Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

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NEWS FLASH

Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html/NationalProvIdentStand/ on the CMS web site.

Note: This article was updated on October 24, 2012, to reflect current Web addresses. All other information remains unchanged.

Notification and Testing of an Integrated Outpatient Code Editor (OCE) for the July 2007 Release

Provider Types Affected

Non-OPPS hospitals submitting outpatient claims to Medicare Fiscal Intermediaries (FIs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5344 which informs FIs of the integration and testing of the non-Outpatient Prospective Payment System (non-OPPS) OCE into the OPPS OCE effective July 1, 2007.

Background

This article is based on Change Request (CR) 5344 which informs your Fiscal Intermediary (FI) of the integration and testing of the non-Outpatient Prospective Payment System (non-OPPS) OCE into the OPPS OCE effective July 1, 2007.

The integration of the non-OPPS OCE into the OPPS OCE:

- Will result in the routing of all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE

eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

- Does not change the current logic that is applied to outpatient bill types that already pass through the OPPS OCE software. It merely expands the software usage to include non-OPPS hospitals. Note: This new software product will be referred to as the Integrated OCE.

Note: Claims with dates of service prior to July 1, 2007 will be routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim.

The principal reason for the integration of the non-OPPS OCE into the OPPS OCE is the long-standing systems issues related to the non-OPPS OCE software that require corrective action.

Editing that only applied to OPPS hospitals (e.g., blood, drug, partial hospitalization logic) in the past will not be applied to non-OPPS hospitals at this time. However, with the integrated OCE non-OPPS hospitals will be assigned specific edit numbers and dispositions, where in the past, this type of detail was not provided.

OPPS OCE

The current OPPS OCE:

- Processes claims for all outpatient institutional providers with the exception of hospitals not subject to OPPS;
- Performs detailed editing and evaluates patient data to help identify possible coding errors, returning a series of edit flags with claim/line item actions;
- Assigns Ambulatory Payment Classification (APC) numbers based on Healthcare Common Procedure Coding System (HCPCS) codes for payment under the OPPS; and
- Sets a series of indicators/flags based on various coding criteria and sends those indicators/flags to the OPPS Pricer to determine pricing.

Non-OPPS OCE

The current non-OPPS OCE:

- Processes claims for the following non-OPPS hospitals: Indian Health Service Hospitals, critical access hospitals (CAHs), Indian Health Service Hospitals (IHS)/ Tribal hospitals including IHS/ Tribal CAHs, Maryland hospitals, as well as hospitals located in American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands;

- Processes claims from Virgin Island hospitals with dates of service 1/1/02 and later, and from hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and later; and

- Does not perform detailed editing and grouping (unlike the OPPS OCE) since it is not required for these hospitals.

CR5344 provides instructions and specifications for the integrated OCE, which will be used to process outpatient claims for the following institutional providers:

- OPPS providers (hospital outpatient departments, Community Mental Health Centers (CMHC's) and for limited services provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System, or to a hospice patient for the treatment of a non-terminal illness);

- Non-OPPS hospitals (Indian Health Service Hospitals, Critical Access hospitals (CAHs)), Maryland hospitals, as well as hospitals located in American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands. In addition, claims from Virgin Island hospitals with dates of service 1/1/02 and later, and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and later are edited in the non-OPPS OCE; and
- All non-hospital outpatient institutional providers (HHAs, Skilled Nursing Facilities, Rural Health Clinics, Federally Qualified Health Centers, Hospices, Renal Dialysis Facilities, Religious Non-Medical Healthcare Institutions, Comprehensive Outpatient Rehabilitation Facilities, and Outpatient Physical Therapy Providers).

The changes specific to the July release for the new integrated OCE will be issued in a separate recurring CR, which will replace the non-OPPS, and the OPPS recurring CRs for July. As a result, there will only be one recurring CR for each quarterly release of the OCE beginning with the July release.

Additional Information

Integrated Edit/Disposition Table for Hospitals

Note: All edits that currently apply to providers other than hospitals remain unchanged with this integrated product.

CR = Claim Rejection, CD = Claim Denial, RTP = Return to Provider, CS = Claim Suspension, LIR = Line Item Rejection, LID = Line Item Denials

Edit	Disposition	Application to hospitals
01 - Invalid diagnosis code	RTP	Apply to all hospital claims
02 - Dx/Age conflict	RTP	Apply to all hospital claims
03 - Dx/Sex conflict	RTP	Apply to all hospital claims
04 - MSP Alert (v1.0,v1.1 only)	--	Inactive (Do not apply)
05 - E-code as Reason for Visit	RTP	Apply to all hospital claims
06 - Invalid procedure code	RTP	Apply to all hospital claims
07 - Procedure/age conflict	--	Inactive (Do not apply)
08 - Procedure/sex conflict	RTP	Apply to all hospital claims
09 – Non-covered service (other than statute)	LID	Apply to all hospital claims
10 - Svc submitted for verification of denial (Condition code 21)	CD	Apply to all hospital claims
11 - Svc submitted for FI review (Condition code 20)	CS	Apply to all hospital claims
12 - Questionable covered svc	CS	Apply to all hospital claims
13 - Service not paid	--	Inactive – 1/1/06
14 – Non-OPPS site of svc	--	Inactive – 1/1/06
15 - Svc units out of range	RTP	Apply to all hospital claims
16 - Multiple bilateral procedures (edit deleted)	--	Inactive (Do not apply)
17 - Inappropriate specification of bilateral proc	RTP	Apply to all hospital claims
18 - Inpatient procedure	LID	Apply to all hospital claims
19 - Mutually exclusive procedure - modifier irrelevant	LIR	Apply to OPPS hospitals only
20 - Comprehensive/ Component proc - modifier irrelevant	LIR	Apply to OPPS hospitals only
21 - Med Visit same day as type T or S w.o modifier 25	LIR	Apply to OPPS hospitals only

22 - Invalid modifier	RTP	Apply to all hospital claims
23 - Invalid date	RTP	Apply to all hospital claims
24 - Date out of OCE range	CS	Use OPPS Date 8/1/2000. For non OPPS, use integration date (planned 7/07)
25 - Invalid age	RTP	Apply to all hospital claims
26 - Invalid sex	RTP	Apply to all hospital claims
27 – Only incidental services reported	CR	Apply to OPPS hospitals only
28 – Code not recognized by Medicare	LIR	Apply to all hospital claims
29- Partial hospitalization service for non-mental health diagnosis	RTP	Apply to OPPS hospitals only
30 – Insufficient services on day of partial hospitalization	CS	Apply to OPPS hospitals only
31 – Partial hospitalization on same day as ECT or type T procedure (edit deleted)	CS	Inactive (Do not apply)
32 – Partial hospitalization claim spans 3 or less days with insufficient services, or ECT or significant procedure on at least one of the days	CS	Apply to OPPS hospitals only
33 – Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	CS	Apply to OPPS hospitals only
34 - - Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	CS	Apply to OPPS hospitals only
35 – Only activity therapy and/or occupational therapy services provided	RTP	Apply to OPPS hospitals only
36 – Extensive mental health services provided on day of ECT or significant procedure (edit deleted)	--	Inactive (do not apply)
37 - Terminated bilateral, or terminated proc w units greater than 1	RTP	Apply to OPPS hospitals only
38 - Inconsistency between implanted device and implantation procedure	RTP	Apply to OPPS hospitals only
39 - Mutually exclusive procedure; allowed if CCI modifier coded	LIR	Apply to OPPS hospitals only

40 - Comp/Comp procedure; allowed if CCI modifier coded	LIR	Apply to OPPS hospitals only
41 - Invalid revenue code	RTP	Apply to all hospital claims
42 - Multiple Med Visits same day w same RevCode, w.o CC G0	RTP	Apply to OPPS hospitals only
43 - Transfusion or blood product exchange w.o specification of blood product	RTP	Apply to OPPS hospitals only
44 - Observation revenue code w non-observation HCPCS	RTP	Apply to OPPS hospitals only
45 – Inpatient separate procedure not paid	LIR	Apply to OPPS hospitals only
46 – PH Cond Code 41 not allowed for TOB	RTP	Apply to all hospital claims
47 - Svc not separately payable	LIR	Apply to OPPS hospitals only
48 – Rev Center requires HCPCS	RTP	Apply to OPPS hospitals only
49 – Svc on same day as inpatient procedure	LID	Apply to OPPS hospitals only
50 – Non-covered based on statutory exclusions	LIR	Apply to all hospital claims
51 – Multiple observations overlap in time (Not activated)	--	Inactive (Do not apply)
52 – Observation does not meet minim hours, qualifying diagnosis, and/or 'T' procedure conditions (edit deleted)	--	Inactive (Do not apply)
53 – Observation G codes only allowed with bill type 13x or 85x	LIR	Apply to all hospital claims
54 – Multiple codes for the same service	RTP	Apply to all hospital claims
55 – Non-reportable for site of service	RTP	NA to hospitals
56 - E/M or ancillary procedure conditions are not met and line item date for obs code G0244 is not 12/31 or 1/1 (edit deleted)	--	Inactive (Do not apply)
57 – E/M or ancillary procedure conditions are not met and line item date for obs code G0378 1/1	CS	Apply to OPPS hospitals only
58 – G0379 only allowed with G0378	RTP	Apply to OPPS hospitals only
59 – Clinical trials requires diagnosis code V707 as other than primary diagnosis	RTP	Apply to OPPS hospitals only

60 – Use of modifier CA with more than one procedure not allowed	RTP	Apply to OPPS hospitals only
61 – Service can only be billed to the DMERC	RTP	Apply to all hospital claims
62 – Code not recognized by OPPS; alternate code for same service may be available	RTP	Apply to OPPS hospitals only
63 – This OT code only billed on partial hospitalization claims	RTP	Apply to OPPS hospitals only
64 – AT service not payable outside the partial hospitalization program	LIR	Apply to OPPS hospitals only
65 – Revenue code not recognized by Medicare	LIR	Apply to all hospital claims
66 – Code requires manual pricing	CS	Apply to OPPS hospitals only
67 – Service provided prior to FDA approval	LIR	Apply to all hospital claims
68-Service provided prior to NCD approval	LIR	Apply to all hospital claims
69-Service provided outside approval period	LIR	Apply to all hospital claims
70 -CA modifier requires patient status code 20	RTP	Apply to OPPS hospitals only
71 - Claim lacks required device code	RTP	Apply to OPPS hospitals only
72 - Service not billable to the Fiscal Intermediary	RTP	Apply to all hospital claims with the exception of CAH Method II billing revenue codes 096X, 097X, and 098X.
73 - Incorrect billing of blood and blood products	RTP	Apply to OPPS hospitals only
74 - Units greater than one for bilateral procedure billed with modifier 50	RTP	Apply to OPPS hospitals only

For more complete details, especially regarding the edits of the integrated OCE, please see the official instruction (CR5344) issued to your intermediary regarding this change. That instruction may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1107CP.pdf on the CMS website.

Current OCE web-based training may be found under Medicare Payment Policy training at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1 on the Internet.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.