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ISSUE PAPER — EDITS AND BILLING ISSUES

State of Connecticut Hospital Payment Modernization (HPM)

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Overview

To support the modernization of hospital payments in the State of Connecticut, the Connecticut Department of Social Services (DSS) will be implementing ambulatory payment classification (APC) grouper software to process outpatient hospital claims. Prior to APC implementation, a detailed data analysis of historical outpatient claims data was performed to support the development of the APC conversion factor. The outpatient claims analysis also provided important insights regarding any data issues that should be addressed prior to APC implementation. Potential data issues were identified by running outpatient claims data through the APC grouper and reviewing the resulting edit codes. The process used for performing this analysis and the development of the resulting Edits and Billing Issues Report are detailed in this paper.

Discussion

Base Data

Outpatient claims data with dates of services from May 1, 2014 through December 31, 2014 paid through April 10, 2015 was used to develop the APC conversion factor. The first date of service was chosen to coincide with the requirement by DSS that outpatient claims include valid procedure codes. An analysis of this data set was performed prior to developing the APC conversion factor.

The outpatient claims data set, prior to policy exclusions, contained:

- 5,625,199 claim details
- $444,907,158 in total payments

Policy Exclusions

DSS has determined that certain services referred to as policy exclusions will be excluded from the APC payment methodology. The initial policy exclusions were removed from the claims data prior to processing the claims through the APC grouper software and creating the Edits and Billing Issues Report. Additional policy exclusions were identified after this process was complete and the report created. See the APC Policy Exclusions issue paper for a complete list of all services excluded from the APC payment methodology.

The following table provides a list of those services that are not included in the Edits and Billing Issues Report:

Services Not Included in Edits and Billing Issues Report

Revenue Center Code (RCC)	Description
960+	Professional Services
42x	Physical Therapy
43x	Occupational Therapy
44x	Speech Therapy
771	Vaccine Administration
907	Extended Day
905, 906, 913	Partial Hospitalization

APC Grouping Process — Three-Month Sample Claims Data Set

A three-month sample data set of outpatient claims with dates of services from May 1, 2014 through July 31, 2014 was first utilized to aid in the identification of potential data issues.

After the services identified by the RCCs in the above table were removed from the sample claims data, the sample data set was processed using the 2014 APC grouper. Claim details that were rejected by the 2014 grouper were then processed through the 2013 grouper to address the rejections that were due to outdated coding practices. Claim details that were rejected by both the 2013 and 2014 APC groupers were then summarized by the outpatient code editor (OCE) edit code assigned and reviewed to determine if a reasonable coding fix could be identified.

Data Handling

Using the 2013 and 2014 APC grouper output for the three-month sample outpatient claims data, each edit code that was present was categorized as follows:

- Fix — Edits for which there was a reasonable data fix identified.
- Ignore — Edits that could be ignored.
- Remove — Edits for which there was not a reasonable fix and could not be ignored, and would be removed from the analytical data set.

The thoughtful review of the claim details and edit codes allowed for a number of data fixes to be identified and applied to the analytical data set. These fixes more accurately reflected future coding practices, and enabled the claim details to successfully process through the APC grouper software. This approach was in line with one of the guiding principles of the HPM project to “use the best available data for system development”.

APC Grouping Process — Analytical Claims Data Set

Before the analytical claims data set was processed by the 2014 grouper, the excluded services identified by the RCCs in the above table were removed. Initially, no modifications were made to the data in order to establish a baseline and also to identify any new edit code failures. Based on the initial run through the 2014 APC grouper, approximately 53% of line items had at least one edit.

Next, all claim details categorized as “Fix” were adjusted as described in the Edits and Billing Issues Report and rerun through the 2014 APC grouper software several more times to resolve as many edits as possible. Some claim details were still rejected by the grouper software even after the data fix was applied. Additionally, some new detail line failures occurred, particularly in instances where a header level edit was corrected and subsequent processing occurred and resulted in new detail line failures. After the data fixes were applied and as many edits resolved as possible, approximately five percent (5%) of line items still had an edit. Depending on the nature of the edit failure, the claim detail was either removed or remained in the analytical data set. The handling of each edit is described in the “Data Handling” column of the Edits and Billing Issues Report.

Proposed Provider Billing Changes

Another guiding principle of the HPM project is to “modify billing practices and requirements, as necessary, to provide accurate payment and robust analytics”. To this end, recommendations were made for billing practices to ensure that claims will process appropriately under the APC methodology. These recommendations are listed in the “Proposed Provider Billing Changes” column of the Edits and Billing Issues Report.

Edits and Billing Issues Report

The Edits and Billing Issues Report lists all edits that were assigned by the grouper OCE in the analytical data set and also provides a count of detail lines by edit code after data fixes were applied to claim details in the “Fix” category.

The following table provides a brief explanation of the fields provided in this report:

Edits and Billing Issues Report Field Descriptions

Field	Description
Edit Code	Edit code assigned to the claim line by the OCE
Edit Description	Description of the edit code assigned by the OCE
Category	Edit codes were categorized as “Fix”, “Ignore”, or “Remove”
Claim Issue	Explanation of issue underlying the assigned edit code
Data Handling	Explanation of how data was handled for the corresponding edit code
Proposed Provider Billing Changes	Explanation of how providers should modify billing practices to improve payment accuracy
Detail Lines	Count of detail lines for which the corresponding edit code was still assigned after data fixes (if any) were applied

Conclusion

The claims grouping, edit analysis and data handling process described in this report resulted in two important outcomes for the HPM project. The first was a solid analytical data set to support the development of the APC conversion factor. As stated above, after the initial 2014 grouping,

approximately 53% of all line details had at least one edit. This was reduced to approximately 5% of all line details with at least one edit by applying the data fixes. Secondly, this process provided insight into current billing practices which will guide many of the required billing changes for the outpatient providers for APC processing.

The results of this process are summarized in the Edits and Billing Issues Report included as Attachment A.

Summary of Edits and Billing Issues

Claim set: May 1, 2014–December 31, 2014

Edit Code	Edit Description	Category	Claim Issue	Data Handling	Proposed Provider Billing Changes	Detail Lines
0006	OCE — Invalid procedure code.	Remove	Invalid procedure code.	Removed entire claim from fiscal impact modeling.	Review State of Connecticut (CT) Addendum B to confirm what services are covered.	1,024
0009	OCE — Service not covered by Medicare but may be covered by other payers.	Ignore	Procedure is not a payable APC procedure. All line items have a status indicator of E.	All line items with this edit assigned a Not APC Payable Status Indicator. Edit ignored.	Review CT Addendum B to confirm what services are covered.	33,715
0012	OCE — Service not always covered by Medicare. Claim suspended for medical review.	Ignore	Several HCPCS are causing the edit. Most of these line items are assigned a SI T with a few N. Two of the most common are remove intrauterine device and abortion.	All line items with this edit assigned an APC Payable Status Indicator. Overrode suspense disposition and allowed claim to process based on APC assignment.	No billing change required. Edit will not be applied and claim will process based on CT Addendum B.	796
0017	OCE — Inappropriate specification of bilateral procedure.	Remove	For any claim, a HCPCS that is considered inherently bilateral has been reported multiple times, based upon occurrences or units of service, on the same date of service without modifier -76 (Repeat procedure or service same physician) or modifier -77 (Repeat procedure or service by another physician) reported on the additional units/lines.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to bilateral codes.	817
0018	OCE — Service considered an inpatient procedure for Medicare patients.	Remove	Procedure is not a payable APC procedure. All line items are a status indicator of C.	Removed entire claim from fiscal impact modeling.	Review CT Addendum B to confirm what services are covered.	167
0020	OCE — NCCI Edit — Code 2 of a code pair with 'XXXXX' that is not allowed even if an appropriate CMS National Correct Coding Initiative (NCCI) modifier is present.	Remove	For the same date of service, a HCPCS code pair has been reported that should not be reported together. The code pairs are defined by the OPPS code set of the NCCI. This edit will be triggered on 'Code 2' of the code pair regardless of any modifier that may be reported. Note: code 81002 is seen the most frequently.	Removed claim detail with 'Code 2' of the code pair. After secondary grouping, edit ignored.	Require providers to follow Medicare billing requirements related to NCCI limitations.	6,893
0021	OCE — Medical visit on same day as a type T or S procedure without modifier -25 (significant separate E&M service).	Fix	A clinic or emergency department visit (Status Indicator V) has been reported, without a modifier -25, on the same date of service as a significant procedure (Status Indicator S or T).	Added modifier 25 to all line items and sent the modified claim through the grouper. After secondary grouping, any line item with an APC Payable Status Indicator that still had an edit was moved to the Excluded table. Otherwise, edit ignored.	Require providers to follow Medicare billing requirements related to E & M codes.	907
0027	OCE — Only incidental services reported.	Fix	Only incidental services reported.	Added modifier L1 to all line items and sent the modified claim through the grouper. After secondary grouping, any line item with an APC Payable Status Indicator that still had an edit was moved to the Excluded table. Otherwise, edit ignored.	Require providers to follow Medicare billing requirements related to lab services.	9,391
0028	OCE — Code not recognized by Medicare.	Fix	Procedure is not a payable APC procedure. Primarily the procedure codes were behavioral health, pharmacy, E & M codes and lab codes.	Assigned the appropriate E & M codes and sent the modified claim through the grouper. After secondary grouping, edit ignored.	Require providers to follow Medicare billing requirements related to E & M codes.	32,467
0040	OCE — NCCI Edit — Code 2 of a code pair with 'XXXXX' that would be allowed if an appropriate NCCI modifier were present.	Fix	For the same date of service, a HCPCS code pair has been reported that should not be reported together. The code pairs are defined by the OPPS code set of the NCCI. A valid NCCI modifier will suppress this edit and should be used if the documentation supports it.	Added modifier 59 to all line items. After secondary grouping, edit ignored.	Require providers to follow Medicare billing requirements related to NCCI limitations.	27,533
0041	OCE — Revenue Code "XXXX" is invalid.	Ignore	Revenue code billed was invalid.	Edit ignored.	Require providers to follow CT billing guidelines for Revenue Codes.	1
0042	OCE — Multiple medical visits with the same revenue code on the same day are not paid without condition code G0.	Remove	Multiple clinic or emergency department visits (Status Indicator V) have been reported on the same date of service with the same revenue code and condition code G0 is not present.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to E & M codes.	22,040

Summary of Edits and Billing Issues

Claim set: May 1, 2014–December 31, 2014

Edit Code	Edit Description	Category	Claim Issue	Data Handling	Proposed Provider Billing Changes	Detail Lines
0043	OCE — Transfusion or blood product exchange without specification of blood product.	Remove	A HCPCS that CMS has identified as a blood transfusion or exchange has been reported and a HCPCS that CMS has identified as a blood product has not been reported. The transfusion/exchange and the blood product do not have to be on the same date of service.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to blood and blood products.	59
0044	OCE — Observation revenue code on line item with non-observation HCPCS code.	Remove	The revenue code for observation services, 0762, has been reported with a HCPCS that is not one that CMS has identified as observation. It is acceptable for the HCPCS associated with revenue code 0762 to be blank. If so, this edit will not be triggered.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to observations.	21
0045	OCE — Inpatient separate procedures not paid when accompanied by another type T procedure.	Remove	All inpatient procedures (Status Indicator C) for the same date of service have been identified by CMS as separate procedures and there is at least one significant procedure to which discounting applies (Status Indicator T HCPCS code) on the same date of service.	Removed entire claim from fiscal impact modeling.	Review CT Addendum B to confirm what services are covered.	3
0047	OCE — Incidental procedure not separately reimbursed.	Fix	All the line items reported have either been denied, rejected or packaged. This is a line item edit whereas 0027 is a header edit.	Added modifier L1 to all line items and sent the modified claim through the grouper. After secondary grouping, any line item with an APC Payable Status Indicator that still had an edit was moved to the Excluded table. Otherwise, edit ignored.	Require providers to follow Medicare billing requirements, related to packaged services, particularly laboratory services.	39,209
0048	OCE — Revenue Code "XXXX" requires HCPCS code on same line.	Fix	HCPCS code was blank on a claim detail where the RCC requires a HCPCS.	If RCC = 274, 470, 471, 510, 634, or 722 then moved line item to Excluded table. If RCC = 636 or 637 then moved to APC Payable table and change Status Indicator to "N".	Follow CT Medicaid guidelines related to RCC procedure code billing.	116,172
0049	OCE — Service provided same day as an inpatient procedure.	Remove	When edit 0018 is triggered, edit 0049 is applied to all other line items on the same date of service. There is one line on each claim that has status indicator C. Medicare recognizes this as an inpatient claim and won't pay any other lines as outpatient.	Removed entire claim from fiscal impact modeling.	Review CT Addendum B to confirm what services are covered.	1,770
0050	OCE — Procedure is on statutory exclusion list and not covered under any Medicare outpatient benefit.	Ignore	Procedure is not a payable APC procedure.	All line items with this edit were assigned a Not APC Payable Status Indicator. Edit ignored.	Review CT Addendum B to confirm what services are covered.	652
0053	OCE — Codes G0378 and G0379 only allowed with bill type 13X or 85X.	Remove	Claim had a bill type not equal to 13x.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to bill type.	1
0058	OCE — G0379 only allowed with G0378.	Fix	G0379 is only allowed with G0378. G0379 indicates to Medicare that the patient arrived as a direct admit, but it does not count as the first hour. G0378 tells Medicare how long the patient stayed in observation.	Added a new line with G0378 and sent the modified claim through the grouper. After secondary grouping any APC Payable line item that still had an edit was moved to the Excluded table. Otherwise, edit ignored.	Require providers to follow Medicare billing requirements related to observations.	-
0061	OCE — This code can only be billed to the DMERC.	Ignore	Procedure is not a payable APC procedure.	All line items with this edit were assigned a Not APC Payable Status Indicator. Edit ignored.	Review CT Addendum B to confirm what services are covered.	8
0062	OCE — Code not recognized by OPPS; alternate code for same service may be available.	Fix	Procedure is not a payable APC procedure.	Replaced incorrect codes with appropriate alternate codes. After secondary grouping, edit ignored.	Require providers to follow Medicare billing requirements for emergency department, Clinic, and Observation visits in an outpatient setting.	2,550
0066	OCE — Code requires manual pricing.	Ignore	HCPCS C9399 has been reported. C9399 should be used to report a drug or biological that has received FDA approval but has not been assigned a product-specific HCPCS code.	All line items with this edit were assigned a Not APC Payable Status Indicator. Edit ignored.	DSS currently developing recommendation.	295

Summary of Edits and Billing Issues

Claim set: May 1, 2014–December 31, 2014

Edit Code	Edit Description	Category	Claim Issue	Data Handling	Proposed Provider Billing Changes	Detail Lines
0071	OCE — Claim lacks required device code 'XXXXX' (with 'YYYYY').	Remove	A procedure that requires the use of a device has been reported and the appropriate device code has not been reported. This edit is not elicited when modifier -52, -73, or -74 has been reported to indicate that the procedure was discontinued. In some instances, there may be more than one device code required.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to devices and their use.	606
0072	OCE — 'XXXXX' not billable to the Fiscal Intermediary/Medicare Administrative Contractor.	Ignore	Procedure is not a payable APC procedure.	All line items with this edit were assigned a Not APC Payable Status Indicator. Edit ignored.	Require providers to follow Medicare billing requirements.	14,129
0073	OCE — Incorrect billing of blood and blood products.	Remove	Identifies claims where HCPCS that CMS has identified as blood/blood products have been reported and corresponding revenue code is not 038X or 039X, or modifier -BL has not been used appropriately, or the sum of the units of service for revenue code 038X lines and the sum of the units of service for 039X lines are not equal.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to blood and blood products.	1
0074	OCE — Units of service greater than one is inappropriate for bilateral procedure reported with modifier 50.	Fix	A HCPCS that CMS has identified as being conditionally bilateral or independently bilateral has been reported with modifier -50 and with more than one unit of service on the same line.	Changed the number of allowed units to equal 1.	Require providers to follow Medicare billing requirements related to units of service.	-
0076	OCE — Trauma response critical care code without revenue code 068X and CPT 99291.	Remove	Additional line with revenue code 68X and HCPCS 99291 needs to be coded.	Removed the line with revenue code 68X and HCPCS G0390. After secondary grouping, edit ignored.	Require providers to follow Medicare billing requirements related to trauma billing.	106
0077	OCE — Claim lacks allowed procedure code 'XXXXX'.	Remove	A procedure that requires the use of a device has been reported and the appropriate device code has not been reported. This edit is not elicited when modifier -52, -73, or -74 has been reported to indicate that the procedure was discontinued. In some instances, there may be more than one device code required.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to devices and their use.	22
0082	OCE — Charge exceeds token charge ($1.01).	Remove	Identifies a radiolabeled product provided during a hospital inpatient stay that is reported with line charges greater than $1.01.	Removed entire claim from fiscal impact modeling.	DSS currently developing recommendation.	2
0084	OCE — Claim lacks required primary code.	Remove	An add-on HCPCS code is reported without a required primary HCPCS code on the same day.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to add-on codes.	1
0087	OCE — Skin substitute application procedure without appropriate skin substitute product code.	Remove	No skin substitute product is coded with the skin substitute procedure.	Removed entire claim from fiscal impact modeling.	Require providers to follow Medicare billing requirements related to skin substitution.	51