

Outpatient Facility Claims Processing Logic

At Prevea360 Health Plan, we are committed to processing claims in a consistent and accurate manner. To support this effort we process outpatient facility claims according to the most recent version of the Centers for Medicare and Medicaid Services (CMS) Outpatient Claims Editor (OCE) rules, National Coding Policies and Guidelines, and Revenue Code Validation rules.

CMS's Outpatient Claims Editor (OCE) rules

The OCE is a software package supplied to Medicare Intermediaries by CMS to edit hospital outpatient claims (bill types 12X, 13X, or 14X). The OCE detects incorrect billing data (e.g., accuracy of units of service, correct modifiers) and reviews each HCPCS and ICD-9-CM code for validity and coverage. The OCE edits are incorporated into Prevea360's current adjudication process and are already being applied to claims submitted by outpatient facilities.

CMS releases quarterly updates to the OCE and program memorandums that detail the application of the OCE. For more information about OCE edits, visit the CMS website.

Revenue Code Validation

Revenue codes are 4-digit codes used to classify types of service. They are required for accurate hospital outpatient claims processing. Revenue codes are required for processing of all outpatient facility claims.

Prevea360 Processing	Additional Detail	Source	Line of Business
Revenue codes received without a required HCPCS code will not be reimbursed	<p>Congress recognized that certain revenue codes lacked sufficient detail to determine what specific services and procedures were performed. Therefore, the Omnibus Budget Reconciliation Act (OBRA) was passed in 1986 requiring that hospitals report HCPCS codes for all outpatient services.</p> <p>Examples of revenue codes that require a corresponding HCPCS include: 450, 360, 636, 761, and 490.</p> <p>A HCPCS code is also required for claims submitted with Bill Type 12X or 14X, when billed without condition code 41 (Partial hospitalization)</p>	CMS	Commercial Medicare
CPT, HCPCS and modifier codes billed with inappropriate revenue codes will not be reimbursed	<p>CPT, HCPCS and modifier codes must be appropriate for use with the billed revenue code. For example:</p> <ul style="list-style-type: none"> Medical/surgical supplies would not be reported under professional revenue codes 0960-0989. Modifier 26 should be appended to diagnostic and 	CMS	All lines

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	radiologic services reported with revenue codes 0960-0989 (professional services)		
Revenue codes that are not appropriate for use with outpatient hospital claims will not be reimbursed when billed	It is inappropriate for certain revenue codes to be billed with outpatient hospital bills (bill types 12X, 13X, 14X). For example, Room and Board revenue codes 010X-021X are intended to be used only in the inpatient hospital setting	CMS	All lines

National Correct Coding Initiative (NCCI)

Prevea360 uses the CMS NCCI tables for Hospital Outpatient PPS in its processing of outpatient facility claims. According to CMS, these policies are based on a number of sources including; AMA coding conventions as defined in the CPT manual, national and local CMS policies, coding guidelines developed by national societies, analysis of standard medical and surgical practices and a review of current coding practices.

The NCCI tables for Hospital Outpatient PPS are available at the CMS website at <http://www.cms.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp>

Prevea360 Processing	Additional Detail	Source	Line of Business
Column II procedure codes will not be reimbursed when submitted with a code from Column I	For both the Mutually Exclusive and C1/C2 tables, the Column II code is considered the component code	CMS	All lines

Maximum Units Policy

Each CPT/HCPCS code has been assigned a maximum number of units that may be billed per day for a member. Where available, Prevea360 has accepted the CMS Medically Unlikely Edit (MUE) value. All other codes have been assigned a maximum-unit-of-service based on the code definition, anatomical site, clinical guidelines and industry standards.

Prevea360 Processing	Additional Detail	Source	Line of Business
Procedures and services billed with a unit amount that is in excess of the assigned value, will not be reimbursed	Each CPT/HCPCS code has been assigned a maximum number of units that may be billed per day for a member	CMS	All lines

Modifier Policy

Modifiers are used to add additional specificity to a procedure or service without changing the meaning of the associated CPT or HCPCS code. Special care should be used to ensure that the modifier reported is appropriate for both the code and the clinical scenario.

Prevea360 Processing	Additional Detail	Source	Line of Business
Procedures billed with modifier 53 will not be	CPT has developed modifiers 73 and 74 for	CPT	All lines

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reimbursed when billed by an outpatient hospital facility or ambulatory surgical center	hospital outpatient use	CMS	
Reimbursement for procedures billed with modifier 73 will be reduced by 50%	According to CMS policy, procedures that are discontinued prior to the administration of anesthesia are reimbursed at 50% of the allowed amount	CMS	All lines
Items billed with modifiers FB (Item provided without cost) or FC (Partial credit received for replaced device) will not be reimbursed when appended to a code with an OPPS status indicator other than S, T, V, and X	According to CMS policy, modifiers FB and FC are for use in the Outpatient Hospital and Ambulatory Surgical Center settings	CMS	All lines
Reimbursement for items billed with modifiers FB or FC will be reduced by the CMS offset percentage	According to CMS policy, modifiers FB and FC indicate that full or partial credit for a device was provided to the provider	CMS	All lines
Non-inpatient only services billed with Modifier CA will not be reimbursed	Modifier CA is allowed once per date of service when appended to inpatient only procedures performed emergently on an outpatient who expires before admission	CMS	All lines

Global Surgical Package / Global Period - Prevea360 has adopted the CMS definition and processing logic for the global surgical package.

Prevea360 Processing	Additional Detail	Source	Line of Business
E/M services are not separately reimbursed when billed with a procedure assigned a Status Indicator of "T" (Surgical services to which the multiple procedure reduction applies)	Unless significant and separately identifiable, payment for E/M services is included in procedures assigned a Status Indicator of "T".	CMS	All lines

Multiple Procedure Reduction

Multiple Procedure Reduction rules apply when a facility performs two or more surgical procedures, identified by CMS as subject to multiple surgery guidelines, on the same date of service.

Prevea360 Processing	Additional Detail	Source	Line of Business
Covered procedures with the highest ASC fee schedule price will be reimbursed as the primary service	Primary procedures are reimbursed at 100%. Subsequent procedures are reimbursed at 50%	CMS	All lines

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Professional, Technical and Global Services Policy

Certain procedures are comprised of a professional (physician) component and a technical (facility) component. The combination of the professional and technical component is considered the global service.

- **Modifier -26** – “Professional Component”. Modifier -26 is appended to the procedure when only the professional component is performed.
- **Modifier -TC** – “Technical Component”. Modifier -TC is appended to the procedure when only the facility component is performed.

Prevea 360 Processing	Additional Detail	Source	Line of Business
Only one professional component will be reimbursed per diagnostic test when billed with Professional-Fee Revenue Codes 0960-0989	Prevea360 will reimburse up to the global amount for covered procedures. Modifiers should be used to indicate a repeat procedure or one that was performed by a different physician so that the appropriate additional reimbursement can be made	CMS	All lines

CMS Coverage Policies

Prevea360 Processing	Additional Detail	Source	Line of Business
CPT codes will not be reimbursed when used to report a service for which CMS requires a Medicare-specific HCPCS code	To ensure appropriate reimbursement under the Medicare program, CMS has instructed hospitals to report certain services with HCPCS codes rather than CPT. For example, when performing radiation treatment delivery, CMS requires G0173 rather than 77372	CMS	Medicare only

Evaluation and Management (E/M) Services

Prevea360 Processing	Additional Detail	Source	Line of Business
A new patient E/M will not be reimbursed when used to report services for an established patient	Under the OPPTS, an established patient is one that has been registered as an inpatient or outpatient of the hospital within the past 3 years. The same patient may be “new” to the physician but “established” to the hospital.	CMS	All lines
Only one E/M is allowed per day per outpatient hospital facility/revenue center	Multiple outpatient hospital E/M encounters on the same date may be reimbursed separately when billed with the appropriate modifier.	CMS	All lines

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Anesthesia

Services involving the administration of anesthesia should be reported using the five-digit anesthesia code (00100-01999).

Prevea360 Processing	Additional Detail	Source	Line of Business
If multiple general anesthesia service codes are received, only the highest submitted charge amount will be paid	When multiple general anesthesia services are billed for the same day, only the anesthesia for the procedure with the highest base value, plus the time for all anesthesia services combined, should be reported. CPT codes 01953, 01968, 01969, 01995, 01996 are excluded	CMS	All lines

Device and Supply Policy

Prevea360 Processing	Additional Detail	Source	Line of Business
Nuclear medicine procedures will not be reimbursed when billed without the appropriate radiopharmaceutical imaging agent	Certain imaging agents are only appropriate for use with specific therapeutic imaging procedures or studies. For example, a vitamin B12 absorption study will not be reimbursed if billed without A9546 or A9559 (cyanocobalamin).	CMS	All lines
Brachytherapy source will not be reimbursed when billed without an appropriate surgical procedure in the ASC	According to CMS policy, separate payment may be available for certain brachytherapy sources that are provided in conjunction with specific, covered surgical procedures. The source will not be reimbursed if it is billed without this procedure. For example, C1717 (brachytherapy) will not be reimbursed if billed without 55875.	CMS	All lines

End Stage Renal Disease (ESRD) Policy

Prevea360 Processing	Additional Detail	Source	Line of Business
CPT 90999 (unlisted dialysis procedure) will not be reimbursed when billed without modifier G1-G6 with bill type 72X (renal dialysis facility)	According to CMS policy, modifiers G1-G6 are used to indicate the most recent URR reading	CMS	All lines

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