New APCs for a new year: more OPPS changes

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The January 1, 2001, update to the Outpatient Prospective Payment System (OPPS) contained significant changes. These changes fall into three categories:

- modifications to the definition of the APCs
- policy changes that affect the claims adjudication process or payment computation
- modifications to the edits in the Outpatient Code Editor (OCE)

The article "New APCs and More: Changes to the Outpatient Prospective Payment System" in the November-December 2000 Journal of AHIMA summarized the October 1, 2000, OPPS update. This article focuses on summarizing the January 1, 2001, changes.

Modifications to the APCs

Two new status indicators were created.

Status indicator K is for drugs and biologicals considered as ancillary. In previous versions of the APCs, drugs and biologicals treated as ancillary were given a status indicator of X like all other ancillary services. Drugs and biologicals categorized as ancillary are paid a standard APC amount and are not paid on a pass-through basis. To differentiate drugs and biologicals treated as ancillary from other ancillary services, the status indicator of K was created.

HCPCS codes with a status indicator of E are considered an error if submitted on an OPPS claim. Any HCPCS code with a status indicator of E on an OPPS claim is denied, rejected, or returned to the provider. However, the fiscal intermediaries are using the editing portion of the OCE to process non-OPPS claims.

Some of the HCPCS codes with a status indicator of E are not an error for non-OPPS claims. Within the OCE, a new status indicator of B was created for HCPCS codes that had a status indicator of E but are not an error on a non-OPPS claim. For OPPS claims, status indicators of E and B are both treated as an error. For non-OPPS claims, a status indicator of E is treated as an error but a status indicator of B is not.

Status indicator B is an OCE distinction. The Federal Register does not distinguish between status indicator B and E because both have the same meaning for hospital OPPS claims.

Effective January 1, 2001, 131 new APCs were added, increasing the number of APC from 945 to 1076. January 2001 Modifications to APCs summarizes the changes.

The majority of new APCs are related to devices. For devices that meet the criteria to be paid on a pass-through basis, there was a net increase of 110 APCs. Also, there was a net increase of nine drug and biological APCs, 10 ancillary drug and biological APCs, and 16 type T procedure APCs.

At the same time, there was a net decrease of 16 type S procedure APCs, primarily because 12 type S procedure APCs were changed to a type K ancillary drug and biological APC. For example, the APCs for Blood Product, APC 949 through 960, were changed from type S to type K.

Policy Modifications

A medical claim with a mental health reason for the visit and an E/M code was treated the same as a claim with the brief individual psychotherapy HCPCS code assigned to APC 322 (Brief Individual Psychotherapy). The intent was to avoid paying

mental health claims differently if the service was coded with an E/M code or the brief individual psychotherapy code.

APC 322 has a payment rate that is less than the higher-level medical visits APCs (i.e., 602, 611, 612). Hospitals questioned the fairness of this policy, especially for high-intensity emergency room visits for mental health problems. As a result, in the January OCE, mental health visits coded with an E/M code are assigned to the standard medical visit APCs (i.e., 600 through 612) and not APC 322.

Type T procedures that are terminated are subject to a 50 percent discount. Modifiers 73 and 52 were use to identify terminated procedures. In the January OCE, modifier 52 (reduced service) is no longer considered a terminated procedure. No terminated procedure discounting is applied to type T procedures with a modifier 52.

There has been some confusion regarding whether a claim with an OCE edit should be submitted to the fiscal intermediary. In general, if the hospital considers the claim to be coded accurately and completely, it should be submitted. Some of the OCE edits will cause an individual line item not to be paid (i.e., line item denial or rejection), but the rest of the claim will be processed by the fiscal intermediary.

For example, the presence of an NCCI edit on a claim will cause the individual line item to be denied or rejected, but the rest of the line items on the claim will be processed and paid. Where the disposition of the OCE edit is returned to provider, and the claim is accurately and completely coded with supporting documentation, the fiscal intermediary should be contacted for advice.

Edit Modifications

The underlying logic of several of the OCE edits was modified in the January OCE release, as summarized in OCE Edit Modifications. Two new edits (44, 46) were added to the OCE, and one edit was eliminated (4).

The content of the knowledge files that underlie each edit was updated. The version of NCCI edits used in the January OCE is 6.3. The NCCI edit files were modified to exclude all code pairs, which included an anesthesia code (00100-01999), an E/M code (92002-92014, 99201-99499), a mental health service (90804-90911), or wound closure using only tissue adhesives (G0168).

Hospitals questioned the upper limit assigned to procedures in the unit edit (edit 15). For the January OCE, the upper limits in the October OCE were increased to always be at least 10. Most codes that are new in January with status indicator of G, J, or K, and brachytherapy seed codes have no upper limit in the units edit. HCFA will be refining the units edits to be more clinically precise for a future release of the OCE.

As a new system, OPPS continues to evolve. The magnitude of the quarterly updates reflects the complexity of the issues associated with outpatient care. HCFA is attempting to respond to the concerns of the hospital industry as well as the pharmaceutical and device manufacturers. As a result, continued changes are likely in 2001.

january 2001 modifications to APCs

	Modifications to October APCs		**January APCs**
Significant procedure, therapy, or services (S,T)	Added 15 Changed 1 Changed 2 Changed 3 Changed 13	Type T Type T to Type S Type S to Type T Type S to Type X	164 Type T 11 Type T New technology 83 Type S 4 Type S New technology 262. Total

		Type S to Type K	
Medical visit (V)	No Change		7
Drugs and biologicals **(G, J, K)**	Added 7 Added 1 Changed 1 Changed 1 Deleted 1 Added 1 Deleted 2 Changed 12 Changed 12	Type G Type J Type H to Type G Type X to Type G Type G Type K Type X Type S to Type K Type X to Type K	229 Pass-through (G, J) 25 Ancillary (K) 254 Total
Devices (H)	Added125 Deleted 14 Changed 1	Pass-through Pass-through Type H to G	495 Pass-through 11 Ancillary new device technology 506 Total
Partial hospitalization (P)	No Change		1
Ancillary tests and procedures (X)	Added 3 Deleted 1	Type X Type X	46
Total	Net addition of 131		1,076

OCE edit modifications

Edit	**October OCE**	**January OCE**

4 Medicare secondary payer alert	Claims with trauma diagnosis are suspended for review to determine if the injury was the result of an accident that is covered by another insurance carrier (e.g., automobile liability)	Edit eliminated
15 Service units out of range for procedure	If the number of times a procedure is performed in a day exceeds a procedure specific limit, the claim is returned to the provider. If modifiers 59, 76, 77, or 91 are present on a line item, the service unit edit is not applied	Modifiers 59, 76, and 77 no longer turn off the service unit edit for a line item. Only modifier 91 causes the service unit edit not to be applied
16/17 Bilateral procedure edits	Claims with more than one bilateral procedure are returned to the provider. The list of bilateral procedures used in the edits contained come procedures that could conceivable be done more than once unilaterally or more than once bilaterally	The list of bilateral procedures used in the edits was modified to include only those procedures that could never be performed more than once either unilaterally or bilaterally
27 Only incidental services reported	The edit occurs if all line items with a HCPCS code have status indicator of N	The edit occurs only if all line items have a status indicator of N, as opposed to only those line items with a HCPCS code. For line items without a HCPCS code, the status indicator is determined from the revenue center
30 Insufficient services on day of partial hospitalization	A partial hospitalization claim that contains one or more days on which there are an insufficient number of services to justify the partial hospitalization per diem is suspended for medical review	If the majority of days on a partial hospitalization claim have sufficient services, the claim is not suspended for medical review because of a few isolated days with insufficient services. Edit 30 is only issued if edit 32, 33, or 34 is also present on the claim
37 Terminated bilateral procedure or terminated procedure with units greater than one	Modifier 52 (reduced service) was considered a terminated procedure	Modifier 52 is no longer considered a terminated procedure
38	Not implemented	Any claim that contains a device (status indicator of H)

Inconsistency between implanted device and implantation procedure		or a HCPCS code assigned to the new device technology APCs (987-997) must have a procedure with a status indicator of T present for the same day. Otherwise, the claim will be returned to the provider
44 (New Edit) Observation revenue code on line item with non-observation HCPCS code		On a line item with the observation revenue center (762), the units specify the number of hours of observation. If the HCPCS code on the line item is assigned an APC, the units will inappropriately be applied to the APC. If revenue center 762 occurs on a line item with a HCPCS code other than 99217-99220, 99234-99236, the claim is returned to the provider
46 (New Edit) Partial hospitalization condition code not approved for bill type	No OCE edits occur if the partial hospitalization condition code (41) occurs on a claim with a bill type of 12x or 14x	If the partial hospitalization condition code (41) occurs on a bill type of 12x or 14x, the claim is returned to provider

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