Welcome to the Introduction of Reimbursement

Documentation and Coding in the outpatient Wound Care and HBOT setting.

SerenaGroup
building the nation's leading wound care team.

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* This presentation is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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Changes Effective 2016: Off campus & On Campus Clarification
Place of Service Codes for Professional Claims

POS Code: 19 (added)

Place of Service Name: Off Campus- outpatient hospital

POS Description: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

POS Code: 22 (revised)

Place of Service Name: On Campus- outpatient hospital

POS Description: A portion of the hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

Why is it important to understand the Place of Service Codes ?

- **QHPs (Quality Healthcare Professionals); such as physicians, podiatrists, NPs, PAs and clinical nurse specialists often practice at a different POS, whether it is at an office location, hospital or HOPD. All have different POS codes.**
- **You must have a process in place for the "billers" to identify the appropriate POS. A POS designation dictates the Medicare fee schedule for the provider.**
- **Do not run the risk of overbilling Medicare!**

General Comments for Survival

- **Be ready to embrace and be open minded in preparing for the rules and regulations of wound care and hyperbaric medicine under the guidelines of the OPPS (Outpatient Prospective Payment System).**
- **For practitioners/providers, this is <u>not</u> an extension of your current scope of practice. This is an advanced modality setting, with specific rules and guidelines, which requires adherence to current practices with regard to billing, coding and documentation requirements.**

Helpful Tip (Question and Answer)

Q: I am a program manager, clinician/assistant, front office staff, HBO tech., or physician. Why should I concern myself with having knowledge of reimbursement, coding, scheduling, etc.?

A: It depends on whether you want to be successful of fail. Granted, we will all agree that we strive for offering excellent patient care, advanced modalities/technology, a high percentage of healing rates, and patient satisfaction; but then you may have missed the <u>BIG PICTURE.</u>

- **Billing/coding/documentation/scheduling/registration process, is at the heart of every outpatient wound care /hyperbaric visit, and is key to the financial success of the program.**
- **Without a financial/compliance understanding, we may be offering costly treatments/procedures, when there may be a more effective and less costly treatment option. What if you missed obtaining a pre-cert.? If you have not documented medical necessity or appropriateness, then the chance for denial is eminent. If the claim is paid, do not interpret this as a guarantee. A RAC audit or request for supporting documentation may reveal a lack of adequate supporting documentation, and the monies may be paid back, denied, or even worse-----placed on Medicare review process.**

Common Terms

New Patient: A person that has not had any service provided by your hospital within the past three years.

Established Patient: A person that has had a visit to your hospital or facilities within the past three years.

- **you may have a patient that is new to your wound care/HBO center, but for billing purposes, it is an established patient.**

Medicare Administrative Contractor (MAC): refers to an entity or a private company that has a contract with the Center for Medicare and Medicaid Services (CMS) to determine and pay part A and part B bills, such as bills from your hospital. The decision made by a MAC or a carrier under Medicare part A and B is called the local coverage determination (LCD) or may refer to the national coverage determination (NCD).

All Centers must know who their MAC is with regard to Wound Care and Hyperbaric Guidelines, and may include skin substitutes (CTP's) and other services.

Common Terms Continued

CPT Code: (Current Procedural Terminology). CPT is a registered trademark of the American Medical Association (AMA). The CPT code set is a "medical code set" maintained by the AMA and describes medical, surgical and diagnostic services as designed to communicate uniform information about medical services and procedures.

ICD-10-CM: (International Classification of Diseases, Tenth Revision, Clinical Modification). It is the current system used in the United States as of late 2015 to classify or assign codes to health related conditions and related information. The code(s) may be entered into a patient's electronic medical record, and used for diagnostic, billing and reporting services.

Common Terms Continued

Modifiers: alters the description of a service without changing the intent of the service provided. It is a two digit alpha or numeric descriptor that is appended to the end of a HCPCS/CPT code to clarify the services billed.

Commonly used modifiers:

-25 Significant, separately identifiable E/M

-50 Bilateral procedures

-58 Staged or related procedure during postop period

-59 Distinct procedural service

-79 Unrelated procedure or service by same physician during the postop period

Modifier -59 applies a 50% discount to each procedure after the first one

Common Terms Continued

RAC: Recovery Audit Contractor. Companies hired to audit medical records to possibly recoup payments back to Medicare.

Target areas include, but not limited to:

- **Debridement documentation**
- **Incorrect billing of skin substitutes**
- **Provider-based billing rules met? Attestation is voluntary, but consider participating to protect yourself in a post-payment audit**

LCD: Local Coverage Determination

NCD: National Coverage Determination

APC: Ambulatory Payment Classification. The hospital is reimbursed based on APC rates as set by Medicare. APC rates are groups of similar services that are priced the same.

Common Terms Continued

OPPS: Outpatient Prospective Payment System. Mandates our Medicare/payer source billing rules.

HOPD: Hospital-based outpatient department. Our centers are a HOPD.

NCCI Report/Edits: National Correct Coding Initiative (NCCI). Reports are received when billing needs to be reviewed to ensure proper placement of modifiers, if applicable. Edits are to prevent unbundling of services and procedures.

MAC : Medicare Administrative Contractor

Denial: Hospital may not be paid or reimbursed for a patient date(s) of service, based on documentation submitted for payment. Timely review of documentation and responding to specific requests is crucial. Correct, resubmit or appeal ASAP.

Why is it important to know your hospital FI, MAC /LCD or NCD?

Provides Medicare Rules that specify the following:

- **Documentation guidelines**
- **Covered/non-covered procedures, modifiers, indications, medical necessity and limitations**
- **Covered diagnosis codes**
- **Utilization criteria**

If the service is not covered under the MAC\LCD\NCD, you must offer the patient the option to pay "fee for service" by means of an "ABN", Advance Beneficiary Notice of Non-coverage.

Commercial and other payer sources may vary. You must check with the payer source for determination and abide by hospital policy!

Common Causes of Denials

- **Incorrect patient identifier information**
- **Missing or invalid CPT/HCPCS codes**
- **Invalid or missing ICD-10-CM**
- **Requires prior authorization or precertification**
- **Request for medical records**
- **Services not covered**
- **Timely filing**
- **No referral on file**
- **Coordination of benefits**
- **Coverage Terminated**

Why do our patients receive two bills?

- ❑ One bill for the physician/provider service/professional fee
- ❑ One bill for the hospital cost/facility fee

- **Facility receives payment**
- **Physician receives payment**
- **Physician payment reflects facility use**
- **Patient co-pay to both facility and physician**

YOU MUST DISPLAY OR GIVE A PATIENT WRITTEN NOTICE OF YOUR BILLING PRACTICES

What if a patient has insurance provided by a commercial/private source, or a HMO, PPO? Do we follow Medicare Guidelines?

- **For wound care, these payers usually follow Medicare rules, but not always. It is the center responsibility to determine when a pre-cert. is required.**
- **Do not assume that commercial/private payers do not cover a service or procedure. Always call and verify policy benefits and limitations. Always document the who, what, when and where. The gathered documentation must be entered into the hospital EMR if appropriate for billing and reimbursement. If your facility bills occurrence/episodic (different account numbers for every visit), the precertification and authorization number may need to be documented again for every visit.**
- **For HBO, if we have an approved indication as stated by your hospital MAC for Medicare (Traditional), then it typically does not require a precertification. In 2015, 3 states implemented a pre-authorization process for CMS (IL,MI,NJ). We anticipate this will be an ongoing trend over the next 3 years. For all other payers, you must contact them by phone or log into their website and review their medical policies for covered indications. Pay special attention to all covered ICD-10-CM codes to ensure appropriate descriptors of the diagnosis code. For HBO, the PRIMARY diagnosis code must be applied for medical necessity and reimbursement. MD documentation must support the medical necessity for the indication!!**

Questions and Answers

Ques. **What if we have a patient that is new to our center, but has been provided a service by our hospital within the past three years. Do I bill for a NP (new patient) or EP (established patient) visit?** **Ans.** **For hospital billing, this would be billed as an established level of service visit or E&M (Evaluation and Management).**

Ques. **So, we have determined that this is an EP visit with the scenario above. What if the MD also performs a debridement, can this also be billed in addition to their E&M?** **Ans.** **Yes. Because this is the patients initial visit to our center, and the MD will be providing a H&P, treatment plan, etc., both services can be billed. A modifier -25 would be appended to the E&M.**

Q & A Continued

Ques. **When the patient has a subsequent visit to our center, and they also have a debridement , can we bill for an E&M and debridement again?** **Ans.** **No, not typically. If it is just a follow-up visit with nothing new that has to be addressed, you can only bill for the debridement.**

Ques. **What if the patient returns for a subsequent visit and has a new wound and the original wound looks infected? The MD cultures the original wound, debrides the new wound and documents a treatment plan. The nurse also obtains the new wound measurements and other documentation. Can we bill both the E&M and Debridement.** **Ans.** **Yes. Because there is a new problem and there is supporting documentation.** **And you must include the modifier 25 on the E&M code.**

Q & A Continued

Ques. **Let's say we have a NP to the center for an initial visit, but for billing purposes it is an EP because they have had services provided by our hospital within the past three years. On our daily census report do I count this visit as a NP?** **Ans.** **YES**

Ques. **What if we discharge a patient as healed and they return to our center in one week with the same wound. Do I count this as a NP or EP?** **Ans.** **Rule of thumb: This would be considered an EP visit. If the time lapse between visits would have been 30 days or greater, it can be considered a NP visit. If this same patient had returned in one week with a new wound, then it is considered a NP visit.**

Q & A Continued

Ques. **When is it appropriate to bill for a chemical cautery or cauterization?** **Ans.** **It can be billed , it if is to address granulation or hypergranulation tissue, "not as a result of". In other words, if you perform a debridement and to stop the bleeding you use a silver nitrate stick, then you cannot bill for a chemical cautery.**

Ques. **Do we need to photograph the wound or ulcer pre and post debridement?** **Ans.** **Yes, it is always recommended for prolonged or repetitive debridement services (especially those that exceed five debridements per wound), or according to your MAC.**

Q & A Continued

Ques. **As a general guideline /rule, what is expected from our scope of practice, to ensure that we have an appropriate treatment plan?** **Ans.** **Medicare coverage on a continuing basis for a particular wound requires documentation in the patient's record, that the wound is improving in response to the treatment plan and the care being provided. It is not reasonable to continue a given type of wound care if the evidence of wound improvement cannot be shown. The supporting documentation, with each visit (weekly, etc.), within a 30 day period must show some signs of measurable improvement. If not, it requires a new approach, which may include the physician reassessment of the underlying nutritional, infection, metabolic, or vascular status and other problems inhibiting wound healing.**

Q & A Continued

Ans. cont'd.

Evidence of improvement may include measurable changes (decreases), but not limited to the following:

- **Infection**
- **Drainage (color, amount, consistency)**
- **Inflammation**
- **Pain**
- **Swelling**
- **Wound dimensions (diameter, depth, tunneling)**
- **Necrotic tissue/slough**

Q & A Continued

Ques. **What is the difference between debridement and paring of a callus?** **Ans.** **Both debridement and paring may require the use of a sharp instrument. Callus refers to the hardened area which lies above the skin, whereas an ulcer or wound sits below the skin. A selective debridement refers to the removal of devitalized tissue within an ulcer or wound. Paring of callus refers to the removal of the hardened callus tissue. In dictation, some physicians may refer to callus tissue, but may also refer to hyperkeratosis or hyperkeratotic tissue. A correct assumption, would be that this is not a selective or excisional debridement. So, if there is only hyperkeratosis or callus, then a paring of callus should be charged. If the physician removes the callus and goes on to debride the wound, then only the debridement should be billed. Please refer to your MAC for more clarification.**

Q & A Continued

Ques. **It is so confusing! What is the difference between coding for a wound, ulcer or burn?** **Ans.** **Correctness and reimbursement.**

Wound codes are coded 8XX.XX (ICD-9-CM), LXX.XXX (ICD-10-CM) for ulcers.

Wound codes typically

- **Denotes trauma**
- **Acute in nature**

Ulcer codes typically

- **Chronic in nature**
- **A wound that has not healed (generally 30 days or greater) and related to a disease process**

Burn codes are coded T series codes and also specify the degree of the burn as the primary diagnosis.

If a diabetic ulcer is dictated as a wound, a coder would be directed to assign the ICD-10-CM code from the SXX.series These claims would be denied for HBO and in some cases, wound care, because these are not covered diagnosis(es), especially for HBO.

Q & A Continued

Ans. cont'd.

This does not mean that a diabetic cannot suffer a traumatic wound. For coding purposes, once the wound fails to heal (normally 30 days), it becomes CHRONIC in nature as it relates to the disease process and CAN BE DESCRIBED AS A DIABETIC ULCER!!

In the instance of a burn, the physician must state the site of the burn, the degree of the burn, and the total body surface area of the burned tissue.

WOUND CARE COMPLIANCE

Clinical Documentation

The importance of specific, detailed and complete clinical documentation in the medical record cannot be stressed enough. It is the basis for medical necessity, continuity of care and accurate billing/reimbursement.

Wounds and other clinical details should be evaluated and described in the medical record as precisely as possible, addressing:

- Wound evaluation including site, size, area, degree, depth, acuity and other features (such as odor or tunneling)
- Previous treatment should be documented if known, and whether that treatment was successful or unsuccessful
- Documenting the underlying cause for the wound can justify patient-specific circumstances such as delayed healing in diabetics and the use of technology like negative pressure pumps
- Procedures planned and/or performed and type of provider
- Patient care plan and education

Wound Care Compliance

Standard Compliance Program

A program to ensure compliance with Medicare rules and regulations should have policies and procedures in place for the following:

- Regularly scheduled internal and/or external audits for medical necessity, clinical documentation, code assignment and billing accuracy
- Monitoring of OIG Work Plan, Recovery Audit Contractor (RAC) targets and the PEPPER report
- Coder and/or biller access to reporting guidance
  - National coverage determination
  - Local coverage determinations
  - CPT Assistant (physician offices, clinics, professional billing)
  - Coding Clinic for ICD-10-CM (inpatient facility billing)
- A process to maintain and update a charge description master, super bills, EMR problem lists and/or their equivalents
- Educational programs for those creating documentation in the medical record as well as those responsible for assigning diagnosis and procedure codes
- A process to monitor denials and appeals if appropriate

Wound Care Compliance

Clinical Documentation

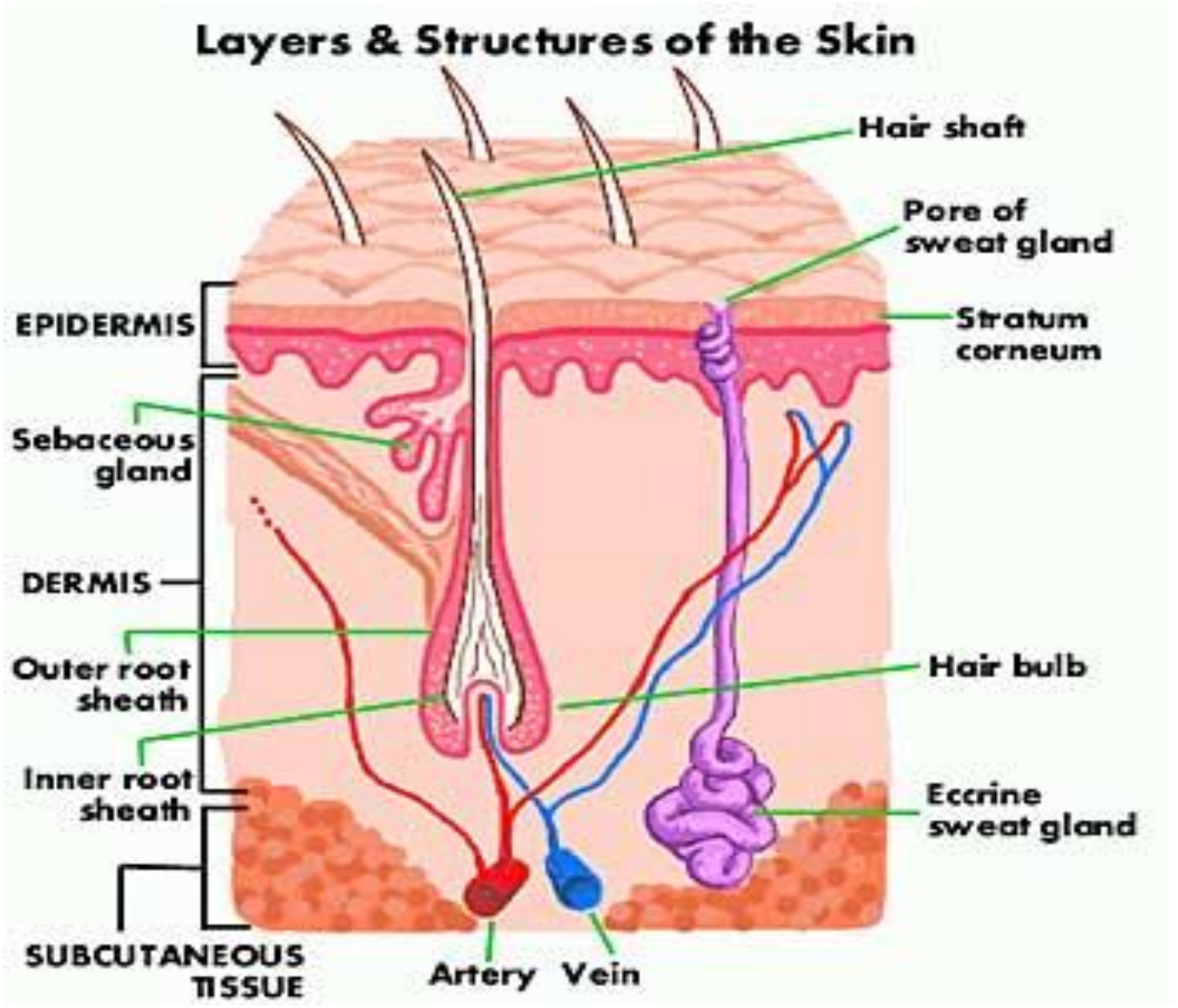
Wound care services have many codes, each having its own criteria for compliant use. Procedures and treatment, performed or planned, should be documented in detail to support medical necessity and most appropriate reimbursement. The reported codes for services performed must be accurate, complete, and have supporting clinical documentation in the medical record.

OIG Work Plan

References

- Department of Health and Human Services, Office of Inspector General. "Medicare Payments for Surgical Debridement Services in 2004." May 2007. Available online at http://oig.hhs.gov/oei/reports/oei-02-05-00390.pdf

- Department of Health and Human Services, Office of Inspector General. "Medicare Payments for Negative Pressure Wound Therapy Pumps in 2004." June 2007. Available online at http://oig.hhs.gov/oei/reports/oei-02-05-00370.pdf


Layers & Structures of the Skin
Hair shaft
Pore of sweat gland
Stratum corneum
EPIDERMIS
Sebaceous gland
DERMIS
Outer root sheath
Hair bulb
Inner root sheath
Eccrine sweat gland
SUBCUTANEOUS TISSUE
Artery
Vein

Layers of the Skin

Epidermis:

The outermost layer of the skin. There are no blood vessels in the epidermis and few nerve endings, but the deepest layer is supplied with lymph fluid. It is the thickest on the palms and on the bottom of the feet.

Dermis or corium layer:

The dermis is a tough and elastic layer containing white fibrous tissue interlaced with yellow elastic fibers. Structures that are embedded in the dermis include: blood vessels, lymphatic capillaries and vessels, sweat glands and their ducts, sebaceous glands, sensory nerve endings, arrectores pilorum, and hair follicles, hair bulbs and hair roots.

Subcutaneous or hypodermis layer:

This is the deepest of the layers of skin. It connects or binds the dermis above it to the underlying organs. This layer is mostly composed of the loose fibrous connective tissue and fat cells interlaced with blood vessels. In females, the hypodermis is generally 8% thicker than in males. The main functions of the hypodermis include insulation, storing of lipids, cushioning of the body and temperature regulation.

Importance of skin and its function

- **Skin is the largest organ in the body**
- **Protects the body against physical injury**
- **Provides protection for the body against numerous pathogenic microbes and chemical agents**
- **Helps to restrict fluid and water loss**
- **Involved in temperature regulation of the body**
- **Helps to prevent excessive water absorption by imparting water resistance to the skin**
- **Provides protection from UV sunlight**
- **The body's main sensory organ for temperature, pressure, touch and pain**
- **Plays a key role in metabolism, including vitamin D synthesis and biotransformation of some chemicals. A lack of vitamin D can lead to soft bones and many associated problems**

Debridement- Selective

<u>Debridement is based on area debrided, not total ulcer size</u>!!!! Must include a Time Out performed, if excisional.

<u>Selective</u> (CPT Codes 97597-97598) The physician removes no living tissue. Usually there is no mention of bleeding (which indicates living tissue).

97597 The removal of nonviable tissue, first 20 sq cm or less

97598* each additional 20 sq cm, or part thereof

Should include the following elements:

- **Location and characteristic**
- **Type or description of tissue removed**
- **% (surface area) of the ulcer debrided**
- **Instrument used (may be sharp)**
- **Patient's tolerance**
- **Dressings applied and treatment plan**
- **Depth should be minimal**

***= Bundled**

Debridement-Excisional

CPT Codes 11042-11047

11042 debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less.

11045* Each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure).

11043 debridement, muscle and/or fascia(includes epidermis, dermis and SQ tissue) first 20 sq cm.

11046* debridement muscle, each additional 20 sq cm.

11044 debridement bone, includes (includes epidermis, dermis, sq. tissue, muscle/fascia) first 20 sq cm.

11047*debridement bone, each additional 20 sq cm.

*** CPT codes not underlined are bundled**

Debridement-Excisional cont'd

Excisional Debridement should include the following elements:

- **Medical decision to perform procedure**
- **Location and characteristics of wound**
- **Type of tissue removed (eschar, fibrin, bone, etc.)**
- **Depth of procedure**
- **% of the surface area of the ulcer debrided**
- **Amount of bleeding and how it was stopped**
- **Instrument used and size of instrument**
- **Patient tolerance and pain control**
- **Dressings applied and treatment follow-up**
- **Pre and post debridement measurements**

Special Attention to Debridement Documentation and other Procedures

All key elements of the procedure needs to be inclusive in the procedure note.

Make A Difference

- **Documentation is critical and must be specific to diagnosis, within our scope of practice in the outpatient setting -e.g., the reason for the visit/problem and something that we can treat.**
- **Appropriate and accurate diagnosis must be documented both by staff members and physician treating the patient.**
- **Clinical staff members and physician documentation must support one another. Conflicting documentation may result in the denial and reimbursement for the visit.**
- **Facility and physician diagnosis codes must match. The diagnosis codes are "physician driven" and are based upon their medical decision and expertise.**

Prioritizing Diagnosis Codes

In an outpatient setting our diagnosis codes must be specific to the reason for treatment, relative to our scope of practice. The description/dictation/impression must be precise for the coders to appropriately code the visit to reflect the priority of the diagnosis codes, especially for HBO and the reimbursement of specific billable products. We must prove and document medical necessity and coding for every visit. At some point (30 days), we need to provide documented proof that the plan of care has a measurable success of improvement and if not, the plan of care needs to be reassessed.

Example of Dictation

1. **Diabetic Ulcer (DFU)**
   - **Incorrect: Rebecca returns to the center today for evaluation and treatment of a non-healing wound on her left foot. She does have a history of diabetes for the past ten years and is insulin dependent. Her left toe wound will be debrided today to remove non viable tissue.----------* A coder may give this visit a wound code vs. a diabetic ulcer.**
   - **Correct: Rebecca returns to the clinic today for evaluation and treatment of a diabetic ulcer of the left great toe, Wagner Grade III, which has been present for the past 45 days and is generally a non healing ulcer despite intervention-------.**

HBOT

- **Hyperbaric Oxygen Therapy is defined as the administration of 100% medical grade oxygen at greater than 1.5 Atmospheres Absolute (ATA), which is equivalent to approximately 15 feet below the surface of the ocean. Most hyperbaric chambers are certified up to 3 ATA's or 66 feet of sea water or deeper (for diving decompression operations). Hyperbarics is further defined as a procedure prescribed by a physician for the administration of oxygen to ameliorate various conditions.**

Covered HBO Conditions according to NCD 20.29

Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one man unit) and is limited to the following conditions:

1. **Acute carbon monoxide intoxication**
2. **Decompression illness**
3. **Gas embolism**
4. **Gas gangrene**
5. **Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened.**
6. **Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened.**
7. **Progressive necrotizing infections (necrotizing fasciitis)**
8. **Acute peripheral arterial insufficiency**
9. **Preparation and preservation of compromised skin grafts (not for primary management of wounds)**
10. **Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management**
11. **Osteoradionecrosis as an adjunct to conventional treatment**

Covered HBO indications according to NCD 20.29 Continued

12. **Soft tissue radionecrosis** as an adjunct to conventional treatment,
13. Cyanide poisoning,
14. **Actinomycosis,** only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment
15. **Diabetic wounds** of the lower extremities in patients who meet the following three criteria

a. Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes

b. Patient has a wound classified as Wagner grade III or higher; and

c. Patient has failed an adequate course of standard wound therapy.

****These indications/conditions may vary according to payer source and your MAC**

Noncovered conditions according to NCD 20.29

1. Cutaneous, decubitus and stasis ulcers
2. Chronic peripheral vascular insufficiency
3. Anaerobic septicemia and infection other than clostridial
4. Skin burns (thermal)
5. Senility
6. Myocardial infarction
7. Cardiogenic shock
8. Sickle cell anemia
9. Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency
10. Acute or chronic cerebral vascular insufficiency
11. Hepatic necrosis
12. Aerobic septicemia
13. Nonvascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease).

Noncovered HBO conditions according to NCD 20.29 continued

14. Tetanus
15. Systemic aerobic infection
16. Organ transplantation
17. Organ storage
18. Pulmonary emphysema
19. Exceptional blood loss anemia
20. Multiple sclerosis
21. Arthritic disease
22. Acute cerebral edema

** Other LCD's and payer sources may vary!!

WAGNER CLASSIFICATION

Grade:

Zero: No ulcer

One: Superficial skin ulcer without penetration to deeper layers

Two: Deeper ulcer penetrating through dermis. Tendon, ligaments, joint capsule or bone may be exposed

Three: Deep ulcer with abscess, osteomyelitis, pyarthrosis, plantar space abscess or infection of the tendon or tendon sheaths

Four: Localized gangrene – forefoot, toes or heel, which may be wet or dry

Five: Gangrene of the foot

Caveats to Remember

- Medical Necessity must be substantiated at each visit/procedure.
- Novitas Solutions-https://www.novitas-solutions.com/webcenter/portal/MedicalPolicy_JH/LCDInfo
- LCD's & Billing Articles to have:
  - Application of Bioengineered Skin Substitutes
  - Debridement of Mycotic Nails
  - Hyperbaric Oxygen Therapy
  - Strapping
  - Wound Care

- Modifier 25- typically used very sparingly, and only when the record supports its use.
- Modifier 59 & X modifiers likewise.
- Status Indicators are notable and should be understood.

Status Indicators that concern us

Indicator	Item/Code/Service	OPPS Payment Status
Q	Packaged Services Subject to Separate Payment Under OPPS Pstatus Indiayment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable.
		(1) Separate APC payment based on 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.

Conclusion

Thank you very much for attending this session on the introduction of reimbursement and documentation. We welcome your feedback and suggestions for topics of interest.

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This concludes the presentation

Any Questions?