

Important Outpatient Prospective Payment System (OPPS) APC – ASC

2nd Quarter (April) 2014 Update Information

MDCH issues a timed release schedule of the annual/quarterly specific software changes for Optum (the 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.).

Meetings are held as the OPPS team initiates the quarterly update process. A conference call was held with Optum March 19, 2014, initiating review of the 2nd quarter OPPS (APC and ASC) updates. MDCH anticipates a timely release of MDCH 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 scheduled as part of a CHAMPS 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 first quarter updates were implemented February 22, 2014. MDCH will recycle any OPH/APC and 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.

MEDICARE 2% SEQUESTRATION

The Senate voted on the bill restoring cuts impacting the recent CMS announcement: the 2% Sequestration remains in effect through FY 2021 (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 packaged/bundling.

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

MDCH will continue to monitor this to determine if Medicare will blend the 2% sequestration reduction into their rate, and respond timely with an OPPS reduction factor adjustment to maintain statewide budget neutrality.

CMS 1601 – FINAL RULE: REVIEW

MDCH's OPPS aligned with the Medicare OPPS CY 2014 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. CMS recently provided new billing guidance for billing OP clinical diagnostic laboratory tests for separate payment effective for DOS on/after 7/01/2014. CMS implemented a new

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policy under CY 2014 retro to 1/01/2014, following the National Uniform Billing Committee (NUBC) recommendations for appropriate billing of Type of Bill (TOB) 014X Non Patient. Packaged payment would apply to all lab tests (other than molecular pathology) billed by OPPS hospitals on a TOB 013X hospital outpatient. CMS provided very limited exceptions to the packaging policy and advising OPH use TOB 014X (Hospital Non Patient) obtain separate payment for:

- Non Patient (referred) specimen
- Hospital collects specimen and furnishes only the OP labs on a given DOS; or hospital conducts OP lab test(s) clinically **unrelated to other hospital OP service(s)** on same DOS.
- “Unrelated” means the lab test is ordered by a different practitioner than the practitioner who order the other OP hospital service(s), and for a different diagnosis.
- CY 14 a new modifier will be used for TOB 013X (instead of the TOB 014X) when non-referred lab tests are eligible when billed appropriately for reimbursement. The new modifier will be effective for claims received on or after 7/01/2014 and retroactive DOS on or after 1/01/2014. CMS noted this will alleviate NUBC and OP Hospitals billing concerns.
- Please reference CMS Change Request (CR) 8572 January Update of the Hospital Outpatient Prospective Payment System (OPPS) **and** subsequent follow up information published recently in Change Request SE 1412 Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing.

There is no identified need to claim adjust any 1st or 2nd quarter claims impacted with the CMS billing instruction. MDCH continues to align with CMS, implementing the revision effective for DOS on/after 7/01/2014 - and will process claims submitted with the new modifier – when it is available. MDCH reviewed potential claim(s) impact, and the OPPS OCE will continue to process TOB 014X appropriately (reimbursement logic) aligning with the change(s). There is no significant impact identified.

MDCH providers who submitted claims during 1st and 2nd quarters with lab service(s) are not required to void/cancel or claim adjust your lab claims. MDCH aligned with CY14 TOB 014X and has reviewed there are no policy related changes – this impacts the billing instruction.

OP CLINIC VISITS – REMINDER – NEW CLINIC VISIT CODE G0463

Effective DOS on/after 1/01/2014, **OP clinic visits CPT 99201-99205 and CPT 99211-99215** are no longer available under the OPPS. CMS collapsed the OP clinic visit levels into one code (G0463). Hospitals **must** appropriately report HCPCS/CPT G0463 (hospital outpatient clinic visit for assessment and management of a patient) for OPH clinic services regardless of the visit level.

HCPCS G0463 has been added to the visits appropriate for combining with observation service hours to trigger the Extended Assessment and Management (EAM) Composite APC (8009).

If you submitted your claims after DOS 1/01/2014 using one of the end dated OP clinic visit CPT codes, **you may (void/cancel) and resubmit the claim using the new code G0463** for timely reprocessing if billed appropriately for services rendered.

CMS did not make any changes to the ED level visits and will continue to pay for ED visits at five levels. CMS noted this only delays recommended changes to ED codes and may revisit after additional study.

MDCH's OPPS aligns with these changes.

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NEW COMPOSITE APC – EXTENDED ASSESSMENT AND MANAGEMENT (EAM) VISITS 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.

NEW: 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.

They 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.

CLINICAL DIAGNOSTIC LAB TESTS

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

CMS implemented packaging of most clinical diagnostic laboratory services (refer to the new Addendum P). CMS OPSS 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.

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

It is the hospital's responsibility to determine when a lab test may be separately billed on a TOB 14X under limited expectations.

Refer MLN SE 1412 for services billed on/after 7/01/2014. CMS will provide a new modifier (to be released soon) for claims that qualified for separate bill (retroactive DOS on/after 1/01/2014).

Interim policy: NUBC approved OP Hospitals may continue to bill using TOB 014X and may continue to use TOB 121 for this scenario, may continue with CR 8572 until further notice and/or follow guideline CMS provided in MLN SE 1421 (applies to CAH's and Sole Community Hospitals – all MDCH enrolled OPSS providers).

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OPHs that appropriately bill TOB 13X with packaged and non-packaged lab services - the non-packaged lab service(s) will be reimbursed/pay as pay status AL (separately), and the packaged lab service(s) will be reimbursed/pay as pay status indicator N.

Providers will not be required to re-bill the first and second quarter DOS, however, will be required to follow the new billing instructions effective DOS on/after July 1, 2014 (watch for new modifier). MDCH will mass adjust and will timely initiate and mass resurrect claims for denied/ungroupable(s) following the January 2014 software system updates.

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. MDCH has identified a list of approximately 100 carrier priced lab codes and is posting an amended OPPS APC Wrap Around List implemented 2nd quarter, retro effective DOS on/after 1/01/2014 and updated to reflect DOS on/after January 1, 2014. This will be reviewed quarterly and revised PRN.

THERAPY SERVICES

Direct Supervision Requirement

CY 2014 all hospitals are expected to be in compliance with the direct supervision requirements to be eligible for Medicare reimbursement. This requires that hospitals ensure 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 have had to hire additional physicians or advanced practice providers to ensure that a qualified clinician was available to supervise care (i.e., infusion and radiation therapy centers).

Senate passes bill to extend direct supervision enforcement – 2/11/2014

The U.S. Senate approved legislation ([S. 1954](#)) that would extend through 2014 the enforcement moratorium for CAHs and rural OPPS with 100 or fewer beds on the OP therapy “direct supervision” policy. If approved, SB 1954 would allow more time for additional legislation that would adopt a default standard of “general supervision” for OP therapeutic services. MDCH will continue to monitor the important legislation although there are no exceptions to how providers are reimbursed under MDCH's OPPS; this remains a potential access to care concern.

The Medicare outpatient physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) (therapy services) coverage requirements, are described in the Code of Federal Regulations (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.

Therapy Reimbursement

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

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pathology (SLP) and occupational therapy (OT) (“therapy”) services that are furnished by a CAH, effective January 1, 2014.

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.

CANCER HOSPITALS

CMS applies PCR for 2014 for OP services for interim monthly payments and an adjustment was made for OP services provided DOS on/after 1/01/2014. This does not apply to MDCH enrolled providers. Chapter 4 section 10.6.4.

OPPS OUTLIER AMOUNTS

MDCH - there was no change in the multiple threshold of 1.75 for CY 2014 (CR 8572)

One Device is eligible for pass-through payment in OPPS Pricer logic – HCPCS code C1841 (MDCH NC)

Changes to Prices Logic: Payment and Copayment Logic – MDCH outlier payment

Changes to Pricer Logic Payment and eligible for pass-through payment off set radiopharmaceuticals (CR 8572).

OPPS I/OCE EDITS

CMS decided to inactivate 6 Pairs of codes effective 01/01/2014. This change will go into the April file. **Retro to 1/01/2014.** This impacts the I/OCE edit changes for the 2nd Quarter following review.

DOS on/after 4/01/2014 retro to 1/01/2014. Column 1 Code	Column 1 CPT Code Descriptor	Column 2 Code	Column 2 CPT Code Descriptor
19282	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)	19281	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance

Michigan Department of Community Health (MDCH)

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19284	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	19283	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance
19286	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	19285	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance
19288	Placement of breast localization device(s) (e.g. clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)	19287	Placement of breast localization device(s) (e.g. clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance
37237	Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extra cranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)	37236	Trans catheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery

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DOS on/after 4/01/2014 retro to 1/01/2014. Column 1 Code	Column 1 CPT Code Descriptor	Column 2 Code	Column 2 CPT Code Descriptor
37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)	37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein

OPPS REFERENCE DOCUMENTS – SECOND QUARTER – AVAILABLE ON MDCH PROVIDER SPECIFIC WEBSITE

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

April 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS) CR#8653 (MM8653)
Revised

April 2014 Integrated Outpatient Code Editor (I/OCE) Specifications Version 15.1 CR# 8658 (MM8658)
Revised

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

April 2014 Update of the Ambulatory Surgical Center (ASC) Payment System CR#8675 (MM8675)

1st and 2nd Quarter 2014 OPPS APC Wrap List (April 1 – June 30, 2014)

1st and 2nd Quarter 2014 OPPS ASC Wrap List (April 1 – June 30, 2014)

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