Michigan Department of Community Health (MMDCH)

Important Outpatient Prospective Payment System (OPPS) APC – ASC

1st Quarter (January) 2015 Update Information

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 2015 (CMS) HCPCS/CPT code review bulletin process is included with the January OPPS updates. The OPPS Team meetings are held as the OPPS Team initiates the quarterly update process. A conference call was held with Optum (MDCH FFS software vendor) December 22, 2014, initiating review of the joint 1st quarter OPPS (APC and ASC) updates. A second call is anticipated timely upon CMS release of the most current files (estimate 1/14/2015).

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 includes time and consideration for additional CMS changes following the initial CMS release of the quarterly updates. The Optum software programing 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 APC and ASC claims for statewide budget-neutrality. In November 2014, CMS finalized changes to the Calendar Year 2015 Medicare OPPS system.

Policy (MSA 06-47) states that MDCH *may* adjust its RF to maintain expenditures within appropriated levels *if* Medicare implements a general rate increase. MDCH also 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 14-51 provided notification MDCH is adjusting the Medicaid OPPS and ASC reduction factor (RF) from **53.4% to 52.3% effective for dates of services (DOS) on or after January 1, 2015,** to maintain current statewide budget neutrality**.** Providers may refer to the RF Outpatient Prospective Payment System and Ambulatory Surgical Center Reduction Factor bulletin available on the MDCH policy bulletin website.

MEDICARE 2% SEQUESTRATION

The sequestration remains currently in effect through FFY 2021 and/or unless Congress intervenes with MDCH closely monitoring.

Additional Information: OPPS 1613 FC CY 2015 *Federal Register* page reference not available:

The final rule does not specifically address the 2 percent sequester reductions to all lines of Medicare payments authorized by the Budget Control Act (BCA) of 2011 and currently in effect through federal fiscal year (FY) 2021, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments. Other Medicare payment lines such as graduate medical education (GME), bad debt, and EHR incentives are also affected by the sequester reductions.

CMS 1613 – OPPS FINAL RULE CY 2015: SIGNIFICANT CHANGES

- Comprehensive APCs
- Procedure/Device editing changes
- Possible increased packaging for imaging services
- Possible outlier changes

APC Changes – Major Areas Reflecting CHANGES

- Cardiovascular and vascular services: Cardiac telemetry
- Gastrointestinal (GI) services: Upper GI procedures
- Genitourinary services
- Nervous System services
- Ocular services: Ophthalmic procedures and services
- Radiology oncology
- Respiratory services: Level II endoscopy lower airway
- Other services

MDCH's OPPS is aligning with the Medicare OPPS CY 2015 changes with few exceptions. The exceptions are posted to the MDCH OPPS APC and ASC Wrap Around Code Lists. These are available on the MDCH provider specific site.

OUTLIER PAYMENTS

- CY 2015 fixed-dollar threshold reduced to $2,775
- CY 2015 multiplier threshold remains 1.75

Updates for drugs, biologicals and radiopharmaceuticals:

- Packaging threshold increased to $95.00

DATA COLLECTION REQUIREMENTS – HOSPITAL CLAIMS (PROVIDER-BASED DEPARTMENT) [PBD]

- Voluntary reporting starting with date of service (DOS) on and after 1/01/2015
- Mandatory reporting starting DOS on/after 1/01/2016
- HCPCS modifier "PO"
- Report the modifier with every code/service(s) rendered in a PBD

PACKAGING: 2014 Expanded – 2,594 codes unconditionally packaged

CY 2015

- Ancillary services that currently pay separately *will not in 2015* when they are rendered on the *same date of service* as a procedure or visit
- Elimination of Status Indicator (SI) "X" (ancillary services)

CY 2015 assigned to:

- Q1 (conditionally packaged STV-packaged codes)
- S (significant procedure, not discounted when multiple)

Impact:
January 1, 2014 = 2,609 codes with SI N & Q1
January I, 2015 = 3,376 codes with SI N & Q1
Add-on codes assigned to device-dependent APCs CY 2014 are packaged in CY 2015
Comprehensive APC's
Add on codes included in the "bundled payment"

COMPREHENSIVE APCs

CMS is transitioning from the fee-based pricing towards increased bundling of services. CMS first proposed Comprehensive APCs in the 2009 federal regulations, and delayed implementation in 2014. The 2015 OPPS final rule implemented the Comprehensive APCs.

Comprehensive APCs – Complexity adjustment. The new category of codes has a single claim payment. Through the OCE logic, the PRICER automatically assigns payment. For multiple unrelated device-dependent services on the same claim, only the highest comprehensive payment is made.

New Status Indicator J1: Identified by a new status indicator J1, the single payment for a primary service and payment for all adjunctive services reported on the same claims will be packaged into payment for the primary service.

New Status Indicator J1: Addendum J: 25 Comprehensive APCs with 12 clinical families; as follows
AICPD = Automatic Implantable Cardiac Defibrillators, Pacemakers & Related Devices

CLINICAL FAMILIES
BREAS = Breast Surgery
ENTXX = ENT Procedures
EPHYS = Cardiac Electrophysiology
EYEXX = Ophthalmic Surgery
GIXX = Gastrointestinal Procedures
NSTIM = Neurostimulators
ORTHO = Orthopedic Surgery
PUMPS = Implantable Drug Delivery Systems
RADTX = Radiation Oncology
UROGN = Urogenital Procedures
VASCX = Vascular Procedures

Hierarchy: If there is more than one code with SI/J1, Highest ranked C-APC, Higher severity = Higher payment, Complexity Adjustment.

Exclusions: Status Indicator F services, Preventive services, Bracytherapy services, pass-through drugs, biologicals and devices separately payable.

NEW CMS COST TO CHARGE RATIOS: **CCRs**

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

New Device Pass through category: one new device pass-through category.

DCH Provider CCR – (OPPS) Provider Specific Site OPH Facilities Fee Screens

OUTPATIENT (MDCH) CCR's – posted to the Provider Specific Website – Outpatient Hospital Fee Screenshttp://www.michigan.gov

INTEGRATED/OUTPATIENT CODE EDITOR – (I/OCE) DEVICE CODE EDITS

Elimination of OCE Edits 71 & 77:
O CE 071 Claim lacks required device for this procedure
OCE 077: Claim lacks insertion procedure for this device

NEW OCE Edit 092 – providers will be required to report any medical device C code listed among the device codes, rather than a particular device C code to meet the requirement for reporting a device-dependent procedure for APCs. CMS will implement additional changes to ensure only correct claims receive edits for these services.

SKIN SUBSTITUTE PROCEDURE EDITS

Payment for skin substitute products that do not qualify for pass-through status will be packaged into payment for the associated skin substitute application procedure. CMS implemented an OPPS edit that requires hospitals to report all high-cost skin substitute products in combination with one of the skin application procedures and to report all low-cost skin substitute products in combination with one of the skin application procedures. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by the specific CPT codes (CPT 15271 – 15278) in the final rule.

Pass-through payments expire for 9 drugs on 12/13/2014.

BILLING FOR "SOMETIMES THERAPY" SERVICES that MAY BE PAID as NON THERAPY SERVICES for HOSPITAL OUTPATIENTS

A list of therapy codes, along with their respective designation, is found on the CMS website, at http://cms.hhs.gov/TherapyServices.

Providers may also reference and find helpful the Multiple Procedure Payment Reduction (MP under 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.)

For 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.

REFERENCE DOCUMENTS

MDCH Provider site or CMS Website
MSA 14-62 All Providers Healthcare Common Procedure Coding System (HCPCS) Code Updates

MSA 14-51 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, 2015): Provider Specific Site

MDCH's OPPS ASC Wrap Around Code List – (Jan. 1 – March 31, 2015): Provider Specific Site

MDCH's OPPS Carrier Priced Lab List: OPH; Provider Specific Site Reviewed with no change January 2015.

MM 9014 I OCE January 2015 Integrated Outpatient Code Editor (I/OCE) Specifications Version 16.0

CMS Transmittal 3150 January 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)

CMS Transmittal R3163CP January 2015 Update of the Ambulatory Surgical Center (ASC) Payment System

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

CMS Transmittal MM9014 January 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS) Effective January 1, 2015

CMS Transmittal R3044CP Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 21.0, Effective January 1, 2015

OUTPATIENT (MDCH) CCR's **–** Provider Specific Website – Outpatient Hospital Fee Screens at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-151012--,00.html

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 and the Addendum is available at:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-andNotices-Items/CMS-1613-FC.html