Connecticut Medical Assistance Program
Policy Transmittal 2015-40

Provider Bulletin 2015-87
November 2015

Roderick L. Bremby, Commissioner

Effective Date: March 1, 2016
Contact: Colleen Johnson @ 860-424-5195

TO: General Acute Care Hospitals, Chronic Disease Hospitals, Children's Hospitals, Psychiatric Hospitals

RE: Outpatient Hospital Modernization – Outpatient Prospective Payment System (OPPS)

In accordance with section 17b-239 of the Connecticut General Statues, as amended, the Department of Social Services (DSS) is modernizing outpatient hospital reimbursement under the Connecticut Medical Assistance Program (CMAP) from the current model to an Outpatient Prospective Payment System (OPPS) similar to Medicare. CMAP OPPS utilizes both revenue center code (RCC) and procedure code information to determine reimbursement levels. Specifically, procedure code information will enable the complexity of the service performed to influence its level of reimbursement.

The goals of this conversion are:

1. administrative simplification for hospital providers and the Department, though aligning more closely with Medicare;
2. greater accuracy in matching reimbursement amounts to relative cost and complexity; and
3. equity and consistency of payments among providers, while maintaining access to quality care.

Outpatient hospital providers that will be affected by this change are general acute care hospitals, chronic disease hospitals, psychiatric hospitals and children's general hospitals. This change also applies to border and out-of-state hospitals. The Department anticipates that OPPS will be implemented on or about March 1, 2016.

GENERAL OVERVIEW

- Claims with dates of service prior to March 1, 2016 will be processed using the current payment methodology.
- Claims associated with dates of service March 1, 2016 or later will be processed using CMAP OPPS methodology.
- The Outpatient Code Editor (OCE) and National Correct Coding (NCCI) edits will be utilized as part of OPPS.
- The Department will be implementing Ambulatory Payment Classification (APC) grouper software to process the majority of outpatient hospital claims.
- Outpatient hospital services excluded from the APC grouper are described below.

PAYMENT METHODOLOGY

To facilitate coordination of reimbursement, CMAP OPPS will, as appropriate, follow Medicare's current OPPS coverage policies. In the event that there is a difference between CMAP's policies or regulations and Medicare policy, CMAP policy will prevail. Reimbursement under the CMAP OPPS system will be through one of the following payment methods:

- Ambulatory Payment Classification (APCs);
- fixed fee based on RCC; or
- fee schedule based on the Healthcare Common Procedural Coding System CPT/HCPCS

APC Payment

Procedure codes billed will be assigned an APC status indicator and an APC group using APC software. The APC group assigned is based on Medicare and takes into consideration services that are clinically similar and that generally require similar amounts of hospital resources.

While services will be billed individually, the grouper software may package services into a single payment for an APC. The payment is then determined by the relative weight assigned to the APC and the CMAP conversion factor. The

Department will use national relative weights and a Connecticut-specific conversion factor to calculate payment. Additionally, services paid via the APC methodology may be discounted or eligible for an outlier payment.

Within each APC, several services are packaged into the payment for the primary service. The cost of the packaged services are allocated to the APC but are not paid separately. Some examples of packaged items are:

- ancillary services;
- implantable medical devices;
- most clinical diagnostic laboratory tests; and
- recovery room use.

Fixed Fee based on RCC

Certain services will continue to be paid based on a fixed fee and will be excluded from the APC methodology. These services will be reimbursed based on revenue center codes. The outpatient services that will be excluded from the APC methodology, include, but are not limited to the following RCCs:

Services Paid by RCC	RCC
Physical Therapy	42X
Occupational Therapy	43X
Speech Therapy	44X
Tobacco Cessation-Group Counseling	953
Vaccine Administration	771
Intensive Outpatient Program	905, 906
Extended Day Treatment	907
Partial Hospitalization	913
Behavioral Health Treatment/Services	90X, 91X
CARES*	769

*Codes loaded only for qualified hospitals that currently provide these services.

Fee Schedule based on HCPCS

Most hospital services paid under OPPS will be processed by the APC grouper. If the service is identified by the APC grouper as not payable as a CMAP APC service, it may still be covered under CMAP. These procedures will be reimbursed based on a specific CMAP fee schedule. Payment amount and billing rules, including prior authorization (PA) and modifiers, will be determined according to the fee schedule to which the Healthcare Common Procedural Coding System (HCPCS) code is allocated.

Fee schedules can be accessed and downloaded from the Connecticut Medical Assistance Web site: www.ctdssmap.com. From this Web page, go to “Provider”, then to “Provider Fee Schedule Download”. Click the “I accept” button and proceed to click on the CSV for the applicable fee schedule and press the control key while clicking the CSV link, then select “Open”.

CMAP’s Addendum B and Status Indicators

Facilities paid under OPPS will utilize CMAP’s Addendum B to determine the method of payment for all outpatient services. The Department will maintain a file that lists each HCPCS and CPT code and the assigned status indicator. The status indicator is used to identify if a CPT or HCPCS code is a payable code and determines the method of payment. Please refer to CMAP’s draft Addendum B to determine which services will be paid based on fixed fee, fee schedule or APC assignment. CMAP’s draft Addendum B can be accessed via www.ctdssmap.com by selecting “Hospital Modernization” Web page.

A list of status indicators utilized by the Centers for Medicare and Medicaid Services (CMS) for Medicare can be located on the CMS website by going to www.cms.gov, and then selecting “Medicare”, then “Hospital Outpatient PPS”

under "Medicare Fee-for-Service Payment", then go to "Hospital Outpatient Regulations and Notices" and select CMS-1613-FC. Under related links, select "CY2015 OPPS Addenda", and then select "Accept" then "Open" and then select "Addendum D1".

NON-OPPS REIMBURSEMENT

Certain services provided in hospital outpatient departments are not reimbursed under OPPS methodology. Some of those services include:

- physician/practitioner services; and
- dental services.

Physician/Practitioner Services

Hospital outpatient services furnished by all physicians (MD or DO), advanced practice registered nurses (APRNs), physician assistants (PAs), certified nurse-midwives (CNMs) and podiatrists must be billed via professional claim forms and will be reimbursed outside of OPPS. All professional services will be reimbursed based on the fee schedule applicable to the practitioner's provider type. Practitioners and their associated groups must comply with all regulations, policies, billing requirements and procedures applicable to their provider type. Please note: not all professional services rendered will have a separately payable professional component.

All of the practitioners listed above who perform services in the hospital setting must either enroll in CMAP as billing providers or enroll as performing providers associated to an appropriate practitioner group. Please contact the Provider Assistance Center at 1-800-842-8440 for assistance with provider enrollment.

Routine Dental Services

Routine dental services are billed under a separate NPI or NPI/taxonomy combination from the general hospital outpatient provider number. Billing and reimbursement for routine dental services will not change from the current reimbursement methodology and will be reimbursed in accordance with the existing dental fee schedule.

ADDITIONAL CONSIDERATIONS

Three Day Rule

For inpatient hospital admissions on or after March 1, 2016, all diagnostic and non-diagnostic outpatient services provided by the hospital or an entity affiliated with the hospital by common ownership or control on the day of admission and two days prior to the day of admission are deemed related to the admission and must be billed as part of the inpatient stay. Exceptions to this are: maintenance renal dialysis, psychiatric evaluations, physical therapy, occupational therapy, speech therapy, and audiology services.

Exception processing is allowed if the hospital is able to attest that the specific services are unrelated to the inpatient hospital claim and are clinically distinct and independent from the reason of admission. Hospitals should bill Condition Code 51 "Attestation of Unrelated Outpatient Non-diagnostic Services" to identify those services that are unrelated, for which separate reimbursement is appropriate.

Please refer to Provider Bulletin 2015-82 *Three Day Rule: Outpatient Stay Prior to Inpatient Admission* for more information on the three day rule.

Prior Authorization

Prior Authorization (PA) will continue to be required for services specified by the Department. There will be no changes in prior authorization for behavioral health, radiology, lab, physical therapy, occupational therapy and speech pathology. The Department will publish additional guidance regarding PA requirements for services such as durable medical equipment (DME), drugs and skin substitute products.

Revenue Center Codes (RCC)

With the implementation of OPPS, hospitals will no longer need to complete and submit the Revenue Center Request Form (W-1504). All general acute care hospitals will have access to all appropriate payable RCCs, with limited

exceptions such as RCC 68X-*Trauma Response*, RCC 769-*CARES*, and RCC 907-*Extended Day Treatment.* Similarly, all psychiatric hospitals and chronic disease hospitals will have access to all appropriate payable RCCs as limited by their scopes of practice and Department policy. Please note: RCC exceptions are based on DSS policy and restrictions.

HOSPITAL MODERNIZATION

Comprehensive information on OPPS can be found at www.ctdssmap.com by selecting the "Hospital Modernization" Web page. This page will provide details regarding how payment information will be communicated, CMAP's version of Addendum B, FAQs, the Provider Type and Specialty to RCC Crosswalk, Provider Publications and Hospital Important Messages. Please refer to this page periodically for updates.

Further information is also available on the DSS Web site at www.ct.gov/dss by selecting "Programs & Services," then "Programs A to Z," then "Medicaid Hospital Reimbursement," then select "Reimbursement Modernization".

CMAP's Version of Addendum B - Feedback

The Department is requesting that hospitals review the draft version of CMAP's Addendum B, as well as the draft Provider Type and Specialty to RCC Crosswalk. Please send any comments or questions to the hospital modernization mailbox: ctxixhosppay@hpe.com.

REGULATIONS

The Department will adopt new outpatient hospital regulations to enable implementation of outpatient hospital modernization. Effective with implementation of outpatient hospital reimbursement modernization, the Department plans to implement binding policies and procedures pending adoption of the regulations pursuant to sections 17b-239 of the Connecticut General Statutes. Further information will be forthcoming. Existing regulations are posted on the CMAP Web site at www.ctdssmap.com, select "Information", then select "Publications", then select "Chapter 7" and choose the appropriate provider or subject.

Regulations and binding operational policies implemented in regulation form take precedence over all policy transmittals, provider bulletins, billing instructions, and other Department correspondence.

Posting Instructions: Policy transmittals can be downloaded from the Web site at www.ctdssmap.com

Distribution: This policy transmittal is being distributed by Hewlett Packard Enterprise to providers enrolled in the Connecticut Medical Assistance Program.

Responsible Unit: DSS, Division of Health Services, Medical Policy and Regulations, Colleen Johnson, Medical Policy at (860) 424-5195.

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