

**Effective Date: 1/1/2015**

**Policy Subject:**

Vermont Medicaid Outpatient Prospective Payment System (OPPS)

**Purpose:**

Final Annual VT Medicaid OPPS updates effective for CY2015

**Policy Summary:**

For CY2015, The DVHA proposes to update rates and status indicators consistent with Medicare rates and status indicator changes described in their final rule published on November 10, 2014. <http://www.gpo.gov/fdsys/pkg/FR-2014-11-10/pdf/2014-26146.pdf>

The DVHA also proposes to add the following methodological and billing updates to the VT Medicaid OPPS.

These items include:

- Implementation of Comprehensive APCs (identified with a J1 status indicator)
- Implementation of select Composite APCs (identified with a Q3 status indicator)
- Addition of payment modifiers 52 and 73
- Updated billing guidance on Bilateral Procedures (50 modifier)
- Continued use of E&M codes 99201-99205 and 99211-99215 on a UB04, as well as G0463
- Changes to reimbursement of select dental codes
- Addition of revenue codes added to the “Packaged Revenue Code” list
- Submission of modifier and new POS codes to identify provider-based status

Adding these additional methodologies and billing updates will help the DVHA align more closely with Medicare. The DVHA is seeking public comment on all the proposals described within this proposal for updates to the VT Medicaid OPPS.



## **Overview of Each Update:**

### 1. Comprehensive APCs:

The DVHA is proposing a comprehensive payment policy that bundles or “packages” payment for the most costly medical device implantation procedures under the OPPS at the claim level. Medicare is defining a comprehensive APC (C-APC) as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. This is being proposed to further improve the accuracy and transparency of payments for these services where the cost of the device is large compared to the other costs that contribute to the cost of the service.

CMS has created a new status indicator, ‘J1’, to identify codes that are paid under 25 new comprehensive APCs within 12 clinical families. A claim with status indicator ‘J1’ will trigger a single payment for the comprehensive service based on all charges on the claim, excluding only select services identified by Medicare which will be separately payable outside of the bundle.

Additionally, there will be the possibility of a Complexity Adjustment to provide increased payment for certain comprehensive services. A Complexity Adjustment is triggered when a certain code combination represents a complex, costly form or version of the primary service. The Complexity Adjustment is applied by promoting qualifying “J1” service code combinations or code combinations of a “J1” service and certain add-on codes from the originating comprehensive APC to a higher paying comprehensive APC in the same clinical family of comprehensive APCs.

**Final: We have received no comments in response to the proposed comprehensive payment policy. Therefore, The DVHA has implemented the comprehensive payment policy as described above.**

### 2. Composite APCs

Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, the DVHA would make a single payment for all of the codes as a whole, rather than paying individually for each code.

CMS has proposed 8 composite APCs for CY2015, including;

- APC 0034 - Mental Health Services Composite



- **APC 8001 - Low Dose Rate Prostate Brachytherapy Composite**
- **APC 8004 - Ultrasound Composite**
- **APC 8005 - CT and CTA without Contrast Composite**
- **APC 8006 - CT and CTA with Contrast Composite**
- **APC 8007 - MRI and MRA without Contrast Composite**
- **APC 8008 - MRI and MRA with Contrast Composite**
- APC 8009 - Extended Assessment and Management Composite

The DVHA is proposing to implement **6** of the 8 composite APCs. These would include APC 8001, 8004, 8005, 8006, 8007, and 8008.

**Final: We have received no comments in response to implementing the 6 proposed composite APCs. Therefore, The DVHA has implemented the 6 composite APCs as described above.**

### 3. Modifier 52 and 73

The DVHA is proposing to implement modifier 52 and 73 when billed on an institutional claim (UB04). A code billed with either of these modifiers would result in a payment equal to 50% of the maximum allowable fee.

- **52 – Reduced services**

- Used to indicate partial reduction or discontinuation of a procedure that does not require anesthesia. May be used on radiology procedures.

- **73 – Discontinued outpatient procedure prior to anesthesia administration**

- Used to indicate that a procedure was discontinued or terminated after the patient had been prepared for the procedure and brought into the procedure room, but prior to the administration of anesthesia. May be used on surgical or diagnostic procedures requiring anesthesia.

**Final: We have received no comments in response to implementing modifier 52 and 73 when billed on an institutional claim (UB04). Therefore, The DVHA has implemented modifier 52 and 73 as described above.**

### 4. Bilateral Procedure Billing

Today, for CPT codes that are not defined as bilateral but are performed bilaterally, the DVHA asks that these services are billed on two separate detail lines. Each detail must contain the



same revenue code, CPT code, and 1 unit of service. This will result in the first line reimbursing 100% of the maximum allowable fee, while the second line would reimburse 50% of the maximum allowable fee, thus resulting in 150% for the bilateral procedure. Modifier 50 is not recognized today on institutional claims (UB04).

The DVHA is proposing to implement modifier 50 when billed on an institutional claim (UB04), as well as updating the billing guidelines for bilateral procedures. Bilateral procedures will now be reported on only one line using modifier 50 with a unit of 1. This will result in that line now reimbursing at 150% of the maximum allowable fee.

<http://www.vtmedicaid.com/Information/BannerPages/Banners%2011-14-14.pdf>

**Final: We have received no comments in response to updating the way bilateral procedures are billed on an institutional claim (UB04). Therefore, The DVHA has implemented the changes in order to allow bilateral procedures to be billed on one line, resulting in reimbursement at 150% of the maximum allowable fee as described above.**

#### 5. Clinic Code G0463

Beginning January 1, 2014, Medicare starting requiring a single code (G0463) for the facility fee on clinic visits. VT Medicaid allowed G0463 for CY2014, but also continued to allow 99201-99205 and 99211-99215, all with the same allowable rate.

For CY2015, the DVHA is proposing to continue to allow the use of E&M codes 99201-99205 and 99211-99215 on facility claims (UB04) however, the payment would continue to be mapped to G0463. Provider-based clinics would now use either the appropriate E&M code or G0463 for the facility fee portion of the outpatient clinic visits. This change would only apply to the hospital or facility portion of clinic visit codes 99201–99205 and 99211–99215.

The physician services claim (CMS1500) would remain the same and continue to utilize the appropriate CPT in code ranges 99201–99205 and 99211–99215.

**Final: We have received no comments in response to continuing to allow the use of 99201-99205 and 99211-99215 as well as G0463 on facility claims (UB04). Therefore, The DVHA will continue to allow these codes for the facility fee on clinic visits as described above. We will also continue to study this issue and make any necessary changes off-cycle if needed.**



## 6. Outpatient Dental Code Rates

As of today, most dental codes on OPPS pay cost to charge ratio (CCR), or said another way, a percentage of the billed charge. We are proposing to update the rates on outpatient dental codes to match the rates that are paid on professional claims for those same codes.

**Final: We have received no comments in response to updating the rates on outpatient dental codes. Therefore, The DVHA has updated the rates on outpatient dental codes to match the rates that are paid on professional claims for those same codes as described above.**

## 7. Additional revenue codes added to “Packaged Revenue Code” list

The DVHA is proposing to follow Medicare in adding additional revenue codes to the already in place Packaged Revenue Code list. Charges for the revenue codes on this list, which are identified by Medicare, get packaged into the primary payment when they are billed without a CPT/HCPCS code. Additional revenue codes being added to the list for CY2015 include;

- 331 – Chemotherapy Administration; Injected
- 332 – Chemotherapy Administration; Oral
- 335 – Chemotherapy Administration; IV
- 360 – Operating Room; General
- 361 – Operating Room; Minor Surgery
- 362 – Operating Room; Organ Transplant-Other than Kidney
- 369 – Operating Room; Other OR Services
- 410 – Respiratory Services; General
- 412 – Respiratory Services; Inhalation Services
- 413 – Respiratory Services; Hyperbaric Oxygen Therapy
- 419 – Respiratory Services; Other Respiratory Services
- 722 – Labor Room/Delivery; Delivery Room
- 724 – Labor Room/Delivery; Birthing Center
- 729 – Labor Room/Delivery; Other Labor Room/Delivery
- 760 – Specialty Services; General
- 761 – Specialty Services; Treatment Room
- 769 – Specialty Services; Other Specialty Services
- 770 – Preventive Care Services; General

**Final: We have received no comments in response to updating the Packaged Revenue Code list. Therefore, The DVHA has followed Medicare by updating the Packaged Revenue Code list as described above.**



## 8. Submission of modifier and POS codes to identify provider-based billing entities

The DVHA is proposing to follow Medicare's guidance related to submission of a modifier and adoption of new POS codes in order to identify and collect data on provider based departments (PBD).

For hospital facility claims, CMS is creating the following HCPCS modifier that is to be reported with every code for outpatient hospital services furnished in an off-campus PBD of a hospital.

- **PO** - Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments

Consistent with Medicare, Medicaid proposes this code not be required to be reported for remote locations of a hospital defined at 42 CFR 412.65, satellite facilities of a hospital defined at 42 CFR 412.22(h), or for services furnished in an emergency department.

Reporting of this new modifier will be voluntary for 1 year (CY 2015), with reporting required beginning on January 1, 2016.

**For professional claims**, CMS will delete current POS code 22 (outpatient hospital department) and will be establishing two new POS codes;

- one to identify outpatient services furnished in on-campus, remote, or satellite locations of a hospital
- one to identify services furnished in an off-campus PBD hospital setting

These new POS codes will be required to be reported as soon as they become available. However, advanced notice of the availability of these codes will be shared publicly as soon as practicable.

**Final:** We have received no comments in response to the voluntary usage of modifier PO for CY2015. Therefore, The DVHA has followed Medicare by allowing the voluntary usage of modifier PO as described above.

