



Medicare Utilization Review Version

KEY CONCEPTS OUTLINE

Module 10: Outpatient Payment Systems and Patient Liability

I. Part B Payment for Hospital Outpatient and Specified Inpatient Services

Payment systems for Medicare Part B payment of hospital services:

- **Outpatient Prospective Payment System (OPPS)** – most services, including procedures, visits, drugs, and diagnostic services, except lab
- **Medicare Physician Fee Schedule (MPFS)** – PT, OT, ST, specified off-campus services, miscellaneous education and preventative services
- **Clinical Laboratory Fee Schedule (CLFS)** – molecular pathology, preventative labs, reference labs, and other labs not paid as part of a visit or procedure
- **Durable Medical Equipment, Prosthetics and Orthotics (DME POS) Fee Schedule** – DME not paid as part of a visit or procedure
- **Ambulance Fee Schedule** – ambulance services

A. Part B payment is HCPCS code driven. CMS publishes a master list of all HCPCS codes (OPPS Addendum B) which identifies the payment system for each code using a Status Indicator and the payment amount under OPPS, if applicable.

1. Addendum B is published with the OPPS Final Rule each year and updated on a quarterly basis. Handout 15 is a sample page from Addendum B.

Link: [OPPS – Addendum A & B under Medicare-Related Sites - Hospital](#)

2. Addendum D provides a key to the Status Indicators and is published with the OPPS Final Rule each year. Handout 16 is the current Addendum D.

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.

II. Overview of the Outpatient Prospective Payment System (OPPS)

A. Applicability of the OPPS

1. The OPPS applies to most hospitals, except certain Maryland hospitals and Critical Access Hospitals¹. <42 C.F.R. 419.20>
2. The OPPS excludes payment for services already included in payments to other providers treating the patient, e.g., services and supplies for ESRD patients and specified services for SNF patients. <42 C.F.R. 419.22(m)(2) and (o)>

B. 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)>
2. Addendum A is the master list of APCs and is published with the OPPS Final Rule each year and updated on a quarterly basis. Handout 17 is a sample page from Addendum A

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

C. Comprehensive APCs (C-APCs)

1. 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 pre-established therapy plan of care
- Cost based services (vaccines, corneal tissue, rural CRNA services)
- COVID-19 Treatments

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

¹ Critical Access Hospitals are paid 101% of their costs, calculated by applying the hospitals outpatient cost to charge ratio (CCR) to the total charge for observation, subject to cost report settlement.

2. There are three types of C-APCs:

- a. HCPCS codes with status indicator J1 trigger surgical C-APCs.
- b. HCPCS codes with status indicator J2 trigger the Observation C-APC, as discussed in a prior module.
- c. Inpatient only procedures reported with modifier -CA are paid under a special C-APC, as discussed in a prior module.

Table 2 of the CY2024 OPPS Final Rule contains a list of the finalized C-APC and is included for reference in the materials behind the outline.

3. Steps to determine assignment of a surgical C-APC

- a. Identify the highest-ranking Status Indicator J1 procedure on Addendum J of the OPPS Final Rule. This “primary” procedure will control assignment of the C-APC.
- b. Determine if the case qualifies for complexity adjustment by looking up the “primary” procedure on the complexity adjustment table of Addendum J. If one of the listed secondary or add-on codes is reported on the claim, the C-APC will receive a complexity adjustment, increasing the APC by one level.
- c. Handout 18 contains a table with surgical C-APC assignment examples.

D. Packaged Services under OPPS

- 1. Packaged services are covered services that 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.

2. There are four types of packaged services:

- a. 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

- b. Services identified by Status Indicator Q1 are packaged if another service with Status Indicator S (significant service), T (surgical service), or V (visit) is reported on the same claim. <OPPS Addendum D1>
 - i. These services are only paid separately if no Status Indicator S, T, or V service is reported on the same claim. <OPPS Addendum D1>

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

- c. Services identified by Status Indicator Q2 are packaged if another service with Status Indicator T (surgical service) is reported on the same claim. <OPPS Addendum D1>
 - i. These services are only paid separately if no Status Indicator T service is reported on the same claim. <OPPS Addendum D1>

Examples: add-on procedures and diagnostic components of

- d. 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>
 - i. These laboratory services are paid separately under the CLFS only if no other OPPS payable service appears on the same claim.

Examples: clinical lab, except molecular pathology and preventative

- 3. Handout 19 is a table with packaging example case studies.

If more than one Q1 or Q2 code is reported, and packaging is not triggered, payment is made only for the highest paying Q1 or Q2 code.

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>

1. The coinsurance amount is calculated based on the payment rate prior to outlier adjustment. <42 C.F.R. 419.41(c)(4)(iv)>
2. 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>
 - a. 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.

C. Coinsurance adjustments

1. For 2024, three APCs have a coinsurance higher than 20% due to a transitional calculation from the beginning of OPPS. <Medicare Claims Processing Manual, Chapter 4 § 30.1>
 - a. On Addendum B, services paid under these APCs will have an amount in the National Unadjusted Copayment column reflecting the applicable coinsurance percentage and an amount in the Minimum Unadjusted Copayment column reflecting the 20% coinsurance amount.
 - b. A table with the affected APCs and their coinsurance percentages is included in the materials behind the outline.
2. A coinsurance cap applies to each APC, including the coinsurance for associated drugs, biologicals and blood products. The coinsurance may not exceed the inpatient deductible for the applicable year (\$1632 for CY2024). <42 C.F.R. 419.41(c)(4)(i)>
 - a. 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>
 - b. Services potentially subject to this cap are noted on Addendum B, however, additional services may be subject to the cap if the wage adjusted payment amount results in a coinsurance greater than the inpatient deductible.
 - c. 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.
3. For drugs with an average sale price that increases faster than the rate of inflation, the coinsurance is based on 20% of the inflation adjusted price rather

than the actual average sales price. This results in a coinsurance that is lower than 20%. <88 *Fed. Reg.* 79040; Fact Sheet: Medicare Prescription Drug Inflation Rebate Program Part B Rebatable Drug Coinsurance Reduction>

- a. On Addendum B, the reduced coinsurance percentage is reflected in the IRA Coinsurance Percentage column and the coinsurance amount is reflected in the Adjusted Beneficiary Copayment column, which may also be subject to the coinsurance cap (i.e., be reduced to the inpatient deductible cap).

Version 02/19/2024
Check for Updates

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	

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

Version 02/19/2024
 Check for Updates

Version 02/19/2024
Check for Updates