



Primer on Payment Methodologies

By Jackie Miller, RHIA, CCS-P, CPC

Billing managers often get questions from their physician clients about whether a particular procedure pays more in the office setting or in the hospital setting. For example, sometimes the physician wants a new scanner or other device and is wondering whether it makes more sense to buy it and put it in his office or to ask the hospital to purchase it. Many billing professionals dread these questions because they are very knowledgeable about physician reimbursement but much less so about how hospitals get paid. In this month's column, we'll look at some key differences between physician and hospital reimbursement and how you can compare the two.

Inpatient Reimbursement

Medicare uses DRGs (Diagnosis-Related Groups) for hospital inpatient reimbursement. After the patient goes home, the hospital's health information management department reviews the medical record and selects the ICD-9-CM diagnosis and procedure codes that are to be reported on the claim. Medicare assigns the patient to a DRG based on these codes, and pays the hospital the fee that is associated with that DRG. The fee is adjusted for factors like labor costs, disproportionate share of low-income patients, medical education costs, outlier status, etc.

The hospital receives a single DRG payment that covers all facility services and supplies provided to the patient during the entire admission. Therefore, it's not possible to say that a specific procedure (like an echocardiogram or CT scan) pays X dollars when performed on an inpatient basis. When you want to compare physician reimbursement with hospital reimbursement, you have to look at how much the hospital is paid when the procedure is performed on an outpatient basis.

Outpatient Reimbursement

Hospital outpatient reimbursement is a little trickier. First, there are many services that are not paid separately when provided to outpatients. These "packaged" services include items like low-cost drugs, routine supplies, imaging guidance, low osmolar contrast material, etc. CMS has instructed hospitals

to list the codes for most packaged items on the claim form so that CMS can track the hospital's costs, but Medicare will not give the hospital a separate payment for them.

Separately payable services are assigned to an APC (Ambulatory Payment Classification). An APC is a group of services that are clinically similar and use similar resources. For example, electromyograms (EMGs) of the extremities (codes 95860-95864) are assigned to the same APC as EMGs of the cranial nerves (codes 95867-95868) because CMS has found that hospitals use similar resources for both types of study.

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When the patient receives multiple services that are all assigned to the same APC, the hospital will usually receive multiple payments. Using our EMG example, if the patient has EMGs of the right arm (95860) and one cranial nerve (95867), the hospital will receive two payments for APC 0218 because both of those codes are assigned to that APC.

Medicare pays for some combinations of services by giving the hospital a single "composite APC" payment. For example, if an outpatient has noncontrast CT scans of the thorax (71250), abdomen (74150), and pelvis (72192) on the same day, Medicare will make a single payment for composite APC 8005. If the scans were paid separately, the hospital would receive about \$585, but the composite APC pays only about \$420, so this is a significant savings for Medicare.

All ultrasound, CT, and MRI studies are subject to composite APC payment when the patient has more than one study using the same modality on the same day. For example, the hospital gets a composite APC payment when the patient has two CT scans on the same day, but not when the patient has an ultrasound exam and an MRI on the same day. Other composite APCs apply to patients undergoing prostate brachytherapy (codes 55875 and 77778 on the [\(continued on next page\)](#))

same day) and electrophysiology ablation procedures (code 93619 or 93620 on the same day as 93650, 93651, or 93652).

Locating the APC Payment Amount

Where can you find the APC payment amount for a CPT or HCPCS code? For a diagnostic test (a code with professional and technical components), the easiest way to find the APC payment is to use the Physician Fee Schedule Look-Up utility on the CMS website:

www.cms.gov/PFSlookup/O2_PFSSearch.asp#TopOfPage

If you enter the procedure code and select the TC modifier, you will get a table showing all of the MPFS payment information for that code. In the far right-hand columns, you will find the OPSS payment amount—that is, the amount that Medicare would pay a hospital for that code when the service is provided to an outpatient.

CMS included the APC amount in the Physician Fee Schedule Look-Up because of the so-called “OPSS payment cap.” The cap applies to diagnostic tests performed in the non-hospital setting (for example, a physician office or freestanding imaging center). In this setting, Medicare’s payment for the technical component of the test is limited to the amount that Medicare would pay a hospital under the APC system. For example, the MPFS says that the average payment for the TC of an MRI of the brain (70551) performed in the non-hospital setting is \$427. However, the far right-hand column of the Look-Up screen tells you that the OPSS payment amount for 70551 is only \$350. Therefore, an imaging center that performs this exam will receive the OPSS amount (\$350) rather than the MPFS amount (\$427).

The Physician Fee Schedule Look-Up does not show the OPSS payment amount for all services, only for diagnostic test technical components. For other types of services, there are several

ways you can locate the OPSS payment amount. First, you can download the OPSS pricer software from the CMS website:

www.cms.gov/PCPricer/O2_guidelines.asp#TopOfPage

The pricer will calculate the OPSS reimbursement for any procedure code. However, it is a self-executing file, so you may have problems downloading it, depending on your firewall settings.

Alternatively (and more easily), you can download the latest version of Addendum B from the OPSS page on the CMS website:

www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage

Addendum B is an Excel spreadsheet that lists CPT and HCPCS procedure codes with their corresponding APC assignments and average payment amounts. Codes with status indicator “N” are packaged and not paid separately. Remember that the OPSS payment amounts are updated on a quarterly basis, so be sure to use the most current version of Addendum B.

Conclusion

If you need precise payment amounts for the hospital setting, there are other factors you must consider, including the geographic area and—in the case of services subject to composite APC payment—the other services that the hospital will provide to the patient on the same day. However, you can use the resources discussed in this column for a ballpark estimate that may be sufficient to help your client decide whether a more detailed analysis is necessary. ■

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