

# OCE Background

## I/OCE Product background

Prior to OPSS, the software focused solely on editing claims without specifying any action to take when an edit occurred. It also did not compute any information for payment purposes.

The OPSS functionality of the Integrated Outpatient Code Editor (I/OCE) software was developed for the implementation of the Medicare outpatient prospective payment system mandated by the 1997 Balanced Budget Act. CMS released the proposed OPSS rules using the Ambulatory Payment Classification (APC) system in the September 8, 1998 Federal Register. Final regulations were published in the April 7, 2000 Federal Register and the system became effective for Medicare on August 1, 2000.

The APC-based OPSS developed by CMS is the outpatient equivalent of the inpatient, DRG-based PPS. The APC system establishes groups of covered services so that the services within each group are comparable clinically and with respect to the use of resources.

Hospitals are required to use HCPCS when billing for outpatient services. HCPCS incorporates the following types of codes:

- Level I - The American Medical Association's Physicians' Current Procedural Terminology (CPT®)
- Level II - National codes developed by the Centers for Medicare and Medicaid Services (CMS)

Like the inpatient system based on Diagnosis Related Groups (DRG's), each APC has a pre-established prospective payment amount associated with it. However, unlike the inpatient system that assigns a patient to a single DRG, multiple APCs can be assigned to one outpatient record. If a patient has multiple outpatient services during a single visit, the total payment for the visit is computed as the sum of the individual payments for each service.

While the software has maintained the editing logic of previous versions, assignment of APC numbers for services has been added to meet Medicare's mandated OPSS implementation. The revised program indicates what actions to take when an edit occurs, and the reason(s) why the actions are necessary. For example, an edit can cause a line item to be denied payment while still allowing the claim to be processed for payment. In this case, the line item cannot be resubmitted but can be appealed.

A major change is the processing of claims with service dates that span more than one day. Each claim is represented by a collection of data, consisting of all necessary demographic (header) data, plus all services provided (line items).

- **Note:** It is the user's responsibility to organize all applicable services into a single claim record and pass them as a unit to the software.

The I/OCE only functions on a single claim and does not have any cross claim capabilities. The software can accept up to 450 line items per claim.

Certain services (e.g., physical therapy, diagnostic clinical laboratory) are excluded from Medicare's prospective payment system for hospital outpatient departments. These services are exceptions paid under fee schedules and other prospectively determined rates.