

Important Outpatient Prospective Payment System (OPPS) APC – ASC

1st Quarter (January) 2016 Update Information

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The Michigan Department of Health and Human Services (MDHHS) issues a timed release schedule of the annual/quarterly specific to software changes for Optum (our MDHHS 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 2016 (CMS) HCPCS/CPT code review bulletin process is included with the January OPPS updates. The Outpatient Prospective Payment System (OPPS) Team meetings are held as the OPPS Team initiates the quarterly update process. A conference call was held with Optum on December 15, 2015, initiating review of the joint 1<sup>st</sup> quarter OPPS (APC and ASC) updates. A second call is anticipated timely upon 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. MDHHS 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. MDHHS 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. MDHHS's OPPS is a Michigan (Medicaid) specific software product, aligning as closely as possible with Medicare.

MDHHS's OPPS requires time for modification to be a MI Specific APC and ASC product. MDHHS 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 1<sup>st</sup> quarter updates.

**NCCI and MUE:** MDHHS 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.

Providers should be careful when reporting multiple services with Status Indicator (SI) J1 on the same claim because NCCI logic may result in no payment for any of the reported comprehensive APC (C-APC) services. Usually when multiple J1 procedures/services are reported on the same claim, the procedure with the highest rank is assigned to the C-APC. Certain code combinations of J1 services will also lead to a complexity adjustment to a higher-paying C-APC.

**OPPS – REDUCTION FACTOR (RF):** MDHHS monitors OPPS (APC) and Ambulatory Surgical Center (ASC) claims for statewide budget-neutrality. In November 2015, the Centers for Medicare and Medicaid Services (CMS) finalized changes to the Calendar Year 2016 Medicare OPPS system.

Policy (MSA 06-47) states that MDHHS *may* adjust its RF to maintain expenditures within appropriated levels *if* Medicare implements a general rate increase. MDHHS 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.

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MSA 15-58 provided notification MDHHS was adjusting the Medicaid OPPS and ASC reduction factor (RF) from 52.3% to **52.5%** effective for dates of services (DOS) on or after January 1, 2016, with the final 52.5% RF implemented in order to maintain current statewide budget neutrality. **MSA 15-58 is replaced with policy bulletin MSA 16-03 that provided notification MDHHS is adjusting the OPPS and ASC RF from 52.3% to 52.6% effective for DOS on or after January 1, 2016.** Providers may refer to the RF Outpatient Prospective Payment System and Ambulatory Surgical Center Reduction Factor bulletin available on the MDHHS bulletin website.

**MEDICARE 2% SEQUESTRATION:** The sequestration remains currently in effect through federal fiscal year (FFY) 2025 and/or unless Congress intervenes with MDHHS closely monitoring. Additional Information: OPPS 1613 FC CY 2015 *Federal Register* page reference not available:

The final rule does not specifically address the two percent sequester reductions to all lines of Medicare payments authorized by the Budget Control Act (BCA) of 2011 and currently in effect through FFY 2021. The sequester will continue unless Congress intervenes, and remains in effect. 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.

**PROVIDER INFORMATION REGARDING CMS 1633 FC:** Published in the Federal Register on November 13, 2015: MDHHS aligns with the changes and any non-covered service will be published on the appropriate OPPS Wrap Around Code List.

**TWO MIDNIGHT RULE:** CMS Finalized (CMS-1633-FC 10/30/2015) 2016: In the CY 2016 OPPS final rule, CMS maintains the benchmark established by the original Two Midnight rule, but permits greater flexibility for determining when an admission that does not meet the benchmark should nonetheless be payable under Part A on a case-by-case basis. This discusses a shift in enforcement of the Two Midnight Rule from MACs to Quality Improvement Organizations (QIOs). This does not require a MDHHS policy change.

- MSA 14-36 ([http://www.michigan.gov/documents/mdch/MSA-14-36\\_475288\\_7.pdf](http://www.michigan.gov/documents/mdch/MSA-14-36_475288_7.pdf)), promulgated policy in response to the CMS Two-Midnight rule. MDHHS follows Medicare's observation care services coverage, claim submission, and reimbursement policies unless otherwise noted. As such, effective October 1, 2013, *MDHHS aligned with Medicare's policy for inpatient hospital admission determination by following the guidelines prescribed by CMS in the Two-Midnight Rule for beneficiaries where Medicaid is the primary payer.* This includes alignment with any current or future CMS implementation timelines, delays or changes associated with the Two-Midnight Rule, unless otherwise specified. When Medicaid is not the primary payer, providers must follow the rules of the primary insurance.

MDHHS adopted Medicare's two midnight rule for FFS MI Medicaid therefore MDHHS (Medicaid) aligns/adopts the CMS two-midnight change, starting with the **10/01/2015** review of medical appropriateness on IPH admissions for short inpatient stays. Under this new process, which **began October 1, 2015**, Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) *review the medical appropriateness of the inpatient admission for short inpatient stays.* Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) will no longer conduct the initial medical reviews of providers that submit short stay inpatient admissions. Claims (reviewed by the QIO) that are out of compliance with the Two-Midnight rule and similar criteria will be referred to the MACs for payment adjustments.

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- If additional information is needed, please refer to:  
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html>
- <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-3.html>

**January 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS):** MDHHS's OPPS is aligning with the Medicare OPPS CY 2016 changes with few exceptions. The exceptions are posted to the MDHHS OPPS APC and ASC Wrap Around Code Lists available on the MDHHS provider specific site.

Providers are advised to refer to the Final Copy 1633 OPPS; refer to the CMS January 2016 OPPS APC and ASC documents for additional detail of the following:

- Device Offset Payment For New Device: HCPCS C1822 should always be billed with CPT 63685 for APC/ASC's.
- HCPCS C1820 description change (to appropriately differentiate between HCPCS C1820 & C1822).
- Device Edit for Procedures Assigned to Device-Intensive APCs/ASCs. CMS did not reinstate the device-to-procedure edits for all procedures that use a device however expects to see the appropriate and correct device code reported on a claim (even without the edits). CMS continues to refine device-to-procedure edits. To trigger an edit (2016) the procedure must be assigned to a device-intensive APC and requires implantation of a device.
- Removal device portion from procedures assigned to a device-intensive APC and that are discontinued before administration of anesthesia.
- Transitional Pass-Through Payments Designated Devices
- Eligible Services for New Technology APC Assignment and Payments
- New Brachytherapy Source Payment: C2645
- CMS did not change the logic for comprehensive APC's: 2016 added 10 new C-APCs in addition to the 25 established for 2015.
- Comprehensive Observation Services C-APC (APC 8011) replaces extended assessment and management (EAM) composite (APC 8009). CMS created a new Status Indicator (J2) to identify combinations of services, when done in combination with each other and reported on OPH claim, would allow all other OPPS payable services and items reported on the claim as adjunctive services representing components of a comprehensive service and resulting in a single prospective payment under C-APC 8011 for comprehensive service based on the costs of all reported services on the claim. The C-APC 8011 rate (without RF application) is higher than the EAM composite APC payment, however providers are reminded that no other services are paid separately under the C-APC logic.
- Billing Instructions for IMRT Planning
- Billing for Stereotactic Radiosurgery (SRS) Planning and Delivery
- Billing Instructions for Corneal Tissue
- Revisions to Laboratory Test Packaging
- Three New HCPCS Codes for Pathogen-Reduced Blood Products
- Drugs, Biologicals, and Radiopharmaceuticals: new CY 2016 HCPCS, other changes to HCPCS and CPT Codes
- Skin Substitute Procedure Edits

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- APCs restructured for nine clinical families:
  - Airway endoscopy procedures
  - Cardiovascular procedures and services
  - Diagnostic tests and related services
  - Eye surgery and other eye-related procedures
  - Gastrointestinal procedures
  - Gynecologic procedures and services
  - Incision and drainage and excision/biopsy procedures
  - Imaging-related procedures
  - Orthopedic procedures

**CA MODIFIER:** If an “inpatient only” service is provided but the patient expires before inpatient admission or transfer to another hospital and the hospital reports the “inpatient-only” service with Modifier CA, then a single payment for all services reported on the claim, including the “inpatient-only” procedure (APC 5881)[Ancillary OP services when the patient dies] is applied. Hospitals should report Modifier CA on only one procedure.

**NEW MODIFIERS:** CMS requires three new modifiers to report

CP: C-APC adjunctive service

ZA: Novartis/Sandoz

CT: CT does not meet NEMA standards

- Effective January 1, 2016, Medicare requires that hospitals and suppliers use modifier CT on claims for CT scans described by applicable HCPCS codes that are furnished on non NEMA Standard XR-29-2013-compliant equipment. Applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes). The use of this modifier will result in a payment reduction of five percent in CY 2016 for the applicable CT services when the service is paid separately. The five percent payment reduction will also be applied to the APC payment for the HCPCS codes listed above that are subject to the multiple imaging composite policy. This includes procedures assigned to the two APCs (8005 and 8006) in the CT and Computed Tomographic Angiography (CTA) imaging family.

Each facility must identify how to operationalize the new modifiers.

**OUTLIER PAYMENTS:** CY 2016 fixed-dollar threshold reduced to \$3,250; 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]:** Mandatory reporting starting DOS on/after 1/1/2016.

- HCPCS modifier “PO.”
- Report the modifier with every code/service(s) rendered in a Provider-based department (PBD) [services, procedures and/or surgeries furnished at an off-campus PB outpatient department].
- Hospital-owned urgent care centers are subject to modifier PO unless it is a type A or type B ED.
- Some Urgent Care Centers might be considered a type B Emergency Department and should review the requirements.

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- Some Urgent Care Centers are like physician offices, however treating patients at an urgent care level and potentially the provider-based requirements are applicable.

Providers may reference: Bipartisan Act of 2015: SEC. 603. *Treatment of New Off-Campus Outpatient Departments of a Provider*: MDHHS will continue to monitor CMS for further information.

- Section 603 would codify the CMS definition of PB off-campus hospital outpatient departments (HOPDs) as those locations that are *not on the main campus of a hospital and are located more than 250 yards from the main campus*. The section defines a “new” PBD HOPD as an entity that executed a CMS provider agreement [after the date of enactment]. Any PBD HOPD executing a provider agreement after the date of enactment would not be eligible for reimbursements from CMS’ Outpatient Prospective Payment System (PPS). New PBD HOPDs, as defined by this section, would be eligible for reimbursements from either the Ambulatory Surgical Center (ASC PPS) or the Medicare Physician Fee Schedule (PFS).

**CMS COST TO CHARGE RATIOS: CCRs:** CY 2016 CMS will continue to use the hospital-specific ancillary and departmental 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).

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

Reference: MDHHS’s OUTPATIENT Cost-to-Charge posted to the Provider Specific Website – Outpatient Hospital Fee Screens <http://www.michigan.gov/medicaidproviders> >> Billing and Reimbursement >> Provider Specific Information.

**SKIN SUBSTITUTE PROCEDURE EDITS:** CMS followed the same process for CY 16 as applied in CY 15. 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. CY 16 CMS identified two skin substitutes (HCPCS Q4121 and C9349) with pass-through payment.

**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 MDHHS OPPS reduction factor.

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>

**DURABLE MEDICAL EQUIPMENT (The Social Security Act for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings):** MDHHS is utilizing the DME urban rates (pricing logic). DME policy reviewed the CMS decision DME competitive fee rates supporting application of the urban file.

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**AMBULATORY SURGICAL CENTERS:**

- New Device Pass-Through Category and Device Offset for Payment: C1822; HCPCS C1822 device must always be billed with CPT 63685
- Modifier 73: when a surgical procedure is planned with planned anesthesia and terminated after the patient is taken to the room but prior to the administration of anesthesia: See MM 9297 for more detail.
- New Brachytherapy: C2645
- New Drugs, Biologicals, and Radiopharmaceuticals: C9458, C9459, C9460, J0714, J1575, J7188, J7340.

CMS adds 17 (existing codes) as new procedures to the ASC payable list: 0171T & 0172T posted to the OPPS ASC Wrap Around Code List: covered the following: CPT 37241-43; CPT 49406; CPT 57120; CPT 57310; CPT 58260; CPT 58262; CPT 58544; CPT 58553; CPT 5855; CPT 58573; CPT 63046; and CPT 63055

**REFERENCE DOCUMENTS: Michigan Medicaid Provider Site or CMS Website**

MSA 16-03: Outpatient Prospective Payment System and Ambulatory Surgical Center Reduction Factor Update

MSA 15-64: All Providers Healthcare Common Procedure Coding System (HCPCS) Code Updates

MSA15-58 OPPS: Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Reduction Factor (RF) update

MDHHS's OPPS APC Wrap Around Code List – (Jan. 1 – March 31, 2016): Provider Specific Site

MDHHS's OPPS ASC Wrap Around Code List – (Jan. 1 – March 31, 2016): Provider Specific Site

MDHHS's OPPS Carrier Priced Lab List: OPH; Provider Specific Site Reviewed; Added CPT 81528 Healthy MI Plan only; January 2016

Final Summary of Data Changes Integrated OCE v 17.0, effective January 1, 2016

CMS Transmittal 3425 Change Request 9486 January 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)

CMS Related Transmittal R3425CP Related Change Request CR9486 January 2016 Update of the Hospital Outpatient Prospective Payment System

CMS CR Transmittal #R3416CP Calendar Year (CY) 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

CMS Transmittal 1542 CR 9284 Implementation of Biosimilar Claim Modifiers

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

OUTPATIENT (MDHHS's) 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](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>

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

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The Addenda relating to the OPPS are available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>. The Addenda relating to the ASC payment system are available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html>.