

Important Outpatient Prospective Payment System (OPPS) APC – ASC

1st Quarter (January) 2014 Update Information

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

The 2014 Centers for Medicare and Medicaid (CMS) Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code review bulletin process is included with the 1st Quarter (January 1 - March 31) OPPS updates. Meetings are held as the OPPS Team initiates the quarterly update process. A conference call was held with Optum on December 16, 2013, initiating review 1st quarter OPPS (APC and ASC) updates. A follow up conference call will be coordinated with Optum for the CMS anticipated timely release of the most current files (estimate 1/14/2014).

A timeline is required for Optum to develop the MI specific software version specific to each OPPS update (including any retro changes), to perform quality control, internal development and testing period. An additional six to eight weeks is required for internal program updates, quality assurance checks, and regression testing. MDCH includes 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. MDCH will recycle any OPH/APC and any ASC claims impacted as a result of the first quarter updates.

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

There were revisions, additions, and deletions addressed during the 1st quarter updates.

NCCI and MUE

MDCH implemented the Medicaid NCCI and MUE in the MI APC/ASC products and began using the Medicaid NCCI and MUE values for dates of service (DOS) on and after July 1, 2013. The Medicaid NCCI and MUE values are reviewed with the quarterly file review and updates.

OPPS – REDUCTION FACTOR (RF)

MDCH monitors OPPS and ASC claims for statewide budget-neutrality. In November 2013 CMS finalized changes to the Calendar Year (CY) 2014 Medicare OPPS system.

Policy bulletin MSA 06-47 states that MDCH may adjust its RF to maintain expenditures within appropriate levels if Medicare implements a general rate increase. Additionally, MDCH reserves the right to adjust the OPPS RF if budget concerns are evident and changing significantly prior to the end of the State's fiscal year (MSA 07-12).

MDCH issued bulletin MSA 13-49 on December 2, 2013, as policy promulgation conducted concurrently with implementation of the change in order to maintain current statewide budget neutrality of the Medicaid

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OPPS and ASC RF, to be adjusted from **54.3% to 53.4%** effective for **dates of services (DOS) on or after January 1, 2014**. MSA 13-49 is available on the MDCH bulletin website.

MEDICARE 2% SEQUESTRATION

This remains currently in effect through federal FY 2021 and/or unless Congress intervenes. MDCH continues to monitor closely. Potential impacts as a result of changes (collapsed into one code) to the Outpatient Patient (OP) Evaluation and Management (E&M) clinic level visits may be noted by the volume of claims/services, outpatient procedure volumes and/or individual specialized outpatient hospital departments.

CMS-1601-F HOSPITAL OPPS AND AMBULATORY SURGICAL CENTER PAYMENT SYSTEMS AND QUALITY REPORTING PROGRAMS (FINAL RULE CHANGES)

Department of Health and Human Services - CMS

CMS issued the final CY 2014 Hospital OPPS and ASC Payment Policy changes and Payment Rates final rule with comment period [CMS-1601-FC] November 27, 2013.

The final rule updates payment policies and rates for hospital outpatient department and ASC services, streamlining programs and encouraging delivery of high-quality care in the applicable outpatient setting that is consistent with policies included in the Affordable Care Act (ACA).

The final rule with comment period expands the categories of services and related items packaged into a single payment for a primary service to make OPPS more of a prospective payment system. CMS proposed expanding an additional seven categories for CY 2014 however did not finalize the proposal. The comment period/final rule expands categories of packaged services and items with five additional categories, indicative of moving OPPS closer to a PPS system and less like a fee schedule. CMS had proposed creating 29 comprehensive APCs to replace 29 existing device-dependent APCs and deferred this to CY 2015.

MDCH's OPPS aligns as closely as possible to Medicare's OPPS for APCs and ASCs. The exceptions are posted to the MDCH OPPS APC and ASC Wrap Around Code Lists. These are available on the MDCH provider specific site.

SIGNIFICANT CHANGES

Op Clinic Visits

CMS collapsed the OP clinic visit levels into one code (G0463 "Hospital outpatient clinic visit for assessment and management of a patient"). CMS did not make any changes to the ED level visits and will continue to pay for ED visits at five levels. They noted this only delays any changes to ED codes and may revisit after additional study.

New Composite APC – Extended Assessment and Management (EAM) Visit APC

There is a new composite APC for Extended Assessment and Management (EAM), replacing two APCs that paid for EAM. The EAM composite pays for certain visits followed by eight hours of observation if no surgery code is reported. This is assigned APC 8009, replacing APCs 8002 and 8003.

All of the following qualifies for payment (when billed appropriately) if furnished by an OP hospital in conjunction with observation services of substantial duration under this APC: Clinic visits, Level 4 or Level 5 Type A ED visit, Level 5 Type B ED visit.

New Categories of Services and Supporting Items: Expanded Five Categories of Items and Services

1. Drugs, Biologicals, and Radiopharmaceuticals That Function as Supplies When Used in a Diagnostic Test or Procedure
2. Drugs and Biologicals That Function as Supplies or Devices When Used in a Surgical Procedure
3. Clinical Diagnostic Laboratory Tests
4. Procedures Described by Add-On Codes
5. Device Removal Procedures

CMS did not package ancillary services (i.e., such as x-rays) - a separate payment will still be made for these items. Ancillary Services are Status Indicator (SI) "X".

CMS did not package Diagnostic Tests on the Bypass List (CMS did remove seven codes from the list in the final rule). HCPCS Codes Removed from CY 2014 Bypass List is noted in the final rule and includes those affected by CY 2014 OPPS packaging policy noted under Diagnostic Tests on the Bypass List.

CMS implemented packaging of other add-on codes, and did not finalize packaging of the drug administration add-on codes so subsequent drug administration codes will continue to be paid separately in addition to the initial service. Add-on codes are services/procedures always rendered in addition to a primary procedure. CPT describes add-on codes. CPT add-on codes are listed in Appendix D of the CPT codebook. Add-on codes may also be Level II HCPCS codes. Additional information is available in the final rule: Procedures Described by Add-on Codes.

Clinical Diagnostic Lab Tests

CMS will consider a lab test(s) under the new packaging rule and will continue to be paid separately at Clinical Lab Fee Schedule (CLFS – MI) rates when billed appropriately.

CMS implemented packaging of most clinical diagnostic laboratory services. HCPCS codes/services packaged for CY 2014 are in both Addendum B and Addendum P in the final rule. CMS OPPS will still pay a laboratory service separately if it is the only service provided on that day, or if it is provided on the day of another service but is unrelated to the other service and ordered by a different practitioner. In these cases, OP hospitals are instructed to bill these laboratory tests with bill type (TOB) 14X, which is normally used for reference laboratory tests where the hospital receives a sample but does not see the patient.

Lab Test Will Not Be Packaged When

1. Lab test is the only service provided to beneficiaries on that DOS.
2. Test is rendered on the same date of service as the primary service but is ordered for a different purpose than the primary service by a different practitioner.

Molecular pathology tests are excluded from packaging (CPT codes 81200-81383, 81400-81408, and 81479)

CMS deferred implementation of comprehensive APCs until 2015 that would have created DRG-like packages for many major outpatient surgical procedures. They noted their intention to continue moving forward with implementing these more "comprehensive" packages.

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CMS finalized proposal to establish 29 new comprehensive APCs to replace 29 existing device-dependent APCs. Implementation is delayed until January 1, 2015.

Proposals are interim final; comments are due to CMS by January 27, 2014

The following categories are included in the comprehensive APCs: Otherwise Packaged Services and Supplies; Adjunctive Services; DMEPOS; OPD Services Reported by Therapy Codes and Hospital-Administered Drugs

New Cost To Charge Ratios: CCRs

CMS finalized new CCRs for Cardiac catheterization, CT Scans and MRI, and finalized continued use of distinct CCR for implantable medical devices (first used in 2013).

Skin Substitutes

Skin substitute(s) costs vary. CMS grouped these items into “high-cost” and “low-cost” groups. Providers may refer to Table 13 in the final rule that identifies each item as high or low cost. Effective DOS on/after January 1, 2014, skin substitutes designated as high cost will be reported with the CPT codes for skin substitute application (15271–15278), packaged, and listed in Addendum P to the final rule. Skin substitutes designated as low cost will be reported with new C-codes C5271–C5278, packaged and listed in Addendum B to the final rule. New C-codes have the same description as the CPT codes with the designation of “low-cost” skin substitutes.

CMS also implemented claims processing edits ensuring that high-cost skin substitutes are reported with the CPT codes and low-cost skin substitutes are reported with the HCPCS Level II C-codes. Guidelines require that any skin substitutes receiving pass-through payment should be reported with the CPT codes. Skin substitute products assigned SI/N CY 2014 is in Addendum P and HCPCS codes for surgical application of low cost.

Radiation Therapy

CMS final rule decision outcome is there is no longer a payment differential for robotic versus non-robotic stereotactic radiosurgery (SRS). They reassigned CPT code 77371 to APC 0067; replaced HCPCS code G0173 with CPT code 77372 and assigned the code to APC 0067; replacing HCPCS codes G0251, G0339, and G0340 with CPT code 77373, and assigning to APC 0066. This may potential note a decrease in reimbursement for SBRT.

Direct Supervision Requirement

CY 2014 all hospitals are expected to be in compliance with the direct supervision requirements to be eligible for Medicare reimbursement, requiring hospitals ensure that a physician or qualified non-physician provider provides direct supervision of outpatient therapeutic services (including chemotherapy administration and radiation therapy).

In 2010, CMS issued clarification and many hospitals hired additional physicians or advanced practice providers to guarantee that a qualified clinician was available to supervise care (i.e., infusion and radiation therapy centers).

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Therapy Services

The Medicare Physician Fee Schedule (MPFS) is used to reimburse Therapy services. Please refer to the CY 2014 MPFS final rule (CMS-1600-F) to review Medicare's policies on application of the therapy caps and related provisions under section 1833(g) of the Act to physical therapy (PT), speech-language pathology (SLP) and occupational therapy (OT) ("therapy") services that are furnished by a CAH, effective January 1, 2014.

The Medicare outpatient PT, OT, and SLP (therapy services) coverage requirements, are described in the CFR at 42 CFR 484.4; provided by a physician, qualified non-physician practitioner (NPP), therapist, or an assistant supervised by a therapist. Therapy services have the AR or AT pay status (on OPPS claims). Under MDCH's OPPS, providers may refer to the Medicare coverage policies found in the CMS manuals.

For the Medicare Therapy Reimbursement logic, providers may access the MPFS 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.

Partial Hospitalization Program (PHP) Rates

Each year CMS updates the payment rates for PHP services. CY 2014 finalized updates to the two payment rates for community mental health centers and for hospital-based PHPs. There are no impacts and/or required system processing logic changes for MDCH's OPPS.

I/OCE EDITS: There are no I/OCE edit changes CY 2014 – 1st Quarter implementation review.

AMBULATORY SURGERY CENTER (ASC)

MDCH's OPPS ASC aligns with Medicare's OPPS ASC with applying the RF adjustment. The final rule updated payment rates and policies for ASCs. MDCH's OPPS aligns as closely as possible to Medicare's OPPS for ASCs. The exceptions are posted to the MDCH OPPS ASC Wrap Around Code Lists.

REFERENCE DOCUMENTS

MDCH Provider Specific Website or MDCH Provider site, or CMS Website

MSA 13-54 All Providers Healthcare Common Procedure Coding System (HCPCS) Code Updates

CMS Change Request 8548 January 2014 Integrated Outpatient Code Editor (I/OCE) Specifications Version 15.0

MSA 13-49 – OPPS: Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Reduction Factor (RF) update

MDCH's OPPS APC Wrap Around Code List – (Jan. 1 – March 31 2014): Provider Specific Site

MDCH's OPPS ASC Wrap Around Code List – (Jan. 1 – March 31, 2014): Provider Specific Site

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MDCH OPPS Reduction Factor History: Provider Specific Site(s)

OPPS Addenda: CMS Website: <http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>

Physician Therapy: Medicare Physician Fee Schedule (MPFS) on the CMS website: <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

Copy of the final rule Federal Register (FR) and other resources related to OPPS on the CMS website:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1601-FC-.html>