

## Outpatient Hospital Modernization FAQs

\*all red text is new for 04/27/2023

The following FAQs address general topics related to Connecticut Outpatient Hospital Modernization project.

1. What APC software version will be used on July 1, 2016?
  - A. DSS will be implementing 3M CMS OCE/APC v17.1 APC grouper software to process the majority of outpatient hospital claims. DSS plans to stay current with Medicare and update the system with January updates and also implement quarterly changes that are consistent with Connecticut Medical Assistance Program's (CMAP) regulations and policy. The specific timing of when the updates will be applied has not yet been finalized and will be dependent on factors such as the release date for the Medicare files.
2. Will there be a CT specific APC grouper software made available to the hospitals?
  - A. It is up to 3M to develop the software. The Department has given 3M the green light to create a CT version of the APC grouper. If the Hospitals are interested in 3M developing a CT version of the grouper, they should be contacting their 3M representative.
3. What type of outpatient hospitals will be affected by OPPS?
  - A. The outpatient hospital provider types that are affected by this change are general acute care hospitals, chronic disease hospitals, psychiatric hospitals and children's hospitals. This change will also impact border and out-of-state hospitals.
4. Will all outpatient services be reimbursed by APCs?
  - A. No. Reimbursement under the CT OPPS system could also be based on a fixed fee based on RCC or the applicable fee schedule for specific HCPCS codes.
5. Where can the hospital find more information on APC payment reimbursement?
  - A. Information on APC payment reimbursement can be found on the "Hospital Modernization" page on the Web site [www.ctdssmap.com](http://www.ctdssmap.com). Hospital reimbursement information is available on the DSS Web site at the [www.ct.gov/dss](http://www.ct.gov/dss) by selecting "Programs & Services", followed by "Programs A to Z", then "Medicaid Hospital Reimbursement", and finally "Reimbursement Modernization".
6. Where do I go if I have questions about the upcoming APC payment reimbursement implementation?
  - A. Questions can be directed to the [www.ctxixhosppay@gainwelltechnologies.com](mailto:www.ctxixhosppay@gainwelltechnologies.com) email box.

7. Will DSS cover Nutrition services? Nutrition codes were previously paying, as of July 1, 2016 they are denying. Medicare may cap at 1 or 2 services per year.

A. Yes. Hospital can bill clinic procedure code G0463. The professional component performed by a physician can be billed under applicable E/M. Registered dietician - no professional component can be billed, hospital can only bill for G0463.

8. Will DSS cover Diabetes education?

A. Yes. Diabetes education will follow same methodology as nutrition counseling - hospital can bill clinic code G0463 - the professional will bill off fee schedule or applicable E/M code only if it is done by a physician. Registered dietician - no professional component can be billed, hospital can only bill for G0463.

9. Will DSS cover Genetic Counseling?

A. Genetic Counseling is considered a professional service and will follow same methodology as nutrition counseling. The hospital should bill the clinic procedure code G0463 - and if genetic counseling is done physician, PA, APRN, certified nurse midwife the practitioner can bill the applicable E/M code on a professional claim.

10. How would a hospital bill for observation services that are over 48 hours, do we enter it in the not covered field?

A. Hospitals can bill more than 48 hours under procedure code G0378 and the hospital will not receive any additional allowance for over 48 hours. The hospital does not have to enter anything over 48 hours as not covered.

11. How would a hospital bill for observation services that are under 8 hours?

A. For observation services with less than eight hours, the outpatient hospital should bill with the following and reimbursement for observation will be dependent upon the status indicator (SI) for the other services billed. In some cases, depending on the SI, only the outpatient hospital clinic or emergency department visit will pay.

- HCPC for observation (G0378) with the corresponding units (units = hours in observation)
- The appropriate procedure code for the Type A or Type B ED visit, Outpatient Hospital Clinic visit or Critical Care

12. Dental surgeries are not covered under CMAP Addendum B. How can the hospital be reimbursed for dental services?

A. Dental procedures should be billed under the dental clinic AVRS ID. If the services are performed in the ASC setting of the hospital, the hospital can bill with CPT code 41899. Professional services should be billed based off the dental fee schedule.

13. How will APC affect Third party liability (TPL) claims?

A. TPL processing (non-Medicare claims) will not change. TPL claims will process as they currently do.

14. Which Revenue Center Codes (RCC) will be excluded from APC pricing?

A. The following RCCs will and pay based on a fixed fee.

Description	RCCs
Diagnosis Mammography	401
Screening Mammography	403
Physical Therapy	421, 424
Occupational Therapy	431, 434
Speech Therapy	441, 444
CARES	769
Vaccine Administration	771
Electro Shock	901
Tobacco Cessation - Group Counseling	953

B. The following RCCs will be pay based on the CT Clinic - Clinic and Outpatient Hospital Behavioral Health Fee Schedule.

Description	RCC	Billable CPT/HCPC
<b>Intensive Outpatient Program (IOP) - MH</b>	905	S9480
<b>Intensive Outpatient Program (IOP) - SA</b>	906	H0015
<b>Extended Day Treatment (EDT)</b>	907	H2012
<b>Partial Hospitalization Program (PHP)</b>	913	H0035
<b>Psych Treatment</b>	900	90791,90792 and 90785
<b>Individual Therapy</b>	914	90832-90838
<b>Group Therapy</b>	915	90853
<b>Family Therapy</b>	916	90846, 90847, 90849
<b>Other BH (Med Management)</b>	919	99201- 99205, 99211 - 99215
<b>Other BH (Autism)</b>	919	H0031, H0032, H2014, 0359T, H0046 and H0032 with modifier TS
<b>Psychiatric Testing</b>	918	96101, 96116, and 96118

15. For Physical, Occupational and Speech Therapies can the hospital use RCC 420, 430 and 440 instead of the specific RCC codes?

A. Outpatient hospital should only bill RCCs; 421 “Phys Therapy visit”, 424 “Phys Therapy Evaluation” or occupational therapy RCCs; 431 “Occup Therapy visit”, 434

“Occup Therapy Evaluation”, 441 “Speech Therapy visit”, and 444 “Speech Therapy Evaluation”.

B. RCC 420, 430 and 440 will still be accepted on a Medicare crossover claim.

16. Are the flat fees already adjusted for wage index?

A. No, the adjusted wage index does not apply to the RCC flat fees.

17. CMAP Addendum B is based on Medicare’s logic, is there a way to determine where DSS differs from this logic?

A. Yes. To determine which service Medicare pays and Medicaid does not, filter Addendum B the following way:

1. Under payment type select “NO” and under APC remove all the “Blanks.”

B. To determine when Medicaid differs from Medicare filter Addendum B the following ways:

1. When both Medicare and Medicaid reimburse a service, but the method of payment is different - under payment type select “FS, FS-CMAP L1, MP, PA and RCC.”

2. To determine when Medicaid pays and Medicare does not - under payment type select “FS, L1 MP and RCC” and under APC keep only the “Blanks.”

18. Who determines a “NO” payment type and is there a correlation to the status indicator?

A. DSS determines the procedures that are not covered by CT Medicaid and there is no correlation to the status indicator. It is strictly based on procedure code and the payment type “NO”.

19. Do the procedure codes with a payment type APC-PR get adjusted for our Wage index or is the rate listed in the CMAP Addendum B the rate the hospitals will be paid? Will these rates change to follow Medicare’s changes?

A. They are reimbursed based on the payment rate field in Addendum B. DSS plans to follow Medicare on any of their updates to this amount.

20. Will NCCI edits be applied?

A. Yes. To comply with federal legislation, DSS has adopted the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) standard payment edits.

21. Will Audiology services be paid based on the RCC code billed?

A. No. Audiology RCC codes are not excluded from APC processing and hospitals should refer to Addendum B to determine how audiology procedure codes will be processed.

22. Will hospitals need to request new RCC codes to their rate schedule?

A. No, with the implementation of OPPTS, hospitals will no longer need to complete and submit the Revenue Center Request Form (W-1504). All hospitals will have access to all appropriate payable RCCs, with limited exceptions such as RCC 68X-Trauma Response. Please refer to the Provider Type and Specialty to RCC Crosswalk to determine which RCC are payable for your scopes of practice as well as which RCC requires to be billed with a HCPC/CPT code. 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.

23. What is the purpose for changing the RCCs for Therapy services?

A. The purpose for the change is to have a more accurate description for therapy services provided.

24. Will there be any changes to the RCC rates for 2016?

A. No. At this time there are no planned rate changes for July 1, 2016.

25. When CMAP Addendum B states there is a payment type of Fee Schedule (FS) and an amount in the APC field, how are the hospitals to determine the correct payment?

A. The first step in determining payment is the payment type field. For services that are not paid under APC and we are pointing to a fee schedule it is only the payment type field that will determine the payment. If the payment type is FS, we will pay off of the CT fee schedule. In future version the APC amount will be removed when the service is not reimbursed via APC model.

26. Will the weights on CMAP Addendum B match Medicare for year 2015 and be updated to current status?

A. Yes. The weights will be updated to current 2016 status.

27. Will APC logic supersede previous communications on procedure codes that were previously not payable? Example: Procedure code 77063 currently not covered, but per CMAP Addendum B this is a payable code.

A. Yes. APC logic will take precedence over any previous provider communication (provider bulletins), hospitals should follow CMAP Addendum B.

28. Will DSS assign the same status indicators as Medicare?

A. Yes. The Status Indicators (SI) A through X will be assigned to all procedure codes. Status Indicators can be found on the CMS Website under Addendum D1. Refer to link below:

<https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1633-FC-2016-OPPS-FR->

[Addenda.zip](#). Then select “Accept” then “Open” and then select “2016 OPPS FR Addendum D1”.

29. Is DSS following Medicare's bundling policy for status indicator “N”?

A. DSS is following Medicare’s bundling process and policy. The few exceptions where a procedure code assigned a status indicator “N” that is not bundled are related to services excluded from APC’s such as Behavioral Health and vaccines or services not covered by DSS.

30. Will all modifiers be available for July 1, 2016?

A. Yes. Please refer to the provider manual chapter 8 “Hospital” for a list of modifiers.

31. Will DSS recognize services billed with Modifier 52?

A. Modifier 52 will only be recognized on BH claims: “For intermediate behavioral health services that qualify for partial day billing, the hospital should submit the appropriate RCC with one of the applicable HCPC/CPT codes and append modifier 52 - Reduced Services. The combination of the RCC, HCPC/CPT and modifier 52 on the claim will allow the claims system to reimburse 50% of the normal allowed amount for intermediate BH services. Please note: modifier 52 will only impact BH claims for partial day billing for intermediate care.

32. Will hospitals need to continue to submit a Medicare cost report to DSS?

A. Yes. Hospitals will still need to submit a Medicare cost report to DSS.

33. How should Observation services be billed if the observation services are over 23 hours for dates of service July 1, 2016 and forward?

A. Observation services will be reimbursed based on the Comprehensive Observation APC if observation exceeds 8 hours. The hours billed should reflect the hours of observation. Please refer to provider bulletin titled “Observation Guidelines” for additional information.

34. Should professional fees need to be billed on professional claim forms to receive separate payment outside of OPPS?

A. Yes. Professional fees, with some exceptions, should be billed via professional claim forms and will be reimbursed outside of OPPS. If the professional component is added to the hospital bill (RCC 96X, 97X and 98X), the detail will deny as outpatient professional fees are excluded from APC pricing and are reimbursed separately.

B. Behavioral health professional fees are included in the behavioral health outpatient rate and should not be billed separately. The exception to this are professional services related to RCC 901 (ECT) and Emergency department services consultations.

35. What fee schedules will be used for Behavioral Health Services?

- A. The majority of Behavioral Health outpatient services will be paid according to the fees on the BH Clinic-Outpatient fee schedule. Specific rate types have been designated for Outpatient Mental Health, Outpatient Enhanced Care Clinic and Outpatient Chronic Disease. The Electroshock Treatment and Tobacco Cessation group Counseling will use the Outpatient Hospital fee schedule.

36. Will ATP lab codes continue to pay at the ATP fee on the laboratory fee schedule?

- A. Yes. If the laboratory services is payable and is not packaged will continue to price at the ATP rate on the laboratory fee schedule.

37. How will lab services be paid?

- A. The approach to payment of lab services is similar to Medicare's payment methodology, differing only when coverage is different. That is, in most cases the APC status indicator will dictate the payment method. This includes the newest status indicator value of Q4, which designates whether services are packaged or paid based on the lab fee schedule used to price lab services provided to non-patients. Please see CMAP Addendum B for specific lab code information.

38. How will Medicaid determine which procedures are considered inpatient?

- A. Medicaid will follow Medicare guidelines on what services are consider an inpatient procedures. Inpatient claims can be identified using CMAP Addendum B and filter by status indicator C "Inpatient Procedure." Hospital can also refer to Addendum E on the [www.cms.gov](http://www.cms.gov) Web site for a list of procedure codes that are considered an inpatient procedure.
- B. DSS has made changes to some procedure codes on CMAP's Addendum B that were considered an inpatient only procedure. Previously, these services had a payment type of "NO" and were not covered in the outpatient setting. DSS has agreed that some of these procedures can be performed in an outpatient setting and these procedures will now show on the CMAP Addendum B with a payment type of SURG "Surgical procedures manually priced" and a payment rate of MP "Manual Priced".

Currently these service will continue to deny with Explanation of Benefit (EOB) 304 "APC - Services Considered an Inpatient Procedure" until there is a system update to suspend these outpatient claims with EOB code 6000 "Claim was Manually Priced or Denied for Missing Information" for DSS to manually price the procedure code and release for payment.

Please be aware these services can still be performed as inpatient as long as it meets the inpatient Level of Care (LOC).

39. Is Medicaid's definition of a "non-patient" the same as Medicare's?

- A. Yes, hospitals can refer to the [www.cms.gov](http://www.cms.gov) Web site for Medicare's definition of a "non-patient."
40. Medicare discontinued the use of Modifier L1 "Separately Payable Lab Test" as of 1/1/2016, will Medicaid follow?
- A. Yes, Medicaid will follow Medicare's approach to reimbursement of lab services for non-patients. If the procedure code's status indicator is Q4, then the L1 modifier is not needed. However, DSS has identified a handful of procedure codes (Procedure codes 80050, 80055, 83992, 85060, 86910 and 86911) that Medicare does not cover would be eligible for Medicaid reimbursement for non-patients. For these codes, if the service was for a 'non-patient' the hospital must include the L1 modifier to be reimbursed for these services.
41. Can the hospital continue to bill for RCC 771 for adults even if it isn't covered?
- A. No. RCC 771 is only covered for client's ages 0-18.
42. How often will an outlier threshold amounts be updated?
- A. DSS plans to follow Medicare's annual updates to the outlier threshold.
43. How will outliers be handled?
- A. Please see the outpatient Outliers Issue paper located on the DSS Home Page you can access this by going to [www.ctdssmap.com](http://www.ctdssmap.com) under the "Hospital Modernization" on the right side column click on "DSS Reimbursement Home Page". Once on the DSS home page click on the link 'Outpatient Hospital Payment Methodology" this will take you to the link "Outpatient Hospitals-View the Hospital Payment Modernization (HPM) Issue Papers." Once you click on the link you will see a list of links click on the "CT HPM Issue Paper-OP Outliers" this will give you all the information on how outlier payments are calculated.
44. Will the Medicaid EOB codes be cross-walked to the 835 codes?
- A. Yes. The new EOB code crosswalk for the APC implementation is currently loaded on the [www.ctdssmap.com](http://www.ctdssmap.com) Web site on the Information, publications page. Scroll down to Claims Processing Information and click on the CT Medical Assistance Program EOB Crosswalk - Pharmacy and Non-Pharmacy link or click on the link below:
- <https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/CTEOBxwalk.pdf>
45. Will procedure code 41899 "unlisted procedure, dental alveolar structures" continue to allow \$2,000?
- A. For DOS 7/1/2016 and forward procedure code 41899 will pay based on APC assignment.



46. Previously the hospitals were billing procedure code 99241 - 99245 in connection to RCC 51X "Clinic". Per addendum B these codes are no longer covered by CT Medicaid. What procedure code should the hospitals use for their clinic services?

A. Procedure code G0463 "Hospital outpt clinic visit" should be billed with clinic RCCs when performed in the hospital's outpatient clinic.

47. What is the difference between hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Payment Classification (APC)?

A. OPPS refers to the Department's outpatient prospective payment system which determines payment for outpatient hospital services using one or more of the following methodologies:

- APC payment
- A fee on the Department's fee schedule for outpatient hospitals
- A fee on one of the Department's outpatient fee schedules other than the outpatient hospital fee schedule.

B. Ambulatory Payment Classification (APC) is a unit of payment under the Outpatient Prospective Payment System (OPPS). The Department of Social Services (DSS) will be converting the outpatient hospital reimbursement methodology from the current model to OPPS similar to Medicare. DSS will be implementing APC grouper software to process the majority of outpatient hospital claims.

48. When will the APC methodology be effective and how will this change affect Medicare crossover claims?

A. DSS will implement APC payment reimbursement including adjustments to Medicare crossovers on outpatient claims starting for dates of service July 1, 2016 and forward.

49. What are the goals of the conversion to APC?

- A. Reimbursement policies aligning more closely with Medicare.
- B. Greater accuracy in matching reimbursement amounts to relative cost and complexity.
- C. Equity and consistency of payments among providers while maintaining access to quality care.

50. What are the characteristics of APC payment?

A. Utilizing the APC grouper software, procedure codes billed have been assigned an APC status indicator and APC group. The APC group assigned is based on Medicare's APC method and takes into consideration services which are clinically similar and require similar resources. The payment is then determined by the relative weight assigned to the APC and the hospital wage adjusted conversion factor.