Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

Special Issue

Implementation of Outpatient Prospective Payment System

Outpatient Prospective Payment System (OPPS) Guidelines

The Health Care Financing Administration (HCFA) has provided final instructions for implementation of the outpatient prospective payment system (OPPS), which is effective for claims with dates of service **on or after July 1, 2000.** This payment system applies to hospital outpatient departments, community mental health centers (CMHCs), and for limited services, as described in "Background" below, provided by comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs) or to hospice patients for the treatment of a non-terminal illness. It **does not apply** to critical access hospitals (CAHs) or hospitals in Maryland that are excluded from this system because they qualify under section 1814 (b) (3) of the Social Security Act ("the Act") for payment under the state payment system. The excluded services are limited to those paid under the state payment system as described in section 1814 (b) (3) of the Act. In addition, Indian Health Service hospitals will be excluded initially, but will be included under OPPS in the future. Payment under this system will result in discontinuation of the blended payment method for radiology and other diagnostic services and ambulatory surgical center (ASC) services provided in a hospital outpatient department. Guidelines stated in this publication supersede instructions currently contained in sections 3626.4, 3627.2, 3627.9 and 3631 of the Medicare Intermediary Manual (MIM).

The *Special Issue for Implementation of Outpatient Prospective Payment System* is published by the Medicare Publications Department to provide timely and useful information to Medicare Part A providers in Florida. Questions concerning this publication may be directed in writing to:

Medicare Publications
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HCFA Health Care Financing Administration

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Outpatient Prospective Payment System Guidelines (continued)

Background

Section 1833 (t) of the Act as added to the Act by section 4523 of the Balanced Budget Act (BBA) of 1997, authorizes HCFA to implement a Medicare PPS for:

- 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
- Vaccines, splints, casts and antigens provided by HHAs that provide medical and other health services
- Vaccines provided by CORFs
- Splints, casts, and antigens provided to hospice patients for the treatment of a non-terminal illness.

A proposed regulation discussing HCFA's proposal to implement OPPS was published on September 8, 1998. The proposed rule originally provided for a 60 day comment period; however, the comment period was extended four times, and closed on July 30, 1999.

On November 29, 1999, President Clinton signed new legislation which incorporates the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) that contains a number of major provisions that affect the development of the OPPS.

The hospital outpatient provisions of the BBRA provide the following:

- Establish payments under OPPS, in a budget neutral manner, based on estimates of amounts payable in 1999 from the Medicare Part B Trust Fund and as beneficiary coinsurance under the system in effect prior to OPPS (although the base rates were calculated using 1999 amounts, these amounts are increased by the hospital inpatient market basket, minus one percent, to arrive at the amounts that are payable in the year 2000.)
- Extend the 5.8 percent reduction in operating costs and ten percent reduction in capital costs (that was due at sunset on December 31, 1999) through the first date the PPS is implemented
- Require annual updating of the PPS payment weights, rates, payment adjustments and groups
- Require annual consultation with an expert provider advisory panel in the review and updating of payment groups
- Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all services included on the submitted outpatient bill for services furnished **before January 1, 2002,** and **thereafter** based on the individual services billed using the appropriate department-specific cost-charge ratio for each services
- Provide transitional pass-through for the additional costs of new and current medical services, drugs, and biologicals for at least two years but not more than three years
- Include under the OPPS payment for implantable devices including durable medical equipment (DME), prosthetics and those used in diagnostic testing
- Establish transitional payments to limit provider's losses under the OPPS; the additional payments are three and a half years for most hospitals and low volume rural hospitals (no more than or equal to 100 beds), and permanent for the ten cancer hospitals
- Limit beneficiary coinsurance for services paid under the OPPS to the inpatient hospital deductible

The Secretary has the authority under the section 1833 (t) of the Act to determine which services are included (with the exception of ambulance services for which a fee schedule is being separately created). Medicare will continue to pay under the Medicare Physician Fee Schedule:

- Clinical diagnostic laboratory services, orthotics, prosthetics, (except as noted above) and for take home surgical dressings on their respective fee schedules
- Chronic dialysis using the composite rate
- Screening mammographies based on the current payment limitation
- Outpatient rehabilitation services (physical therapy including speech language pathology and occupational therapy)

Acute dialysis (e.g., for poisoning) will be paid under OPPS. The ten cancer centers exempt from inpatient PPS are included in this system. Hospital outpatient services furnished by Maryland hospitals are under an inpatient PPS waiver and will not be paid under this system. CAHs will also be excluded from this payment system and will continue to be paid on a cost basis.

APC Payment Groups

Payment for services under the OPPS is calculated based on grouping outpatient services into ambulatory payment classification (APC) groups. Services within an APC are similar clinically and require similar resource use. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC. APCs require no changes to the billing form, however, hospitals are required to include HCPCS codes for all services paid under OPPS. A hospital may require a number of APC payments for the services furnished to a patient on a single day, however, multiple surgical procedures furnished on the same day are subject to discounting.

Outpatient Prospective Payment System Guidelines (continued)

Calculation of APC Payment Rates

- A group's relative weight is calculated based on the median cost (operating and capital) of the services included in the group;
- Median costs were developed from a database of calendar year (CY) 96 hospital outpatient claims using "the most recent" cost report data available;
- Used hospital-specific, department-specific cost-to-charge ratios to convert billed charges to median costs for each group;
- Weights are converted to payment rates using a conversion factor which takes into account group weights, the volume of services for each group, and an expenditure target specified in the law; and
- Hospital outpatient payments that would have been effective in CY 99 are calculated, in a budget neutral basis, to equal projected 1999 payments to hospitals for services included under the OPPS.

The rates that will go into effect when OPPS is implemented are the 1999 rates updated by the hospital market basket minus one percent.

Packaging

- Initially, only minimal packaging (e.g., payment for a procedure or medical visit) will not include payment for the related ancillary services such as laboratory tests or X-rays;
- Payment for clinical diagnostic laboratory tests which are paid under the clinical diagnostic fee schedule and radiology and other diagnostic services paid under OPPS will be made in addition to the OPPS payment for a surgical procedure or medical visit performed on the same day; and
- APC payments will include certain packaged items, such as anesthesia, supplies, certain drugs and the use of recovery and observation rooms.

Discounting

- Multiple surgical procedures furnished during the same operative session will be discounted;
- The full amount is paid for the surgical procedure with the highest weight; 50 percent is paid for any other surgical procedure(s) performed at the same time;
- Similar discounting occurs now under the physician fee schedule and the payment system for ASCs;
- Surgical procedures terminated after a patient is prepared for surgery but before induction of anesthesia will be paid at 50 percent of the APC payment; and
- When multiple surgical procedures are performed during the same operative session, beneficiary coinsurance is discounted in proportion to the APC payment.

Payment Adjustments

- BBA requires payments to be adjusted to reflect geographic differences in labor-related costs; and
- The Secretary may also establish other adjustments or special adjustments for certain classes of hospitals.

Geographic Adjustment

- Adjustments for differences in wages across geographic areas will be made using inpatient hospital PPS wage index (post-reclassification, post-floor); and
- It is estimated that 60 percent of the group payment represents labor-related costs and will be subject to the geographic adjustment.

Updates

- HCFA will annually review/update groups, relative weights, wage indexes and other adjustments;
- BBA requires rates to be updated annually based on the hospital market basket less one percent for the years 2000 through 2002, and based on the hospital market basket for subsequent years; and
- New outpatient procedures and services will be added to the payment system as needed and weights will be adjusted to reflect changes in outpatient care.

Additional Edit Requirements

All services paid under OPPS will be edited to assure that the correct CPT/HCPCS codes are reported.

Deductible Application

The PRICER software applies deductible to OPPS services on a claim, and the fiscal intermediary applies the deductible to other types of services subject to other payment methods on the same claim. PRICER will automatically apply deductible to the APC line item with the largest national unadjusted coinsurance as a percent of the APC payment, and then to the next largest coinsurance as a percent of the APC payment, and so on, until the deductible is met or no other payments can be used to satisfy the deductible. This method of applying the deductible is the most advantageous for the beneficiary. If less than $100 or less than the beneficiary's remaining deductible amount is applied, the total deductible applied to the OPPS claim must be added to any applicable deductible for any other types of payments on the same claim and then be submitted to the common working file (CWF). If the amount submitted to CWF is under or over applied, the claim must be repriced by the PRICER software.

Deductible does not apply to the influenza virus vaccines, pneumococcal pneumonia vaccine, clinical diagnostic laboratory services (which includes screening pap smears), screening mammographies, screening pelvic examinations, and screening prostate examinations. Only influenza virus vaccine, pneumococcal pneumonia vaccine and screening pelvic examinations are subject to OPPS.

Outpatient Prospective Payment System Guidelines (continued)

Coinsurance

Under current law, coinsurance for hospital outpatient and CMHC services is based on 20 percent of the hospital's or CMHC's billed charges. OPPS freezes coinsurance at 20 percent of the national median charge for the services within each APC (wage adjusted for the provider's geographic area) but coinsurance for an APC cannot be less than 20 percent of the APC payment rate. As the total payment to the provider increases each year based on market basket updates, the present or *frozen* coinsurance amount will become a smaller portion of the total payment, until coinsurance represents 20 percent of the total payment. Once coinsurance becomes 20 percent of the payment amount, the annual updates will also increase coinsurance so that it continues to account for 20 percent of the total payment. As previously stated, the wage-adjusted coinsurance for a service under OPPS cannot exceed the inpatient deductible amount.

For screening colonoscopies and sigmoidoscopies, the coinsurance amount is 25 percent of the payment rate. The APC payment rate is limited to the lower of the hospital outpatient rate or the ASC payment rate. The payment rate for screening barium enemas is the same as that for diagnostic barium enemas. The coinsurance amount for screening barium enemas is 20 percent of the APC payment rate.

Coinsurance does not apply to influenza virus vaccines, pneumococcal pneumonia vaccines and clinical diagnostic laboratory services (which includes screening pap smears and screening prostate specific antigen testing).

See coinsurance calculations below for more detail.

Coinsurance Election

The transition to the standard Medicare coinsurance rate (20 percent of the APC payment rate) will be gradual. For those APC groups for which coinsurance is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. The law offers hospitals the option of electing to reduce coinsurance amounts and advertise their reduced rates for all OPPS services. Hospital may elect to receive a coinsurance payment from Medicare beneficiaries that is less than the wage adjusted coinsurance amount per APC. This coinsurance reduction must be offered to all Medicare beneficiaries. Hospital should review the list of APCs and their respective coinsurance amounts that is published in the ***Federal Register*** as a final rule. After adjusting those coinsurance amounts for the wage index applicable to their metropolitan statistical area (MSA), hospitals must notify the intermediary if they wish to charge their Medicare beneficiaries a lesser amount until the following calendar year. ***The first election must be filed by June 1, 2000***, for the period July 1, 2000 through December 31, 2000. Future calendar year elections must be made by December 1st of the year preceding the calendar year for which the election is being made. The lesser amount elected may not be less than 20 percent of the wage adjusted APC payment amount. The lesser amount elected may not be greater than the inpatient hospital deductible for that calendar year ($776 for 2000). The lesser amount elected will not be wage adjusted by the intermediary or HCFA. Once an election to reduce coinsurance is made, it cannot be rescinded or changed until the next calendar year. National unadjusted and minimum unadjusted coinsurance amounts will be posted in the addenda of the OPPS final rule (HCFA-1005FC) on HCFA's web site (www.hcfa.gov).

This coinsurance election does not apply to partial hospitalization services furnished by CHMCs, vaccines provided by a CORF, vaccines, splints, casts and antigens provided by HHAs or splints, casts, and antigens provided to a hospice patient for the treatment of a non-terminal illness. It also does not apply to screening colonoscopies, screening sigmoidoscopies, or screening barium enemas.

Complete the form attached to the Provider Audit and Reimbursement notification and return to:

Provider Audit and Reimbursement Dept.
Attn: Rita Boccio
First Coast Services Options, Inc.
P. O. Box 45268
Jacksonville, FL 32232-5268

The intermediary will send an acknowledgment to the hospital that their election has been received within 15 calendar days of receipt. The reduced coinsurance amount, elected by the hospital, will be validated to ensure it is not less than 20 percent of the wage adjusted APC amount nor more than the inpatient deductible for the year of the election.

Calculating the Medicare Payment Amount and Coinsurance

A program payment percentage is calculated for each APC by subtracting the unadjusted national coinsurance amount for the APC from the unadjusted payment rate and dividing the result by the unadjusted payment rate. The payment rate for each APC group is the basis for determining the total payment (subject to wage-index adjustment) a hospital will receive from the beneficiary and the Medicare program. (A hospital that elects to reduce coinsurance, as described in "Coinsurance Election" above, may receive a total payment that is less than the APC payment rate.) The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. In addition, the amount calculated for an APC group applies to all the services that are classified within that APC group. The Medicare payment amount for a specific service classified within an APC group under OPPS is calculated as follows:

Step 1 Apply the appropriate wage index adjustment to the payment rate that is set annually for each APC group

Step 2 Subtract from the adjusted APC payment rate the amount of any applicable deductible

Step 3 Multiply the adjusted APC payment rate, from which the applicable deductible has been subtracted, by the program payment percentage determined for the APC group or 80 percent, whichever is lower. This amount is the ***preliminary Medicare payment amount***

Outpatient Prospective Payment System Guidelines (continued)

Step 4 Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less the amount of any applicable deductible. If the resulting amount does not exceed the annual hospital inpatient deductible amount for the calendar year, the resulting amount is the beneficiary coinsurance amount. If the resulting amount exceeds the annual inpatient hospital deductible amount, the beneficiary coinsurance amount is limited to the inpatient hospital deductible and the Medicare program pays the difference to the provider

Step 5 If the wage-index adjusted coinsurance amount for the APC is reduced because it exceeds the inpatient deductible amount for the calendar year, add the amount of this reduction to the amount determined in Step 3 above to get the final Medicare payment amount.

Example 1

The wage-adjusted payment rate for an APC is $300, the program payment percentage for the APC group is 70 percent, the wage-adjusted coinsurance amount for the APC group is $90, and the beneficiary has not yet satisfied any portion of his or her $100 annual Part B deductible.

(A) Adjusted APC payment rate: $300.

(B) Subtract the applicable deductible: $300 - $100 = $200.

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount: 0.7 x $200 = $140.

(D) Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less any unmet deductible to determine the coinsurance amount, which cannot exceed the inpatient hospital deductible for the calendar year: $200 - $140 = $60.

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation. $140 + $0 = $140.

In this case, the beneficiary pays a deductible of $100 and a $60 coinsurance, and the Medicare program pays $140, for a total payment to the provider of $300. Applying the program payment percentage ensures that the program and the beneficiary pay the same proportion of payment that they would have paid if no deductible were taken.

If the annual Part B deductible has already been satisfied, the calculation is as follows:

(A) Adjusted APC payment rate: $300.

(B) Subtract the applicable deductible: $300 - 0 = $300.

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount: 0.7 x $300 = $210.

(D) Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the amount of the inpatient hospital deductible for the calendar year: $300 - $210 = $90.

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation: $210 + $0 = $210.

In this case, the beneficiary makes a $90 coinsurance payment and the Medicare program pays $210, for a total payment to the provider of $300.

Example 2

This example illustrates a case in which the inpatient hospital deductible limit on coinsurance amount applies. Assume that the wage-adjusted payment rate for an APC is $2,000, the wage-adjusted coinsurance amount for the APC is $900, the program payment percentage is 55 percent, the inpatient hospital deductible amount for the calendar year is $776, and the beneficiary has not yet satisfied any portion of his or her $100 Part B deductible.

(A) Adjusted APC payment rate: $2,000.

(B) Subtract the applicable deductible: $2,000 - $100 = $1,900.

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount: 0.55 x $1,900 = $1,045.

(D) Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the inpatient hospital deductible amount of $776: $1,900 - $1,045 = $855, but the coinsurance is limited to $776.

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation ($855 - $776 = $79). $1,045 + $79 = $1,124.

In this case, the beneficiary pays a deductible of $100 and a coinsurance that is limited to $776 and the program pays $1,124 (which includes the amount of the reduction in beneficiary coinsurance due to the inpatient hospital deductible limitation) for a total payment to the provider of $2,000.

Medical Review

The methodology of review for hospital outpatient and CMHC claims does not change under the OPPS. The goal is to identify inappropriate billing for hospital outpatient and partial hospitalization services and to ensure that payment is not made for non-covered services. ❖

Outpatient Prospective Payment System (OPPS) Billing and Coding Instructions

The following article compiles significant billing and coding instructions related to the implementation of the outpatient prospective payment system.

Partial Hospitalization Services

Claims submitted by hospitals and CMHCs for partial hospitalization services must include a mental health diagnosis and indicate the HCPCS and revenue codes that best describe the services furnished for each day of service. The outpatient code editor (OCE) will determine that, for each day of service appropriate codes are identified and that the services reflect the intensive nature of a partial hospitalization program. For example, the OCE will determine that at least three partial hospitalization HCPCS codes, as indicated in MIM sections 3651 and 3661, are included for each day of service, one of which must be a psychotherapy HCPCS code (other than brief psychotherapy). For claims that pass these OCE edits, each day of service will be assigned to the partial hospitalization APC and the partial hospitalization per diem amount will be paid. Claims that include days that do not pass these edits will be identified for further review.

The total amount payable for psychiatric services furnished in a hospital outpatient department (not under the partial hospitalization program) for an individual for one day will be limited to the APC payment amount for partial hospitalization.

Partial hospitalization services provided by hospital outpatient departments must be reported under bill type 13(x) with condition code 41. This supersedes instructions in section 3661 of the MIM, which currently allows these claims to be billed under bill type 14(x).

Coding for Clinic and Emergency Visits

Formerly hospitals could report CPT code 99201 to indicate a visit of any type. Under OPPS, 31 codes are used to indicate visits, with payment differentials for more or less intense services. Hospitals should code the site of the visit and the level of intensity, using the following codes:

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.

Because CPT is more descriptive of practitioner than of facility services, hospitals should use CPT guidelines when applicable, or crosswalk hospital coding structures to CPT. For example, a hospital that has eight levels of emergency and trauma care, depending on nursing ratios, should walk those eight levels to the CPT codes for emergency care.

CPT/HCPCS and Revenue Code Chart

The following chart reflects CPT/HCPCS coding required to be reported under OPPS by hospital outpatient departments. This chart supersedes coding instructions and edit requirements for outpatient surgery, diagnostic and medical services and radiology services represented in sections 3626.4, 3627.9 and 3631 of the MIM. **This chart may be used by hospitals as a guide to assist them in reporting services rendered. Note that this chart does not represent all CPT/HCPCS coding subject to OPPS and will be expanded at a later date.**

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
*	D0150, D0240-D0274, D0277, D0460, D0472- D0999, D1510-D1550, D2970, D2999, D3460, D3999, D4260-D4264, D4270-D4273, D4355-D4381, D5911-D5912, D5983-D5985, D5987, D6920, D7110-D7260, D7291, D7940, D9630, D9930, D9940, D9950-D9952	Dental Services
*	92502-92596, 92599	Otorhinolaryngologic Services (ENT)
278	E0749, E0782, E0783, E0785	Implanted Durable Medical Equipment

Outpatient Prospective Payment System Coding and Billings Instructions (continued)

Revenue Code	HCPCS Code	Description
278	E0751, E0753, L8600, L8603, L8610, L8612, L8614, 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	70010-76999	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 and Other Vascular Studies
481	93501-93571	Cardiac Catheterization
482	93015-93024	Stress Test
483	93303-93350	Echocardiography
5lX	92002-92499	Ophthalmological Services
51X	99201, 99215, 99241-99245, 99271-99275	Clinic Visit
510, 517, 519	95144-95149, 95163, 95170, 95180, 95199	Allergen Immunotherapy
519	95805-95811	Sleep Testing
530	98925-98929	Osteopathic Manipulative Procedures
636	A4642, A9500, A9605	Radionclides
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	95812-95827, 95950-95962	Electroencephalogram (EEG)
762	99217-99220	Observation
771	G0008-G0010	Vaccine Administration
88X	90935-90999	Non-ESRD Dialysis

Outpatient Prospective Payment System Coding and Billing Instructions (continued)

Revenue Code	HCPCS Code	Description
901	90870,90871	Psychiatry
903	90910, 90911, 90812-90815, 90823, 90824, 90826-90829	Psychiatry
909	90880	Psychiatry
910	90801, 90802, 90865, 90899	Psychiatry
914	90804-90809, 90816-90819, 90821, 90822, 90845, 90862	Psychiatry
915	90853, 90857	Psychiatry
916	90846, 90847, 90849	Psychiatry
917	90901-90911	Biofeedback
918	96100- 96117	Central Nervous System Assessments /Tests
92X	95829-95857, 95900-95937, 95970-95999	Miscellaneous Neurological Procedures
920, 929	93875-93990	Non Invasive Vascular Diagnosis Studies
922	95858-95875	Electromyography (EMG)
924	95004-95078	Allergy Test
940	96900-96999	Special Dermatological Procedures
940	98940-98942	Chiropractic Manipulative Treatment
940	99195	Other Services and Procedures
943	93797-93798	Cardiac Rehabilitation

*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). Hospitals must report these CPT/HCPCS codes under the revenue center where the services were performed.

NOTE: **The listing of HCPCS codes contained in the above chart does not assure coverage of the specific service. Current coverage criteria apply.**

New HCPCS Coding Requirements for CORFs and HHAs

As stated in the background section above, payments will be made under OPPS:

- To CORFs (bill type 75[x]) for vaccines;
- To HHAs (bill type 34[x]) for splints, casts, vaccines and antigens when provided as a medical and other health service; and
- For splints, casts and antigens when provided to hospice patients for treatment of a non-terminal illness by other than a hospital outpatient department. This requires reporting of condition code 07.

CORFs, HHAs, and other providers must report CPT/HCPCS codes for these services, in order to assure payment under this system. Payment will continue to be made for vaccines provided to hospice patients by the Medicare Part B carrier. The appropriate HCPCS codes are as follows:

Antigens	95144-95149, 95165, 95170, 95180 and 95199
Vaccines	90657-90659, 90732, 90744, 90746, 90748, G0008, G0009, and G0010
Splints	29105-29131, 29505-29515
Casts	29000-29085, 29305, 29450, 29700-29750, 29799

Outpatient Prospective Payment System Guidelines (continued)

NOTE: **CORFs must report the above CPT/HCPCS codes using revenue code 510 (Clinic). HHAs must report these codes with the exception of vaccines under Revenue Code 550 (Skilled Nursing). The only time revenue codes 550 and 510 must be reported is when the HHAs or CORFs are billing for the above revenue codes. See section 3660.7 of the MIM for the reporting of vaccines by HCPCS codes.**

Corneal Tissue

Corneal tissue will be paid on a cost basis, not under OPPS. To receive cost based reimbursement, bill for corneal tissue using HCPCS code V2785.

Appropriate Bill Types

The following bill types are subject to OPPS:

- All outpatient hospital Part B bills (bill types 12[x], 13[x] with condition code 41, 13[x] without condition code 41 or 14[x]) with the exception of bills from hospitals in Maryland, Indian Health Service, and CAH bills;
- CMHC bills (bill type 76[x]);
- CORF and HHA bills containing certain HCPCS codes as described in *"New HCPCS Coding Requirements for CORFs and HHAs"* above (bill types 75[x] or 34[x]); and
- Any bill containing a condition code 07 with certain HCPCS codes as described in *"New HCPCS Coding Requirements for CORFs and HHAs"* above.

NOTE: **For bill type 34X only vaccines and their administration, splints, casts, and antigens will be paid under OPPS. For bill type 75(x) only vaccines and their administration will be paid under OPPS. For bills containing condition code 07 only splints, casts, and antigens will be paid under OPPS.**

Discontinuation of Bill Type 83X for Hospitals Subject to OPPS

Since bill type 83X "Ambulatory Surgical Center Services to Hospital Outpatients" will not be utilized under OPPS, hospitals are required, beginning with claims with dates of service on or after July 1, 2000, to report the earliest date services were rendered in Form Locator 6 "Statement Covers Period From Date." As a result, pre-operative laboratory services will always have a line item date of service within the from and through dates on the claim. The instructions in section 3626.4 of the MIM only apply to claims with dates of service prior to July 1, 2000.

Indian Health Service hospitals continue to bill for surgeries utilizing bill type 83(x).

Discontinuation of Value Code 05 Reporting

With line item date of service reporting, there will be no way to correctly allocate professional component charges reported in value code 05 to specific line items on the claim. As a result, professional component charges can no longer be reported in value code 05. Reporting the professional component in value code 05 is discontinued.

Provider Reporting Requirements

All providers paid under OPPS must submit two separated claims for services provided during June 2000 and July 2000. Date of services for June 2000 and July 2000 cannot be included on the same claim. Claims submitted to the intermediary will be edited to assure that a hospital or CMHC claim does not contain dates of service that span June 2000 and July 2000. In addition, every effort should be made to report all services performed on the same day on the same claim to assure proper payment under OPPS. Multiple claims submitted for the same date of service will be returned to the provider (except duplicates or those containing condition code 20 or 21) with a notification that an adjustment bill should be submitted.

Procedures for Submitting Late Charges

Hospitals and CMHCs may not submit a late charge bill (Step 5 in the third position of the bill type) for bill types 12(x), 13(x), 14(x), and 76(x) effective for claims with dates of service on or after July 1, 2000. They must submit an adjustment bill for any services required to be billed with HCPCS codes, units and line item dates of service by reporting a 7 in the third position of the bill type. Separate bills containing only late charges will not be permitted.

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 OPPS.

Subject adjustment claims to the same edits that you apply to initial claims.

Instructions in section 3603.B of the MIM regarding monthly billing of repetitive services still apply.

Proper Reporting of Condition Code G0 (Zero)

Hospitals report condition code G0 on FLs 24-30 when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation is a beneficiary going to the emergency room twice on the same day; in the morning for a broken arm and later for chest pain.

Proper reporting of condition code G0 allows for payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of condition code G0.

Outpatient Prospective Payment System Coding and Billing Instructions (continued)

Proper Reporting of Condition Codes 20 and 21

Hospitals and CMHCs may report condition codes 20 and 21 when they realize the services are excluded from coverage but:

- The beneficiary has requested a formal determination (condition code 20); or
- The provider is requesting a denial notice from Medicare to bill Medicaid or other insurers (condition code 21).

When billing condition codes 20 and 21, a separate claim must be submitted. Covered and non-covered services should not be reported on the same claim.

Implanted DME, Prosthetic Devices and Diagnostic Devices

Implanted DME, implanted prosthetic devices, and implanted diagnostic devices are paid under OPPS and therefore are no longer payable under the DME/Prosthetic fee schedules. The following are the appropriate HCPCS codes for payment under OPPS.

Implanted DME:	E0749, E0782 ,E0783, E0785
Implanted Prosthetic Devices:	E0751, E0753, L8600, L8603, L8610, L8612, L8613, L8614, L8630, L8641, L8642, L8658, L8670, L8699
Implanted Diagnostic Device:	E0616

Therefore, effective with claims with dates of service on or after July 1, 2000 discontinue billing the local carrier for these services.

This supersedes instructions in section 3629A of the MIM regarding implanted devices.

Clinical Diagnostic Laboratory Services Furnished to Inpatients Under Part B

Payment for clinical diagnostic laboratory services furnished under the inpatient Part B benefit (bill type 12X) that are currently reimbursed on cost will not be paid under OPPS. Therefore, payment for these services will be made under the clinical diagnostic laboratory fee schedule. This supersedes instructions in section 3628B of the MIM that requires payment based on a reasonable cost basis.

The appropriate HCPCS codes must be reported for clinical diagnostic laboratory services. ❖

Addresses

CLAIMS STATUS

Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231
(904) 355-8899

APPEAL RECONSIDERATIONS

Claim Denials (outpatient services only)
Medicare Fair Hearings (Part A)
P. O. Box 45203
Jacksonville, FL

REVIEW REQUEST

Denied claims that may have been payable under the Medicare Part A program
Medicare Part A Reconsiderations
P. O. Box 45053
Jacksonville, FL 32232

OVERPAYMENT COLLECTIONS

Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or Program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
(904) 791-8430

ELECTRONIC CLAIM FILING

"Getting Started"
Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231
(904) 791-8131

FRAUD AND ABUSE

Medicare Fraud Branch
P. O. Box 45087
Jacksonville, FL 32231
(904) 355-8899

MEDICARE SECONDARY PAYER (MSP)

Information on Hospital Protocols
Admission Questionnaires
Audits
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32231

General MSP Information
Completion of UB-92 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231
(904) 355-8899

Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Medicare Secondary Payer Subrogation
P. O. Box 44179
Jacksonville, FL 32231

Phone Numbers

PROVIDERS

Automated Response Unit
904-355-8899

Customer Service Representatives:
904-355-8899

MEDICARE ONLINE BBS

Access
800-838-8859
904-791-6991

Technical Problems
904-791-8384

BENEFICIARY

904-355-8899

ELECTRONIC MEDIA CLAIMS

EMC Start-Up:
904-791-8767

EMC Front-End Edits/Rejects:
904-791-8767

Electronic Remittance Advice
904-791-6895

Electronic Claim Status
904-791-6895

Electronic Eligibility
904-791-6895

PC-ACE Support
904-355-0313

Testing:
904-791-6865

Help Desk (Confirmation/ Transmission)
904-791-9880