

Important Outpatient Prospective Payment System (OPPS) APC – ASC

3rd Quarter (July) 2014 Update Information

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The Michigan Department of Community Health (MDCH) issues a timed release schedule of the annual/quarterly specific to software changes for Optum (our MDCH software vendor). Optum and the OPPS Team members closely monitor the CMS site impacting updates. Work immediately begins reviewing policy impacts for coverage of Medicaid service(s) once CMS releases the files for any changes or updated files, (i.e., Integrated Outpatient Code Editor (I/OCE) Specifications, HCPCS, etc.).

The OPPS Team meeting was held June 5, 2014, initiating review of the 3<sup>rd</sup> quarter OPPS (APC and ASC) updates. DCH anticipates a timely release of DCH specific files pending CMS release of the most current files.

A timeline is required for Optum to develop the MI specific software version specific to each OPPS update (including any retro changes), perform quality control, internal development and testing period. An additional 6–8 weeks is required for internal program updates, quality assurance checks, and regression testing. MDCH allows time and consideration for additional CMS changes following the initial CMS release of the quarterly updates. The Optum software programming is separate and distinct from CHAMPS unit acceptance testing (UAT).

Once Optum has developed the MI APC specific software, the product is delivered to CNSI and scheduled as part of a maintenance release. MDCH works directly with Optum during development, however Optum needs adequate time to modify the MI specific APC product and complete internal control steps/development testing with each release. MDCH's OPPS is a Michigan (Medicaid) specific software product, aligning as closely as possible with Medicare.

MDCH's OPPS requires time for modification to be a MI Specific APC and ASC product. The second quarter updates were implemented, June 11, 2014. MDCH will recycle any OPH/APC and ASC claims impacted as a result of the second quarter updates.

OPPS/APC and ASC Wrap Around Code Lists are revised to reflect quarterly updates as well as system updates, and posted timely to the provider specific sites.

### **MEDICARE 2% SEQUESTRATION**

The 2% Sequestration remains in effect through FY 2024 (pending any further congressional intervention). Potential impacts (hospital specific) resulting from CY 14 changes to the OP E&M clinic level visits may be considered by the volume of claims/services, outpatient procedure volumes and/or individual specialized outpatient hospital departments, and changes related to package/bundling.

There potentially will be no direct impact on the state with the Medicare announcement continuation in applying the sequestration cuts. DCH (L-Letter 13-19 [May 2013] on the provider website), noted this logic happens after the original processing of the claim.

MDCH will continue to monitor closely to determine if any adjustments are required and will respond timely with an OPPS reduction factor adjustment to maintain statewide budget neutrality.

**OPPS I/OCE EDITS and MUE's** are reviewed with the quarterly process and updated with the I/OCE. Refer to CMS Change Request (CR) 8776 and CR 8764 for the most current information.

**3<sup>rd</sup> QUARTER SUMMARY OF CHANGES:** The exceptions are posted to the MDCH OPPS APC and ASC Wrap Around Code Lists. These are available on the DCH provider specific website.

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**CHANGES to DEVICE EDITS JULY 2014:** Refer to the Device and Procedure Edits at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS> for a complete list.

**BILLING LAB TESTS FOR SEPARATE PAYMENT**

CMS provided new billing guidance for billing OP clinical diagnostic laboratory test for separate payment. They released information in an OPPS update Transmittal 2971 and Transmittal 2957 for dates of service (DOS) on/after July 1, 2014, officially announcing the new L1 modifier for use for separate payment.

DCH providers will not be required to rebill the first and second quarter DOS - however will be required to follow the new billing instructions effective for DOS on/after July 1, 2014. DCH mass adjusted and timely initiated, and mass resurrected claims for denied/ungroupable(s) following the January 2014 software system updates. DCH will adjust any claims submitted with the new L1 modifier with DOS on/after July 1, 2014 impacted prior to the third quarter OPPS/APC update installation.

Transmittal 2971 – and Modifier L1: separately payable labs should be billed on TOB 13X and with modifier L1. OPHs may bill non-patient labs on TOB 14X consistent with the NUBC definition of this bill type.

Modifier L1 is to be used with lab services **only** in either of these two scenarios:

- When the hospital collects the specimen and only provides lab services on that date of service; or
- When the hospital provides outpatient lab services and they are clinically unrelated to other hospital outpatient services furnished on the same day.

Unrelated means: “the lab test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.”

If the definition is met, the lab test is eligible to be billed using modifier L1 to trigger separate payment. If the definition is not met, the lab test is not eligible, and the lab payment would be packaged into another separately payable service.

**REMINDER: CPT 36415:** collection of venous blood by venipuncture is considered a lab service. Previously under OPPS, this code was assigned status indicator A (paid under fee schedule or payment system other than OPPS) and was reimbursed based on the laboratory fee schedule. As part of the bundling of clinical laboratory services in CY 2014, the status indicator for CPT 36415 was changed to N (items and services packaged into APC rates).

CPT 36415 billed on a 13x bill type, the payment for the venipuncture - will be bundled into the main service(s) along with the lab tests. Providers should monitor - you receive reimbursement when billing lab services, including the venipuncture, on a 14x bill type.

**CARRIER PRICED LAB CODES – SEPARATE POSTING OPPS APC WRAP AROUND CODE LIST**

Medicare’s payment policy for laboratory services is, generally, based on fee schedules. Each carrier jurisdiction has its own fee schedule. DCH has identified a list of approximately 100 carrier priced lab codes and is posting an amended OPPS APC Wrap List implemented second quarter, with retro effective DOS on/after 1/01/2014, and updated to reflect DOS on/after January 1, 2014. This list will be reviewed quarterly and revised PRN.

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**OPPS/THERAPY REIMBURSEMENT**

For the Medicare Therapy Reimbursement logic, providers may access the Medicare physician fee (MPFS) schedule on the CMS website: <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>. Providers may also reference and find helpful the Multiple Procedure Payment Reduction (MP under MDCH's OPPS Outpatient Hospital claims billed appropriately with therapy services are reimbursed using the MPFS and the MPPR and then apply the applicable MDCH OPPS reduction factor.)

**OPPS REFERENCE DOCUMENTS THIRD QUARTER – MDCH Provider Specific website:**

January 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)  
CR #8572 (MM8572)

July 2014 Integrated Outpatient Code Editor (I/OCE) Specifications Version 15.2 CR#8764 8776

Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing CR#8572  
(MM8572) SE1412

Coding Requirements for Laboratory Collection Update CR#8339

July 2014 Update of the Ambulatory Surgical Center (ASC) Payment System CR#R2770CP  
Implementing Part B Inpatient Payment Policies CMS 1599-F CR#R182BP

Proper Use of Modifier 59 CR SE 1418 Revised

3<sup>rd</sup> Quarter 2014 OPPS APC Wrap List (July 1 – September 30, 2014)

Carrier Priced Lab Codes – OPPS APC Wrap Around Code List (Jan 1, 2014)