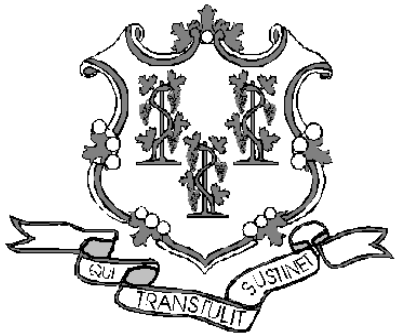
Connecticut Department of Social Services

Making a Difference

Hospital Ambulatory Payment Classification (APC) Workshop



Presented by

The Department of Social Services

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Training Topics

- Intro to Outpatient Modernization and Overview
- Outpatient Payment Methodology
- APC Payment
- Fixed fee Based on Revenue Center Codes (RCC)
- CT Fee Schedules
- Addendum B
- Discounts and Outliers
- Physician / Practitioner Services
- Hospital Billing Changes
- Upcoming Changes
- Hospital Modernization Web Page
- Upcoming Training, Wrap Up and Questions

Intro to Outpatient Modernization and Overview

- 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.
  - This implementation is targeted for dates of service July 1, 2016 and forward
  - It impacts general acute care hospitals, chronic disease hospitals, psychiatric hospitals and children's general hospitals.

- Certain services provided in hospital outpatient departments are not reimbursed under OPPS methodology. Some of those services include:
  - Physician/practitioner services; and Dental services.

Intro to Outpatient Modernization and Overview

- What is APC?
  - Ambulatory Payment Classification (APC) is a unit of payment under the Outpatient Prospective Payment System (OPPS). DSS will move from the current system of reimbursement based on Revenue Center Codes [some paid based on fixed fees, some based on a ratio of costs to charges] to a prospective payment system utilizing both revenue center code (RCC) and procedure code information to determine reimbursement levels.
- DSS will be implementing APC grouper software to process the majority of outpatient hospital claims. The grouper software will not be available on the www.ctdssmap.com.
- Hospitals will be paid under CT OPPS which will utilize Connecticut's Addendum B to determine method of payment for all outpatient services.

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Intro to Outpatient Modernization and Overview

- What are the goals of the conversion to an APC model?
  - Administrative simplification for hospital providers and DSS, through consistency and reimbursement policies aligning more closely with Medicare.
  - Greater accuracy in matching reimbursement amounts to relative cost and complexity.
  - Equity and consistency of payments among providers while maintaining access to quality care.

Outpatient Payment Methodology

Outpatient Payment Methodology

- What are the characteristics of APC payment?
  - Reimbursement under the CMAP OPPS system will be through one of the following payment methods:
    - Ambulatory Payment Classification (APCs)
    - Fixed fee based on Revenue Center Codes (RCC).
    - Fee schedule based on the Healthcare Common Procedural Coding System (CPT/HCPCS).

- In addition to the payment methods, additional allowance can come from outliers and discounts.

APC Payment

APC Payment

- Utilizing the APC grouper software, procedure codes billed will be 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.
  - If it does assign an APC then payment will be determined by;
    - The relative weight assigned to the APC.
    - The conversion factor (adjusted for geographical wage factor).
    - The units billed on the claim.

- To facilitate coordination of reimbursement, Connecticut OPPS will follow, as appropriate, Medicare's current CT OPPS coverage policies.
  - In the event there is a difference between Connecticut's policies and Medicare, Connecticut policy prevails.

Fixed Fee Based on Revenue Center Code (RCC)

Fixed Fee Based on RCC

- Fixed fee based on RCC
  - DSS has determined that certain services will continue to be reimbursed based on the contract rate for the RCC.

- The following RCCs will be excluded from APC methodology and pay based on a fixed fee:

Description	RCCs
Physical Therapy	421, 423, 424
Occupational Therapy	431, 433, 434
Speech Therapy	441, 443, 444
CARES	769
Vaccine Administration	771
Electro Shock	901
Intensive Outpatient Program (IOP)	905, 906
Extended Day	907
Partial Hospitalization Program (PHP)	913
Tobacco Cessation – Group Counseling	953

CT Provider Fee Schedules

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CT Fee Schedules

- Details billed paid off of CT Fee schedule based on HCPCS/CPT.
  - Hospitals already use the CT fee schedule for laboratory services.

- CT fee schedules can be accessed and downloaded by going to the Connecticut Medical Assistance Program (CMAP) Web site www.ctdssmap.com.

- From this Web page, go to the hospital modernization page and on the right hand side under Helpful Information & Publications click on “CT Fee Schedule”, Click on the “I accept” button then selecting the appropriate fee schedule.

- To access the CSV file, press the control key while clicking the CSV link, then select “Open”.

CT Fee Schedules

Provider Fee Schedule Download

- Acquired Brain Injury CSV
- Acquired Brain Injury II CSV
- Ambulatory Detoxification CSV
- Autism Spectrum Disorder CSV
- Behavioral Health Clinician CSV
- Chiropractor CSV
- Clinic - Ambulatory Surgical Center CSV
- Clinic - Behavioral Health CSV
- Clinic - Chemical Maintenance CSV
- Clinic - Dialysis CSV
- Clinic - Family Planning / Abortion CSV
- Clinic - Medical CSV
- Clinic - Rehabilitation CSV
- Community First Choice - Assessments CSV
- Community First Choice - Services CSV
- CT Home Care CSV
- Dental CSV
- Home Health PDF
- Hospice CSV
- Independent Audiology and Speech and Language Pathology CSV
- Independent Physical Therapy and Occupational Therapy CSV
- Independent Radiology CSV
- Lab CSV
- MEDS - DME CSV
- MEDS-Hearing Aid/Prosthetic Eye CSV
- MEDS-Medical/Surgical Supplies CSV
- MEDS-MISC CSV
- MEDS-Parenteral-Enteral CSV
- MEDS-Prosthetic/Orthotic CSV
- Mental Health Waiver CSV
- Natureopath PDF
- Optician/Eyeglasses CSV
- Outpatient CSV
- Personal Care Assistant CSV
- Physician Anesthesia CSV
- Physician Office and Outpt Services CSV
- Physician Radiology CSV
- Physician Surgical CSV
- Psychologist CSV

Addendum B and Status Indicators

Addendum B and Status Indicators

- DSS will maintain Addendum B which is a file that lists each HCPCS and CPT code.
  - The status indicator is used to identify if certain HCPCS or CPT code is a payable code and determines the method of payment. DSS will follow Medicare's guidelines for status indicators.
- Addendum B document is an excel sheet that will have 3 tabs.
  1. CT Addendum B version with the list of all the procedure codes, a short description, payment type, status indicator, APC code, relative weight and CT fee schedule.
  2. Addendum B Legend with field descriptions and valid values.
  3. CT fee schedule legend with the fee schedules and descriptions.
- The following Addendum B is based on 2015. DSS is currently working on revising it to add 2016 updates.

Addendum B and Status Indicators

1. HCPCS Code	2. Short Descriptor	3. Payment Type	4. Status Indicator	5. APC	6. Relative Weight	7. CT Fee Schedule
12005	Rpr s/n/a/gen/trk12.6-20.0cm	APC	T	0015	1.9702	
19298	Place breast rad tube/caths	APC	J1	0648	100.6339	
19366	Breast reconstruction	APC	T	0029	40.6181	
19367	Breast reconstruction	No	C			
61797	Srs cran les simple addl	No	B			
61880	Revise/remove neuroelectrode	APC	Q2	0688	28.7006	
70553	Mri brain stem w/o & w/dye	APC	Q3	0337	6.5129	
70555	Fmri brain by phys/psych	APC	S	0336	3.8614	
74263	Ct colonography screening	FS	E			PHRAD
74300	X-ray bile ducts/pancreas	APC	N			
77062	Breast tomosynthesis bi	FS	E			PHRAD
77063	Breast tomosynthesis bi	FS	A			PHRAD
77071	X-ray stress view	APC	Q1	0260	0.8004	
80050	General health panel	L1	E			LAB - ModL1
80502	Lab pathology consultation	APC	Q1	0342	0.7318	
81000	Urinalysis nonauto w/scope	APC	N			
81250	G6pc gene	FS	A			LAB
90371	Hep b ig im	FS	K	1630		OFOUT
90471	Immunization admin	RCC	S	0437	0.7218	RCC 771
90472	Immunization admin each add	RCC	N			RCC 771
90473	Immune admin oral/nasal	RCC	S	0437	0.7218	RCC 771
90655	Flu vac no prsv 3 val 6-35 m	FS	L			OFOUT
90785	Psytx complex interactive	FS	N			Clinic- BH
90791	Psych diagnostic evaluation	FS	Q3	0323	1.5574	Clinic- BH
90837	Psytx pt&/family 60 minutes	FS	Q3	0323	1.5574	Clinic- BH
90840	Psytx crisis ea addl 30 min	NO	N			
90870	Electroconvulsive therapy	RCC	S	0320	6.0169	RCC 901
92507	Speech/hearing therapy	RCC	A			Therapy RCC
97001	Pt evaluation	RCC	A			Therapy RCC
97003	Ot evaluation	RCC	A			Therapy RCC
99204	Office/outpatient visit new	FS	B			Clinic- BH if RCC =90x or 91x
99218	Initial observation care	No	B			
99241	Office consultation	No	E			
99283	Emergency dept visit	APC	V	0614	2.6747	
99406	Behav chng smoking 3-10 min	No	S	0031	0.3508	
A4261	Cervical cap contraceptive	FS	E			FP/OFOUT
C9027	Injection, pembrolizumab	FS	G	1490		NDC
E0149	Heavy duty wheeled walker	No	Y			
E0604	Hosp grade elec breast pump	FS	A			MEDS - DME
V5248	Hearing aid, binaural, cic	FS	E			MEDS - Hearing Aid

Addendum B and Status Indicators

- Field 1 – HCPCS
  - The five digit CPT or HCPCS code billed by the hospitals in conjunction to the revenue center code.
- Field 2 – Short Description
  - Short description of the CPT or HCPCS billed.
- Field 3 – Payment Type
  - Identifies the payment method used by DSS to determine how the procedure code will be reimbursed.
    - APC – Reimbursed using APC methodology.
    - FS – Reimbursed using CT Fee schedule in Column 7.
    - No – Not covered in an outpatient setting.
    - RCC – Reimbursed using RCC contract rates.

Addendum B and Status Indicators

- MP – Manually priced by DSS.
- TBD – To be determined, DSS still reviewing these codes.

- Field 4 – Status Indicator
  - The status indicator returned by the APC grouper . The list of status indicators can be found on the CMS Web site under Addendum D1. Refer to link below:
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/CMS1506FC_Addendum_D1.pdf
  - The provider can also go to the CMS Web site www.cms.gov, then select “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”.

Addendum B and Status Indicators

- Field 4 – Status Indicator (SI) (data from 2015). J2 and Q4 will be new SIs for 2016.

APC Payable	Not APC Payable
APC paid – Line item details are paid based on APC assigned SI = J2, R, S, T, U, V, X, Q1, Q2, Q3	CT Paid – Line item details are paid based on Connecticut (CT) policy (e.g., other fee schedule payment). SI = A, B, C, E, F, G, H, K, L, M, P, Q4, W, Y
Packaged – line items or details may be zero paid. The payment for these services is often included in an APC payment on the claim for another detail. SI = J1, N, Q1, Q2, Q3, Q4	CT Denied – Line item details are denied based on CT policy. SI= A, B, C, E, F, G, H, K, L, M, P, W, Y, Z

  - APC Paid - If the status indicator is under APC paid it will process the detail lines according to CMS/Medicare guidelines.
  - Packaged – Line item details may zero paid, because the reimbursement for these services are included in another APC payment on the claim for another detail.

*In some circumstances details with SI “Q1, Q2, Q3 and Q4” will not be packaged and could pay a separate APC payment.

Addendum B and Status Indicators

- Example: Procedure code 77071 “X-ray Stress View”, payment indictor “APC” and status indicator “Q1”.
  - If there is a APC payable code with a status indicator of “S, T or V” on another detail of the claim, this service will be packaged and detail will zero pay.
  - If there is not a APC payable code with one of those status indicators it will pay APC.

Addendum B and Status Indicators

- 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.

    - Example: Procedure code 81000 “Urinalysis non-auto w/scope”, payment indictor “APC” and status indicator “N”.

  - CT Paid – Line item paid based on CT policy (CT fee schedule payment).

    - Example: Procedure code 77062 “Breast tomosynthesis bi”, payment indictor “FS” and status indicator “E”.

Addendum B and Status Indicators

- CT Denied – Line item denied based on CT policy.
  - Example: Procedure code 61796 “Srs cranial lesion simple”, payment type “No” and status indicator “B”.

- Field 5 – APC
  - The APC group assigned by APC grouper software for that procedure code.
  - Medicare Addendum B will have the APC group number and Medicare Addendum A will have the APC descriptions.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

- Field 6 – Relative Weight
  - The relative weight assigned by CMS for the APC group assigned. This amount is used in the calculation of the APC payment.
  - Base APC Payment = (Provider Wage Adjusted Conversion Factor * units) * APC Weight.

Addendum B and Status Indicators

- **Calculate the detail Base APC Payment**
  - Procedure code 99283 “Emergency Department Visit” has an APC Weight 2.6747 and using a Provider Wage Adjusted Conversation factor as 82.74.
    - Base APC Payment = (Provider Wage Adjusted Conversion Factor * units) * APC Weight.
    - (82.74*1) * 2.6747 = $221.30
    - APC Base Payment of $221.30 for that procedure code.

- Outpatient claims will pay allowed greater than billed at the detail for each procedure code, but be capped at the header billed amount.

Addendum B - CT Fee Schedule

Addendum B - CT Fee Schedule

- Field 7 – CT Fee Schedule
  - Identifies which fee schedule will be utilized for a given HCPC/CPT code billed when the payment type field 3 indicates “FS”.
    - Example: Procedure code 74263 “CT Colonography Screening”, payment type “FS” and status indicator “E”.
    - This will processing using the allowance from the Physician Radiology Fee Schedule.

Addendum B - CT Fee Schedule

- Field 7 – CT Fee Schedule

Field 7	CT Fee Schedule
Clinic BH	Clinic – Behavioral Health. These services are excluded in the APC process.
Clinic BH if RCC 90X or 91X	Clinic – Behavioral Health, but these procedure codes should only be billed with a RCC 90X or 91X. Excluding RCC 901.
Dialysis	Clinic – Dialysis
FP/OFOUT	340B hospitals will use the Clinic -Family Planning. Non-340B Hospitals will use the Physician Office and Outpatient.
Lab	Lab
MEDS DME	Meds-DME
MEDS Hearing Aid	Meds-Hearing Aid/Prosthetic Eye
NDC	National Drug Code (NDC) – Average Wholesale Price (AWP) – 16.5%.

Addendum B - CT Fee Schedule

- Field 7 – CT Fee Schedule

Field 7	CT Fee Schedule
OFOUT	Physician Office and Outpatient.
PHRAD	Physician Radiology.
Rehab/Clinic	Clinic-Rehabilitation
RCC 771*	The procedure code on Addendum B must be billed with RCC 771*.
RCC 901*	The procedure code must be billed with RCC 901*.
Therapy RCC*	The procedure code on Addendum B must be billed with the corresponding therapy RCCs (42x, 43x or 44x*).

* Fixed Fee Based on RCC.

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Addendum B - CT Fee Schedule

- Example: If the hospital billed for RCC 914 with procedure code 90832, and it is payable, and will price at the Clinic – Behavioral Health fee schedule per Addendum B and allow $50.95. This rate is for hospitals not specifically enrolled as a Enhanced Care Clinic which will allow $67.67.

HCPCS Code	Short Descriptor	Payment Type	Status Indicator	APC	Relative Weight	CT Fee Schedule
90785	Psytx complex interactive	FS	N			Clinic- BH
90791	Psych diagnostic evaluation	FS	Q3	0323	1.5574	Clinic- BH
90792	Psych diag eval w/med srvcs	FS	Q3	0323	1.5574	Clinic- BH
90832	Psytx pt&/family 30 minutes	FS	Q3	0322	1.2065	Clinic- BH
90833	Psytx pt&/fam w/e&m 30 min	FS	N			Clinic- BH
90834	Psytx pt&/family 45 minutes	FS	Q3	0323	1.5574	Clinic- BH

	Clinic - Behavioral Health						
	Please contact CT BHP at 1-877-552-8247 for all Prior Authorizations						
Procedure	Proc description	Mod1	Rate Type	Max Fee	Effective I	End Date	PA
0359T	Behavioral id assessment		ECC	612	1/1/2015	12/31/2299	Y
0359T	Behavioral id assessment		MMH	612	1/1/2015	12/31/2299	Y
90785	Psytx complex interactive		ECC	14.95	7/1/2015	12/31/2299	Y
90785	Psytx complex interactive		ECC	3.68	1/1/2013	6/30/2015	Y
90785	Psytx complex interactive		MMH	11.26	7/1/2015	12/31/2299	Y
90785	Psytx complex interactive		MMH	3.68	1/1/2013	6/30/2015	Y
90832	Psytx pt&/family 30 minutes		ECC	67.67	7/1/2015	12/31/2299	Y
90832	Psytx pt&/family 30 minutes		ECC	[illegible]	1/1/2013	6/30/2015	Y
90832	Psytx pt&/family 30 minutes		MMH	50.95	7/1/2015	12/31/2299	Y
90832	Psytx pt&/family 30 minutes		MMH	[illegible]	1/1/2013	6/30/2015	Y

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Addendum B - CT Fee Schedule

- Rate Types - Under each fee schedule there are different rate types. The hospital will need to refer to the rate type under the fee schedule to determine the allowance.

Rate Types	Descriptions
DEF	Default Rate
MPH	Melded Physician
MMH	Melded Mental Health
ECC	Enhanced Care Clinic - only if enrolled specifically as an enhanced care clinic.
DC	Dialysis Clinic
FP	Family Planning
PRA	Physician Radiology

Discounts and Outliers

Discounts and Outliers

- In addition to a base detail APC price, detail pricing can be impacted by a discount factor and outlier threshold values.

- The Base APC payment amount is calculated first, followed by adjustments related to the discount factor or an outlier payment.

- Discount factors returned from the APC grouper will apply to the detail base payment and could results in a:
    1. decrease,
    2. increase to the Base APC payment or result in
    3. no discount being applied.

Discounts and Outliers

- Outlier adjustments ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers.

- The hospital outlier policy is calculated on a service basis using both fixed-dollar and multiplier thresholds to determine outlier eligibility.

Physician / Practitioner Services

Physician / Practitioner Services

- Effective July 1, 2016, 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.
  - Most behavioral health services are bundled and should not be billed under a professional claim.

- 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.

- For outpatient services on or after July 1, 2016, hospitals should no longer bill for their professional fees on their inpatient claims with RCCs 960+.

Physician / Practitioner Services

- Billing instructions are located on the Web site, www.ctdssmap.com, by selecting “Information”, then “Publications”, and scrolling to the Provider Manual section. From the Chapter 8 drop down box, choose the appropriate provider type.

- An enrollment bulletin will soon be published providing additional information regarding this transition to billing hospital based professional services on a professional claim.

- All professional services will be reimbursed based on the fee schedule applicable to the practitioner’s provider type.
  - Not all professional services rendered will have a separately payable professional component.

Hospital Billing Changes - Modifiers

Hospital Billing Changes - Modifiers

- Effective for dates of service July 1, 2016 and forward, in accordance with coding and DSS guidance hospitals will need to bill with modifiers.

- When billing for radiology services the hospital must bill with modifier TC to ensure that they are paid for the technical component only.
  - The professional component is paid directly to the physician.

- In certain situations the hospital will be paid based on procedure code used, but also the modifier they enter in connection to that procedure code.
  - Failure to bill the correct modifier will cause the detail to either pay the incorrect allowance or deny the detail service billed.

Hospital Billing Changes - Modifiers

- When the hospital is billing procedure code 70010, the hospital needs to bill with modifier TC.

	Physician Radiology						
	Rate type = to PED; pediatric services; or OBS; obstetrical services; indicates a						
	_____unique rate for services for qualified clients and claim data. You may						
	_____disregard any other rate type.						
Procedure	Proc description	Mod1	Mod1 des	Rate Type	Max Fee	Effective Da	End Date
70010	Contrast x-ray of brain			PRA	136.68	8/18/2010	12/31/2299
70010	Contrast x-ray of brain	26	PROFESSI(	PRA	60.65	8/18/2010	3/31/2015
70010	Contrast x-ray of brain	26	PROFESSI(	PRA	34.87	4/1/2015	12/31/2299
70010	Contrast x-ray of brain	TC	TECHNICA	PRA	101.81	8/18/2010	12/31/2299
70015	Contrast x-ray of brain			PRA	77.86	8/18/2010	12/31/2299
70015	Contrast x-ray of brain	26	PROFESSI(	PRA	61.66	8/18/2010	3/31/2015
70015	Contrast x-ray of brain	26	PROFESSI(	PRA	35.45	4/1/2015	12/31/2299
70015	Contrast x-ray of brain	TC	TECHNICA	PRA	42.41	8/18/2010	12/31/2299
70030	X-ray eye for foreign body			PRA	17	8/18/2010	12/31/2299
70030	X-ray eye for foreign body	26	PROFESSI(	PRA	8.9	8/18/2010	3/31/2015
70030	X-ray eye for foreign body	26	PROFESSI(	PRA	5.12	4/1/2015	12/31/2299
70030	X-ray eye for foreign body	TC	TECHNICA	PRA	11.88	8/18/2010	12/31/2299

Hospital Billing Changes – NCCI / MUE

Hospital Billing Changes – NCCI / MUE

- To comply with federal legislation, DSS has adopted the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) standard payment edits. With the hospitals moving to payment via HCPCS and CPT codes, the hospital will be subject to NCCI edits via the APC grouper.
- The NCCI edits are designed to promote correct coding and to control improper coding that could lead to inappropriate payments.
  - Medically unlikely edits (MUE) - For codes if the incorrect units are billed this will cause the detail to deny; however, billing with appropriate modifiers on multiple lines could allow additional units to pay.
  - Procedure-to-procedure (PTP) edits define pairs of HCPCS/CPT codes that should not be reported together on the same date of service for a variety of reasons and prevent reimbursement for both procedures.

Hospital Billing Changes – NCCI / MUE

- Visit the CMS Web site https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html for:
  - Instructions on how to use NCCI.
  - How to locate the NCCI Tables Manual.
  - How to look up PTP code edits.
  - Use of bypass modifiers.

- A complete list of the modifiers and modifier indicators as well as additional guidance for billing with these modifiers will be added to the Hospital Provider Manual chapter 8 “Provider Specific Claims Submission Instructions” found on the www.ctdssmap.com Web site or on the CMS Web site www.cms.gov.

Hospital Billing Changes – NCCI / MUE

– Medicaid NCCI procedure-to-procedure edits have a single column 1/column 2 correct coding edit (CCE) file.

CPT only copyright 2014 American Medical Association. All rights reserved.					
Column1/Column 2 Edits					
Column 1	Column 2	Effective Date	Deletion Date	Modifier	PTP Edit Rationale
			*=no data	0=not allowed	
				1=allowed	
				9=not applicable	
40490	0213T	20100701	*	1	Misuse of column two code with column one code
40490	0216T	20100701	*	1	Misuse of column two code with column one code
40490	0228T	20101001	*	1	Standards of medical / surgical practice
40490	0230T	20101001	*	1	Standards of medical / surgical practice
40490	10021	20020401	*	1	Sequential procedure
40490	10022	20020401	*	1	Sequential procedure
40490	11100	20140401	*	1	Mutually exclusive procedures
40490	12001	20121001	*	1	Misuse of column two code with column one code
40490	12002	20121001	*	1	Misuse of column two code with column one code
40490	12004	20121001	*	1	Misuse of column two code with column one code

- For some code pairs when indicated by modifier 1 “Allowed”, a modifier may be used to bypass CCE.

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Hospital Billing Changes – RCC Updates

Hospital Billing Changes – RCC Updates

- Effective July 1, 2016 the following RCC can be billed:
  - For physical therapy hospitals should only bill with one of the following RCCs; 421 “Phys Therapy visit”, 423 “Phys Therapy Group” and 424 “Phys Therapy Evaluation”.
  - For occupation therapy hospitals should only bill with one of the following RCCs; 431 “Occup Therapy visit”, 433 “Occup Therapy Group” and 434 “Occup Therapy Evaluation”.
  - For speech therapy hospitals should only bill with one of the following RCCs; 441 “Speech Therapy visit”, 443 “Speech Therapy Group” and 444 “Speech Therapy Evaluation”.

Hospital Billing Changes – RCC Updates

- The hospitals should no longer bill the following physical therapy RCCs as of July 1, 2016:

RCC	Descriptions
420	Physical Therapy
422	Physical Therapy/Hour
429	Other Physical Therapy
430	Occupation Therapy
432	Occupation Therapy/Hour
439	Other Occupation Therapy
440	Speech Pathology
442	Speech Pathology /Hour
449	Other Speech Pathology

Hospital Billing Changes - Billing Claims

Hospital Billing Changes –Billing Claims

- Hospitals are reminded all outpatient services for a single date of service must be billed on one claim to process using CMAP OPPS methodology.
  - If the hospital needs to submit late changes they should be adjusting the original claim and adding those additional late services.
    - Hospitals should not be billing late charges on a separate claim, in most cases, the subsequent claim will deny.

Hospital Billing Changes - Three (3) Day Rule

Hospital Billing Changes - Three (3) Day Rule

- In preparation for Hospital Modernization and payment based on APCs, DSS has implemented the 3 day rule (2 days plus the admission date) effective for admissions on or after November 1, 2015 in a post and pay status to give hospitals the opportunity to adjust to the new edits that will be effective with Ambulatory Payment Classification (APC) implementation.
  - The post and pay status means the new edits will display on the claim, but the claim will still continue to pay and not be denied.

- Outpatient services provided within 3 days of the hospital admission, provided by the hospital or an entity wholly owned or wholly operated by the hospital, must be billed on an inpatient claim.

Hospital Billing Changes - Three (3) Day Rule

- EOB code 5077 “Inpatient stay denied due to a paid outpatient claim within 3 days prior to inpatient admission.”
  - If an outpatient claim is submitted prior to the inpatient bill, the outpatient claim will pay as it does today. If an inpatient claim is later submitted and the outpatient claim was 3 days prior, the inpatient claim will post EOB code 5077.
- EOB code 5078 “Outpatient claim denied due to a paid inpatient claim within 3 days after an outpatient claim.”
  - If an inpatient claim is submitted prior to the outpatient bill, the inpatient claim will pay as it does today. If an outpatient claim is later submitted and the outpatient claim was 3 days prior to the inpatient admission, the outpatient claim will post EOB code 5077.

- The new EOB code will post to the hospital’s Remittance Advice (RA).

Hospital Billing Changes - Three (3) Day Rule

- Exclusions to the three (3) day rule:
  - Maintenance renal dialysis services. Identified by RCCs 082X, 083X, 084X and 085X.
  - Physical therapy, occupational therapy, speech therapy and audiology services. Identified by RCCs 42X, 43X, 44X and 47X.
  - Behavioral Health services. Identified by ECT RCC 901, IOP RCCs 905-906, Extended Day Treatment RCC 907, PHP RCC 913 and routine Behavioral Health services RCCs 914-916.

Hospital Billing Changes - Three (3) Day Rule

- Outpatient services that are deemed unrelated to the admission
  - Hospitals should bill the outpatient claim with Condition Code 51 “Attestation of Unrelated Outpatient Non-diagnostic Services” to identify those services that are unrelated and for which separate outpatient reimbursement is appropriate.

- Once the post and pay period ends on July 1, 2016, the outpatient or inpatient claim will begin to deny payment with either EOB code 5077 or 5078.

- For any admissions on or after July 1, 2016, the hospitals are required to bill all related outpatient services within 3 days (2 days plus the admission date) prior to inpatient admission on the inpatient claims.

Upcoming Changes – Prior Authorization

Upcoming Changes – Prior Authorization

- Prior Authorization (PA) will continue to be required for services specified by DSS. There will be no changes in prior authorization for radiology, lab, physical therapy, occupational therapy and speech pathology.
  - One change for PA that is effective for dates of service January 1, 2016 and forward is that hospitals will no longer be required to obtain prior authorization for Audiology RCCs:
    - RCCs 470 – 472 and 479.

- Behavioral Health Services will continue to require PA, but the CT Behavioral Health Partnership (Value Options) will begin to authorize services based on procedure codes for some RCCs.

- DSS will publish additional guidance regarding PA requirements for services such as durable medical equipment (DME), drugs and skin substitute products in the near future.

Upcoming Changes – HCPC with RCC Requirement

Upcoming Changes – HCPC with RCC Requirement

- DSS has added the following RCCs to the requirement to be billed with a valid CPT/HCPCS procedure code effective for dates of service January 1, 2016 and forward on outpatient claims.
  - RCC 273-274, 277, 470-472 and 479.
    - All claim details with these RCCs that are not billed with a valid CPT/HCPCS code will deny for Explanation of Benefit (EOB) code 390 “Revenue Center Code Requires a HCPCS/Procedure Code.”

- For a complete list of RCCs requiring a CPT or HCPCS go to the Web site www.ctdssmap.com, go to the hospital modernization page and click on the “Provider Manuals” and select Chapter 8. Choose “Hospitals” from the drop down box and refer to Attachment B “List of All Revenue Center Codes Requiring CPT/HCPCS Codes.

Upcoming Changes – Other RCCs

Upcoming Changes – Other RCCs

- 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, 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.

  - 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.

Upcoming Changes – Regulations

- DSS will adopt new outpatient hospital regulations to support the implementation of outpatient hospital modernization. Effective with the implementation of the outpatient hospital reimbursement modernization, DSS 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.

- Additional changes to the Web claim status panel to include APC information and changes to the ASC 835 X12 health care Payment/Advice Transaction will also be forthcoming in the future.

Hospital Modernization Web Page

Hospital Modernization Web Page

- Comprehensive information on CT OPPS can be found on the "Hospital Modernization" page on the Web site www.ctdssmap.com. Please refer to this page often, as this will be continue to be updated throughout the year.

- The link has two options - "Inpatient Hospital" and "Outpatient Hospital".

- The Web page has been updated and includes Quick links, CMAP's version of Addendum B, Provider Type and Specialty to RCC crosswalk, DRG Provider Publications, Hospital APC FAQs, Hospital Important Messages, Provider Manual updates, Provider Training, and Contact Information.

- Addendum B will be updated periodically, please always refer to the most current version for your date of service.

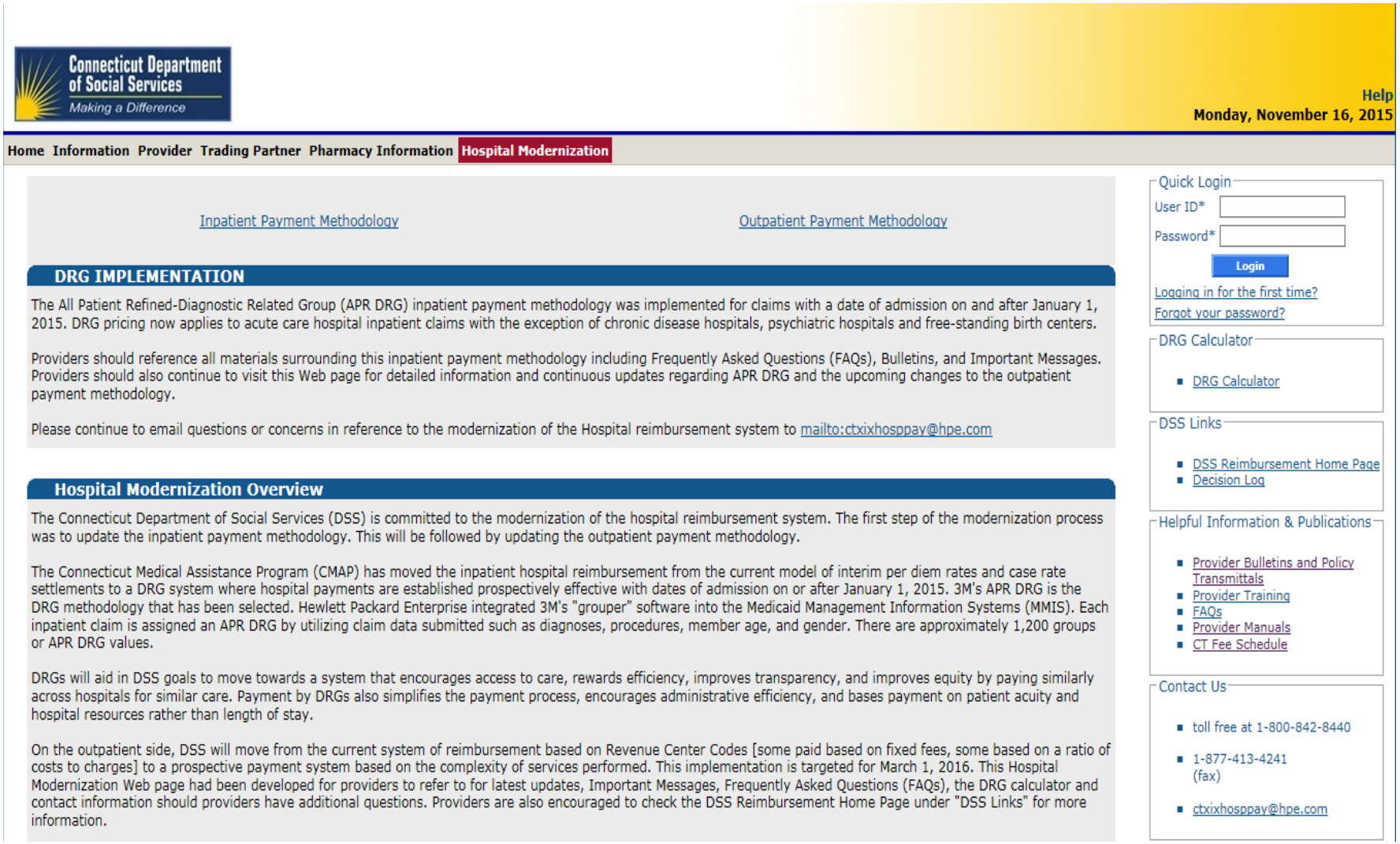
Hospital Modernization Page

- 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.

- New Explanation of Benefit (EOB) codes will be created and posted to claims to help identify how an outpatient claim is priced using APC payments.

- Once the EOBs are finalized and approved, the hospital FAQs on the Hospital Modernization page will be updated to list all the new APC EOBs.

Hospital Modernization Web Page



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Hospital Modernization Web Page

Important Messages - Connecticut Hospital Modernization

Hospital interChange Issues (Updated 11/20/15)

Provider Type and Specialty to Revenue Center Code Crosswalk

CT Addendum B

Outpatient Hospital APC December Workshops

Hospital Inpatient Payment Methodology - Diagnosis Related Group (DRG)

The Connecticut Medical Assistance Program (CMAP) has moved inpatient hospital reimbursement statewide from the current model of interim per diem rates and case rate settlements to a DRG system where hospital payments are established prospectively effective with dates of admission on or after January 1, 2015.

See the following for more detailed information:

APR DRG FAQs
Interim Billing
3-Day Rule: Outpatient Services Prior to Inpatient Admission
Claims Paid Per Diem Rates
Health Care Acquired Condition (HCAC) / Present on Admission (POA)
Hospital Based Practitioners - Inpatient Services

DRG Calculator

DRG Calculator

Hospital Outpatient Payment Methodology - Ambulatory Payment Classification (APC)

DSS will move from the current system of hospital outpatient payment methodology based on Revenue Center Codes (some paid based on fixed fees, some based on a ratio of costs to charges) to a prospective payment system based on the complexity of services performed. This change is scheduled for March 1, 2016.

APC FAQs

Connecticut Addendum B
CT Medicaid's OPPS processing will be based on the CT version of Addendum B which is derived from Medicare's Addendum B. The differences between the CT version of Addendum B and the Medicare version of Addendum B primarily involve detail service coverage and pricing methodology. Please refer to CMAP's draft Addendum B to determine which services will be paid based on fixed fee, fee schedule or APC assignment. Also, background information for CT Addendum B can be found on the Connecticut Department of Social Services Reimbursement Modernization web site at: http://www.ct.gov/dss/cwp/view.asp?a=4598&q=538256
CT Addendum B

Provider Type and Specialty to Revenue Center Code Crosswalk
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, 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. Please refer to the Provider Type and Specialty to RCC Crosswalk to determine which RCC are payable for your scopes of practice.
Provider Type and Specialty to Revenue Center Code Crosswalk

Upcoming Training, Wrap Up and Questions

Hewlett Packard Enterprise

Upcoming Training, Wrap Up and Questions

- DSS and Hewlett Packard Enterprise will be providing a professional enrollment workshop in December 2015. DSS and Hewlett Packard Enterprise will be providing two virtual room workshops.

- A follow up APC training will occur in February 2016. For this workshop DSS and Hewlett Packard Enterprise will be providing one internet virtual room workshop and one workshop at the Connecticut Hospital Association in Wallingford.

- Workshop dates have yet to be scheduled for the professional or the follow up workshop, but once finalized an invitation to attend will be e-mailed to the hospitals and will be posted on the Hospital Modernization page under Important Messages and Provider Training.

Upcoming Training, Wrap Up and Questions

- Where to go for more information: www.ctdssmap.com
  - Hospital Modernization Web Page
  - Provider Bulletins
    - 2015-87 “Outpatient Hospital Modernization – Outpatient Prospective Payment System (OPPS)”

- DSS Reimbursement Home Page

  http://www.ct.gov/dss/cwp/view.asp?a=4598&q=538256

- Hewlett Packard Enterprise has also made available an email address, ctxixhosppay@hpe.com, that can be used to submit questions related to APC.

Upcoming Training, Wrap Up and Questions

- Provider Assistance Center (PAC): Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays:
  - 1-800-842-8440
  - 1-800-688-0503 (EDI Help Desk)

Upcoming Training, Wrap Up and Questions

- Questions & Answers

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