# Outpatient Prospective Payment System (OPPS) Legend

**Definitions**

**Description:** The short procedure code description. Refer to the appropriate official CPT or HCPCS coding manual for complete definitions to assure correct coding.

**Ambulatory Payment Classification (APC):** Most services in the outpatient setting are paid using the Ambulatory Payment Classification (APC) system developed by Medicare. The DHCF has adopted Medicare definitions and weights for APCs and those codes paid through the APC method.

**Composite APC:** An APC fee calculation that takes into consideration the presence of multiple procedures performed on the same date of service and may discount the total payment due to the procedures being performed in combination rather than in separate situations.

**APC Relative Weight:** The DHCF has adopted Medicare's relative weights for each APC. Each APC code is assigned a relative weight to determine how it will price for payment.

**Conversion Factor:** A conversion factor is a standard dollar amount that is used to translate relative weights into payment. For current conversion factors review the APC fee schedule available on the website. Medicaid has designated four (4) conversions for the following facility types:

- General Acute Care Hospitals
- Children's Hospitals
- Critical Access Hospitals
- Ambulatory Surgical Centers

**Status Indicators:** Certain procedures are not assigned an APC category but are instead referred back to the Medicaid fee schedule for pricing.

| Status Code | Description | Comments |
|---|---|---|
| 1 | Not Covered | Indicates a service that is not covered by Medicaid (e.g., a service that cannot be provided in an outpatient hospital setting or that is not a covered Medicaid benefit). |
| 2 | Paid a percentage of charges | Paid by multiplying billed charges by a hospital-specific cost-to-charge ratio. |
| 3 | Other fee schedule | Indicates a service that is excluded from the APC-based methodology, e.g., laboratory and screening mammography's. |

| Status Code | Medicare Description | Wyoming Use of Status Indicators |
|---|---|---|
| A | Services not Paid under OPPS; Paid under fee schedule or other payment system | Not paid under OPPS. |
| B | Non-allowed item or service for OPPS | Not paid under OPPS. |
| C | Inpatient procedure | Not paid under OPPS. |
| D | Discontinued Codes | Not Paid under any system. |
| E1 | Items and services not covered by Medicare | Not paid under any outpatient system. |

| Status Code | Medicare Description | Wyoming Use of Status Indicators |
|---|---|---|
| E2 | Items and services for which pricing information and claims data are not available | Not paid under any outpatient system. |
| F | Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines | Not paid under OPPS. Paid at reasonable cost. |
| G | Pass-through drugs and biologicals | Paid under OPPS; Separate APC payment includes pass through amount. |
| H | (1) Pass-through device categories (2) Therapeutic Radiopharmaceuticals | Paid under OPPS; (1) separate cost-based pass-through payment; (2) separate cost-based non pass-through payment. |
| H1 | Non-Opioid Medical Devices for Post-Surgical Pain Relief | Paid under OPPS; separate APC payment. |
| J1 | Hospital Part B services paid through a comprehensive APC | Paid under OPPS; (1) composite APC payment; (2) packaged if billed on the same date of service as other J1 services. |
| J2 | Hospital Part B services that may be paid through a comprehensive APC | Paid under OPPS; (1) Comprehensive Observation; (2) If multiple visit codes with status indicator J2 are present, the visit code with the highest standard APC payment rate is chosen as the comprehensive observation APC; all other visit codes are packaged. |
| K | Non-pass-through drugs and biological | Paid under OPPS; separate APC payment. |
| K1 | Non-Opioid Drugs and Biologicals for Post-Surgical Pain Relief | Paid under OPPS; separate APC payment. |
| L | Flu/PPV vaccines | Not paid under OPPS. Paid at reasonable cost. |
| M | Services that are only billable to carriers and not to fiscal intermediaries | Not paid under OPPS. |
| N | Items and services packaged into APC rates | Paid under OPPS; Payment is packaged into payment for other services. |
| P | Partial Hospitalization Service | Not Paid under OPPS. |
| Q1 | STVX-Packaged codes subject to separate payment under OPPS payment criteria. | Paid under OPPS; (1) Packaged APC payment if billed on the same date of service as a STVX procedure code; (2) separate APC payment. |
| Q2 | T packaged codes subject to separate payment under OPPS Payment criteria. | Paid under OPPS; (1) Packaged APC payment if billed on the same date of service as a T procedure code; (2) separate APC payment. |
| Q3 | Codes that may be paid through a Composite APC | Paid under OPPS; (1) Composite APC payment based on composite criteria; (2) Paid through a separate APC; (3) Payment is packaged into payment for other services. |

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|---|---|---|
| Q4 | Conditionally packaged laboratory services | Paid under OPPS; (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3”. |
| R | Blood and Blood Products | Paid under OPPS; separate APC payment. |
| S | Procedure or service, not discounted when multiple | Paid under OPPS; separate APC payment. |
| | | |

| Status Code | Medicare Description | Wyoming Use of Status Indicators |
|---|---|---|
| T | Procedure or service, multiple reduction applies | Paid under OPPS; separate APC payment. |
| U | Brachytherapy Sources | Paid under OPPS; pays at % of Charges. |
| V | Clinic or emergency department visit | Paid under OPPS; separate APC payment. |
| Y | Non-implantable durable medical equipment (DME) | Not paid under OPPS. |

**Fees:** Fees are affected by modifiers, units, discount formulas, and revenue codes.

**Modifiers:** Modifiers add clarification and specificity to procedures. Failure to use modifiers or use of an incorrect modifier may adversely affect the payment for some outpatient services.

**Hospital Outpatient Services Modifiers:** The table below indicates modifiers that Medicaid will accept for outpatient hospital or ASC claims reimbursed through OPPS.

| Level I (CPT) Modifiers | | | | | Level II (HCPCS) Modifiers | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 25 | 50 | 63 | 73 | 91 | BL | CA | EA | FA | GA | J1 | KG | LC | Q0 | PO | RC | TA | V1 | XE |
| 27 | 52 | | 74 | 95 | | CO | EB | F1 | GG | J2 | KK | LD | Q1 | P1 | RT | TB | V2 | XP |
| 33 | 58 | | 76 | 96 | | CQ | EC | F2 | GH | J3 | KL | LT | QA | P2 | | T1 | V3 | XS |
| | 59 | | 77 | 97 | | CP | ER | F3 | G0 | JG | KT | | QB | P3 | | T2 | VM | XU |
| | | | 78 | | | CR | E1 | F4 | GR | | KU | | QQ | P4 | | T3 | | X1 |
| | | | 79 | | | CS | E2 | F5 | GS | | KV | | QR | P5 | | T4 | | X2 |
| | | | | | | CT | E3 | F6 | GZ | | KW | | | P6 | | T5 | | X3 |
| | | | | | | | E | F7 | | | KY | | | PN | | T6 | | X4 |
| | | | | | | | | F8 | | | | | | PT | | T7 | | X5 |
| | | | | | | | | F9<br>FQ<br>FR<br>FS<br>FT | | | | | | | | T8 | | |
| | | | | | | | | FX | | | | | | | | T9 | | |
| | | | | | | | | FY | | | | | | | | | | |

**Discount Formula:** Medicaid will discount payment for certain multiple, bilateral or discontinued procedures as described below to type “T” and non-type “T” procedures. Type “T” procedures are procedure codes assigned a status indicator of “T”.

**Discounting for Type "T" Procedures (Significant Procedures Subject to Discounting)**

• **Multiple procedures:** Medicaid will discount payment for certain procedures when a hospital performs two (2) or more type "T" procedures on the same day for the same patient. The "T" procedure with the highest relative weight will not be discounted. The remaining "T" procedures will be multiple procedures discounted. If any of the following modifiers are present on the claim line item, the procedure will not be subject to multiple procedure discounting:

- 76 Repeat procedure by same physician.
- 77 Repeat procedure by another physician.
- 78 Return to the operating room for a related procedure during the postoperative period.
- 79 Unrelated procedure or service by the same physician during the postoperative period.

• **Bilateral procedures:** The first type "T" bilateral procedure, indicated by modifier 50 (bilateral procedure) will not be discounted. The remaining "T" bilateral procedures will be bilateral procedure discounted. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.

• **Discontinued procedures:** Medicaid will discount type "T" procedures that a hospital discontinues before completion, indicated by modifier 52 (reduced services) or 73 (discontinued outpatient procedure prior to anesthesia administration). The "T" discontinued procedure with the highest relative weight will be discounted 50 percent of the payment rate. The remaining "T" discontinued procedures will be discontinued procedure discounted. Any applicable offset will be applied prior to selecting the type "T" procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first before the terminated procedure discount.

**Discounting for Non-Type "T" Procedures:**

- **Bilateral procedures:** The first non-type "T" bilateral procedure, indicated by modifier 50 (bilateral procedure) will not be discounted. The remaining non-type "T" bilateral procedures will be bilateral procedure discounted. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.
- **Discontinued procedures:** Medicaid will discount non-type "T" procedures that a hospital discontinues before completion, indicated by modifier 52 (reduced services) or 73 (discontinued outpatient procedure prior to anesthesia administration).
- **Credit received from the manufacturer for a replaced medical device:** When the credit for the device is 50% or more of the total cost of the device, the Provider will need to indicate this on their claim by using a value code of "FD" and indicating the total amount of the credit.