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Reminder on Billing Requirements Implemented for non-OPPS Providers

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PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is intended for non-Outpatient Prospective Payment System (OPPS) hospital providers (for example, Maryland Waiver hospitals, Critical Access Hospitals (CAH)) and other non-OPPS provider types (for example, Outpatient Rehabilitation Facility (ORF), Comprehensive Outpatient Rehabilitation Facility (CORF), Skilled Nursing Facility (SNF), End Stage Renal Disease (ESRD) Facility, Home Health Agency (HHA)).

WHAT YOU NEED TO KNOW

This article conveys enforcement editing requirements for the Medicare Claims Processing Manual, Chapter 12, Section 30 which describes Correct Coding Policy, Section D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code and Chapter 23, Section 20.9 which describes the Correct Coding Initiative. These requirements are not new requirements. Previously, these requirements were discussed in CRs 10504 and 10699, which were effective on April 1, 2018 and July 1, 2018. MLN Matters article for CR 10699 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10699.pdf. CR 10504 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2044OTN.pdf. Make sure your billing staff is aware of these instructions.

BACKGROUND

Correct Coding Initiative (CCI) Edits History

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper

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coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

Since 1996 the Medicare NCCI procedure to procedure (PTP) edits have been assigned to either the Column One/Column Two Correct Coding edit file or the Mutually Exclusive edit file based on the criterion for each edit. The Mutually Exclusive edit file included edits where two procedures could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal, or gender considerations. All other edits were assigned to the Column One/Column Two Correct Coding edit file.

In order to simplify the use of PTP edit files, CMS consolidated the two edit files into the Column One/Column Two Correct Coding edit file. This change occurred for PTP edits in NCCI version 18.1 scheduled for April 1, 2012. After this date, it will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits.

NCCI PTP edits are used by Medicare Administrative Contractors (MACs) to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services. They are not applied to facility claims for inpatient services.

Although the NCCI was initially developed for use by Medicare Carriers (A/B MACs processing practitioner service claims) to process Part B claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by Fiscal Intermediaries (A/B MACs processing outpatient hospital service claims) to process claims for Part B outpatient hospital services. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in NCCI. Effective January 2006, all therapy claims at most sites of service paid by A/B MACs processing facility claims (Fiscal Intermediaries) were also subject to NCCI PTP edits in the OCE. These include, but are not limited to, therapy services reported by SNFs, CORFs, HHAs, and outpatient rehabilitation agencies (OPTs - outpatient physical therapy and speech pathology services). NCCI PTP edits used for practitioner claims are also used for Ambulatory Surgical Center claims.

Prior to January 1, 2012, NCCI PTP edits incorporated into OCE appeared in OCE one calendar quarter after they appear in NCCI. Effective January 1, 2012, NCCI PTP edits in OCE appear synchronously with NCCI PTP edits for practitioners. 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. Prior to January 1, 2012, the new edits for these codes did not appear in OCE until the following April 1. Hospitals were required to code correctly during the three month delay.

OCE will generate CCI edit dispositions. All current CCI edits will be incorporated in the OCE.

The CCI edits are applicable to claims submitted on behalf of the same beneficiary, provided by the same provider and on the same date of service. The edits are of two major types of coding situations. One type, referred to as the comprehensive/component edits, are those edits which

are applied to code combinations where one of the codes is a component of the more comprehensive code. In this instance only the comprehensive code is paid. The other type, referred to as the mutually exclusive edits, are those edits which are applied to code combinations where one of the codes is considered to be either impossible or improbable to be performed with the other code. Other unacceptable code combinations are also included. One such code combination consists of one code that represents a service "with" something and the other is "without" the something. The edit is set to pay the lesser priced service.

OCE / OPPS OCE / Non-OPPS OCE / IOCE History

OCE

Prior to OPPS implementation in August 2000, all outpatient claims processed through the OCE for basic editing. The software focused solely on editing claims without specifying any action to take when an edit occurred. It also did not compute any information for payment purposes. With the implementation of the OPPS in August 2000, CMS planned to apply CCI edits within the OCE, with the exception of anesthesiology, to hospital outpatient claims. The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, CCI edits check for mutually exclusive code pairs. These edits were being implemented to ensure that only appropriate codes are grouped and priced. All of this editing was maintained by a single OCE

While the software maintained the editing logic of previous versions, assignment of APC numbers for services has been added to meet Medicare's mandated OPPS implementation. The revised program indicates what actions to take when an edit occurs, and the reason(s) why the actions are necessary. For example, an edit can cause a line item to be denied payment while still allowing the claim to be processed for payment. In this case, the line item cannot be resubmitted but can be appealed.

A major change was the processing of claims with service dates that span more than one day. Each claim is represented by a collection of data, consisting of all necessary demographic (header) data, plus all services provided (line items).

Note: It is the user's responsibility to organize all applicable services into a single claim record and pass them as a unit to the software.

The OCE only functions on a single claim and does not have any cross claim capabilities. The software can accept up to 450 line items per claim.

Certain services (for example, physical therapy, diagnostic clinical laboratory) are excluded from Medicare's prospective payment system for hospital outpatient departments. These services are exceptions paid under fee schedules and other prospectively determined rates.

OPPS OCE versus non-OPPS OCE

Due to the uniqueness of some institutional claims processing and payment methodologies, it was necessary to separate the OCE into two separate software packages (an OPPS OCE and a non-OPPS OCE until the differences could be addressed. This separation began in January 1,

2001. It continued until January 2008. Many of the specific editing with dispositions had to be abandoned for the non-OPPS hospital claims.

The 'Integrated' Outpatient Code Editor (I/OCE)

Finally in July 2007, the OCE logic could be updated and implemented with an “Integrated” approach. The I/OCE program processes claims for all outpatient institutional providers including hospitals that are subject to the OPPS as well as hospitals that are NOT (Non-OPPS). Claim will be identified as 'OPPS' or 'Non-OPPS' by passing a flag to the OCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1.

The I/OCE software combines editing logic to disposition with the new Ambulatory Payment Classification (APC) assignment program designed to meet the mandated OPPS implementation. The software performs the following functions when processing a claim:

- Edits a claim for accuracy of submitted data
- Assigns APCs
- Assigns CMS-designated status indicators
- Assigns payment indicators
- Computes discounts, if applicable
- Determines a claim disposition based on generated edits
- Determines if packaging is applicable
- Determines payment adjustment, if applicable

This integration does not change current logic that is applied to outpatient bill types that already pass through the OPPS OCE software.

Editing that only applied to OPPS hospitals (for example, blood, drug, partial hospitalization logic) in the past will not be applied to non-OPPS hospitals at this time. However, with the I/OCE, line items on claims from non-OPPS hospitals will be assigned specific edit numbers and dispositions, where in the past; this type of detail was not provided.

Addition of Specific Edit Numbers and Dispositions for non-OPPS Hospitals

With the implementation of the July 2018 release of the I/OCE, CMS was able to revisit and re-instate NCCI PTP editing, along with additional editing with disposition into the system logic for non-OPPS hospitals and other non-OPPS provider types.

- NCCI Add-on Code editing with Edits 106, 107, and 108
- Invalid procedure code editing with Edit 6
- Invalid modifier editing with Edit 22
- NCCI PTP editing with Edits 20 and 40

As indicated by the development of the NCCI program, it has always been CMS’s intent that all

providers code correctly as we continue to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims regardless of our ability to edit on a pre-payment basis.

Tables 6.3 and 6.4 were updated in the I/OCE CMS Specifications V19.2.R1 Effective 07/01/2018 as found on our website on the OCE Quarterly Release Files July 2018 Quarterly Data file zip file link at https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html.

6.3 OCE Edits Applied by OPPS Bill Type Table [OPPS Flag =1]

Row #	Provider/Bill Types	Edits Applied (by edit number	APC Buffer
1	12x or 14x with condition code 41	46	Buffer not completed
2	12x or 14x without condition code 41	1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52-54, 56-58, 60-79, 81-85, 87, 92, 93, 94, 98, 99, 100, 102, 103, 105	Buffer completed
3	13x with condition code 41	1-9, 11-18, 20-23, 25-28, 29-34, 37, 38, 40-45, 47-50, 52, 54, 56-58, 60-62, 65-80, 82–85, 87, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 105	Buffer completed
4	13x without condition code 41	1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52, 54, 56-58, 60-79, 81, 82-85, 87, 92, 93, 94, 98, 99, 100, 101, 102, 103, 105	Buffer completed
5	76x (CMHC)	1-9, 11-13, 15, 18, 20, 22, 23, 25, 26, 29-34, 38, 40, 41, 43-45, 47-50, 53-55, 61, 65, 69, 71-73, 75, 77- 80, 82, 84, 85, 87, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 105	Buffer completed
6	34x (HHA) with Vaccine Administration, Antigens, Splints, Casts or NPWT	1-5,7-9, 11-13, 15, 18, 20, 25-26, 28, 38, 40, 41, 43-45, 47, 49-50, 53-55, 62, 65, 69, 71, 73, 75, 77-79, 82, 84, 85, 87, 92, 93, 94, 98, 99, 100, 105	Buffer completed

Row #	Provider/Bill Types	Edits Applied (by edit number	APC Buffer
7	34x (HHA) without Vaccine Administration, Antigens, Splints, Casts or NPWT	1-5, 7-9, 11-13, 20, 25, 26, 40-41, 44, 50, 53-55, 65, 69, 94	Buffer not completed
8	43x (RNHCI)	25, 26, 41, 44, 46, 55, 65	Buffer not completed
9	71x (RHC), 77x (FQHC through v15.2)	1-5, 6, 25, 26, 41, 61, 65, 72, 91, 94, 104	Buffer not completed
10	77X (FQHC PPS) [v15.3 -]	1-6, 25, 26, 41, 65, 72, 84, 88, 89, 90, 91, 94	Buffer not completed
11	Any bill type except 12x, 13x, 14x, 34x, 43x, 71x, 73x/77x, 76x, with CC 07, with Antigen, Splint, or Cast	1-9, 11-13, 18, 20, 23, 25, 26, 28, 38,40, 41, 43-45, 47, 49, 50, 53-55, 62, 65, 69, 71, 73, 75, 77 -79, 82, 84, 85, 87, 92, 93, 94, 98, 99, 100, 105, 106, 107, 108	Buffer completed
12	75x (CORF)	1-9, 11-13, 15, 20,22, 23, 25, 26, 40, 41, 44, 48, 50, 53-55, 61, 65, 69, 72, 94, 106, 107, 108	Buffer not completed
13	22X, 23X (SNF),	1-9, 11-13, 20, 23, 25, 26, 28, 40-41, 44, 50, 53, 54, 55, 61, 62, 65, 69, 72, 94, 106, 107, 108	Buffer not completed
14	32X, (HHA)	1-9, 11, 12, 20, 22, 25, 26, 40, 41, 44, 50, 53-55, 65, 69, 86, 94, 106,107, 108	Buffer not completed
15	72X (ESRD)	1-9, 11, 12, 20,22,25, 26, 40,41, 44, 50, 53, 54, 55, 61, 65, 69, 72, 94, 106, 107, 108	Buffer not completed
16	74X (ORF)	1-9, 11-13, 20, 22, 25, 26, 40-41, 44, 48, 50, 53, 54, 55, 61, 65, 69, 72, 94, 106, 107, 108	Buffer not completed
17	81X (Hospice), 82X	1-9, 11, 12,20, 22, 25, 26, 40, 41, 44, 50, 53-55, 65, 69, 86, 94, 106, 107, 108	Buffer not completed

6.4 OCE Edits Applied by Non-OPPS Hospital Bill Type Table [OPPS Flag = 2]

Row #	Provider/Bill Types	Edits Applied (by edit number)	APC buffer
1	12X or 14X with condition code 41, and OPPS flag = 2	46	Buffer not completed
2	12X or 14X without condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 53, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108	Buffer not completed
3	13X with condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108	Buffer not completed
4	13X without condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108	Buffer not completed
5	85X, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 74, 83, 94, 106, 107, 108	Buffer not completed

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
September 4, 2018	Initial article released.

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