA
75635	Ct angio abdominal arteries	Q3	5571	8006	CT/CTA
0609T	Mrs disc pain acquisj data	Q3	5523	8007	MRI/MRA
76391	Mr elastography	Q3	5523	8007	MRI/MRA
77046	Mri breast c- unilateral	Q3	5523	8007	MRI/MRA
77047	Mri breast c- bilateral	Q3	5523	8007	MRI/MRA
C9762	Cardiac mri seg dys strain	Q3	5524	8007	MRI/MRA
C9763	Cardiac mri seg dys stress	Q3	5524	8007	MRI/MRA
70336	Magnetic image jaw joint	Q3	5523	8007 or 8008	MRI/MRA
70540	Mri orbit/face/neck w/o dye	Q3	5523	8007 or 8008	MRI/MRA
70544	Mr angiography head w/o dye	Q3	5523	8007 or 8008	MRI/MRA
70547	Mr angiography neck w/o dye	Q3	5523	8007 or 8008	MRI/MRA
70551	Mri brain stem w/o dye	Q3	5523	8007 or 8008	MRI/MRA
70554	Fmri brain by tech	Q3	5523	8007 or 8008	MRI/MRA
71550	Mri chest w/o dye	Q3	5523	8007 or 8008	MRI/MRA

HCPCS Code	Short Descriptor	SI	Single Code APC Assignment	Composite APC Assignment	Composite APC
72141	Mri neck spine w/o dye	Q3	5523	8007 or 8008	MRI/MRA
72146	Mri chest spine w/o dye	Q3	5523	8007 or 8008	MRI/MRA
72148	Mri lumbar spine w/o dye	Q3	5523	8007 or 8008	MRI/MRA
72195	Mri pelvis w/o dye	Q3	5523	8007 or 8008	MRI/MRA
73218	Mri upper extremity w/o dye	Q3	5523	8007 or 8008	MRI/MRA
73221	Mri joint upr extrem w/o dye	Q3	5523	8007 or 8008	MRI/MRA
73718	Mri lower extremity w/o dye	Q3	5523	8007 or 8008	MRI/MRA
73721	Mri jnt of lwr extre w/o dye	Q3	5523	8007 or 8008	MRI/MRA
74181	Mri abdomen w/o dye	Q3	5523	8007 or 8008	MRI/MRA
75557	Cardiac mri for morph	Q3	5523	8007 or 8008	MRI/MRA
75559	Cardiac mri w/stress img	Q3	5524	8007 or 8008	MRI/MRA
C8901	Mra w/o cont, abd	Q3	5523	8007 or 8008	MRI/MRA
C8910	Mra w/o cont, chest	Q3	5523	8007 or 8008	MRI/MRA
C8913	Mra w/o cont, lwr ext	Q3	5523	8007 or 8008	MRI/MRA
C8919	Mra w/o cont, pelvis	Q3	5523	8007 or 8008	MRI/MRA
C8932	Mra, w/o dye, spinal canal	Q3	5523	8007 or 8008	MRI/MRA
C8935	Mra, w/o dye, upper extr	Q3	5523	8007 or 8008	MRI/MRA
70542	Mri orbit/face/neck w/dye	Q3	5572	8008	MRI/MRA
70543	Mri orbt/fac/nck w/o &w/dye	Q3	5572	8008	MRI/MRA
70545	Mr angiography head w/dye	Q3	5572	8008	MRI/MRA
70546	Mr angiograph head w/o&w/dye	Q3	5572	8008	MRI/MRA
70548	Mr angiography neck w/dye	Q3	5572	8008	MRI/MRA
70549	Mr angiograph neck w/o&w/dye	Q3	5572	8008	MRI/MRA
70552	Mri brain stem w/dye	Q3	5572	8008	MRI/MRA
70553	Mri brain stem w/o & w/dye	Q3	5572	8008	MRI/MRA
71551	Mri chest w/dye	Q3	5573	8008	MRI/MRA
71552	Mri chest w/o & w/dye	Q3	5572	8008	MRI/MRA
72142	Mri neck spine w/dye	Q3	5572	8008	MRI/MRA
72147	Mri chest spine w/dye	Q3	5572	8008	MRI/MRA
72149	Mri lumbar spine w/dye	Q3	5572	8008	MRI/MRA
72156	Mri neck spine w/o & w/dye	Q3	5572	8008	MRI/MRA
72157	Mri chest spine w/o & w/dye	Q3	5572	8008	MRI/MRA
72158	Mri lumbar spine w/o & w/dye	Q3	5572	8008	MRI/MRA
72196	Mri pelvis w/dye	Q3	5572	8008	MRI/MRA
72197	Mri pelvis w/o & w/dye	Q3	5572	8008	MRI/MRA
73219	Mri upper extremity w/dye	Q3	5572	8008	MRI/MRA
73220	Mri uppr extremity w/o&w/dye	Q3	5572	8008	MRI/MRA
73222	Mri joint upr extrem w/dye	Q3	5573	8008	MRI/MRA
73223	Mri joint upr extr w/o&w/dye	Q3	5572	8008	MRI/MRA
73719	Mri lower extremity w/dye	Q3	5572	8008	MRI/MRA
73720	Mri lwr extremity w/o&w/dye	Q3	5572	8008	MRI/MRA
73722	Mri joint of lwr extr w/dye	Q3	5573	8008	MRI/MRA

HCPCS Code	Short Descriptor	SI	Single Code APC Assignment	Composite APC Assignment	Composite APC
73723	Mri joint lwr extr w/o&w/dye	Q3	5572	8008	MRI/MRA
74182	Mri abdomen w/dye	Q3	5572	8008	MRI/MRA
74183	Mri abdomen w/o & w/dye	Q3	5572	8008	MRI/MRA
75561	Cardiac mri for morph w/dye	Q3	5572	8008	MRI/MRA
75563	Card mri w/stress img & dye	Q3	5573	8008	MRI/MRA
C8900	Mra w/cont, abd	Q3	5572	8008	MRI/MRA
C8902	Mra w/o fol w/cont, abd	Q3	5572	8008	MRI/MRA
C8903	Mri w/cont, breast, uni	Q3	5571	8008	MRI/MRA
C8905	Mri w/o fol w/cont, brst, un	Q3	5572	8008	MRI/MRA
C8906	Mri w/cont, breast, bi	Q3	5572	8008	MRI/MRA
C8908	Mri w/o fol w/cont, breast,	Q3	5572	8008	MRI/MRA
C8909	Mra w/cont, chest	Q3	5572	8008	MRI/MRA
C8911	Mra w/o fol w/cont, chest	Q3	5572	8008	MRI/MRA
C8912	Mra w/cont, lwr ext	Q3	5572	8008	MRI/MRA
C8914	Mra w/o fol w/cont, lwr ext	Q3	5572	8008	MRI/MRA
C8918	Mra w/cont, pelvis	Q3	5572	8008	MRI/MRA
C8920	Mra w/o fol w/cont, pelvis	Q3	5572	8008	MRI/MRA
C8931	Mra, w/dye, spinal canal	Q3	5572	8008	MRI/MRA
C8933	Mra, w/o&w/dye, spinal canal	Q3	5572	8008	MRI/MRA
C8934	Mra, w/dye, upper extremity	Q3	5572	8008	MRI/MRA
C8936	Mra, w/o&w/dye, upper extr	Q3	5572	8008	MRI/MRA
0362T	Bhv id suprt assmt ea 15 min	Q3	5821	8010	Mental Health
0373T	Adapt bhv tx ea 15 min	Q3	5821	8010	Mental Health
90791	Psych diagnostic evaluation	Q3	5823	8010	Mental Health
90792	Psych diag eval w/med srvc	Q3	5823	8010	Mental Health
90832	Psytx w pt 30 minutes	Q3	5823	8010	Mental Health
90834	Psytx w pt 45 minutes	Q3	5823	8010	Mental Health
90837	Psytx w pt 60 minutes	Q3	5823	8010	Mental Health
90839	Psytx crisis initial 60 min	Q3	5823	8010	Mental Health
90845	Psychoanalysis	Q3	5823	8010	Mental Health
90846	Family psytx w/o pt 50 min	Q3	5823	8010	Mental Health
90847	Family psytx w/pt 50 min	Q3	5823	8010	Mental Health
90849	Multiple family group psytx	Q3	5823	8010	Mental Health
90853	Group psychotherapy	Q3	5822	8010	Mental Health
90865	Narcosynthesis	Q3	5823	8010	Mental Health
90880	Hypnotherapy	Q3	5822	8010	Mental Health
90899	Unlisted psyc svc/therapy	Q3	5821	8010	Mental Health
96112	Devel tst phys/qhp 1st hr	Q3	5721	8010	Mental Health
96116	Nubhvl xm phys/qhp 1st hr	Q3	5722	8010	Mental Health
96130	Psycl tst eval phys/qhp 1st	Q3	5722	8010	Mental Health
96132	Nrpsyc tst eval phys/qhp 1st	Q3	5723	8010	Mental Health
96136	Psycl/nrpsyc tst phy/qhp 1st	Q3	5734	8010	Mental Health

HCPCS Code	Short Descriptor	SI	Single Code APC Assignment	Composite APC Assignment	Composite APC
96138	Psycl/nrpsyc tech 1st	Q3	5735	8010	Mental Health
96146	Psycl/nrpsyc tst auto result	Q3	5731	8010	Mental Health
96156	Hlth bhv assmt/reassessment	Q3	5822	8010	Mental Health
96158	Hlth bhv ivntj indiv 1st 30	Q3	5823	8010	Mental Health
96164	Hlth bhv ivntj grp 1st 30	Q3	5821	8010	Mental Health
96167	Hlth bhv ivntj fam 1st 30	Q3	5821	8010	Mental Health
97151	Bhv id assmt by phys/qhp	Q3	5822	8010	Mental Health
97152	Bhv id suprt assmt by 1 tech	Q3	5822	8010	Mental Health
97153	Adaptive behavior tx by tech	Q3	5822	8010	Mental Health
97154	Grp adapt bhv tx by tech	Q3	5821	8010	Mental Health
97155	Adapt behavior tx phys/qhp	Q3	5823	8010	Mental Health
97156	Fam adapt bhv tx gdn phy/qhp	Q3	5821	8010	Mental Health
97157	Mult fam adapt bhv tx gdn	Q3	5821	8010	Mental Health
97158	Grp adapt bhv tx by phy/qhp	Q3	5821	8010	Mental Health
G0451	Devlopment test interprt&rep	Q3	5822	8010	Mental Health

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Check for Updates

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	Coinsurance Percentage
5166	Cochlear Implant Procedure	J1	365.6520	\$31,951.40	\$6,974.13 *	\$6,390.28 *	21.827%
5191	Level 1 Endovascular Procedures	J1	35.5305	\$3,104.73	\$863.75	\$620.95	27.820%
5611	Level 1 Therapeutic Radiation Treatment Preparation	S	1.4795	\$129.28	\$31.05	\$25.86	24.018%

* Capped by the inpatient deductible of \$1632

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Attachment B – Claim Examples**Example 1 of inpatient deductible capped amount:**

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$888.00.

The Inpatient Part A deductible is \$1,288.00 for 2016

$\$1,288.00 - \$888.00 = \$400.00$ remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$800.00.

$\$400.00$ cap remaining / $\$800.00$ drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

Drug Line A has a final payment of \$1,800.00, and coinsurance of \$200.00.

Drug Line B has a final payment of \$900.00, and coinsurance of \$100.00.

Drug Line C has a final payment of \$450.00, and coinsurance of \$50.00.

Drug Line D has a final payment of \$450.00, and coinsurance of \$50.00.

Example 2 of inpatient deductible capped amount:

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$1,588.00.

The Inpatient Part A deductible is \$1,288.00 for 2016

$\$1,588.00$ is greater than $\$1,288.00$. The OPPS Pricer will cap the coinsurance amount to be applied on the highest wage adjusted national coinsurance procedure line prior to application of the cap on the drug lines.

Drug Lines A-D coinsurance is \$800.00.

$\$0$ cap remaining / $\$800.00 = 100\%$ reduction to coinsurance due to inpatient deductible cap

Drug Line A has a final payment of \$2,000.00, and no coinsurance.

Drug Line B has a final payment of \$1,000.00, and no coinsurance.

Drug Line C has a final payment of \$500.00, and no coinsurance.

Drug Line D has a final payment of \$500.00, and no coinsurance.

Example 3 of inpatient deductible capped amount with procedure, blood, and drug lines:

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.
 Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.
 Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.
 Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$800.00.

Coinsurance on blood line is 88.00.

The Inpatient Part A deductible is \$1,288.00 for 2016

$\$1,288.00 - \$888.00 = \$400.00$ remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$800.00.

$\$400.00$ cap remaining / $\$800.00$ drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

Drug Line A has a final payment of \$1,800.00, and coinsurance of \$200.00.
 Drug Line B has a final payment of \$900.00, and coinsurance of \$100.00.
 Drug Line C has a final payment of \$450.00, and coinsurance of \$50.00.
 Drug Line D has a final payment of \$450.00, and coinsurance of \$50.00.

Example 4 of inpatient deductible capped amount equals procedure, blood, and drug line coinsurance:

Drug Line A has a fee of \$200.00, a payment of \$160.00, and coinsurance of \$40.00.
 Drug Line B has a fee of \$100.00, a payment of \$80.00, and coinsurance of \$20.00.
 Drug Line C has a fee of \$50.00, a payment of \$40.00 and coinsurance of \$10.00.
 Drug Line D has a fee of \$50.00, a payment of \$40.00 and coinsurance of \$10.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$1,120.00.

Coinsurance on blood line is 88.00.

The Inpatient Part A deductible is \$1,288.00 for 2016

$\$1,288.00 - \$1208.00 = \$80.00$ remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$80.00.

$\$80.00$ cap remaining - $\$80.00$ drug line(s) coinsurance = reduction to coinsurance due to inpatient deductible cap does not apply

Drug Line A has a fee of \$200.00, a payment of \$160.00, and coinsurance of \$40.00.
 Drug Line B has a fee of \$100.00, a payment of \$80.00, and coinsurance of \$20.00.
 Drug Line C has a fee of \$50.00, a payment of \$40.00 and coinsurance of \$10.00.
 Drug Line D has a fee of \$50.00, a payment of \$40.00 and coinsurance of \$10.00.

Example 5 of procedure and blood coinsurance equal inpatient deductible cap:

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.
 Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.
 Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.
 Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$1200.00.

Coinsurance on blood line is 88.00.

The Inpatient Part A deductible is \$1,288.00 for 2016

$\$1,288.00 - \$1,288.00 = \$0.00$ remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$800.00.

$\$0.00$ cap remaining / \$800.00 drug line(s) coinsurance = 100% reduction to coinsurance due to inpatient deductible cap.

Apply 100% reduction of the coinsurance amounts for each line and add the remaining 100% back into the payment amount.

Drug Line A has a final payment of \$2,000.00, and coinsurance of \$0.00.
 Drug Line B has a final payment of \$1,000.00, and coinsurance of \$0.00.
 Drug Line C has a final payment of \$500.00, and coinsurance of \$0.00.
 Drug Line D has a final payment of \$500.00, and coinsurance of \$0.00.

Example 6 of part B deductible applies to drug charges prior to inpatient deductible capped amount:

Drug Line A has a fee of \$2,166.00, a deductible of \$166.00, a payment of \$1,600.00, and coinsurance of \$400.00.
 Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.
 Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.
 Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$888.00.

The Inpatient Part A deductible is \$1,288.00 for 2016

$\$1,288.00 - \$888.00 = \$400.00$ remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$800.00.

$\$400.00$ cap remaining / \$800.00 drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

Drug Line A has a deductible of \$166.00, a final payment of \$1,800.00, and coinsurance of \$200.00.
 Drug Line B has a final payment of \$900.00, and coinsurance of \$100.00.
 Drug Line C has a final payment of \$450.00, and coinsurance of \$50.00.
 Drug Line D has a final payment of \$450.00, and coinsurance of \$50.00.