Codify
BY AAPC

Outpatient Facility Coding Alert

Reimbursement: Watch 6 Letters to Know Whether to Expect OPPS Payment Approval or Refusal

Tip: Keep tabs on the Status Indicators along with alternate HCPCS codes.

When you want to verify whether a procedure is payable under Ambulatory Payment Classifications (APCs), your first checkpoints are Status Indicators (SIs). Not having clarity on what these are or how to use them can seriously sideline your claims. Read on for a refresher on what each SI means to your coding and billing.

Basics: The SIs are divided into 23 categories and tie in with certain HCPCS or CPT® codes. The SI(s) are defined in Addendum D1 of the Outpatient Prospective Payment System (OPPS) Final Rule every year.

Watch for Packaged Services With 'N'

The SI "N" designates items and services which are part of "Packaged Services" of the APC. These services are reportable but not separately payable, such as:

- Moderate sedation (99143 □ 99145, Moderate sedation services [other than those services described by codes 00100-01999] provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status ...) performed in conjunction with procedures in Appendix G or other packaged services such as pulse oximetry (94760 □ 94761, Noninvasive ear or pulse oximetry for oxygen saturation ...)
- IV starts to facilitate infusion services (36000, Introduction of needle or intracatheter, vein).

Steer Clear of Non-reportable 'B' Codes

Status Indicator "B" stands for the "Non-reportable" codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).

Exception: Status Indicator B codes might be paid by intermediaries, however, when submitted on a different bill (such as 75x [CORF]). An alternate code for the 'Non-reportable' services may be available.

Example: You'll find an example of non-reportable services with alternate coding with unilateral magnetic resonance imaging (MRI) of the breast, without and/or with contrast material(s). For Medicare, you would report HCPCS codes C8903-C8905 instead of 77058 in order to distinguish whether contrast was used.

Don't Expect OPPS Payment for 'E' Status

A Status Indicator of "E" means the code is "Non-covered." These codes are not reimbursable under OPPS but are separately billable. Document the service in the "Noncovered" column of your UB-04 form. These non-covered items or services expected to be paid by the patient, so don't require Medicare denial before you bill the patient.

Examples: Some common non-covered services include:

- Self-administered drugs (e.g., acetaminophen/codeine tab with HCPCS A9270GY and UB-04 revenue code 0637)
- Autopsies (88000-88099)
- Acupuncture (97810-97814)
- Specimen handling (99000-99001)

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- Visual acuity screen (99173).

Get Paid for R, U and Sometimes C

Status Indicators R (Blood and blood product) and U (Brachytherapy) are fairly new status indicators, which became effective January 1, 2009. These are payable under OPPS. Inpatient procedures (SI "C") are naturally not payable under OPPS. However, on the rare occasion such a procedure is performed on an outpatient who expires prior to inpatient admission, you can bill the procedure under OPPS. It has to be reported with modifier -CA (Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission) and discharge status code 20 (Patient expired). (Medicare PM A-02-129).

The CA modifier is allowed when all of the following conditions are met:

- the status of the patient is outpatient;
- the patient has an emergent, life-threatening condition;
- a procedure on the inpatient only list is performed on an emergency basis (either in the emergency room or the operating room) to resuscitate or stabilize the patient); and
- the patient dies without being admitted as an inpatient.Also, refer to the Integrated OCE (IOCE) CMS Specifications V15. 0 - Effective 01/01/2014 (http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/IntegOCEspecsV150_508.pdf).

Bottom line: Individual payers determine which procedures and codes they'll reimburse in certain situations, but don't forget to check the OPPS schedule for additional details. By getting familiar with the alphabetic characters of Status Indicators, you'll get a fair idea up front of whether your physicians' procedures are payable under OPPS.