



HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM



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Learn about these Hospital Outpatient Prospective Payment System (OPPS) topics:

- Background
- Ambulatory Payment Classifications (APCs)
- Setting payment rates
- OPPS payment rates
- Hospital Outpatient Quality Reporting (OQR) Program
- Innovation
- Resources

BACKGROUND

Authorized by [Social Security Act \(SSA\) § 1833\(t\)](#), the Centers for Medicare & Medicaid Services (CMS) started the OPPS to pay for:

- Designated hospital outpatient items and services
- Certain Medicare Part B services for hospital inpatients when Medicare **cannot pay** Part A
- Community Mental Health Centers (CMHCs) partial hospitalization services and certain inpatient hospital services paid by Medicare Part B
- Home Health Agency-furnished hepatitis B vaccines and their administration, splints, casts, and antigens for patients not under a home health plan of care or for hospice patients for treatment of non-terminal illness or related conditions
- Comprehensive Outpatient Rehab Facility (CORF)-furnished hepatitis B vaccines and their administration
- An Initial Preventive Physical Examination (IPPE) within the first 12 months of Medicare Part B coverage

Medicare excludes payment for certain types of OPSS services, such as outpatient therapy services and screening and diagnostic mammography. For more information about these services, refer to [42 Code of Federal Regulations \(CFR\) § 419.22](#).

The Balanced Budget Refinement Act of 1999 mandates these additional OPSS provisions:

- Establishes budget-neutral payments based on estimates of amounts payable in 1999 from the Medicare Part B Trust Fund and patient coinsurance under the system prior to OPSS.
- Extends the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs through the first OPSS start date.
- Requires annual update of payment weights, relative payment rates, wage adjustments, outlier payments, other adjustments, and APC groups.
- Requires an annual expert provider advisory panel consultation to review and update APC groups.
- Budget-neutral outlier adjustments based on individual services billed.
- Gives transitional pass-through payments for additional costs of new and current medical devices, drugs, and biologicals for at least 2 years but not more than 3 years.
- Gives OPSS payment for implantable devices, including durable medical equipment (DME), prosthetics, and DME used in diagnostic testing.
 - Beginning calendar year (CY) 2020, for claims with APCs which require implantable devices and have significant device offsets (greater than 30%), Medicare applies a device offset cap based on the credit amount listed in the “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) value code.
- Establishes transitional corridor payments (also known as transitional outpatient payments [TOPs]) to limit providers’ OPSS losses for cancer hospitals. Medicare will pay CMHCs and most hospitals the additional payments for 3.5 years, and permanently for the non-PPS cancer hospitals.
- Limits patient copayment for an individual OPSS service paid to the inpatient deductible each year.

The Medicare, Medicaid, and State Children’s Health Insurance Program Benefits Improvement and Protection Act of 2000 includes the following OPSS revisions still in effect:

- Accelerates patient copayment reductions
- Establishes permanent transitional children’s hospitals outpatient payments

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established these Medicare OPSS drug payment changes:

- Pays drugs separately at the average hospital acquisition cost. If hospital drug acquisition cost data is unavailable, Medicare pays them based on one of several methods calculated and adjusted by the Secretary of Health & Human Services under the SSA §1842(o), §1847A, or §1847B.
- Adjusts APC weights for specific, covered outpatient drugs to account for handling costs hospitals incur.
- Pays separate APCs for drugs and biologicals costing at least \$50 per administration. OPSS packages items with a per day cost of less than or equal to \$130 for CY 2020.
- Excludes outlier payments for separately paid drugs and biologicals priced at 95 percent of AWP.

The Affordable Care Act of 2010 included this change for certain preventive services:

- Medicare pays any U.S. Preventive Services Task Force recommended grade A or B preventive services, and providers accept the payment as payment in full; there are no [coinsurance or deductible](#) charges

The Bipartisan Budget Act of 2015 included this OPSS revision:

- Effective January 1, 2017, OPSS no longer covers certain outpatient off-campus provider-based departments' (PBDs) items and services, and Medicare pays them under the Physician Fee Schedule (PFS). However, Medicare exempts items and services furnished in the following outpatient settings from this provision:
 - In a dedicated emergency department (ED)
 - In a PBD on campus or within 250 yards of the hospital or a remote hospital location

OPSS payment applies to designated hospital outpatient services furnished in all classes of hospitals, except:

- Hospitals furnishing only inpatient Part B services
- Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) and Tribal hospitals, including IHS Tribal CAHs
- Hospitals located in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands
- Hospitals in Maryland and those paid under Maryland All-Payer Model

CMS established the following for CY 2020:

- A 2-year exemption from Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to Recovery Audit Contractors (RACs) and “patient status” RAC reviews (that is, site of-service) for procedures removed from the OPPS inpatient only (IPO) list.
- Based on stakeholder feedback, made changes to the IPO list.
- Completed the phase-in of the payment reduction for the clinic visit services described by HCPCS code G0463 furnished in expected off-campus provider-based departments to control unnecessary increases in volume of this service.
- Approved device pass-through applications that met the criteria for transitional pass-through status for a three year period.
- Change from direct supervision to general supervision for all hospital outpatient therapeutic services furnished by all hospitals and CAHs. This ensures a standard minimum level of supervision for each hospital outpatient service furnished incident to a physician’s service.
- Changes to substantial clinical improvement criterion in CY 2020. Devices approved under FDA’s Breakthrough Devices Program qualify for device pass-through status with determinations effective on or after January 1, 2020.
- Announced 340B hospital survey to collect drug acquisition cost data for CY 2018 and 2019.

AMBULATORY PAYMENT CLASSIFICATIONS (APCS)

APCs are the OPPS unit of payment in most cases. CMS assigns individual services (HCPCS codes) to APCs based on similar clinical characteristics and similar costs. The APC payment rate and calculated copayment apply to each service within the APC.

Until cost data are available to permit assignment to a clinical APC, new services are sometimes assigned to New Technology APCs based only on resource-similarity use. A New Technology APC payment rate is set at midpoint of the applicable New Technology APC’s cost range. [42 CFR § 419.31](#) describes the APC system and payment weights.

Medicare pays some services separately, including but not limited to:

- Many surgical, diagnostic, and non-surgical therapeutic procedures
- Blood and blood products
- Most clinic and ED visits
- Some drugs, biologicals, and radiopharmaceuticals
- Brachytherapy sources
- Corneal tissue acquisition costs
- Certain preventive services

Medicare pays partial hospitalization on a per diem basis. The payment represents the expected daily cost of care in facilities, hospital outpatient departments, and CMHCs. In 2017, CMS replaced the two-tiered APC structure for partial hospitalizations with a single APC by provider type for furnishing three or more services per day.

A critical OPSS feature is “packaging,” or grouping integral, ancillary, supportive, dependent and adjunctive services into the payment for the associated primary procedure or service. Packaging encourages better use of hospital resources. Medicare makes no separate packaged service payments. [42 CFR § 419.2\(b\)](#) describes some types of packaged items and services including:

- All supplies
- Ancillary services
- Anesthesia
- Operating and recovery room use
- Clinical diagnostic laboratory tests
- Capital-related costs
- Procedures described by add-on codes
- Implantable medical devices used in connection with diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests, such as pacemakers
- Inexpensive drugs under a per-day drug threshold packaging amount
- Intraocular lenses (IOLs)
- Drugs, biologicals, and radiopharmaceuticals functioning as supplies, including diagnostic radiopharmaceuticals, contrast agents, stress agents, implantable biologicals, and skin substitutes
- Guidance services
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Observation services

Refer to [42 CFR § 419.2\(c\)](#) for a list of costs not included in the hospital OPSS.

CMS policy packages payment for all items and services typically packaged under the OPSS. It also packages payment for other items and services not typically packaged under the OPSS.

The single payment for a comprehensive APC does not include services that cannot be covered Outpatient Department (OPD) services, services that cannot be paid under the OPSS by statute, and services separately paid as required by statute.

SETTING PAYMENT RATES

CMS determines separately payable medical and surgical payment rates by multiplying the service's clinical APC, prospectively established scaled **relative weight** by a **conversion factor (CF)** to arrive at a national unadjusted APC **payment rate**. The relative weight for an APC measures the resource service needs based on the APC geometric mean services cost.

The CF translates the scaled relative weights into dollar payment rates. For the national unadjusted payment rates and copayments for each HCPCS code in the addendums section of each rulemaking page, refer to the [Hospital Outpatient Regulations and Notices](#) webpage.

To account for geographic input price differences, CMS further adjusts the labor portion of the national unadjusted payment rate (60 percent) by the hospital wage index for the area where Medicare makes the payment. CMS does not adjust the remaining 40 percent.

For CY 2020, CMS uses the post-reclassified wage index for urban and rural areas to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount. CMS limits all copayment amounts to a maximum of 40 percent of the APC payment rate.

Hospitals may get the following payments added to standard OPPS payments:

- Pass-through payments for specific drugs, biologicals, and devices in delivering services that meet the criteria for pass-through status (these items are generally too new to have the data needed to set payment rates)
- Outlier payments for individual services that cost hospitals much more than the services' APC group payment rates
 - CMHCs get a separate capped outlier threshold from hospitals
- Transitional outpatient payments for certain cancer hospitals and children's hospitals
- An adjustment for certain cancer hospitals
- A rural adjustment (currently an increased payment of 7.1 percent) for most services by Sole Community Hospitals (SCHs) including Essential Access Community Hospitals (EACH) located in rural areas

The annual review of APCs and their relative weights considers:

- Changes in hospital and medical practices
- Changes in technology
- Adding new services and taking away obsolete services
- New cost data
- Hospital Outpatient Payment Panel recommendations
- Other relevant information

CMS calculates the OPPS update factor by reducing the hospital market basket update by a multi-factor productivity adjustment and an additional 0.75 percentage points.

For CY 2020, CMS increased the payment rates under the OPPS by an OPD fee schedule increase factor of 2.6 percent.

CMS further updates the CF by reducing it 2.0 percentage points for hospitals failing to meet OQR Program reporting requirements for the update year. This can result in reduced payment for most services.

CMS creates payment rates through alternative methods for certain other items and services categories, such as:

- Separately payable drugs and biologicals
- Separately payable drugs and biologicals acquired under the [340B Program](#)
- Brachytherapy sources
- Therapeutic radiopharmaceuticals
- Services assigned to New Technology APCs

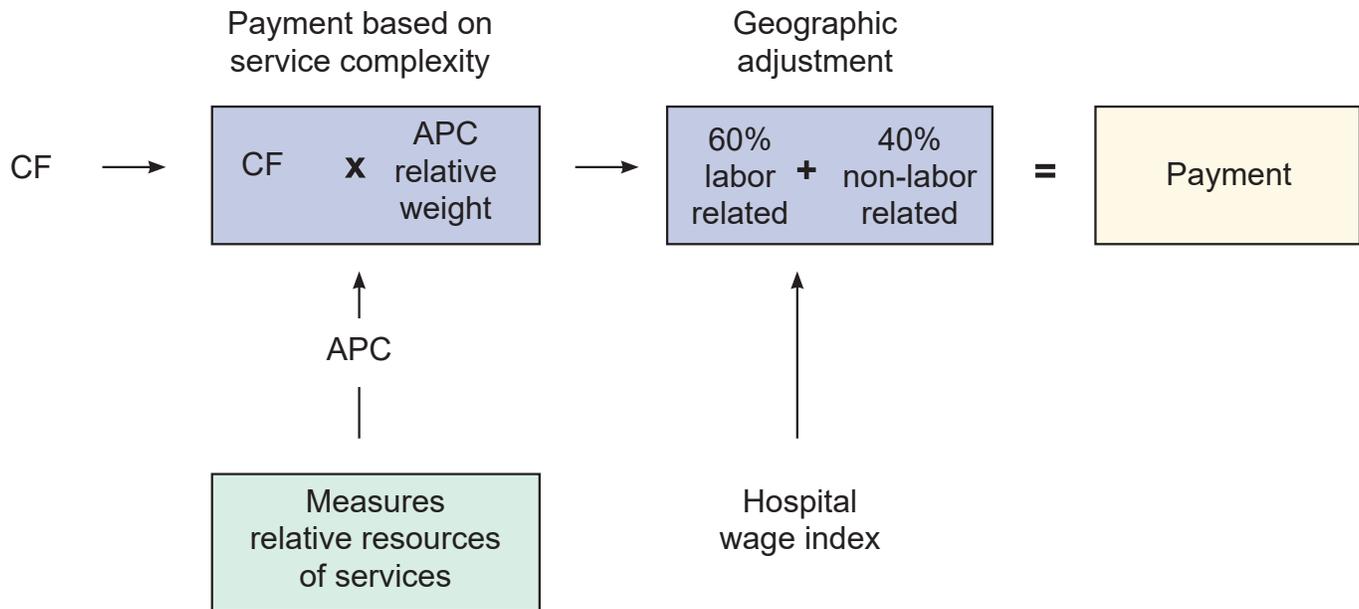
CMS updates OPPS payment files quarterly to account for mid-year changes, such as:

- New pass-through drugs and/or devices
- New services and procedures to clinical and New Technology APCs
- New HCPCS codes added during the year
- Updated payment rates for separately payable drugs and biologicals based on the most recent available average sales price (ASP) data

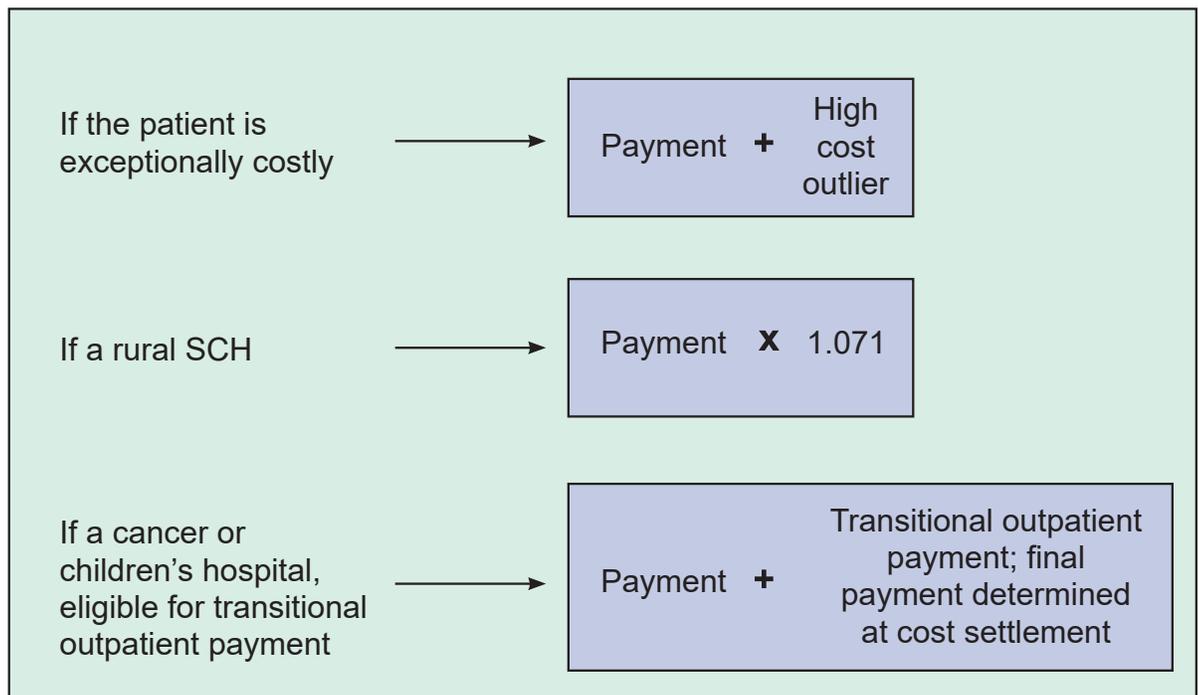
CMS establishes payments for items and services based on annual scaled relative weights and generally does not update them quarterly. For more information about payment adjustments, refer to [Chapter 4 of the Medicare Claims Processing Manual](#).

Beginning in 2019, CMS applies a PFS-equivalent payment rate for the clinic visit service when furnished at an off-campus PBD under the OPPS. In CY 2020, Medicare pays these departments the site-specific PFS rate for the clinic visit service. The clinic visit is the most common service billed under the OPPS. For more information about the OPPS payment updates, refer to the [CY 2019 Hospital OPPS Final Rule](#).

OPPS PAYMENT RATES



Special Exceptions



HOSPITAL OQR PROGRAM

The Hospital OQR Program is a pay-for-reporting quality program for the hospital outpatient department. The Hospital OQR Program requires hospitals meet quality reporting requirements or get a 2.0 percentage point reduction in their annual payment update.

Hospitals qualify for the full OPPTS update factor by submitting required quality data for specific quality of care measures. For more information, refer to the [Hospital OQR Program](#) and [QualityNet Hospital OQR Program](#).

INNOVATION

CMS is providing an alternative pathway for transformative devices that have an FDA Breakthrough Device designation to qualify for device pass-through payment status, when the “substantial clinical improvement” criterion would not apply to these devices. The devices must still meet the other criteria for pass-through status. This alternative pathway will apply to devices that get pass-through payment status on or after January 1, 2020.

Beginning July 1, 2020, you must request prior authorization for the following outpatient department services:

- Blepharoplasty
- Botulinum toxin injections
- Panniculectomy
- Rhinoplasty
- Vein ablation

Medical necessity documentation requirements remain the same.



RESOURCES

Table 1. Hospital OPPS Resources

Resource	Website
42 CFR Part 419—Prospective Payment System for Hospital Outpatient Department Services	ECFR.gov/cgi-bin/text-idx?SID=e1c552acb58d17797f3d2d4ea8343660&mc=true&node=pt42.3.419&rgn=div5
Hospital OPPS	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf CMS.gov/files/document/r4494cp.pdf
Physician Fee Schedule and OPPS/ASC Final Rules Presentation	CMS.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-11-06-ASC-Presentation.pdf

Table 2. Hyperlink Table

Embedded Hyperlink	Complete URL
340B Program	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Billing-340B-Modifiers-under-Hospital-OPPS.pdf
42 CFR § 419.2(b)	https://www.ecfr.gov/cgi-bin/text-idx?SID=6d973e57e925321a332cbff3ccbd77ce&mc=true&node=pt42.3.419&rgn=div5#se42.3.419_12
42 CFR § 419.2(c)	https://www.ecfr.gov/cgi-bin/text-idx?SID=6d973e57e925321a332cbff3ccbd77ce&mc=true&node=pt42.3.419&rgn=div5#se42.3.419_12
42 Code of Federal Regulations (CFR) § 419.22	https://www.ecfr.gov/cgi-bin/text-idx?SID=be41baebc3808313fca31adcccc2179f&mc=true&node=pt42.3.419&rgn=div5#se42.3.419_122

Table 2. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
42 CFR § 419.31	https://www.ecfr.gov/cgi-bin/text-idx?SID=6d973e57e925321a332cbff3ccbd77ce&mc=true&node=pt42.3.419&rgn=div5#se42.3.419_131
Chapter 4 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
CY 2019 Hospital OPSS Final Rule	https://www.federalregister.gov/d/2018-24243
Coinsurance or Deductible	https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance
Hospital OQR Program	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram
Hospital Outpatient Regulations and Notices	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices
QualityNet Hospital OQR Program	https://www.qualitynet.org/outpatient
Social Security Act (SSA) § 1833(t)	https://www.ssa.gov/OP_Home/ssact/title18/1833.htm

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