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**Public Employees  
Insurance Agency**

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# **Outpatient Hospital Prospective Payment Billing Manual**

**February 2008**

This PEIA Outpatient Hospital Prospective Payment Billing Manual is a modified version of the Hospital Manual titled “United States Government Services, LLC, Hospital Manual”. The contents have been modified to reflect PEIA general guidelines for reimbursement under OPSS.

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# Public Employees Insurance Agency Hospital Outpatient Prospective Payment System

## Introduction

This *February 2008 Outpatient Hospital Prospective Billing Manual* is a modified version of the United Government Services Hospital Manual. Modifications include:

- changes to reflect the Public Employees Insurance Agency's (PEIA) benefit plan,
- types of hospitals/providers that PEIA will include/exclude from OPPS reimbursement,
- types of services that PEIA will include/exclude from OPPS reimbursement.

It is the intent of PEIA that Medicare billing guidelines apply to outpatient hospital services billed for PEIA members unless otherwise indicated in this manual. PEIA's third party administrator, Acordia National, will use Medicare's APC Grouper including the processing edits. Codes not processed under the Grouper will continue to be subject to PEIA reimbursement methodologies and Acordia's claim edits, including CodeReview.

These instructions also apply to the Children's Health Insurance Plan (CHIP).

## OPPS Information & Billing Instructions

### Implementation

The implementation phase of OPPS is essentially budget neutral with respect to the reimbursement level of the services paid through this system. Future updates will include a transition to reimbursement level that is similar to that of PEIA's RBRVS (Resource-Based Relative Value Scale) reimbursement system.

Medicare's base conversion factor for OPPS for 2008 is \$70.70. PEIA's weighted average conversion factor (CF) is \$73.58. Future updates of these factors will include consideration of each hospital's cost of providing services and the hospital's cost relative to Medicare reimbursement.

### Effective Date

PEIA has adopted a modified version of Medicare's Outpatient prospective Payment System (OPPS). For claims with dates of service on/after February 1, 2005, PEIA reimburses outpatient hospital services based on OPPS rather than the discount from charge.

### CY 2008 Changes

For CY2008, the fixed dollar threshold is \$1,575. The multiple threshold does not change, therefore, the new outlier threshold is the maximum of  $1.75 * APC\_Pay + 1575$ .

The cap for the conversion factor of \$70.70 represents 111% of Medicare's reimbursement rates.

PEIA has established a goal that all hospitals reimbursed through OPPS will have their rates set at 111% of Medicare's rates. PEIA will transitioned this reimbursement change over a 3-year period beginning with Calendar Year 2006.

### Update Process

PEIA is following a modified version of Medicare's OPPS reimbursement methodology.

Medicare's periodic updates will be considered and adopted by PEIA if they are applicable to coding and edits that affect APC assignment, bundling, and/or pass-through determination. Otherwise, the annual update schedule will be followed for adjustment to the reimbursement rates applied to PEIA's APC rates. **Updates will be published by memorandum which will be sent to each facility.**

### **Hospitals/Providers Paid Through OPPS**

The Outpatient Prospective Payment System (OPPS) applies to all West Virginia hospital outpatient departments except:

- Critical Access Hospitals (CAHs),
- Skilled Nursing facilities,
- Hospice,
- Psychiatric hospitals,
- Rehabilitation hospitals, and
- Veterans Administration (VA) hospitals.

For PEIA, partial hospitalization services furnished by Community Mental Health Centers (CMHCS) are not paid through OPPS.

### **Services Excluded From Hospital OPPS**

The following services are excluded from the scope of services paid as APCs through OPPS:

- Services already paid under fee schedules or other payment systems including, but not limited to:
  - Screening mammography,
  - ESRD paid under the ESRD composite rate,
  - Professional services of physicians and non-physicians paid under the Medicare physician fee schedule,
  - Laboratory services paid under the clinical diagnostic laboratory fee schedule,
  - Non-implantable DME, orthotics, prosthetics and prosthetic devices, prosthetic implants, and take-home surgical dressings will be paid under the DME fee schedule;
- Hospital outpatient services furnished to SNF inpatients as part of his or her resident assessment or comprehensive care plan;
- Services and procedures that require inpatient care;
- Hospice services;
- Home health care services,
- Freestanding psychiatric facility services,
- Freestanding substance abuse and rehabilitation facility services,
- Ambulance services, physical, speech and occupational therapy services; and
- Drugs and supplies that are used within a dialysis session where payment is not included in the composite rate.

PEIA will reimburse covered services indicated as "pass-through" services using OPPS or PEIA rates.

### **Ambulatory Payment Classification (APC) Groups**

OPPS reimbursement is based on Ambulatory Payment Classification (APC) groups. APCs include groups of services that are similar clinically and require similar resource use. APCs require no changes to the billing form; however, providers are required to include HCPCS codes for all services in order to be paid accurately under OPPS.

## **Coinsurance for Hospital OPPS**

Coinsurance for outpatient hospital services will be processed at the lesser of 20 percent of the APC allowance and 20 percent of the charge amount. If the APC allowance is more than the provider's charge, then the coinsurance is calculated on the charge amount. As applicable, deductibles and emergency room copayments will also apply. Preventive care services that are covered in full by PEIA will be processed to pay 100% of PEIA's maximum allowance (no coinsurance will apply).

## **Bill Types**

The bill type is a code indicating the specific type of bill (inpatient, outpatient, adjustments, cancels, late charges). This is a three-position field and is mandatory for all outpatient bills paid under the Outpatient Prospective Payment System (OPPS).

The three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of the bill in this particular episode of care and is referred to as the frequency code.

Data elements in the CMS uniform billing specifications are consistent with the Form CMS-1450. The type of bill is located in field 4 of the CMS-1450. For providers paid under the Outpatient Prospective Payment System, the following bill types are subject to OPSS:

- 13X with condition code 41 (partial hospitalization),
- 13X without condition code 41, and
- 14X.

## **Line Item Dates of Service**

Under the hospital OPSS, hospitals are required to report all services utilizing HCPCS coding in order to assure proper payment. This requirement applies to:

- Acute care hospitals,
- Hospital outpatient departments, and
- Comprehensive outpatient rehabilitation and psychiatric facilities.

Under OPSS, the date of service must be reported on line items where a HCPCS code is required, even if the "from" and "through" dates are the same. Claims will be returned to the provider if they are submitted with a HCPCS code and no corresponding line item date of service, or with a line item date of service outside the 'statement covers' period.

## **Reporting of Service Units**

Service units for hospital outpatient services, where HCPCS codes are required, must be reported as the number of times the service/ procedure was performed according to the HCPCS code definition.

The beginning and ending time of the treatment must be recorded in the patient's medical record along with the note describing the treatment.

If more than one HCPCS/CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time.

For example, if 24 minutes of 97112 and 23 minutes of 97110 were furnished, then the total treatment time was 47 minutes; therefore, only three units can be billed for the treatment. The correct coding is two units of 97112 and one unit of 97110; thus assigning more units to the service that took more time. Claims that do not contain service units for a given HCPCS code will be returned to the provider.

# HCPCS Coding

## HCFA Common Procedure Coding System (HCPCS)

Implementation of OPSS requires that hospitals report services using HCPCS coding in order to receive proper outpatient payment. There are three levels of HCPCS codes:

- Level I codes contain the American Medical Association’s Current Procedural Terminology (CPT) coding system. This level consists of all numeric codes (the emerging technology Category III CPT codes are numeric-alpha with a T at the end),
- Level II codes (national codes) contain the codes for physician and non-physician services, which are not included in CPT 4 codes. These are alphanumeric codes maintained jointly by CMS, Blue Cross and Blue Shield Association and the Health Insurance Association of America (HIAA), and
- Level III (local codes) contain the codes that Medicare fiscal intermediaries and carriers develop as needed.

There are certain HCPCS codes that are not used by Medicare and also will not be used by PEIA. If hospitals report them on a claim with other services that are covered, Acordia National will deny the line item as non-covered.

### HCPCS/Revenue Code Chart

The following chart represents HCPCS coding to be reported and paid under the OPSS system.

Revenue Code	HCPCS Code	Description
*	10040-69990	Surgical procedure
*	92950-92961	Cardiovascular
*	96570, 96571	Photodynamic therapy
*	99170, 99185-99186	Other services and procedures
*	99291-99292	Critical care
*	99440	Newborn care
*	90782-90799	Therapeutic or diagnostic injections
*	D1050, D0240-D0274, D0277, D0460, D0472-D0999, D1510-D1550, D2970, D2999, D3460, D399, D4260-D4264, D4270-D4273, D4355-D4381, D5911-D5912, D59-D5984, D5987, D6920, D7110-D7260, D7291, D7940, D9630, D9930, D9940, D9950-D9952	Dental services
*	92502-92596, 92599	Otorhinolaryngologic services (ENT)
278	E0749, E0792-E0783, e0785	Implanted durable medical equipment
278	E0751, E0753, L8600, L8603, L8610, L8612, L9714, L8619, L8630, L8641-L8642, L8658, L8670, L8699	Implanted prosthetic devices
302	86485-86586	Immunology
305	85060-85102, 86077-86079	Hematology
31X	80500-80502	Pathology – lab
310	88300-88365, 88399	Surgical pathology
311	88104-88125, 88160-88199	Cytopathology
32X	70010-76092, 96-94-70999	Diagnostic radiology
333	77261-77799	Radiation oncology

34X	78000-79999	Nuclear medicine
37X	99141-99142	Anesthesia
413	99183	Other services and procedures
45X	99281-99285	Emergency
46X	94010-94799	Pulmonary function
480	93600-93790, 93799, G0166	Intra electrophysiological procedures & other vascular studies
481	93501-93571	Cardiac catheterization
482	93015-93024	Stress test
483	93303-93350	Echocardiography
51X	92002-92499	Ophthalmologic services
51X	92201, 99215, 99241-99246, 99271-99275	Clinic visit
510, 517, 519	95144-95149, 95165, 95170, 95180, 95199	Allergen immunotherapy
519	95805-95811	Sleep testing
530	98925-98929	Osteopathic
636	A4642, A9500, A9605	Radionuclides
636	90296-90379, 90385, 90389-90396	Immune globulins
636	90476-90665, 90675-90749	Vaccines, toxoids
73X	G0004-G0006, G0015	Event recording ECG
730	93005-93014, 93040-93224, 93278	Electrocardiograms (ECGs)
731	93225-93272	Holter monitor
74X	95812-95837, 95950-95962	Electroencephalogram (EEG)
75X	95812-95827, 95950-95962	Electroencephalogram (EEG)
762	99217-99220	Observation
771	G0008-G0010	Vaccine administration
88X	90935-90999	Non-ESRD dialysis
901	90870-90871	Psychiatry
903	90812-90815, 90823-90829	Psychiatry

\*Revenue codes have not been identified for these procedures, as they can be performed in a number of revenue centers within a hospital, such as emergency room (450), operating room (360), or clinic (510). Providers are to report these HCPCS codes under the revenue center where the service was performed. The listing of HCPCS codes contained in the chart does not assure coverage of the specific service. PEIA's current coverage criteria will apply. This chart was created by Medicare as a guide for hospitals to assist them in reporting services rendered. It also applies for PEIA. This chart does not represent all HCPCS coding subject to OPPS, but will be expanded at a later date.

Outpatient hospital claims that include expenses billed with revenue code (RC) 637 (Self-Administrable Drugs) will be processed as follows:

RC 637 with expenses billed in the "Total Expenses" column (field 47) will be bundled with the APC payment and may not be billed to the member.

RC 637 with expenses in the "Non-covered Expenses" column (field 48) will be denied as "Not Covered" and will be billable to the member.

This applies to PEIA secondary as well as primary claims. If Medicare denies the expense as "Not Covered," since PEIA also does not cover this expense, the expense will be denied.



### **Reporting of HCPCS Codes**

Under OPSS, when basing payment on HCPCS/CPT codes, the range of costs reflect hospitals' billing patterns in increasing levels of intensity. Increasing increments are due largely to hospitals' use of chargemaster systems, which generate bills using predetermined charges for codes. Hospitals should not use the lowest level CPT code 99201 to bill for all clinic visits. This would distort the data causing inflation in both the volume and cost of low-level clinic visits.

It is important that hospitals use the appropriate level of intensity of their clinic visits and report codes properly, based on internal assessment of the charges for those codes, rather than failing to distinguish between low- and mid-level visits, because the payment is the same.

The billing information that hospitals report during the first years of implementation of OPSS will be vitally important to the revision of weights and other adjustments that affect payment in future years. Each facility will be accountable for following its own system for assigning the different levels of HCPCS codes.

### **Critical Care - HCPCS Code 99291**

Hospitals can use HCPCS code 99291 (critical care E & M service) in place of, but not in addition to, a code for a medical visit/service in a clinic, observation room, or emergency department. The CPT definition of critical care is the evaluation and management of a critically injured patient who requires periods of continual attendance of a physician.

### **Coding for Clinic and Emergency Visits**

Prior to OPSS, hospitals could report CPT code 99201 to indicate a visit of any type or intensity. Under OPSS, 31 codes are used to indicate visits with payment differentials. The following HCPCS codes are billable under OPSS:

92002, 92004, 92012, 92014, 99201, 99202, 99203,  
99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241,  
99242, 99243, 99244, 99245, 99271, 99272, 99273, 99274,  
99275, 99281, 99282, 99283, 99284, 99285, G0101 and G0175.

Hospitals should use CPT guidelines when applicable or crosswalk hospital coding structures to CPT codes. For example, a hospital that has eight levels of emergency and trauma care depending on nursing ratios should crosswalk those eight levels to the CPT codes for emergency care.

### **Medical Conference - HCPCS Code G0175**

Hospitals can use HCPCS code G0175 in reporting a scheduled medical conference with the patient involving a combination of at least three health care professionals, at least one of whom is a physician.

### **Implanted DME, Prosthetic Devices, Diagnostic Devices & Implanted Diagnostic Devices**

Implanted Durable Medical Equipment (DME) and implanted prosthetic devices are paid under the Outpatient Prospective Payment System. The following are the appropriate HCPCS codes for payment under OPSS.

#### **Implanted DME**

E0749  
E0782  
E0783  
E0785

#### **Implanted Prosthetic Devices**

L8600      L8603  
L8610      L8612  
L8630      L8641  
L8642      L8658  
L8670      L8699

# Modifiers

## Correct use of Modifiers

A Modifier is a two position alpha or numeric code that is added to the end of a HCPCS code to clarify the services billed. Modifiers provide a means by which the description of a service can be altered without changing the procedure code. They add more information, such as the anatomical site, to the HCPCS code. In addition, they help to eliminate the appearance of duplicate billing and unbundling.

There are CPT-4 and Level II HCPCS Modifiers. They are used to increase accuracy in reimbursement, coding consistency, editing, and to capture payment data. Billing accurately with Modifiers is an integral part of the OPSS.

## CPT-4 Modifiers

Use the Modifiers identified below, when appropriate, for surgical procedures (HCPCS codes 10000–69999), radiology (HCPCS codes 70010–79999), and other diagnostic procedures (HCPCS codes 90700–99199).

### Not All Codes Will Require Modifiers

Do not use modifiers to indicate:

- an anatomical site location on body (Modifier 50 or Level II Modifiers) if the narrative definition of a code indicates multiple occurrences.

**Example:** The code definition indicates two to four lesions.

**11056** – Paring or cutting hyperkeratotic lesion, leg (for example a corn or callous); two or four lesions. The code definition indicates multiple lesions.

**73565** – Radiologic examination; both knees, standing, anteroposterior. The code definition indicates the specific site.

- an anatomic site (Modifier 50 or Level II Modifiers) if the narrative definition of a code indicates the procedure applies to more than two sites.

**11600** (Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less)

### Guidelines for Using Modifiers with Radiology Services

- Use Modifiers 50, 52, 59, 73, 74, 76, 77, and level II Modifiers.
- Do not report a radiology procedure that was canceled.

**Modifier 50 - Bilateral Procedures** – is used to report bilateral procedures that are performed at the same session. Report the appropriate HCPCS code and add Modifier 50 to the procedure code to identify that the procedure was performed on a contralateral site. Units should be reported as one.

**Example:** Procedure 19000 (Puncture aspiration of cyst of breast) was performed on the right and left breast during the same operative session. This is billed as 1900050.

### Use Modifier 50 for:

- surgical procedures (CPT 10000-69990),
- radiology procedures as applicable, and

- any bilateral procedure performed on both sides at the same session.

**Do Not Use Modifier 50 for:**

- procedures identified by their terminology as bilateral, for example, 27395 (Lengthening of hamstring tendon, multiple, bilateral)
- procedures identified as unilateral or bilateral, for example, 52290 (Cystourethroscopy, with meatotomy, unilateral or bilateral)

**Do Not:**

- submit two line items to report a bilateral procedure or
- submit with Modifiers RT and LT when Modifier 50 applies

**Payment Implications**

- When Modifier 50 is reported, reimbursement is for two procedures. The APC Grouper will apply the rules for calculating payment for multiple procedures and the provider will be reimbursed at 150% of the rate.
- Radiology is reimbursed at 200%. (Reimbursed for two procedures).

**Modifier 52 Reduced Services** – is used where Modifier 73 or 74 would have been appropriate, but since the use of anesthesia was not an inherent part of performing the procedure, Modifier 52 is used to show that the procedure was discontinued.

**Example:** If a colonoscopy, HCPCS code 45378 (flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) was started (conscious sedation had been administered), but it was found that the patient was inadequately prepped for the procedure, so the procedure was discontinued, and no exam of even the sigmoid was possible. This should be billed as 4537852.

It is not appropriate to use Modifier 52 if a portion of the intended procedure was completed and a code exists, which represents the completed portion of the intended procedure.

**Example:** If a colonoscopy, HCPCS code 45378, was partially completed, that is, the colonoscopy was advanced as far as the splenic flexion, to the extent that the procedure meets the definition of a sigmoidoscopy, HCPCS code 45330, it is appropriate to bill that code. Otherwise, if no codes exist for what has been done, report the intended code with Modifier 52.

**Special guidelines for Modifier 52**

- Code to the extent of the procedure that was performed and
- If no code exists for what has been done, report the intended code with Modifier 52

**Payment Implications**

- If Modifier 52 is reported, payment will be 50 percent of the rate.

**Modifier 73 - Discontinued Outpatient Hospital Surgical Procedure** – is used with procedures for which anesthesia (general, regional, or local) is planned.

**Example:** A patient is prepared for procedure 49590 (repair spigelian hernia). Before anesthesia is administered, the physician decides the procedure should not be performed. This is billed as 4959073.

**Use Modifier 73 for:**

- procedures requiring anesthesia
- an outpatient hospital procedure that was discontinued
  - after the patient has been prepared for the procedure and/or
  - before the induction of anesthesia (e.g., local, regional block(s) or general anesthesia)

**Do Not:**

- use Modifiers 50 and 73 together

**Payment Implications**

- A terminated procedure with Modifier 73 will be allowed at 50%.

**Modifier 74 - Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure or Diagnostic Procedure or Service after the Administration of Anesthesia** – is used for surgical procedures for which anesthesia (general, regional, or local) has been started.

**Example:** Anesthesia for procedure 33010 (Pericardiocentesis: initial) is given and the procedure has been started, but the physician terminates the procedure before it is completed. This is billed as 3301074.

**Use Modifier 74 for:**

- procedures requiring anesthesia,
- an outpatient hospital/ambulatory surgery center (ASC) or diagnostic procedure discontinued after the administration of anesthesia.

**Additional Instructions for Coding Discontinued Surgical Services**

When multiple procedures were planned and there was a termination:

- If one of more of the procedures were completed, report the completed procedure(s) as usual. The other(s) planned and not started procedures(s) are not reported.
- If none of the planned procedures were completed, report the first procedure that was planned with Modifier 73 or Modifier 74. The others are not reported.

**Modifier 59 - Distinct Procedures** -- is used for procedures/services that are not normally reported together, but may be performed under certain circumstances.

**Example:** Procedures 23030 (Incision and drainage, shoulder area; deep abscess or hematoma) and 20103 (Exploration of penetrating wound; extremity) are performed on the same patient on the same date of service. The incision and drainage of the shoulder is the definitive procedure and any exploration of the area preceding this is considered an inherent part of the procedure. However, the exploration procedure was conducted on a different part of the same limb. Adding the 59 Modifier to code 23030 will explain the circumstance and prevent denial of the service. If these two codes were billed together without Modifier 59, code 20103 would be denied.

**Use Modifier 59 to:**

- Indicate that a procedure/service was distinct or independent from other services performed on the same day.
- Represent different procedure or surgery,
- Indicate different site or organ system,
- Indicate separate incision, or separate injury (or area of injury in extensive injuries) *not* ordinarily encountered or performed on the same day by the same physician, and
- Indicate different session or patient encounter

**Do Not Use Modifier 59 if:**

- A Level II HCPCS Modifier can be used to indicate different body areas

**Modifier 76 – Repeat Procedure by Same Physician** – is used to indicate that a procedure or service was repeated in a separate session on the same day by the same physician. This Modifier may be reported for services ordered by physicians but performed by technicians. The procedure code is listed once, and then listed again with Modifier 76 added (two line items). The number of times that the procedure was repeated is reported on separate lines.

**Example:** EKG 93000 (Electrocardiogram) routine EKG with at least 12 leads; with interpretation and report) is performed at 8:00 a.m. An EKG, 93000 is ordered and repeated at 1:00 p.m. The patient's condition requires another EKG, the physician orders it and the EKG is done at 10:00 p.m. This is billed as 93000, one unit (first line) and 9300076, two units (next line).

**For Surgical Procedures**

For surgical procedures, report the HCPCS code without Modifier 76 to indicate the first time the procedure was performed. For each additional time the procedure was performed, the HCPCS code is repeated with Modifier 76 added. Do not use the 'units' field to indicate that the procedure was repeated more than once on the same day.

**Example:** Procedure 27236, open treatment of femoral fracture, proximal end neck, internal fixation or prosthetic replacement (direct fracture exposure) was performed. Later, while in the recovery room, the internal fixation pin is dislodged, so that operating surgeon needs to repeat the procedure. This is reported as 27236 (first time) and 2723676 (next line) both will have units reported as one.

**Modifier 77 - Repeat Procedure by Another Physician** is used for a procedure that had to be repeated by a different physician in a separate session on the same day. The procedure code is listed once and then listed again with Modifier 77 added. The number of times the procedure was repeated is reported on separate lines. Do not use the 'units' field to indicate that the procedure was performed more than once on the same day. For surgical procedures, report the HCPCS code without Modifier 77 to indicate the first time the procedure was performed. For each additional time the procedure was performed, the HCPCS code is repeated with Modifier 77 added. Do not use the 'units' field to indicate that the procedure was performed more than once on the same day.

**Example:** Procedure 44366, small intestinal endoscopy beyond second portion of duodenum, not including ileum, performed two times in a day. The only difference is that a different physician repeats the procedure. Modifier 77 is used instead of 76.

**Modifiers 76 and 77** If you are not sure who ordered the second procedure, or whether the same physician ordered both procedures, code them based on the physician who performed the procedures. The repeated procedure must be the same procedure.

**Modifier 25 - Modifier for Evaluation & Management Services** – is used to identify significant, separately identifiable E & M services by the same physician on the same day of a procedure or other service. Modifier 25 is billed with an E & M code to indicate that on the same day a procedure was performed, the patient's condition required a significant, separately identifiable E & M service (even though the E & M service may be necessary because of the symptom or condition for which the procedure was provided).

**Use Modifier 25 for an E & M Service:**

- that is above and beyond the procedure performed,
- that is beyond the usual pre- and post-operative care associated, and
- when there was a separate history, physical, and medical decision.

**Do Not Use Modifier 25 to Report:**

- an E & M service that resulted in a decision to perform surgery.

**Modifier 58 - Modifier for Staged or Related Procedures** – is used to report a staged or related procedure/service on the same day, by the same physician during the postoperative period. Modifier 58 is billed to indicate that the performance of a procedure or service during the postoperative period was for hospital services; the post operative period refers to same calendar day.

**Use Modifier 58**

- for services/procedures planned prospectively at the time of the original procedure (staged),
- for more extensive than the original procedure, and
- for therapy following a diagnostic surgical procedure

**Do Not Use Modifier 58**

- to report the treatment of a problem that requires a return to the operating room (see Modifier 78).

**Modifier 78 - Return Trip to the Operating Room for a related procedure during the Postoperative Period** – is used to indicate that another procedure was performed during the postoperative period of the initial procedure.

**Example:** Procedure 33535 (coronary artery bypass, using arterial graft(s), three arterial graft, suspect possible bleeding returned to the operating room for 35820 (exploration for postoperative hemorrhage)

**Use Modifier 78 if:**

- the subsequent procedure relates to the first procedure; *and*
- the subsequent procedure requires the use of an operating room.

**Modifier 79 - Unrelated Procedure/Service by the Same Physician during a Postoperative Period** – is used to indicate that the performance of a procedure or service by the same physician during the post-operative period was unrelated to the original procedure that was performed earlier in the day.

**Example:** Procedure 27226 (open treatment of posterior or anterior acetabular wall fracture, with interior fixation, e.g., hip fracture). The patient develops severe stomach pain and returns to the operating room for 44950 appendectomy.

**Level II (HCPCS) Modifiers**

The following HCPCS level II Modifiers are added, as appropriate, primarily to codes for procedures performed on paired organs etc., on eyelids, fingers, toes, or arteries. These Modifiers are used to prevent erroneous denials when duplicate HCPCS codes are billed to report separate procedures performed on different anatomical sites or different sides of the body. When a Modifier is needed, the most specific Modifier should be used first.

**Example:** Use Modifier E1 for the upper left eyelid, instead of Modifier LT.

If more than one level II Modifier applies, repeat the HCPCS code on another line with the appropriate level II Modifier.

**Example:** Code 26010 (drainage of finger abscess; simple) done on the left hand, thumb and second finger, would be billed: 26010FA (one line) and 26010F1 (separate line).

### Modifiers LT and RT

- Apply to codes that identify procedures which can be performed on contralateral anatomic sites (joints, bones) or on paired organs, extremities and, for example, ears, eyes, nasal passages kidneys, lungs, ureters and ovaries
- Required when the procedure is performed on only one side, to identify the side operated upon

See chart below for Level II Modifiers and decision tree for modifiers LT and RT.

Level II Modifiers					
E1	Upper left, eyelid	LC	Left circumflex coronary artery	TA	Left foot, great toe
E2	Lower left, eyelid		(Hospitals use with codes 92980–92982, 92995, and 92996)	T1	Left foot, second digit
E3	Upper right, eyelid	LD	Left anterior descending coronary artery (Hospitals use with codes 92980–92982, 92995, and 92996)	T2	Left foot, third digit
E4	Lower right, eyelid			T3	Left foot, fourth digit
FA	Left hand, thumb	LT	Left side (used to identify procedures performed on the left side of the body)	T4	Left foot, fifth digit
F1	Left hand, second digit			T5	Right foot, great toe
F2	Left hand, third digit	RC	Right coronary artery (Use with codes 92980–92982, 92995, and 92996.)	T6	Right foot, second digit
F3	Left hand, fourth digit	RT	Right side (used to identify procedures performed on the right side of the body)	T7	Right foot, third digit
F4	Left hand, fifth digit			T8	Right foot, fourth digit
F5	Right hand, thumb			T9	Right foot, fifth digit
F6	Right hand, second digit				
F7	Right hand, third digit				
F8	Right hand, fourth digit				
F9	Right hand, fifth digit				

Do not use Modifiers LT and RT to report bilateral surgical procedures; use Modifier 50 (Bilateral Procedure).

**Example:**

Example Number	Right side?	Left side?	Same operative session?	Same doctor?	Repeat Procedure same day?	Code	Service Units
1	Y					XXXXXRT	1
2		Y				XXXXXLT	1
3	Y	Y	Y			XXXXX50	1
4	Y	Y	N			XXXXXRT	1
						XXXXXLT	1
5	Y	Y	Y	Y	Y, right side* only	XXXXX50	1
						XXXXXRT76	1
6	Y	Y	Y	N	Y, right side* only	XXXXX50	1
						XXXXXRT77	1
7	Y			Y	Y, right side* only	XXXXXRT	1
						XXXXXRT76	1
8	Y			N	Y, right side* only	XXXXXRT	1
						XXXXXRT77	1

(XXXXXX represents the five-digit CPT-4 code)

\*Right side is used here for purposes of illustration only.  
For the left side, the Modifier LT should be used instead of RT.  
Examples 4 through 8 above reflects very rare circumstances.  
The use of Modifier 50 (bilateral) or RT and LT as described in the grid above only applies to CPT4 codes where “bilateral” is not already inherent in the CPT code description.

## Condition Code G0

### Condition Code G0 (Zero)

Hospitals must report Condition Code G0 in Form Locator 24-30 when multiple medical visits

occur on the same day in the same revenue center, if the visits were distinct and constituted independent visits.

**Example:** A patient went to the emergency room twice (morning and afternoon) on the same day for chest pain. This situation would apply if the patient came back for a different or same reason.

If Condition Code G0 is not present and service units are greater than 1, the system will reject multiple medical visits on the same day with the same revenue code.

## Observation Services

Observation services are generally packaged services. Therefore, in most cases, no separate payment is made for observation services, as the payment for observation is included in the APC payment for the procedure or visit with which it was furnished. Separate APC payments for observation services that are provided under certain specific conditions are covered.

Hospitals will bill HCPCS code G0378 when observation services are provided to any patient admitted to observation status. HCPCS code G0379 is used when observation services are the result of a direct admission to observation status without an associated ED visit, hospital outpatient clinic visit or critical care visit on the same day or day prior to the observation services. HCPCS code G0378 (hourly observation) is billed in addition to G0379 (direct admit to OBS) in order to receive payment for a direct admit to observation.

HCPCS codes G0378 and G0379 have been assigned to new status code indicator Q that is defined as “packaged services subject to separate payment under OPPS payment criteria”. The units of service reported with HCPCS code G0378 is equal to the number of hours the patient is in observation status.

Separately payable observation status will list G0378 (hospital observation services, per hour) on the claim. In addition there are criteria that must be met for a hospital to receive separate OPPS payment for medically necessary observation services provided to a patient. That criteria includes:

1. Meeting the diagnosis requirements for congestive heart failure, chest pain or asthma that must be listed in the reason for visit field (FL 76) or principal diagnosis field (FL 67) of the UB-92.
2. Observation time must be documented in the medical record and must equal or exceed 8 hours. The number of hours is reported with G0378. Hours begin with a physician order and the patient’s admission to an observation bed and end when all clinical interventions have been completed. A physician order to discharge the patient or admit the patient to inpatient status must be documented in the medical record.
3. There must be an E & M code or G0379 on the same day of or day prior to the observation code. No procedure with a status indicator T can be listed on the claim on the day of or day prior to observation services for observation to be separately paid.
4. The patient must be under the care of a physician during the entire period of observation.



# Drugs and Biologicals

## Billing for Drugs and Biologicals

Most drugs are packaged under OPPS. Their costs are recognized and captured, but paid as part of the service with which they are billed. Certain drugs, however, are paid separately. These include:

- chemotherapeutic agents and the supportive and adjunctive drugs used with them,
- immunosuppressive drugs,
- orphan drugs,
- radiopharmaceuticals, and
- certain other drugs, such as those given in the emergency room for heart attacks.

These drugs and the codes used to bill for them are listed in Addendum B of the final rule, and on the CMS web site, <http://www.cms.hhs.gov>. PEIA will also use this list of drugs and codes for OPPS processing.

# Partial Hospitalization Services

## Billing Guidelines for Partial Hospitalization Services

Payment for Partial Hospitalization services is made under a Prospective Payment System for services provided in the outpatient department of a hospital.

The following reporting is required to assure proper payment under OPPS:

- HCPCS codes and revenue codes that best describe the services furnished;
- A line item date of service is required for each revenue line;
- Service units must be entered on the claim, showing the number of times a particular service or procedure was performed, based on the HCPCS code definition; and
- Claims for partial hospitalization services must include a mental health diagnosis to support each service.

These outpatient hospital services are submitted as bill type 13X. Below are the HCPCS codes for each revenue code billable by a partial hospitalization program:

Revenue Code	Description	HCPCS Code
<b>250</b>	Drugs & biologicals	Not required
<b>43X</b>	Occupational therapy	G0129 *
<b>904</b>	Activity therapy	G0176 **
<b>910</b>	Psychiatric services	90801 90802 90899
<b>914</b>	Individual psychotherapy	90816 90817 90818 90819 90821 90822 90823 90824 90826 90827 90828 90829
<b>915</b>	Group psychotherapy	90849 90853 90857
<b>918</b>	Psychiatric testing	96100 96115 96117
<b>942</b>	Education training	G0177 ***

\* The definition of code G0129: Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day.

\*\* The definition of code G0176: Activity therapy, such as music, dance, art or play therapies not

for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).

\*\*\* The definition of code G0177: Training and education services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) The TPA will edit to assure that HCPCS codes are present when the above revenue codes are billed and that they are valid HCPCS codes. The FI will not edit for matching the revenue code to the HCPCS.

### **Reporting of Service Units**

The number of visits should not be reported as units. Report Service Units, as the number of times the service or procedure was performed, as defined by the HCPCS code.

**Example:** A beneficiary received psychological testing (HCPCS Code 96100, which is defined in one hour intervals) for a total of 3 hours during one day. The hospital reports Revenue Code 918; HCPCS code 96100, and three units.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (minutes, hours or days), do not bill for sessions of less than 45 minutes.

Claims will be returned to the provider that contain more than one unit for HCPCS Codes G0129, and G0172 or that do not contain service units for a given HCPCS code.

Use the most appropriate HCPCS code available to describe the service provided.

**Example:** If a beneficiary receives 50 minutes of individual psychotherapy in a single session, bill with HCPCS Code 90818 (Individual psychotherapy, approximately 45 to 50 minutes...) as opposed to two units of 90816 (Individual psychotherapy, approximately 20 to 30 minutes...).

**Note:** Service units are not required for drugs and biologicals (Revenue Code 250).

### **Line Item Date of Service Reporting**

A line item date of service is required for each revenue code line for partial hospitalization claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the date the service was provided for every occurrence. Service date format should be MMDDYY. Claims that span two or more dates will be returned to the provider if a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the 'statement covers' period.

### **Professional Services Provided to Partial Hospitalization Patients:**

The services listed below are the only professional services that are separately covered in a hospital outpatient partial hospitalization program. The following professional services should be billed on a CMS 1500 claim form and will be paid under PEIA's RBRVS reimbursement methodology:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- Physician Assistant services, as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and,

- Clinical psychologist services, as defined in §1861(ii) of the Act.

The services of other practitioners, (including clinical social workers and occupational therapists) are bundled in the OPPTS payment when furnished to outpatient hospital patients. The hospital must bill the TPA for such non-physician practitioner services as part of the partial hospitalization services. Payment for these services is then made to the hospital as part of the APC payment.

**Payment**

Reimbursement for partial hospitalization will be based on the partial hospitalization per diem APC amount. Hospitals must continue to maintain documentation to support the medical necessity of each service provided, including the beginning and ending time of the service.

## **Late Charges/Adjustments**

**Procedures for Submitting Late Charges vs. Adjustments**

Providers billing under Outpatient Prospective Payment System (OPPS) may not submit a late charge bill for bill types 12X, 13X, 14X, 34X, 75X, 76X or any claim containing condition code 07 and certain HCPCS codes. An adjustment bill is required for any service that is billed with HCPCS codes, units, and line item dates of service by reporting a “7” in the third position of the bill type.

The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing by OCE, and payment under OPPTS.

One of the following claim change condition codes must be included on each adjustment. Adjustment claims should be coded to reflect the way the claim should process.

<b>Condition Code</b>	<b>Bill Type</b>	<b>Explanation</b>
D0 (zero)	XX7	Changes in service dates
D1	XX7	Changes in charges
D2	XX7	Changes in revenue codes/HCPCS
D3	XX7	Second or subsequent interim PPS bill
D4	XX7	Changes in GROUPER input (diagnosis or procedure)
D5	XX8	Cancel only to correct a HICN or provider identification number
D6	XX8	Cancel only to repay a duplicate payment or overpayment and DRG window
D7	XX7	Change to make Medicare the secondary payer
D8	XX7	Any other change
E0 (zero)	XX7	Change in patient status

## **Miscellaneous Issues**

**Designated Drugs or Biologicals**

Certain current designated drugs and biologicals will be assigned to special APCs and identified by the OCE as eligible for payment at PEIA’s fee schedule or 95 percent of the average wholesale

price minus the portion of the otherwise applicable APC payment amount. Price will determine the proper allowance for these APCs as well as the coinsurance and any applicable deductible. Certain new designated drugs and biologicals may be approved for payment. The payment for the newly approved items will be calculated in the same manner as listed above for current designated drugs and biologicals. These new designated drugs and biologicals will be identified separately from the current designated drugs and biologicals.

Included in designated drugs and biologicals are:

- Orphan drugs, as designated under § 526 of the Federal Food, Drug and Cosmetic Act
- Current cancer therapy drugs, biologicals, and brachytherapy devices. These items are those drugs or biologicals that are used in cancer therapy including (but not limited to) chemotherapeutic agents, antiemetics, hematopoietic growth factors, colony stimulating factors, biological response modifiers, bisphosphonates, and brachytherapy devices.
- Current radio/pharmaceutical drugs and biological products used for diagnostic, monitoring, or therapeutic purposes.
- New drugs or biologicals.

In order to receive proper payment for drugs or biologicals, the provider must bill with Revenue Code 636 (drugs that require detail coding) and the HCPCS codes listed on pages 6 and 7.

**Designated Devices**

Certain designated new devices will be identified by the OCE as eligible for payment based on the reasonable cost of the new device. Reimbursement will be reduced by the Medicare payment amount of the old device that was included in the APC assigned to the implementation of the old device. The Pricer program will determine the proper payment amount for these APCs, as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated device.

The table below is a comprehensive listing of the *Pass-Through Device Category Codes* that are eligible for pass-through payment under PEIA’s OPPS. If a device is described by one of the existing device categories but is packaged as a component of a system, only the device that meets the pass-through criteria would be eligible for pass-through payment under the appropriate category.

<b>HCPCS</b>	<b>Category Long Descriptor</b>
C1765	Adhesion barrier
C1783	Ocular implant, aqueous drainage assist device
C1814	Retinal tamponade device, silicone oil
C1818	Integrated keratoprosthesis
C1884	Embolization protective system
C1888	Catheter, ablation, non-cardiac, endovascular (implantable)
C1900	Lead, left ventricular coronary venous system
C2614	Probe, percutaneous lumbar discectomy
C2618	Probe, cryoablation

C2632	Brachytherapy solution, iodine – 125, per m Ci
C2634	Brachytherapy source, high activity Iodine-125, greater than 1.01m Ci, per source
C2635	Brachytherapy source, high activity Paladium-103, greater than 2.2m Ci, per source
C2636	Brachytherapy, linear source, Palladium-103, per 1mm

### **Process for Identifying Items Potentially Eligible for Payment as New Technologies or Pass-Throughs**

A manufacturer or other interested party who wishes to bring attention to items that may be eligible for payment as new technologies under the pass-through provision, should mail their requests for consideration to the following address:

PPS New Tech/Pass-Through, Division of Practitioner & Ambulatory Care  
 Mailstop C4-03-06  
 Health Care Financing Administration  
 7500 Security Boulevard  
 Baltimore, MD 21244-1850

To be considered, requests must include the following information:

- Trade/brand name of item.
- A detailed description of the clinical application of the item, including HCPCS code(s) to identify the procedure(s) with which the item is used.
- Current wholesale cost of the item.
- Current retail cost of the item (that is., actual cost paid by hospitals net of all discounts, rebates, and incentives in cash or in kind).
- For drugs, submit the most recent average wholesale price (AWP) of the drug and the date associated with the AWP quote.
- If the item is a service, itemize the costs required to perform the procedure, such as, labor, equipment, supplies, overhead, etc.
- If the item requires FDA approval, submit information that confirms receipt of FDA approval and the date obtained.
- If the item already has an assigned HCPCS code, include the code and its descriptor in your submission, plus a dated copy of the HCPCS code recommendation application previously submitted for this item.
- If the item does not have an assigned HCPCS code, follow the procedure for obtaining HCPCS codes, and submit a copy of the application with your payment request.
- Name, address, and telephone number of the party making the request.

### **Corneal Tissue Acquisition Costs**

CMS has decided not to package payment for corneal tissue acquisition costs with the APC payment for corneal tissue transplant procedures, and PEIA has concurred in this decision. Payment will be based on the hospital’s reasonable cost incurred to acquire corneal tissue. Final payment will be subject to cost report settlement. To receive payment for corneal acquisition costs, hospitals must submit a bill using HCPCS code V2785. Providers should report the acquisition cost rather than the hospital’s charge on the bill. Acordia National may request a copy of the hospital’s invoice for the acquisition cost.

### **Repetitive Services**

The following revenue categories are considered repetitive services and must be continuously billed monthly to receive the proper reimbursement, although not all services are paid under OPSS.

<b>Service</b>	<b>Revenue Code</b>
Therapeutic Radiology	330-339
Therapeutic Nuclear Medicine	342
Respiratory Therapy	410-419
Occupational Therapy	430-439
Speech Therapy	440-449
Inpatient Renal Dialysis	800-804
Physical Therapy	420-429
Kidney Dialysis Treatments	820-859
Cardiac Rehab Services	482 & 943
Psychological Services	910-919

Monthly billing is expected if the patient is being seen repeatedly during a monthly billing period. If the patient has an isolated service, that service may be billed as a single date of service claim.

## **Outlier Payments**

### **Outlier Payments for Hospitals**

PEIA will follow Medicare's 2005 outlier calculation and guidelines. Outlier payments will be made by PEIA if the cost of providing a service exceeds both 1.75 times the OPSS payment and the OPSS payment plus \$1,175. The amount of the outlier payment will be 50% of the amount by which the provider's costs exceeds 1.75 times the OPSS payment.

## **PEIA Procedures**

### **Audits**

Outpatient claim and APC coding reviews will be conducted at least annually and will include but not be limited to:

- Accuracy of ICD-9-CM and HCPCS/CPT code assignment and linkage,
- Documentation for services and procedures billed,
- Pass-through and "wasted" drug billing and utilization,
- APC outlier payments,
- Duplicate billing,
- APC distribution irregularities, and
- Codes identifying inpatient-only services.

### **Billing Procedures**

The provider must file claims for services rendered to PEIA insureds on the CMS 1450 claim form. The provider, or his or her authorized representative, must accurately complete and sign the claim form (signature stamp is acceptable). Electronic billing is preferred. If you need assistance with the implementation of electronic submission of claims, contact Acordia.

All claims must be filed within 6 months from the date of service, or 6 months from process date if Medicare is the patient's primary carrier. If the claim is not submitted timely, the provider will be responsible for the charges. The denied expenses may not be billed to the patient.

Examine the PEIA Medical ID card to determine the correct ID number for claim submission. Carefully check the insured's identification number for accuracy. Errors in completing the claim form may delay processing and payment. Mail the original claim form to the following address:

Acordia National  
P. O. Box 2451  
Charleston, WV 25329-2451

Acordia National also processes claims for PEIA through an electronic claims submission system with two national vendors. This system facilitates prompt and accurate payment of claims.

### **Pre-Authorization**

Pre-authorization of some services is highly recommended. For pre-authorization of a procedure or service, please submit your written pre-authorization request to Acordia National with all necessary medical documentation, such as clinical notes, lab results, biopsy results, pictures if applicable, etc. The Medical Management Department at Acordia National will review the pre-authorization for PEIA plan coverage eligibility and medical necessity. This is not the precertification required for inpatient admissions and certain outpatient procedures. Normally, requests for pre-authorization by Acordia National are for procedures covered only under certain documented circumstances, such as chelation, vision or massage therapy and accident-related dental care.

The provider should request pre-authorization in sufficient time to complete the review prior to the scheduled date for the service.

### **Medicare/PEIA Beneficiaries**

In situations where Medicare is the primary payer and PEIA is the secondary payer, the provider must submit the original claims and the associated Medicare Explanation of Benefits (EOMB) to ACORDIA NATIONAL.

Medicare Crossover - If the Medicare EOMB indicates that the claim was electronically forwarded to ACORDIA NATIONAL, submission by the health care provider is not necessary. Claims which are electronically submitted by Medicare have a remark code of MA18 on the Medicare EOMB.

### **Commercial/Private Insurance**

PEIA coordinates with other commercial insurance policies for dependents and spouses. In some cases, even the member may have coverage that is primary to PEIA due to early retirement status, COBRA, or other extenuating circumstances. PEIA may coordinate with individual plans and automobile policies with medical payments coverage, as appropriate. PEIA determines primary coverage for dependent children using the Birthday Rule. Please send all appropriate information regarding other insurance or payments along with the claim at the time of submission to assure prompt and accurate payment.

### **Third-Party Liability (TPL)**

The PEIA has a Subrogation Recovery policy. Benefits paid due to an accident involving third party liability are subject to this policy. Beacon Recovery Group, PEIA's subrogation vendor, will pursue recovery of any payments made by the PEIA that are the responsibility of a third party.

### **Provider Remittance Advice**

The Remittance Advice provides detailed information on the payment of claims submitted. It also provides a record of claims denied (for any reason). The Remark Code (RMK CODE) explains why a line item on a claim or the entire claim was rejected or why the full charge was not paid. Remark Codes and explanations are printed on the Remittance Advice form.

### **Timely Payments**

Acordia National's target turnaround time for a "clean" claim is 12 working days from receipt date. A "clean" claim is a claim for which no additional information or review is required for adjudication.

### **Adjustment Of Denied/Paid Claims**

Several situations may necessitate the adjustment of a claim:

- receipt of additional information;
- reconsideration of payment due to medical necessity;
- identification of an adjudicator error; or
- corrected billings.

In situations where a health care professional feels payment is in error, or payment should have been made on a rejected service, a written explanation is necessary and should be submitted to Acordia National's customer service department for reconsideration.

In situations where there is no payment due to missing information such as "other carriers" payments or billing information, please resubmit the claim with the requested information for reprocessing of the claim.

Please mail this correspondence to:

Acordia National  
P. O. Box 2451  
Charleston, WV 25329-2451

### **Request For Additional Information**

Certain circumstances require that Acordia National send a request for additional information from the provider or member. Upon receipt of the requested information, the pended claim will be processed. If the requested information is not received within 30 days from the date the letter was sent, the claims will be denied. Once the requested information is returned to Acordia National, the denied claims will be reconsidered. If the requested information is not received within 60 days of the initial request date, the claim will not be reprocessed.

### **CMS Web Page**

CMS Hospital Outpatient Prospective Payment System Web Page:

<http://www.cms.hhs.gov/providers/hoppps/>

### **Who To Call With Questions**

For questions regarding OPSS reimbursement and/or billing instructions, call Acordia National at 888-440-7342. Remember generally, PEIA will follow Medicare guidelines and billing criteria.



## **Pricing and Updates to OPSS**

With the 2006 OPSS update, PEIA established a goal that all hospitals reimbursed through OPSS would have their rates set at 111% of Medicare's rates. There was a transition of this reimbursement change over a 3-year period, beginning with calendar year 2006. In February 2008, the third year of the transition, hospital rates were set at 111% of Medicare's rates completing the transition. Annual updates to the conversion factor will continue.

In addition to the annual update of the conversion factor, there are also quarterly updates to the OPSS grouper used to assign APCs. Updates include changes initiated by CMS such as adjustments to the status codes assigned to each APC. For your convenience, the status codes are listed in Appendix A.

## **Questions & Answers**

1. Question: Is radiology included in PEIA's OPSS?  
**Answer: Yes, PEIA includes all radiology services, except the professional component, in APCs.**
2. Will Electron Fund Transfers (EFTs) be available when the West Virginia State Treasurer's Office starts issuing checks?  
**Answer: This is yet to be determined. PEIA is awaiting information from the Treasurer's office regarding providers who currently receive EFTs.**
3. Will managed care companies use the same grouper to apply payments?  
**Answer: PEIA will make this payment system available to Carelink and The Health Plan. It will be their decision whether or not they implement OPSS.**
4. If the APC payment is higher than the charge amount, will the member see the actual charge or the allowed amount on their explanation of benefits (EOB)?  
**Answer: The member's coinsurance will be determined by the lesser of the charge amount and the allowed amount. This is the amount that will appear on the members EOB.**
5. Will facilities be held harmless for the 1<sup>st</sup> year of OPSS?  
**Answer: Not necessarily. The APC conversion factors for PEIA are hospital specific and were intended to be budget neutral. Since the intensity of services and billing criteria may change, payments to providers may vary from the pre-OPSS payments. The APC system for outpatient hospital services will be reviewed and possibly adjusted during the course of the first 6 months.**
6. Is the TC modifier required?  
**Answer: No.**
7. Will the new CPT/HCPCS codes for January 2005 be included in the Grouper?  
**Answer: Yes, PEIA will use the 2005 grouper for the January 2005 implementation.**

8. Will PEIA's OPPS be able to handle "zero dollar" lines, such as with surgery claims?  
**Answer: Yes, PEIA will handle as per Medicare's policy and billing instructions.**
9. Are outpatient services provided within 72 hour of outpatient visits bundles with the APC payment?  
**Answer: No, but services provided on the same day of the outpatient service is bundled.**
10. How is observation care billed and processed?  
**Answer: See pages 15 & 16 of this manual.**
11. Are CAH facilities included in OPPS?  
**Answer: No, CAH hospitals will continue to be paid with the 45% discount and RBRVS reimbursement methodologies.**
12. Does PEIA use Medicare local or National coverage determinations?  
**Answer: Local coverage determinations/policy is preferred. At times, National determinations/policy may be followed.**

## **Appendix A**

**CMS-1506-P**

**Addendum D1.— Payment Status Indicators**

Indicator	Item/Code/Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPSS, for example:</p> <ul style="list-style-type: none"> <li>• Ambulance Services</li> <li>• Clinical Diagnostic Laboratory Services</li> <li>• Non-Implantable Prosthetic and Orthotic Devices</li> <li>• EPO for <b>ESRD</b> Patients</li> <li>• Physical, Occupational, and Speech Therapy</li> <li>• Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital</li> <li>• Diagnostic Mammography</li> <li>• Screening Mammography</li> </ul>	Not paid under OPSS. Paid by fiscal intermediaries under a fee schedule or payment system other than <b>OPSS</b> .
B	Codes that are not recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x).	<p>Not paid under OPSS.</p> <ul style="list-style-type: none"> <li>• May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPSS.</li> <li>• An alternate code that is recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.</li> </ul>
C	Inpatient Procedures	Not paid under OPSS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPSS or any Medicare payment system.
E	Items, Codes, and Services:	Not paid under OPSS or any Medicare payment system.

	<ul style="list-style-type: none"> <li>• That are not covered by Medicare based on statutory exclusion.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• That are not covered by Medicare for reasons other than statutory exclusion.</li> </ul>	
	<ul style="list-style-type: none"> <li>• That are not recognized by Medicare but for which an alternate code for the same item or service may be available.</li> </ul>	
	<ul style="list-style-type: none"> <li>• For which separate payment is not provided by Medicare.</li> </ul>	
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) Radiopharmaceutical Agents	(1) Separate cost-based pass-through payment; Not subject to coinsurance. (2) Separate cost-based non-pass-through payment.
K	(1) Non-Pass-Through Drugs, Biologicals, and	(1) Paid under OPPS; Separate APC payment.
	(2) Brachytherapy Sources	(2) Paid under OPPS; Separate APC payment.
	(3) Blood and Blood Products	(3) 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 & Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.

Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria,	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on
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		OPPS payment criteria.
		(2) If criteria are not met, payment is packaged into payment for other services, including outliers.
		Therefore, there is no 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.
V	Clinic or Emergency Department Visit	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.
X	Ancillary Services	Paid under OPPS; Separate APC payment.