The Basics of Outpatient Claims and OPPS

Differences Between Outpatient Facility and Professional Claims and A Brief Overview of OPPS

April 2014

Discussion Outline

1. **Comparison between facility and professional claim elements**
    - Claim forms UB-04 (CMS 1450) vs CMS 1500
    - Providers, Physicians and Suppliers
    - Resources vs. knowledge
    - Bill Type
    - Revenue Codes
    - Place of service
    - Value, condition, status and occurrence codes
    - Diagnosis coding and reporting
    - Dates of service
2. **Rules, information and fee schedules**
    - Addendum B vs. MPFSDB
    - Manuals
    - CCI and MUE
3. **OPPS: Outpatient Prospective Payment System**
4. **Questions**

Linville Falls – Linville NC

Disclaimer

The comments expressed throughout this presentation are our opinions, predicated on our interpretation of CMS regulations/guidelines and our professional healthcare experiences.

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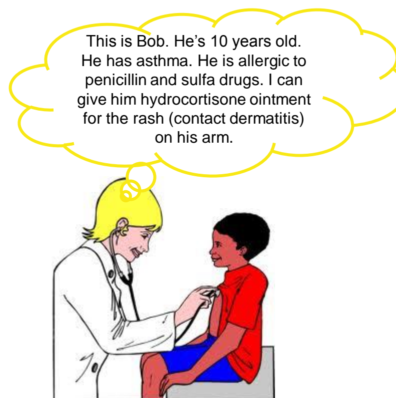
Resources vs. Knowledge/Decision Making

The key concept to consider when trying to grasp the differences between facility and physician billing is that the facility is supplying the resources (rooms, supplies, drugs, nursing) and the physician is supplying the decision making, knowledge and his or her skills).

- Real estate – cost of the physical location
- Equipment – x-ray, autoclaves , furniture
- Supplies – bandages, depressors, etc.
- Staff – nurses, front desk, technicians

This is Bob. He's 10 years old. He has asthma. He is allergic to penicillin and sulfa drugs. I can give him hydrocortisone ointment for the rash (contact dermatitis) on his arm.

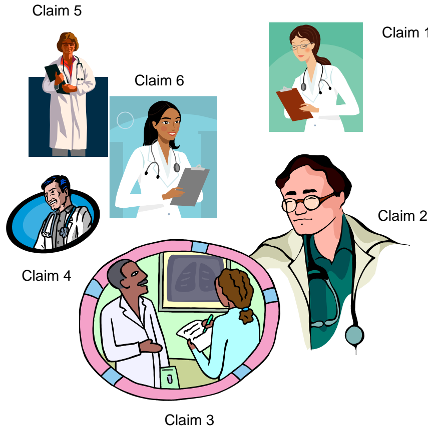


Do you think the global surgery concept would apply to the facility?

Single vs. multiple claims

Each professional will submit a claim for his/her individual services. All services for the same patient, same date of service at the same facility must be submitted on a single claim.

Professional



Facility

Single claim

Claim Forms

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf

1500
HEALTH INSURANCE CLAIM FORM

Provider, Physician and Supplier Defined

Provider - A clinic, rehabilitation agency, or public health agency including:
hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), clinics, rehabilitation agencies, and public health agencies, comprehensive outpatient rehabilitation facilities (CORFs), hospices, critical access hospitals (CAHs), and community mental health centers (CMHCs).

Physician/Practitioner -A doctor of medicine, doctor of osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function. The following practitioners may deliver services without direct physician supervision: nurse practitioners and physician assistants, qualified clinical psychologists, clinical social workers, certified nurse midwives, and certified registered nurse anesthetists.

Supplier - An entity that is qualified to furnish health services covered by Medicare, other than providers, physicians, and practitioners. Suppliers include ambulatory surgical centers (ASCs), independent physical therapists, mammography facilities, DMEPOS suppliers, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities, rural health clinics, and Federally-qualified health centers.

Provider

Mission Hospital – Ashville, NC

Practioner

Supplier

Facility Concept - Bill Type (Type of Bill or TOB)

- Key Element on a facility claim
- Four digit alphanumeric code
  1. Leading 0 (ignored by Medicare; the second digit is considered to be the first digit)
  2. Type of Facility
     - 1= Hospital
     - 2= Skilled Nursing
     - 3= Home Health
     - Etc.
  3. Bill Classification (these are the most common second digits but can vary, double check in CMS or NUBC when in doubt)
     - 1= Inpatient
     - 2= Inpatient (Part B only – is considered outpatient)
     - 3= Outpatient
     - Etc.
  4. Frequency
     - 1= Admit thru discharge (total course of treatment)
     - 7= Replacement of a prior claim (corrected claim)
     - 8= Void/Cancel prior claim (wrong patient etc)
     - Etc.

Bill type also determines which payment system is applicable for the services provided (111 IPPS, 131, OPPS, etc.).

Facility Concept - Revenue Codes

- Codes that identify the location and/or type of service being provided; every line on a facility claim must contain a revenue code.

- Four digit numeric code; the last digit represents the subcategory – examples:
  - 020x – Intensive Care Unit
    - 0201 – Intensive Care Unit – Surgical
  - 036x – Operating Room Services
    - 0360 – General OR
  - 045x – Emergency Room
    - 0456 – Urgent Care
  - 051x – Clinic
    - 0515 – Pediatric Clinic
  - 068x – Trauma Response
    - 0682 – Level II Trauma Response
  - 210x – Alternative Therapy Services
    - 2101 – Acupuncture

Duke University Children's Hospital

Physician Claim Concept – Place of Service (POS)

- Place of service codes determine whether payment is made at the facility or non-facility rate.
  - POS 11 – Office is paid at the non-facility rate
  - POS 22 – Outpatient hospital is paid at the facility rate

When services are performed in the outpatient hospital, the hospital bears the costs associated with the services; therefore, the physician payment rate would be lower than when performed in a non-facility setting (where the physician would bear the costs e.g., equipment, routine supplies, nursing).

Correlation of POS, Type of Bill and Rev Code

POS determines whether physician services are paid at the facility or non-facility rate. CMS-1500 only.

The type of bill indicates the type of facility where services were provided (inpatient, outpatient, SNF, etc.) UB only.

Revenue codes per the National Uniform Billing Committee (NUBC) are “Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements”. In general, the revenue code ties the charges to a specific cost center(s) in a facility. In other words, the area which bears the costs for the services. (Example: rev code 450 – emergency department) UB only.

Examples

POS	Type of Bill	Rev Code	Notes
11 - office			in POS 11, physician office bears the costs
22 - outpatient hospital	131 - outpatient	510 - clinic	where a physician sees the patient in hospital based clinic, facility bears the costs
23 - emergency room hospital	131 - outpatient	450 - emergency room	where a physician sees the patient in the ED, facility bears the costs
21 - inpatient hospital	111 - inpatient		in POS 21, the facility bears the costs

Facility Concepts - Value, Condition, Status and Occurrence Codes

Value Codes

Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim.

Value codes contain additional information to process a claim.

Example – value code 48 is used to report the most recent hemoglobin reading prior to claim start date. This information is used to determine if certain drugs (epo, darbo) are appropriate (medically necessary).

Status Codes

Patient Discharge Status – Many health plans use discharge status in reimbursement policies.

- 01 – discharged to home
- 07 – left against medical advice or discontinued care
- 20 - expired

Condition Codes

Code(s) used to identify conditions or events relating to the bill that may affect processing.

CC – 02 Condition is employment related

CC – 21 Billing for denial

CC – 30 Qualified clinical trial

CC – 41 Partial hospitalization

CC – 44 inpatient admission changed to outpatient

Occurrence and Occurrence Span Codes

Codes and associated dates defining significant events that may affect payer pricing.

OC 10 – date of last menstrual period

OC 16 – last date of therapy

OC 42 – date of discharge

OSC 74 – non-covered level of care or leave of absence dates

Diagnosis Coding and Reporting

The Official Guidelines for Coding and Reporting ICD-9-CM codes are in the front of your ICD-9 book
"Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under HIPAA."

Section I. Conventions, general coding guidelines and chapter specific guidelines
Section II. Selection of Principal Diagnosis (non-outpatient)
Section III. Reporting additional Diagnosis Codes (non-outpatient)
Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

Diagnosis codes are entered in the header of the UB facility claim. There is no diagnosis pointer on the lines. Facility outpatient claims are frequently coded by HIM. All services for that episode of care are presented on a single claim. Therefore, you will see many and more varied diagnosis codes on a single claim.

Diagnosis codes are entered in the header of the CMS 1500 but are tied to specific lines via the diagnosis pointer (block 24E). Coding is usually done by a physician coder. Each physician submits a claim so diagnosis codes will probably be more related/similar.

Date(s) of Service

Facility

Facility(UB) claims have a statement covers period located in the header including a from and through date. In addition, each line has a service date. When the same services are provided on different dates they would be listed on separate claim lines. A single claim line does not span multiple dates.

Professional

Date(s) of service on professional(CMS-1500) claims are reported at the line level. There is a from and through date for each line. A single claim line could contain multiple units and a date span.

Payment

Facility

Most facility Medicare outpatient claims are paid under the Outpatient Prospective Payment System(OPPS). In general, payment is not made on a line by line basis. Many services are packaged (bundled) into Ambulatory Payment Classifications (APCs). There are many rules applied to claims as they are processed through the Outpatient Code Editor (OCE) prior to pricing and payment of the claims. The general OPPS rules will be discussed in the next section. The OCE rules will be covered in a separate session.

Professional

Professional claims are considered on line by line basis. Although some lines may be bundled (for example, CCI), payment for services are paid on the line level.

Facility and Professional claims for the same services may not be coded identically. A patient seen in the Emergency Department may require many resources resulting in a higher level E&M but may be fairly straight forward physician decision making. For example, an inebriated patient who has fallen and subsequently transported to the ED might be stabilized, possibly strapped to a back board, and may require additional monitoring/testing to ensure there are no further health issues. The same case may be fairly straight forward from a physician perspective a quick review of x-rays, review of blood work and a quick exam may be sufficient. The ED facility may warrant a level 4 E&M code while the physician E&M may only warrant a level 3. It is not uncommon for these codes to differentiate. However, surgical codes should match in most circumstances (for example you'd expect both the facility and physician to bill a "with contrast" code if contrast was used in a case.

Medicare Physician Fee Schedule

Name	Type	Compressed size	Password ...	Size	Ratio	Date modified
14LOCCO	Microsoft Excel Comma S...	2 KB	No	6 KB	67%	12/3/2013 2:02 PM
14LOCCO	Microsoft Excel Worksheet	15 KB	No	18 KB	18%	12/3/2013 2:01 PM
14LOCCO.prn	PRN File	2 KB	No	9 KB	79%	12/3/2013 2:00 PM
ANES 2014_V0103	Microsoft Excel Comma S...	2 KB	No	3 KB	54%	1/3/2014 3:52 PM
ANES 2014_V0103	Text Document	2 KB	No	7 KB	80%	1/3/2014 3:48 PM
ANES 2014_V0103	Microsoft Excel Worksheet	12 KB	No	14 KB	19%	1/3/2014 3:51 PM
CY 2014 GPCI_12172013	Microsoft Excel Comma S...	2 KB	No	4 KB	58%	12/23/2013 10:44 AM
CY 2014 GPCI_12172013	Text Document	2 KB	No	7 KB	71%	12/23/2013 10:23 AM
CY 2014 GPCI_12172013	Microsoft Excel Worksheet	15 KB	No	18 KB	19%	12/23/2013 10:44 AM
OPPSCAP_V1219	Microsoft Excel Comma S...	114 KB	No	572 KB	81%	12/23/2013 10:48 AM
OPPSCAP_V1219	Text Document	122 KB	No	669 KB	82%	12/23/2013 10:13 AM
OPPSCAP_V1219	Microsoft Excel Worksheet	507 KB	No	632 KB	20%	12/23/2013 10:48 AM
PPRRVU14_V1219	Microsoft Excel Comma S...	302 KB	No	2,064 KB	86%	12/23/2013 10:56 AM
PPRRVU14_V1219	Text Document	330 KB	No	2,681 KB	88%	12/23/2013 10:55 AM
PPRRVU14_V1219	Microsoft Excel Worksheet	1,586 KB	No	2,115 KB	26%	12/19/2013 2:41 PM
RVUPUF14	Adobe Acrobat Document	85 KB	No	106 KB	20%	12/30/2013 10:32 AM

Medicare Physician Fee Schedule

2014 National Physician Fee Schedule Relative Value File January Release

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RELEASED 12/19/2013

HCPCS	MOD	DESCRIPTION	STATUS CODE	WORK RVU	NON-FAC PE RVU	NON-FAC NA INDICATOR	FACILITY PE RVU	FACILITY NA INDICATOR	MP RVU	NON-FACILITY TOTAL	FACILITY TOTAL	PCTC IND	GLOB DAYS	PRE OP	INTRA OP	POST OP	MULT PROC	BILAT SURG	ASST SURG	CO-SURG	TEAM SURG	ENDO BASE
23929		Shoulder surgery procedure	C	0.00	0.00		0.00		0.00	0.00	0.00	0	YYY	0.00	0.00	0.00	2	0	2	1	1	
23930		Drainage of arm lesion	A	2.99	6.36		2.55		0.58	9.93	6.12	0	010	0.10	0.80	0.10	2	1	1	0	0	
23931		Drainage of arm bursa	A	1.84	5.96		2.39		0.33	8.13	4.56	0	010	0.10	0.80	0.10	2	1	1	0	0	
23935		Drain arm/elbow bone lesion	A	6.38	6.90	NA	6.90		1.19	14.47	14.47	0	090	0.10	0.69	0.21	2	1	0	0	0	
24000		Exploratory elbow surgery	A	6.08	6.36	NA	6.36		1.12	13.56	13.56	0	090	0.10	0.69	0.21	2	1	0	1	0	
24006		Release elbow joint	A	9.74	8.78	NA	8.78		1.74	20.26	20.26	0	090	0.10	0.69	0.21	2	1	2	2	0	
24065		Biopsy arm/elbow soft tissue	A	2.13	4.75		2.31		0.33	7.21	4.77	0	010	0.10	0.80	0.10	2	1	1	0	0	
24066		Biopsy arm/elbow soft tissue	A	5.35	11.01		5.32		1.03	17.39	11.70	0	090	0.10	0.69	0.21	2	1	1	0	0	
24071		Exc arm/elbow les sc 3 cm/>	A	5.70	4.72	NA	4.72		1.11	11.53	11.53	0	090	0.10	0.69	0.21	2	1	2	0	0	
24073		Ex arm/elbow tum deep 5 cm/>	A	10.13	7.60	NA	7.60		1.92	19.65	19.65	0	090	0.10	0.69	0.21	2	1	2	0	0	
24075		Exc arm/elbow les sc < 3 cm	A	4.24	8.75		4.31		0.80	13.79	9.35	0	090	0.10	0.69	0.21	2	1	1	0	0	
24076		Ex arm/elbow tum deep < 5 cm	A	7.41	6.61	NA	6.61		1.42	15.44	15.44	0	090	0.10	0.69	0.21	2	1	1	0	0	
24077		Resect arm/elbow tum < 5 cm	A	15.72	10.81	NA	10.81		3.04	29.57	29.57	0	090	0.10	0.69	0.21	2	1	1	1	0	
24079		Resect arm/elbow tum 5 cm/>	A	20.61	13.07	NA	13.07		4.19	37.87	37.87	0	090	0.10	0.69	0.21	2	1	2	1	0	
24100		Biopsy elbow joint lining	A	5.07	5.82	NA	5.82		0.97	11.86	11.86	0	090	0.10	0.69	0.21	2	1	2	1	0	
24101		Explore/treat elbow joint	A	6.30	6.73	NA	6.73		1.16	14.19	14.19	0	090	0.10	0.69	0.21	2	1	2	0	0	
24102		Remove elbow joint lining	A	8.26	7.78	NA	7.78		1.48	17.52	17.52	0	090	0.10	0.69	0.21	2	1	2	1	0	
24105		Removal of elbow bursa	A	3.78	5.43	NA	5.43		0.69	9.90	9.90	0	090	0.10	0.69	0.21	2	1	1	0	0	
24110		Remove humerus lesion	A	7.58	7.69	NA	7.69		1.43	16.70	16.70	0	090	0.10	0.69	0.21	2	1	1	1	0	
24115		Remove/graft bone lesion	A	10.12	8.96	NA	8.96		1.90	20.98	20.98	0	090	0.10	0.69	0.21	2	1	2	1	0	

Medicare Physician Fee Schedule

NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2014

Contents: This file contains information on services covered by the Medicare Physician Fee Schedule (MPFS) in 2012. For more than 10,000 physician services, the file contains the associated relative value units (RVUs), a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.).

Bilateral Surgery
(Modifier 50) 117-117 x(1) Indicates services subject to payment adjustment.
0=150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.
1=150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.
2=150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).
The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.
3=The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.
9=Concept does not apply.

Medicare Physician Fee Schedule – Status Codes

The Status Code definitions are located in Attachment A of the RVUPUF.pdf

ATTACHMENT A

STATUS CODE A = Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled Code. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient).

C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

D = Deleted Codes. These codes are deleted effective with the beginning of the applicable year. These codes will not appear on the 2006 file as the grace period for deleted codes is no longer applicable.

Hospital Outpatient Regulations and Notices

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Hospital Outpatient PPS

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- Pass-Through Payment Status and New Technology Ambulatory Payment Classification (APC)
- OPPS Guidance
- Program Transmittals
- Hospital Outpatient Program Memoranda
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- Addendum A and Addendum B Updates
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- Annual Policy Files

Hospital Outpatient Regulations and Notices

The list below shows the federal regulations and notices for the Hospital Outpatient Prospective Payment System.

Show entries: 10

Filter On:

Regulation No.	Title	Year
CMS-1601-P	Hospital Outpatient Prospective Payment- Proposed Rule	2014
CMS-1601-N	Hospital Outpatient Prospective Payment- Proposed Rule Correction and Limited Extension of Comment Period	2014
CMS-1601-FC	Hospital Outpatient Prospective Payment- Final Rule with Comment	2014
CMS-1589-P	Hospital Outpatient Prospective Payment- Proposed Rule	2013
CMS-1589-FC	Hospital Outpatient Prospective Payment - Final Rule with Comment Period and CY2013 Payment Rates	2013

Addendum B

Hospital Outpatient PPS

- Device, Radiolabeled Product, and Procedure Edits
- Device, Radiolabeled Product, and Procedure Edits Archive
- Revenue Code to Cost Center Crosswalk
- Pass-Through Payment Status and New Technology Ambulatory Payment Classification (APC)
- OPPS Guidance
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- Hospital Outpatient Program Memoranda
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Hospital Outpatient PPS

Changes to Wage Indices and Hospital Reclassifications Impacting Certain OPPS Hospitals

Changes to wage indices and hospital reclassifications for two provider systems are being implemented in accordance with section 302 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) as amended b section 3001 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA). The TPTCCA and MCTRJC extend the expiration date for certain geographic reclassifications and special exception wage indices from Octob 2011, through March 31, 2012 for both the hospital inpatient prospective payment systems for acute care hospita (IPPS) and the hospital outpatient prospective payment system (OPPS).

Beyond the general adoption of IPPS fiscal year wages on a calendar year basis under the OPPS, there will be a additional changes. A small subset of section 508 OPPS providers will receive different wages between the last th months of CY 2011 and the first three months of CY 2012, even though the full section 508 extension would norm apply for six months. For these providers, the final wage in each of the three months may change depending on whether the CY 2011 OPPS final wage or CY 2012 OPPS final wage (as adopted under the IPPS) would be more appropriate. These differences occur because section 508 wages are implemented on the same fiscal year calen as under the IPPS. The tables reflecting accurate wages for the two three month periods (for the section 508 hospitals) are located in the "Downloads" section below.

A hyperlink to the Federal Register Notice (CMS-1442-N) describing the provisions effecting hospitals is posted ir "Related Links" section below.

CMS Final Decisions on the Recommendations of the Hospital Outpatient Payment Panel on Supervisio Levels for Select Services: Based on the recommendations of the Hospital Outpatient Payment Panel at its meeting on February 27-28, 2012, CMS is changing the required level of supervision for select services effective Ju 1, 2012. The reference document is located in the "downloads" section below.

Addendum B

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Hospital Outpatient PPS
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Addendum A and Addendum B Updates

Updates of Addendum A and B are posted quarterly to the OPPS website. These addenda are a "snapshot" of HCPCS codes and their status indicators, APC groups, and OPPS payment rates, that are in effect at the beginning of each quarter. The quarterly updates of Addendum A and Addendum B reflect the OPPS Pricer changes that are part of the quarterly OPPS recurring update notification transmittals.

Show entries: 10

Filter On:

Release Date	Subject	Year
January 2014	Addendum A	2014
January 2014	Addendum B	2014
January 2013	Addendum A	2013
January 2013	Addendum B	2013
April 2013	Addendum A	2013

Addendum B – Example

	Addendum B.-Final OPPS Payment by HCPCS Code for CY 2012							
	CPT codes and descriptions only are copyright 2011 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2011/12 American Dental Association. All Rights Reserved.							
HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
23920	Amputation at shoulder joint	C						
23921	Amputation follow-up surgery	T	0136	16.7455	1172.45	.	234.49	
23929	Shoulder surgery procedure	T	0129	1.5023	105.19	.	21.04	
31576	Laryngoscopy with biopsy	T	0074	21.3453	1494.51	.	298.91	
31577	Remove foreign body larynx	T	0073	4.4183	309.35	67.83	61.87	
31578	Removal of larynx lesion	T	0075	30.4202	2129.9	445.59	425.98	
31579	Diagnostic laryngoscopy	T	0073	4.4183	309.35	67.83	61.87	
95920	Intraop nerve test add-on	N						
99212	Office/outpatient visit est	V	0605	1.0309	72.18	.	14.44	
99213	Office/outpatient visit est	V	0605	1.0309	72.18	.	14.44	

Addendum D1 – Status Indicators

CMS-1525-FC_Addenda.zip - ZIP archive, unpacked size 5,284,910 bytes

Name	Size	Packed	Type
..			File Folder
508_Compliant_Version_of_2012 FR Addendum A.txt	52,705	19,418	Text Document
508_Compliant_Version_of_2012 FR Addendum B.txt	3,132,575	190,621	Text Document
508_Compliant_Version_of_2012 FR Addendum C.txt	294,187	73,915	Text Document
508_Compliant_Version_of_2012 FR Addendum E.txt	60,193	13,793	Text Document
508_Compliant_Version_of_2012 FR Addendum M.txt	9,611	2,373	Text Document
508_Compliant_Version_of_Add L.txt	17,253	5,399	Text Document
508_Compliant_Version_of_Addendum N.txt	15,530	5,239	Text Document
508_Compliant_Version_of_APC Category Names New.txt	859	445	Text Document
CMS-1525-FC_FINAL Addendum A.10.28.11.xlsx	70,925	67,610	Microsoft Excel Worksheet
CMS-1525-FC_FINAL Addendum B.10.27.11.xlsx	900,607	826,784	Microsoft Excel Worksheet
CMS-1525-FC_FINAL Addendum C.10.28.11.xlsx	376,853	301,716	Microsoft Excel Worksheet
CMS-1525-FC_FINAL Addendum D1.10.27.11.pdf	85,857	73,298	Adobe Acrobat Document
CMS-1525-FC_FINAL Addendum D2.10.27.11.pdf	15,405	5,895	Adobe Acrobat Document
CMS-1525-FC_FINAL Addendum E.10.27.11.xlsx	71,767	64,580	Microsoft Excel Worksheet
CMS-1525-FC_FINAL Addendum L.xls	88,576	23,699	Microsoft Excel 97-2003 Worksheet
CMS-1525-FC_FINAL Addendum M.10.27.11.xlsx	18,791	15,714	Microsoft Excel Worksheet
CMS-1525-FC_FINAL Addendum N.xls	73,216	17,874	Microsoft Excel 97-2003 Worksheet

OPPS Addenda – Status Indicators

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example:	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS.
		Services are subject to deductible or coinsurance unless indicated otherwise.
	● Ambulance Services	
	● Clinical Diagnostic Laboratory Services	Not subject to deductible or coinsurance.
	● Non-Implantable Prosthetic and Orthotic Devices	
	● EPO for ESRD Patients	
	● Physical, Occupational, and Speech Therapy	
	● Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital	
	● Diagnostic Mammography	
	● Screening Mammography	Not subject to deductible or coinsurance.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS.
		● May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS.
		● An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.

OPPS Addenda – Status Indicators

Indicator	Item/Code/Service	OPPS Payment Status
E	Items, Codes, and Services:	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
	● That are not covered by any Medicare outpatient benefit based on statutory exclusion.	
	● That are not covered by any Medicare outpatient benefit for reasons other than statutory exclusion.	
	● That are not recognized by Medicare for outpatient claims but for which an alternate code for the same item or service may be available.	
	● For which separate payment is not provided on outpatient claims.	
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.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC	Not paid under OPPS.

OPPS Addenda – Status Indicators

Indicator	Item/Code/Service	OPPS Payment Status
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.
Q1	STVX-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable.
		(1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator “S,” “T,” “V,” or “X.”
		(2) In all other circumstances, payment is made through a separate APC payment.
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable.
		(1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator “T.”
		(2) In all other circumstances, payment is made through a separate APC payment.
Q3	Codes That May Be Paid Through a Composite APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable.
		Addendum M displays composite APC assignments when codes are paid through a composite APC.
		(1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.
		(2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.

OPPS Addenda – Status Indicators

Indicator	Item/Code/Service	OPPS Payment Status
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Significant Procedure, Not Discounted When Multiple	Paid under OPPS; separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; separate APC payment.
U	Brachytherapy Sources	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.
X	Ancillary Services	Paid under OPPS; separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

Comparing Status Indicators

HCPCS Code	Modifier	Short Descriptor	MPFS SI	Description	Addendum B SI	Description
23920		Amputation at shoulder joint	A	Active Code	C	Inpatient Procedure - not paid for outpatient
23921		Amputation follow-up surgery	A	Active Code	T	Significant Procedure - Multiple Reduction Applies
23929		Shoulder surgery procedure	C	Carriers price the code.	T	Significant Procedure - Multiple Reduction Applies
31576		Laryngoscopy with biopsy	A	Active Code	T	Significant Procedure - Multiple Reduction Applies
31577		Remove foreign body larynx	A	Active Code	T	Significant Procedure - Multiple Reduction Applies
31578		Removal of larynx lesion	A	Active Code	T	Significant Procedure - Multiple Reduction Applies
31579		Diagnostic laryngoscopy	A	Active Code	T	Significant Procedure - Multiple Reduction Applies
95920		Intraop nerve test add-on	A	Active Code	N	Items and Services Packaged into APC rates
95920	TC	Intraop nerve test add-on	A	Active Code		
95920	26	Intraop nerve test add-on	A	Active Code		
99212		Office/outpatient visit est	A	Active Code	V	Clinical or Emergency Department Visit
99213		Office/outpatient visit est	A	Active Code	V	Clinical or Emergency Department Visit

Where to find information – CMS Manuals

Internet-Only Manuals (IOMs)

The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' p
issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, r
guidelines, models, and directives. The CMS program components, providers, contractors, Medicare
organizations and state survey agencies use the IOMs to administer CMS programs. They are also
of Medicare and Medicaid information for the general public.

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Publication #	Title
100	Introduction
100-01	Medicare General Information, Eligibility and Entitlement Manual
100-02	Medicare Benefit Policy Manual
100-03	Medicare National Coverage Determinations (NCD) Manual
100-04	Medicare Claims Processing Manual

Where to find information – CMS Manuals

Publication #	100-04
Title	Medicare Claims Processing Manual

Downloads

Chapter 1 - General Billing Requirements [PDF, 1MB]
Chapter 1 Crosswalk [PDF, 458KB]
Chapter 2 - Admission and Registration Requirements [PDF, 238KB]
Chapter 2 Crosswalk [PDF, 355KB]
Chapter 3 - Inpatient Hospital Billing [PDF, 2MB]
Chapter 3 Crosswalk [PDF, 376KB]
Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS) [PDF, 1MB]
Chapter 4 Crosswalk [PDF, 353KB]
Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services [PDF, 304KB]
Chapter 5 Crosswalk [PDF, 120KB]
Chapter 6 - Inpatient Part A Billing and SNF Consolidated Billing [PDF, 447KB]
Chapter 6 Crosswalk [PDF, 177KB]
Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule) [PDF, 135KB]
Chapter 7 Crosswalk [PDF, 97KB]
Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims [PDF, 644KB]
Chapter 8 Crosswalk [PDF, 333KB]
Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers [PDF, 215KB]
Chapter 9 Crosswalk [PDF, 198KB]
Chapter 10 - Home Health Agency Billing [PDF, 856KB]
Chapter 10 Crosswalk [PDF, 203KB]
Chapter 11 - Processing Hospice Claims [PDF, 445KB]
Chapter 11 Crosswalk [PDF, 104KB]
Chapter 12 - Physicians/Nonphysician Practitioners [PDF, 1018KB]

CCI Physician and Facility

Downloads

- How to Use The National Correct Coding Initiative (NCCI) Tools [PDF, 2MB]
- R1386CP [PDF, 167KB]
- MM5824 [PDF, 69KB]
- NCCI Policy Manual for Medicare Services - Effective January 1, 2014 [ZIP, 749KB] ← Manual
- Correspondence Language Manual for Medicare Services - Effective April 1, 2013 [PDF, 208KB]
- Chapter 23 - Fee Schedule Administration and Coding Requirements [PDF, 1MB]
- Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service [PDF, 59KB]

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims.

Physician and outpatient facility services are subject to Part B. Inpatient claims are subject to Part A.

CCI Physician and Facility

Related Links

- Hospital CCI Edits V18.2 Effective July 1, 2012
- Physician CCI Edits V18.2 Effective July 1, 2012

The facility and professional CCI lists do not match exactly.

There are codes on the professional CCI list such as 72141, 72146, 72148 (MRI – spine) that do not have corresponding edits on the facility side. These codes are comprehensive to 01922 (anesthesia for non-invasive imaging) with no modifier override allowed. Anesthesia codes are status N (packaged) per Addendum B. The result is that the anesthesia would not get additional payment on either the professional or outpatient facility claim.

There are codes on the professional CCI list which also have facility CCI edits but not on the same codes. For example, 97605(negative pressure wound therapy) is comprehensive to codes 11000(debridement), 64447(injection, anesthetic agent, femoral nerve), 96372 (therapeutic, prophylactic or diagnostic injection – subcutaneous or IM) on professional CCI but not on the facility CCI.

MUE – Medically Unlikely Edits

The MUE tables are also different for physicians and facilities.

Physician MUE (Practioner)

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HCPCS/CPT Code	Practitioner Services MUE Values
10040	1
10060	1
10061	1
10080	1
10081	1
10180	3
11000	1
11004	1
11005	1
11006	1
11008	1
11010	1
11011	1
11012	2
11042	1
11043	1

Facility MUE

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HCPCS/CPT Code	Outpatient Hospital Service
10040	1
10060	1
10061	1
10080	1
10081	1
10180	3
11000	1
11001	2
11010	1
11011	1
11012	2
11042	1
11043	1
11044	1
11055	1
11056	1

MUE – Medically Unlikely Edits

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE.

MUE was implemented January 1, 2007 and is utilized to adjudicate claims at Carriers, Fiscal Intermediaries, and DME MACs.

Related Links

MUE FAQs

Practitioner Services MUE Table - Updated 7/1/12

Facility Outpatient Services MUE Table - Updated 7/1/12

DME Supplier Services MUE Table (Note: This file will include HCPCS A-B, D-H, K-V codes at this time and will not just include HCPCS codes under DME MAC jurisdiction) - Updated 7/1/12

OPPS – Outpatient Prospective Payment System

Excerpts from CMS Manual

- **Section 1833(t) of the Social Security Act**
- **Balanced Budget Act (BBA) of 1997**
  - Hospital outpatient services, including partial hospitalization services;
  - Certain Part B services furnished to hospital inpatients who have no Part A coverage;
  - Partial hospitalization services furnished by CMHCs;
  - Hepatitis B vaccines and their administration, splints, cast, and antigens provided by HHAs that provide medical and other health services;
  - Hepatitis B vaccines and their administration provided by CORFs; and
  - Splints, casts, and antigens provided to hospice patients for treatment of non-terminal illness.
- **The Balanced Budget Refinement Act of 1999 (BBRA) Hospital outpatient services, including partial hospitalization services**;
  - Establish payments under OPPS
  - Require annual updating of the OPPS payment weights, rates, payment adjustments and groups;
  - Require annual consultation with an expert provider advisory panel in review and updating of payment groups;
  - Hepatitis B vaccines and their administration provided by CORFs; and
  - Splints, casts, and antigens provided to hospice patients for treatment of non-terminal illness.
  - Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all OPPS services included on the submitted outpatient bill for services furnished before January 1, 2002, and thereafter based on the individual services billed;
  - Provide transitional pass-throughs for the additional costs of new and current medical devices, drugs, and biologicals for at least two years but not more than three years;
  - Provide payment under OPPS for implantable devices including durable medical equipment (DME), prosthetics and those used in diagnostic testing;
  - Establish transitional payments to limit provider's losses under OPPS; the additional payments are for 3 1/2 years for CMHCs and most hospitals, and permanent for the 10 cancer hospitals; and
  - Limit beneficiary coinsurance for an individual service paid under OPPS to the inpatient hospital deductible.

OPPS – Outpatient Prospective Payment System

- **The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA),**
  - Accelerated reductions of beneficiary copayments;
  - Increase in market basket update for 2001;
  - Transitional corridor provision for transitional outpatient payments (TOPs) for providers that did not file 1996 cost reports; and
  - Special transitional corridor treatment for children's hospitals.

The Outpatient Prospective Payment System (OPPS) applies to all hospital outpatient departments except for hospitals that provide Part B only services to their inpatients; Critical Access Hospitals (CAHs); Indian Health Service hospitals; hospitals located in American Samoa, Guam, and Saipan; and, effective January 1, 2002, hospitals located in the Virgin Islands. It also applies to partial hospitalization services furnished by Community Mental Health Centers (CMHCs).

Certain hospitals in Maryland that are paid under Maryland waiver provisions are also excluded from payment under OPPS but not from reporting Healthcare Common Procedure Coding System (HCPCS) and line item dates of service.

APC – Ambulatory Payment Classification

- APCs group clinically similar services which require similar resources into a single payment classification.
- Payment is made based on the APC(s) assigned to the service(s) provided
- Each covered service is assigned to an APC (see Addendum B)

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate
25118	Excise wrist tendon sheath		T	0050	32.3792	$2,267.06
25119	Partial removal of ulna		T	0050	32.3792	$2,267.06
25120	Removal of forearm lesion		T	0050	32.3792	$2,267.06
25125	Remove/graft forearm lesion		T	0050	32.3792	$2,267.06
25126	Remove/graft forearm lesion		T	0050	32.3792	$2,267.06
25130	Removal of wrist lesion		T	0050	32.3792	$2,267.06
25135	Remove & graft wrist lesion		T	0050	32.3792	$2,267.06
25136	Remove & graft wrist lesion		T	0050	32.3792	$2,267.06
25145	Remove forearm bone lesion		T	0050	32.3792	$2,267.06
25150	Partial removal of ulna		T	0050	32.3792	$2,267.06
25151	Partial removal of radius		T	0050	32.3792	$2,267.06
25170	Resect radius/ulnar tumor	CH	T	0050	32.3792	$2,267.06
25210	Removal of wrist bone		T	0050	32.3792	$2,267.06
25215	Removal of wrist bones		T	0050	32.3792	$2,267.06
25230	Partial removal of radius		T	0050	32.3792	$2,267.06
25240	Partial removal of ulna		T	0050	32.3792	$2,267.06
25246	Injection for wrist x-ray		N			

- A single claim can have multiple APCs; although, some of the APC payments may be reduced when there are multiple procedures present
- As an outpatient claim is processed through the Outpatient Claims Editor (OCE), the APC and/or the status indicator may change (for example, there is an Extended Assessment and Management APC which is assigned when there are > 8 hours of observation and an ED visits or Critical Care on the same day or previous day. The Composite APC would be assigned to the highest weighted code and the observation would be packaged. (Note – observation (G0378) is always packaged but in this case, a higher payment rate applies to the primary code to compensate for >8 hours of observation.)

Facility Concept - Packaging

Packaging is similar to bundling. Packaged items are covered and are paid but not always paid separately.

Types of Packaging

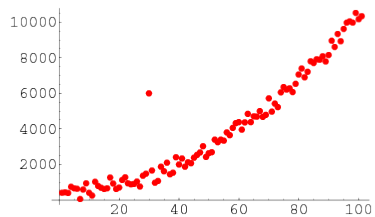
- Unconditional packaging. Status N codes are covered and packaged into an APC assigned to the claim. These items are never paid separately.
- STVX – packaging. Status Q1 codes that are covered and packaged into an APC when billed on the same day as a HCPCS code with status indicator of STV or X. If no STVX procedure is present, separate payment is made.
- T-packaging. Status Q2 codes that are covered and packaged into an APC of the HCPCS code with status T on the same date. If no T procedure is present, separate payment is made.
- Composite APC packaging. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Services mapped to composite APCs are assigned status indicator Q3.

Discounting

- Payment reductions are applied when procedures are discontinued (modifiers 73, 74) - 50% of the APC payment.
- Multiple surgical reductions are applied similar to multiple procedure discounting for physicians. The highest ranking APC is paid 100% and other status T procedures are reduced 50%.

Outliers

- Outliers were created to relieve providers (facilities) from financial risk when the costs of services are excessive (costs are the dollars spent by the facility to provide services).
- These are very specific rules for outliers, please consult the Claims Processing Manual for additional information.



72 hour / 3 day rule

72 hour rule (3 day rule) - The policy requires payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission to be bundled (i.e., included) with the payment for the beneficiary's inpatient admission if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital. The policy applies to all diagnostic outpatient services and non-diagnostic *services* (i.e., therapeutic) that are **related** to the inpatient stay. Ambulance and maintenance renal dialysis services are not subject to the payment window.

Facility Modifiers

The Integrated Outpatient Code Editor (I/OCE) accepts all valid CPT and HCPCS modifiers on OPPS claims.
Note that all modifiers are accepted – not that all are appropriate or even considered. For example, modifier 51 – multiple procedure is not relevant because payment reductions are based on the status indicators and APCs and are calculated within the I/OCE.

This section has some very good definitions, examples of modifiers and guidelines for appropriate modifier usage.

C-Codes

"C" codes are codes HCPCS codes created by Medicare for "pass through" items.

- New procedures or services, devices, drugs, and/or biologicals
- Example: A new device (usually more expensive) replaces and old device in a procedure, pass through payment may be made until the procedure is updated and/or a permanent HCPCS code is established.
- There are edits in the Integrated Outpatient Code Editor (I/OCE) which may require matching between devices and procedures/drugs/biologicals. These edits were removed in Jan 2014. This will be covered in more detail in the OCE session later today.

Questions?

Cape Hatteras Lighthouse

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