HMI Corporation

CODING & BILLING FOR PROSPECTIVE PAYMENT SYSTEMS

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OPPS Same Day Rule

The Same Day Rule is based on the discounting requirements of the Outpatient Prospective Payment System (OPPS) where certain ambulatory payment categories (APCs) are paid at 50% when performed on the same date as another APC.

This rule differs from the so called "72-hour rule," which requires that all related outpatient services performed within three calendar days of an admission be combined with the admission and will be paid as a part of the DRG payment. The "same day rule" applies only to outpatient services.

Patient accounts managers are constantly faced with the need to correct claims for services when they are provided on the same day. The issue of creating a new claim or posting the charges to an existing claim for recurring services seems to have been a thorn in the side for a number of years.

On September 12, 2002, Medicare issued transmittal A-02-087 to fiscal intermediaries. This transmittal clarifies that all OPPS services provided on the same date of service are to be billed on the repetitive claim (Medicare's term in the transmittal for claims with recurring services). If a non-OPPS service (i.e., laboratory, occupational therapy, physical therapy, physical therapy, speech therapy) is provided on the same date as an OPPS service, they may be billed separately.

Services reported using revenue codes 33X, 342, 41X, 42X, 43X, 44X, 482, 493, and 91X are considered to be repetitive services. All services reported using these revenue codes with the exception of 42X, 43X, and 44X are subject to OPPS.

Some examples of how claims should be submitted under the Same Day Rule:

- If an emergency department (ED) service is provided on May 15th, the same date as a radiation therapy service, they must both be submitted on the repetitive claim submitted for radiation therapy.
- If an ED service is provided on May 15th and radiation therapy is provided on May 14th and May 16th, the ED claim may be submitted as a separate claim.
- A laboratory service performed on May 15th and not related to an ED visit also on May 15th may be submitted on separate claims.

As you can see, the clarification to the fiscal intermediaries still leaves patient accounts managers with the same dilemma. A possible solution would be to flag any new registration for a patient with an open recurring account in order to alert the registrar that an account already exists and should be used for all charges. The coding staff will need to be brought into the loop in order to ensure appropriate coding of the combined services on the recurring claim. This solution would lessen the problems of the patient accounts department while increasing the complexity of coding the claims.

http://www.cms.hhs.gov/manuals/pm_trans/A02087.pdf

FDA Approves Drug Eluting Stents

FDA approval has been granted for Cordis Corporation's drug eluting stents. The stent releases a drug to prevent re-blockage following coronary angioplasty and carries a list price of approximately $3,200. Two new codes G0290 and G0291 (assigned to APC 656) were created for reporting this service for outpatient payment. CMS has stated that an updated program memorandum outlining the new effective date and use of the codes will be released.

Infusion Therapy and Observation	As of January 1, 2003, the OCE will now accept infusion therapy HCPCS code Q0081 with observation services. Previously, claim rejections would occur whenever infusion therapy and observation services were billed together.
Ambulatory Surgery Center Approved Procedures	Within the March 28, 2003 Federal Register, Medicare has recently released its updated list of approved ambulatory surgery center (ASC) procedures. The list included 288 CPT code additions and removed 141 approved codes. There is a 90-day comment period, and the rule takes effect July 1, 2003. The above listed Federal Register document can be found at: http://www.access.gpo.gov/su_docs/fedreg/a030328c.html
Dialysis Treatments	Generally, Medicare does not allow payment under the OPPS for routine dialysis treatments furnished to End Stage Renal Disease (ESRD) patients in the outpatient department of a hospital that does not have a certified dialysis facility. However, in certain medical situations when the ESRD patient cannot receive her or his regularly scheduled dialysis treatment at a certified ESRD facility, the OPPS rule for 2003 allows payment for non-routine dialysis treatments furnished to ESRD patients in the outpatient department of a hospital that does not have a certified dialysis facility. Payment is limited to unscheduled dialysis for ESRD patients in the following circumstances: • Dialysis performed following or in connection with a vascular access procedure; • Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, we allow the hospital to provide and bill Medicare for the dialysis treatment; or • Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment. In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using a new HCPCS code, G0257 - *Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility.* This new code is assigned to APC 0170, with status indicator (SI) "S". http://www.cms.hhs.gov/manuals/pm_trans/A02129.pdf

Do you have a specific coding question or topic that you would like to see addressed in our next newsletter? Please fax (615) 661-5147 or go to feedback on HMI's website: http://www.hmi-corp.com. We would like to hear from you.

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