Fundamentals of Medicare’s Outpatient Prospective Payment System (OPPS)

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Discussion Topics

• Basic history of OPPS
• Introduction to online OPPS resources
• Proposed & final rules (Federal Register)
• Addendum B and status indicators
• National Correct Coding Initiative (NCCI)
• Outpatient visit codes (hospital E&M)
Brief History and Overview

• The Balanced Budget Act of 1997 required CMS to implement a hospital outpatient prospective payment system.

• Reimbursement rates would be known prospectively before services are rendered and would generally be based on CPT® codes.

Brief History and Overview

• Medicare’s Outpatient Prospective Payment System (OPPS) commenced on Aug. 1, 2000.

• For hospital outpatient services prior to this date, Medicare reimbursed providers based on hospital-specific costs.
Brief History and Overview

“The implementation of OPPS increased the importance of accurate procedure coding for hospital outpatient services. With the OPPS, procedure codes effectively became the basis for Medicare reimbursement. Because incorrect procedure coding may lead to overpayments and subject a hospital to liability for the submission of false claims, hospitals need to pay close attention to coder training and qualifications.”

OIG Supplemental Compliance Program Guidance for Hospitals
Jan. 31, 2005; 70 Federal Register 4860

Charging or Coding

• Reimbursement through OPPS requires correct CPT®/HCPCS code reporting
• Accurate charging alone will not result in reimbursement
• Charging without the correct CPT® code/Revenue Center will result in lost and/or inaccurate reimbursement
Hospital Outpatient PPS

Overview

- Affordable Care Act – Provisions Impacting Outpatient Payments
- Revenue Code to Cost Center Crosswalk
- Pass-Through Payment Status and New Technology Ambulatory Payment Classification (APC)
- OPPS Guidance
- Program Transmittals
- Hospital Outpatient Program Memoranda
- Hospital Outpatient Regulations and Notices
- Addendum A and Addendum B Updates
- Hospital Outpatient PPS Transmittals
- Annual Policy Files

On March 23, 2010, President Obama signed into law a 1.5 percentage point reduction to the OPPS market basket effective July 1, 2010.

The Centers for Medicare & Medicaid Services is working on the implementation of this provision in the late May/early June timeframe and is working on future changes to OPPS payments to reflect the impact on current and future claims.

CMS Will Not Enforce Supervision Requirements (see downloads below)

Instructions on the Submission of OPPS ASP Data for Hospital Outpatient Drugs and Radiopharmaceuticals with Pass-Through Status

Federal Register

Part II—Continued

Department of Health and Human Services

42 CFR Parts 410, 416 and 419

Medicare program changes to the Hospital Outpatient Prospective Payment System and CY 2010 Physician Fee Schedule Changes to the Ambulatory Surgical Center Payment System and CY 2010 Physician Fee Schedule, Corrections, Final Rule, Notice, and Proposed Rule
Final Rule—April 2000

The meaning of ‘new’ and ‘established’ pertain to whether the patient already has a hospital medical record number.

Final Rule—CY 2007

“...we stated in the April 7, 2000 final rule with comment period that the meanings of ‘new’ and ‘established’ pertain to whether or not the patient already has a hospital medical record number. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient to the hospital.”
Final Rule—CY 2008

“We note that we neither proposed a change to the definitions of new and established patient visits in the CY 2008 OPPS/ASC proposed rule nor solicited comment on the definitions of new and established patient visits.”

Final Rule—CY 2009

“Specifically, beginning in CY 2009, the meanings of “new” and “established” patients pertain to whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years.”
Status Indicator “A” Examples

- 80051 Electrolyte panel
- 81005 Urinalysis
- 97001 PT evaluation
- 97116 Gait training
- A0425 Ground mileage (ambulance)
- L1847 Knee orthosis

Status Indicator “B” Examples

- 27096 Injection procedure for SI joint, arthrography and/or anesthetic/steroid
  See G0259/G0260
- 77372 Radiation treatment delivery, stereotactic radiosurgery, linear accelerator based
  See G0251, G0339, G0240
Status Indicator “C” Examples

- 31225 Maxillectomy, w/o orbital exenteration
- 43610 Excision, local; ulcer or benign tumor of stomach

Status Indicator “E” Examples

- 55970/55980 Sex transformation, male to female/female to male
- 65771 Radial keratotomy
- 69090 Ear piercing
Status Indicator “N” Examples

- 00402 (anesthesia, skin, breast reconstructive)
- 19290 (preop placement needle loc wire, breast) See 19125 [T] (excision of breast lesion marked by preop marker)
- 27093 (injection for hip arthrography) See 73525 [Q2] (S&I) code
- 94760 or 94761 (pulse ox, single/multiple)
- C1887 (catheter, guiding)

Status Indicator “Q1” Examples

- 38792 Injection procedure for identification of sentinel node (Usually followed by dissection 38500-38542, thus the Q1 status)
- 94762 Continuous overnight pulse ox
Status Indicator “Q2” Examples

• 70010 Myelography S&I
• 75630 Aortography, abdominal w/iliofemoral runoff S&I
• 76975 GI endoscopic ultrasound S&I

Status Indicator “Q3” Examples

• 76700 US exam, abdom, complete
• 76705 US exam, abdom, limited
• 76770 US exam abdom back wall, comp
• 76775 US exam abdom back wall, limited
• 76776 US exam kidney transpl w/doppler

• Also reference addendum M
“Isn’t that a ‘professional only’ charge?”

- 85097 Bone marrow, smear interpretation
- 88302 Tissues exam by pathologist
- 43752 Naso- or oro-gastric tube placement requiring physician’s skill
- 96101 Psychological testing per hour of psychologist’s or physician’s time

Regular OPPS updates

CMS Manual System
Pub 100-04 Medicare Claims Processing
Transmittal 804

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Date: JANUARY 3, 2006
Change Request 4250

Transmittal 786, dated December 16, 2005, is being rescinded and replaced by Transmittal 804, dated January 3, 2006 due to errors contained in the Recurring Notification. In the Recurring Notification section 1.B.2, the third paragraph was inadvertently left out, and we have removed the words “or “Y” in Requirement 4250.3.3. All other information remains the same in this instruction.

SUBJECT: January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes, OPPS PRICER Logic Changes, and Instructions for Updating the Outpatient Provider Specific File (OPSF)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the January 2006 OPPS update. This notification further describes changes to the OPPS PRICER logic and provides instructions for updating the Outpatient Provider Specific File (OPSF).
National Correct Coding Initiative

• Also known as “CCI” edits
• CMS’ list of codes they consider “mutually exclusive” or “components of a comprehensive service”
• Appropriate use of modifiers are necessary to by-pass these edits when the clinical circumstances dictate and as supported in the medical record
• http://www.cms.gov/NationalCorrectCodInitEd/
NCCI Policy Manual

- Introduction and General Principles Chapters
- Chapters for each section of CPT® with narrative above and beyond the table of edits
Introduction/Guidelines

NCCI edits incorporated into OCE appear in OCE one calendar quarter after they appear in NCCI. Hospitals like physicians and other providers must code correctly even in the absence of NCCI or OCE edits. For example, new category I CPT codes are generally effective on January 1 each year, and many new edits for these codes appear in NCCI on January 1. However, the new edits for these codes do not appear in OCE until the following April 1. Hospitals must code correctly during the three month delay.

In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the

Introduction/Guidelines

The National Correct Coding Initiative Policy Manual for Medicare Beneficiaries and the edits were developed for the purpose of encouraging consistent and correct coding and reducing inappropriate payment. The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. If a provider
Introduction/Guidelines

Most HCPCS/CPT code defined procedures include services that are integral to them. Some of these integral services have specific CPT codes for reporting the service when not performed as an integral part of another procedure. (For example, CPT code 36000 (introduction of needle or intracatheter into a vein) is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT code 36000 is not separately reportable with these types of nuclear medicine procedures. However, CPT code 36000 may be reported alone if the only service provided is the introduction of a needle into a vein.) Other integral services do not have specific CPT codes. (For example, wound irrigation is integral to the treatment of all wounds and does not have a HCPCS/CPT code.) Services integral to HCPCS/CPT code defined procedures are included in those procedures based on the standards of medical/surgical practice. It is inappropriate to separately report services that are integral to another procedure with that procedure.

NCCI Policy Manual Narrative Examples

16. Renal artery angiography at the time of cardiac catheterization should be reported as HCPCS code G0275 if selective catheterization of the renal artery is not performed. HCPCS code G0275 should not be reported with CPT code 36245 for selective renal artery catheterization or CPT codes 75722 or 75724 for renal angiography. If it is medically necessary to perform selective renal artery catheterization and renal angiography, HCPCS code G0275 should not be additionally reported.

17. Placement of an occlusive device such as an angio seal or vascular plug into an arterial or venous access site after cardiac catheterization or other diagnostic or interventional procedure should be reported with HCPCS code G0269. A physician should not separately report an associated imaging code such as CPT code 75710 or HCPCS code G0278.
NCCI Example

- CPT 33210 (temporary pacing) is considered a component of 92982 (PTCA), thus it would “hit” a CCI edit.
- Modifier -59 will bypass this edit, but should only be added when the temporary pacing is performed separately from the PTCA (e.g., it was performed at a separate session, not inherent in the PTCA, such as an earlier ER visit on the same day for acute MI).
### NCCI Ortho/Fluoro Example

- **24516** Treatment of humeral shaft fracture, with insertion of intramedullary implant, w/ or w/o cerclage and/or locking screws
  - **76000/76001** Fluoroscopy (time based)
Other NCCI Examples
For Hospital Outpatients

- 36555/36556 Insertion of non-tunneled centrally inserted central venous catheter
  - 71010/71020 One and two view chest x-rays

- 31622 Diagnostic Bronchoscopy
  - 76000/76001 fluoroscopy (code description for 31622 states, “including fluoroscopic guidance when performed”)
  - 36600 Arterial puncture, withdrawal of blood for diagnosis (e.g., blood draw for arterial blood gases or ABG’s)
MD vs. OPPS CCI

- Differences in edits as well as modifier indicators between professional (MD) CCI edits and OPPS edits.
- Critical Care (99291)
Modifier -59

MODIFIER -59 ARTICLE

The CPT Manual defines modifier -59 as follows:

Modifier -59: "Distinct Procedural Service: Under certain

Clinic Visits

“…each facility should develop a system for mapping the provided services or combination of services furnished to the different levels of effort represented by the codes….We will hold each facility accountable for following its own system for assigning the different levels of HCPCS codes. (continued)

Clinic Visits

“As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that it is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill. (continued)
Clinic Visits

Therefore, we would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility."

-Federal Register, April 7, 2000, pg. 18451

Clinic Visits

“…hospitals are to bill follow-up care, such as suture removal, using an appropriate medical visit code. We did not propose, nor have we included in this final rule with comment period, provision for a global period for hospital outpatient services analogous to the global period affecting payments for professional services made under the Medicare physician fee schedule.”

-Federal Register, April 7, 2000, pg. 18448
Clinic Visits

“We were also concerned that all the proposed guidelines allow counting of separately paid services (for example, intravenous infusion, x-ray, EKG, lab tests, and so forth) as “interventions” or “staff time” in determining a level of service. We believe that, within the constraints of clinical care and management protocols, the level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable.”

-Federal Register, Nov. 1, 2002, pg. 66791

Clinic Visits

“if a visit and another service is also billed (that is, chemotherapy, diagnostic test, surgical procedure) the visit must be separately identifiable from the other service because the resources used to provide non-visit services including staff time, equipment, supplies, and so forth, are captured in the line item for that service. Billing a visit in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate.”

-Federal Register, Nov. 1, 2002, pg. 66793
Modifier -25

“Should a separately identifiable E/M service be provided on the same date that a diagnostic and/or therapeutic procedure(s) is performed, information substantiating the E/M service must be clearly documented in the patient’s medical record, to justify use of the modifier –25.”

-Transmittal A-00-40; July 20, 2000

Clinic Visits

- AHIMA-AHA proposed model (June 24, 2003)
ACEP

- American College of Emergency Physicians (ACEP)
- ED Facility Level Coding Guidelines
CY 2008 Final Rule

“...we note our expectation that hospitals’ internal guidelines would comport with the principles listed below.”

— Federal Register, Nov. 27, 2007 pg. 66805

Eleven Principles

(1) The coding guidelines should follow the intent of the CPT- code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.
Eleven Principles

(2) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources.

(3) The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.

Eleven Principles

(4) The coding guidelines should meet the HIPAA requirements.

(5) The coding guidelines should only require documentation that is clinically necessary for patient care.

(6) The coding guidelines should not facilitate upcoding or gaming.
Eleven Principles

(7) The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.

(8) The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.

Eleven Principles

(9) The coding guidelines should not change with great frequency.

(10) The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
Eleven Principles

(11) The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

Senior Care Clinic Example

S: Mrs. J has been having a lot of problems with her arthritis. She has not really, though, been taking anything for it, as she just does not like to take pills. The daughters try to get her to take some Tylenol on occasion. She is having a lot more problems with her right shoulder today and has difficulty lifting it. It is the shoulder operated on for rotator cuff problems in the past. She may be a little bit worse as far as her cognition.
Senior Care Clinic Example

O: VITAL SIGNS: Wt is stable at 166, B/P 130/60, T 97.7, P 64, R 15. GENERAL: No acute distress. SKIN: Clear. LUNGS: Clear. HEART: Regular rhythm and rate with a II/VI systolic murmur. ABDOMEN: Nontender. EXTREMITIES: She has marked tenderness in the posterior of the right shoulder with decreased range of motion. She has generalized arthritic changes elsewhere.

Senior Care Clinic Example

NEUROLOGIC: Mental status: She is alert. She is cooperative. On her functional activity questionnaire, she scores 16 points, which is up from 11 points. She is unable to do some of her executive level functions, like assembling financial documents and requires assistance for most other things except for doing things like paying attention and understanding reading material, TV shows, etc.
Senior Care Clinic Example

A: 1. Dementia of Alzheimer's type with a little bit of progression and loss of her functional activities despite the Aricept.
2. Generalized osteoarthritis, particularly involving right shoulder where she had rotator cuff injury in the past.
3. Hypertension, under good control.

Senior Care Clinic Example

P: The trigger point right posterior shoulder was injected with a mix of 0.5 cc Sensorcaine and 1 cc Kenalog without difficulty. Tylenol or Aleve p.r.n. No change in her other medications. In reviewing her labs, her lipid panel and chemistry panel look satisfactory. Next scheduled visit in three months.
Senior Care Clinic Example

The facility reported an E/M code for the physician only.

The physician should report his E/M code as well as a procedure code for the trigger point injection. The facility should also report an E/M code with modifier –25 plus the procedure (CPT® 20552).

Questions—Now or Later?

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http://www.utsystem.edu/compliance/
(web site also includes recorded coding and compliance webinars for UT System employees)