Medical Review FAQs

Outpatient Prospective Payment System (OPPS)

QUESTION 1: Can a hospital bill an Emergency Room (ER) visit when the patient leaves the ER before they see the physician?

ANSWER:

YES. Under OPPS the hospital may bill Medicare for the ancillary services they provide to the patient. Capturing nursing services when there is not a physician encounter and the nurse has performed triage in the ER is allowed.

New 4/1/2003; reviewed 7/27/2004

QUESTION 2: What modifiers are appropriate to use when billing services to the Fiscal Intermediary (FI)?

ANSWER:

The Level I (CPT) and Level II (HCPCS) **Modifiers approved for Hospital Outpatient** use are listed in the Medicare Online Manual System, Section 20.6 – Use of Modifiers found in the Medicare Claims Processing Manual (CMS Pub. 100-04) and the Current Procedural Terminology (CPT) 2004.

New 4/1/2003; reviewed 7/27/2004

QUESTION 3: When should a hospital use Modifier - 91?

ANSWER:

The definition of Modifier 91 is repeat clinical diagnostic laboratory test. (CMS Medicare Learning Network, Understanding CCI, April 2002)

Use Modifier 91 when:

- **Clinical diagnostic tests** that are the same CPT/HCPC code, performed on the same day, append modifier 91 on the subsequent test **or**A panel test is performed and **a component of that panel test is repeated** on the same day, append modifier 91 on subsequent test.Additional like tests or component of panel tests must be medically necessary and documented in the medical records.

- Modifier 91 **should not be used to report** repeat laboratory testing due to laboratory error, quality control, or confirmation of test results.

New 4/1/2003; reviewed 7/27/2004

QUESTION 4: When should a hospital use Modifier - 59?

ANSWER:

Modifier 59 is defined as: "Procedures/services that are not normally reported together, but may be performed under certain circumstances".

Use modifier 59 for:

- Indicating that a procedure or service was distinct or independent from other service performed on the same day.
- Representing:
    - Different procedure(s) or surgery,
    - Different site(s) or organ system(s),
    - Separate incision(s), **or**
    - Separate injury (or area of injury in extensive injuries) **not** ordinarily encountered or performed on the same day by the same physician
    - Different session or patient encounter.**DO NOT USE Modifier 59 if:**

A level II HCPCS modifier can be used to indicate different body areas

New 4/1/2003; reviewed 7/27/2004

QUESTION 5: When should a hospital use Modifier - 25?

ANSWER:

Modifier 25 is defined as: "Significant, separately identifiable Evaluation and Management (E & M) service by the same physician on the same day of a procedure of other service".

In most cases, prospective payment for outpatient hospital diagnostic and therapeutic services includes certain basic evaluation and management services (e.g., taking the patient's blood pressure and temperature), so it is not appropriate to bill for these services separately. (**Please refer to PMA 00 - 040 and PMA 01 – 80 for detailed information)**

Use modifier 25 for a hospital E & M service:

- When the patient's condition requires a significant separately identifiable E&M service above and beyond what is customary. The information substantiating the E&M service must be clearly documented in the patient's medical record.
- That is beyond the usual pre-operative and post-operative care associated with the procedure.
- When a separate history was taken, a separate physical was performed, and a separate medical decision was made and is documented in the medical record.

- Medicare requires that modifier -25 ***always be appended to the emergency department (ED) E/M code (99281-99285)*** **when** provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s). **(A procedure code that has a status indicator of "S" or "T.")**

New 4/1/2003; reviewed 7/27/2004

QUESTION 6: When you are performing a blood specimen collection from an implanted VAD, in the outpatient IV Therapy department, CPT 36540 is the most descriptive CPT; however, it has a N status indicator. As no other procedure is being performed in this department, can we utilize CPT 36540 with an E/M code/-25 modifier to capture the facility charge?

ANSWER:

YES, you may capture the facility fee using an E/M code with the -25 modifier to capture the facility charge. You may also bill the 36540 to capture the specimen collection.

New 7/30/2003; reviewed 7/27/2004

QUESTION 7: I noted in OPPS bill type "reference diagnostics." I am not familiar with that, could I get a little further explanation?

ANSWER:

Bill type 14X is considered Hospital/Other Part B, which is usually used for "reference diagnostics." Mammograms are the most common diagnostic test that is billed under this revenue code. Another reference diagnostic service is laboratory where a specimen is dropped off. The Intermediary manual describes clinical diagnostic laboratory services other than to inpatients as follows:

If the tests are for an outpatient, those referred to a reference laboratory are payable at 60 percent. If a sole community hospital agrees to bill for both, it must prepare two bills: one for the laboratory tests payable at 62 percent, the other for the reference laboratory tests payable at 60 percent. The bill for tests performed by the reference lab includes nonpatient type of bill coding.

Billing for fee schedule laboratory tests is included with billing for other outpatient services to the same beneficiary on a single bill except where a qualified hospital laboratory is billing for a reference laboratory as described above. Reference: Medicare Intermediary Manual 3628.

New 7/30/2003; reviewed 7/27/2004

QUESTION 8: I am finding that with colonoscopies (CPT 45378, 45385 and G0121), the bills will not drop for Medicare claims that have a 90784 and one of

the colonoscopies procedures. Even when modifier -59 is placed on 90784, an edit appears. Is this not acceptable with Medicare?

ANSWER:

The National Correct Coding Initiative (CCI) edit manual was referenced for colonoscopies (CPT 45378, 45385 and G0121). CCI shows that 90784 is a comprehensive component of a Colonoscopy procedure and you cannot bill it separately even if a modifier - 59 is used.

Under OPPS "costs directly related and integral to performing a procedure or furnishing a service...are included in the OPPS payment rates." In this instance the injection of IV meds 90784 is considered an integral part of the procedure, and is not separately billable. So, when billing for services you always have to ask if the services you want to bill separately are integral to the procedure or service being performed. Reference: 67 FR 66767.

New 7/30/2003; reviewed 7/27/2004

QUESTION 9: We have performed two myelograms on different sites of the spinal canal (72240 + 72265) and our claims are being denied. Is there an edit or Local Medical Review policy that was implemented to deny these claims?

ANSWER:

CMS implemented an edit through the Part B National Correct Coding Initiative (CCI) and Outpatient Code Editor on 7/1/2002. When radiological S & Is for two or more myelograms of different sites of the spinal canal have been performed on the same date of service, then the provider should bill 72270 and not 77240 + 77265 separately. The 77265 is considered a comprehensive/component grouping of the 77240 code.

When both procedures of the code pair were performed on the same date of service, then a third code, 72270, is the correct code to bill and not either of these two individual codes. The rationale for the OCE edit is misuse of column 2 code with column 1 code. In this instance billing the third code should always be the correct coding choice if 72240 +72265 or 72255 + 72265 or 72240 + 72255 (there are similar edits for these codes as pairs) when performed on the same date of service.
New 7/30/2003; reviewed 7/27/2004

QUESTION 10: What was the effective date for when the Observation LMRP was rescinded?

ANSWER:

The Observation LMRP was not rescinded. We RETIRED the Observation Policy AZ01-1197 on 9/1/02. We no longer have an active medical review edit for these claims because observation has been packaged since 8/2000. However, the CMS guidelines are still current for observation services and need to be followed.

New 7/30/2003; reviewed 7/27/2004

QUESTION 11: What are the current written order requirements for observation? Does the term OBS or observation need to be in the order itself (as opposed to the name of a designated area?) Will a clarification order for observation be accepted after an initial admission order to a hospital unit has been written?

ANSWER:

The CMS guidelines for observation services are still current and even though the LMRP AZ01-1197 Observation Policy - was RETIRED 9/1/02, we are required to follow the instructions in the Medicare manuals.

The Intermediary Manual, Hospital Manual, and Program Integrity Manual that state:

"Observation...services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests."
and
"Coverage of Outpatient Observation Services.--Generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight. (See §210 regarding coverage of inpatient admissions.) When a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient.

CMS recognizes only inpatient admissions and observation admissions.
Following the manual instruction the order must be either for inpatient or observation. So admissions to hospital departments, extended recovery or any acronyms as HOPS, Short stay, etc. are not recognized as meeting the guidelines for observation services.

New 7/30/2003; reviewed 7/27/2004

QUESTION 12: If three (3) Electrocardiograms' (EKG's) are performed on the same day, will all three be paid?

ANSWER:

Yes. They will get paid, but modifier '-76" is required for the second and third EKG. In addition, the physician must order each of the diagnostic services and the medical record must show that each of the three EKG's are medically necessary.

NEW 8/5/2004

QUESTION 13: How do hospitals report drugs that have an assigned HCPCS code?

ANSWER:

They should use the units' field to report multiples of the dosage identified in the code descriptor. Fractions of the dose specified in the code descriptor may be reported as 1 unit or one additional unit as appropriate. That is, if the amount of the drug administered to a patient is less than the amount described by the HCPCS code, a hospital may bill for one unit. This requirement has not changed under OPPS.

- Clinical Example #1: Adenosine 3mg IV (J0150) is drawn from a 6 mg ampule and administered to convert a supraventricular arrhythmia. Report HCPCS code J0150 once, even though the entire 6 mg ampule dose was not administered.
- Clinical Example #2: One gram of Immune globulin (J1561) is administered from two 500 mg vials. Report HCPCS code J1561 with the number two in the units field to indicate that two, 500 mg dose vials were used.

NEW 8/5/2004

QUESTION 14: Shouldn't surgical procedures performed in the ER be reported under revenue code 450?

ANSWER

Yes. OPPS requires that the services are billed under the revenue center where they were performed.

NEW 8/5/2004

QUESTION 15: Can hospitals HCPCS code all drugs and biologicals packaged using revenue code 636, if they choose, or are they limited to the published list?

ANSWER

Packaged drugs can be billed with revenue code 250. Packaged drugs billed in revenue code 250 may also be HCPCS coded. However, any drug that will

receive separate APC payments or transitional pass-through payments must be billed with revenue code 636 and HCPCS coded.

NEW 8/5/2004

QUESTION 16: Do we still have to report OR, Recovery Room, Anesthesia, Observation, and supply charges on the UB-92 even though they are not separately reimbursable under APCs?

ANSWER

Implementation of OPPS does not change the way hospitals currently report OR, recovery room, anesthesia, observation and supply charges on the UB-92. Even though APCs are based on HCPCS not revenue codes, revenue codes are still required to be reported. All charges related to OPPS services are used to calculate outlier payments.

NEW 8/5/2004

QUESTION 17: How often will the Correct Coding Initiative (CCI) edits be updated for FIs?

ANSWER

The Correct Coding Initiative (CCI) edits are updated quarterly. CCI Version 6.0 was utilized for the initial implementation of OPPS.

NEW 8/5/2004

QUESTION 18: What is your definition of “signed orders”?

ANSWER:

It is the policy of this Fiscal Intermediary to accept full handwritten signatures, stamped signatures, initials, or electronic signatures. The only requirement is that the providers’ documentation and internal controls be able to specifically identify the signature and give reasonable assurance to prevent unauthorized usage of the signature.

NEW 9/16/2004

QUESTION 19: How soon after a verbal order is received must the ordering practitioner sign the order?

ANSWER:

There are no CMS guidelines published that designate a specific time limitation for signing verbal orders. It is this Fiscal Intermediaries (FI) recommendation that providers get the orders signed within seven (7) calendar days. At a minimum the orders should be signed prior to the claim being submitted to Medicare. The

providers should also take into account the order authentication guidelines established through State regulations.

NEW 9/16/2004