

**Important Notice of
Outpatient Prospective Payment System Implementation Progress
Originally Posted August 22, 2000
Updated September 8, 2000**

The majority of claims covered by the Outpatient Prospective Payment System (PPS) are being processed correctly. In fact, just today, the Health Care Financing Administration (HCFA) informed the fiscal intermediaries that PPS Contingency Plan 1 is not needed because the systems are functioning. This plan was designed to pay Medicare PPS claims in the event that HCFA's systems were not processing such claims. HCFA also told the fiscal intermediaries that they can offer PPS Contingency Plan 2 to those providers whose systems cannot submit proper PPS claims. Contingency Plan 2 permits providers whose systems are not functioning properly to request accelerated payments.

Given the complexity of the PPS system, some glitches were to be expected and were found during continued systems testing and implementation. As part of our ongoing provider outreach effort, HCFA is publishing this document to inform providers about the glitches we have found in the standard systems and Outpatient Code Editor (OCE). It is likely that some of these will result in claims processing errors.

HCFA is committed to making sure that claims are paid timely and correctly. To that end, we are continuing to work with the standard system maintainers and the OCE contractor to address these glitches as quickly as possible. We expect virtually all of the glitches to be addressed no later than October 1, 2000. In fact, many of the problems will be fixed well before October 1, and in such cases we have noted the target date for correction.

To the extent that processing errors occur due to the HCFA standard systems or HCFA's OCE, HCFA will be responsible for reviewing claims processed for the dates of service in question and making any necessary adjustments. As always, providers have the option of holding claims that are potentially affected by the glitches until corrections are made.

To assure that claims are submitted accurately, we have also included a number of reminder items. These items do not involve any issues with our systems or the OCE, but rather are facts that providers need to know to help ensure prompt and accurate processing of claims.

We have asked that our fiscal intermediaries post this information on their web sites. We encourage providers to contact their intermediary with any questions they may have or to request assistance with any problems.

1. Standard System Maintainer Issues

- The FISS system is rejecting claims with condition code G0 as duplicates. These claims should be processed for payment. A fix is scheduled for implementation at the intermediaries the week of August 28, 2000.
- The FISS receives an error code E6101 from the Common Working File (CWF) because the total charge line is not equal to the sum of the revenue lines on a claim. The claim is being rejected to the contractor suspense file until a fix can be implemented for this problem. A fix is scheduled for implementation at the intermediaries the week of August 28.
- In the FISS system, a surgical claim that contains two revenue lines for surgery with charges displayed on line one and no charges on line two will pay correctly. Even though the payment is correct, the Medicare Summary Notice does not reflect complete data. This gives the beneficiaries incomplete information regarding the deductible and coinsurance information. A fix is scheduled for implementation at the intermediaries during the week of September 4.
- The CWF system generates an error code when PPS outlier payments are involved. The claims will be suspended until the problem is corrected. The CWF maintainer is working on this problem and is scheduled to have it resolved the week of August 28. Once the problem is fixed, the suspended claims will be released for normal processing.
- **HCFA has learned that the charges on a small number of Medicare Summary Notices generated by the FISS standard system are being overwritten when there are long descriptors for some HCPCS codes. A fix for this problem is scheduled for implementation by the intermediaries during the week of September 11. (Posted September 8, 2000)**
- **The FISS standard system is not recognizing that some facilities are Sole Community Hospitals. Claims for these facilities are being suspended within the system. They will be processed when a fix is installed at the affected intermediaries the week of September 4. (Posted September 8, 2000)**

2. Outpatient Code Editor (OCE) Issues

Certain OCE issues discussed below may affect payment to providers or are significant enough to bring to your attention.

HCFA will be making modifications to the OCE software to correct these problems. Claims with dates of service on or after August 1, 2000, but received

before implementation of these modifications in our systems will experience problems as indicated. To the extent that processing errors occur due to the HCFA standard systems or HCFA's OCE, HCFA will be responsible for reviewing claims processed for the dates of service in question and making any necessary adjustments.

OCE Issues Scheduled for Resolution No Later Than October 1, 2000

- Edit 17 (inappropriate specification bilateral procedure)

Some claims with multiple occurrences of the same bilateral procedure may have more than one bilateral procedure paid. If the same type "T" procedure is reported multiple times on the same line item, the OCE is not rejecting all but one of the bilateral procedures as it should. When the multiple bilateral procedures are reported on separate line items the OCE is working correctly.

- Edit 22 (invalid modifier)

OCE currently does not contain a complete list of valid modifiers for ambulance services and pet scans. As a result, a small number of claims did not process to payment. A fix was implemented in intermediary systems to work around these edits.

- Edits 19, 20, 39, 40 (mutually exclusive/component of comprehensive procedure that would be allowed if appropriate modifier were present)

Multiple psychiatric services provided on the same day may be edited incorrectly by OCE because the Correct Coding Initiative (CCI) v6.2 edit table in the current OCE incorrectly includes mental health codes. A PRICER modification is scheduled for implementation in our system no later than the week of September 4 to fix this problem.

- Edit 42 (multiple medical visits on the same day, with the same revenue code, without Condition Code G0)

If multiple E&M codes are reported on separate line items the OCE is working correctly. When multiple E&M codes are reported with a unit greater than one on a line item, the OCE edit is not working correctly. The result is that some claims with multiple occurrences of an E&M code with the same revenue center might have more than one E&M code paid. To avoid this occurrence, providers should bill multiple E&M services in the same revenue center on separate line items.

- Revenue Codes Without HCPCS

OCE currently assigns a line status indicator of “A” (services not paid under PPS) to some revenue codes without a HCPCS code. These should be packaged in the PPS payment.

- ER/Observation

Currently, claims which span more than one day and which include ER or observation services are being processed by the OCE as a single day. To avoid this occurrence, hospitals may submit each day of a multiple day claim that contains ER or observation services on separate claims.

- Non-payable HCPCS Codes

Currently the OCE does not assign a reason code for some non-payable HCPCS codes.

- Multiple Edits Issued for Same HCPCS Code

Currently the OCE issues two different edits for some HCPCS codes. In the future only one edit will be generated. This may affect the timeliness of payment to the providers to some limited degree.

OCE Issues Scheduled for Resolution No Later Than January 2001

Some issues were only recently identified and cannot be fixed in the October version of the OCE. Claims for these services that are incorrectly processed will be reprocessed as soon as an OCE fix can be installed. As noted, we will fix these problems on or before January 1, 2001. If the fix is made prior to January 1, we will amend this posting to reflect the date of correction.

- Modifier 52 (reduced services)

Claims containing Modifier 52 with type T procedures are being inappropriately discounted in the OCE.

- Modifiers 76 (repeat procedure by same physician), 77 (repeat procedure by another physician), 79 (unrelated procedure or service by the same physician during the post-operative period)

Claims containing these modifiers are being inappropriately discounted in OCE.

3. Reminder Items

The following are some items that providers need to keep in mind to assure compliance under PPS.

- Hospitals are responsible for proper reporting of units of service. Instructions were issued in Transmittal 747 of the Hospital Manual in December 1999 explaining the proper reporting of units.
- Hospital Manual Transmittal number 747 issued also requires providers to report a line item date of service on every line that requires a HCPCS code, even if the dates of service span is the same day (i.e., 08-01-00 - 08-01-00). If the line item date of service is not shown, the claim will be returned to the provider.
- As stated in PM A-00-36, dated June 2000, non-RHC services provided by hospital based RHC facilities on or after August 1, 2000 will be subject to payment under PPS. As a result, hospital-based RHCs need to discontinue billing non-RHC services on the RHC claim (bill type 71X). When a patient receives services from a hospital-based facility certified both as a hospital-based RHC and as part of the hospital outpatient department, the claim for non-RHC hospital outpatient services must be submitted utilizing the hospital bill type (13X or 14X) along with the hospital's provider number, since the services are not covered as RHC services, but instead may be covered hospital outpatient services paid under PPS or an existing fee schedule.

This change is needed to assure proper payment under PPS. RHC services remain subject to the encounter rate payment methodology and will continue to be billed using the RHC provider number, RHC bill type (71X) and revenue codes 52X and 91X. Failure to bill appropriately will result in the claim being returned to the provider.

- As stated in PM A-00-36, dated June 2000, payment for clinical diagnostic laboratory services furnished under the inpatient Part B benefit (bill type 12X) which were paid on cost prior to PPS are now paid under PPS. These services must be billed with the appropriate HCPCS code to assure proper payment.
- When an implantable device such as E0751 or L8600 is billed with revenue code 274, CWF will reject the claim. Since these devices are no longer subject to payment under the orthotic/prosthetic fee schedule, they should be reported under revenue code 278.
- As stated in PM A-00-45 dated August 2000, there were a number of HCPCS codes which will be removed from the "inpatient only" list. As a result, these codes have been assigned APCs. To avoid rejection of a claim containing any of the codes listed in this PM, hospitals should implement one of two options. They should hold claims containing these codes until October 1, 2000 or submit claims for all services furnished to a beneficiary with the exception of these codes. If the

hospital chooses the second option, it must submit an adjustment claim containing all services provided (including any of the codes listed in the PM that were not previously billed) on or after October 1, 2000. In the event a hospital submits a claim containing any of the listed codes prior to October 1, 2000, the claim will be rejected by the OCE. HCFA will identify and reprocess any claims erroneously rejected because of this issue.

- The Electronic Remittance Advice (ERA) files **do** contain the APC number assigned at the line, but when files are run through PC Print, the APC number is not printing on the remits. At this time, PC Print is not designed to show this information and there are no plans at this time to modify PC Print to accommodate this functionality. Providers who need such detail may want to consider moving to an ERA format. **NOTE: September 8, 2000 Update----** **HCFA is now working with the standard system maintainer responsible for PC Print and the program will be modified to include the functionality of showing the APC. This change should be effective in a PC Print version that will be available no later than October 1, 2000.**