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Agency of Human Services

Providers,

Please review the following policy summary and attached materials that describe the specific changes being proposed as part of the DVHA's annual hospital outpatient prospective payment system (OPPS). The DVHA invites comments and feedback regarding the all aspects of the proposed changes.

Any comments should be submitted to the DVHA Reimbursement Unit by the due date specified. Your comments must be received by the due date to be considered before the final policy is released.

Send Comments to: DVHA Reimbursement Unit
312 Hurricane Lane, Suite 102
Williston, VT 05495
AHS.DVHAReimbursement@state.vt.us

Thank you for your consideration,



Kara Suter, M.S., Director of Payment Reform and Reimbursement
Christine Blackburn, Interim DVHA Rate Setting Manager



Comments Due: 12/15/2014

Proposed Effective Date: 1/1/2015

Policy Subject:

Vermont Medicaid Outpatient Prospective Payment System (OPPS)

Purpose:

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.

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.

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.

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>



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.

6. Outpatient Dental Code Rates

As of today, most dental codes on OPSS 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.

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

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

Earlier this year, the DVHA requested that all hospitals bill outpatient hospital setting of care (i.e., the Place of Service code) consistent with how they bill Medicare and hence, consistent with federal regulations governing provider-based billing status. Also this year, the DVHA lifted restriction on the 51x revenue code series which were previously non-covered. As such, we expect increased volume in CY 2015 and are adjusting our proposed rates to accommodate this change.

Based on our preliminary review of the data to assess the impact of this change, we estimate this change will increase spending by approximately \$10 million in CY 2015. Therefore, as reflected in the impact tables included in this proposed policy, it was necessary to reduce the absolute percentages in median rates so that total aggregate spending would remain unchanged in CY2015.

We believe the current data however, is preliminary and will revisit this analysis and make mid-year adjustments to these rates if necessary. The data also presents challenges in that it is difficult to identify provider based billing in the current claims data. Therefore, 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.



Provider Impact

	Model 0 (Baseline)	Proposed Model	Model with High Level Estimate to Include Provider-Based Billing
Utilization Used in Model	CY 2013	CY 2013	
Medicare National Medians Used	CY 2014	CY 2015	
Pct of Nat'l Median - Standard	79.20%	69.80%	
Pct of Nat'l Median - Dartmouth Hitchcock	84.80%	74.76%	
Pct of Nat'l Median - In State No SCH Adjuster	98.30%	86.64%	
Pct of Nat'l Median - In State with SCH Adjuster	105.30%	92.79%	
Fixed Outlier Threshold	\$2,900	\$3,100	
Lab Fees Used	DVHA Nov 2014	DVHA Nov 2014	
Comprehensive APC Logic in pricing	No	Yes	
Composite APC Logic in pricing	No	Yes	
Modifier 52 and 73 Logic in pricing	No	Yes	
Change to Clin Lab Logic in pricing	No	Yes	
Provider Based Billing Adjustment built in	No	Yes	

Hospital	Number of Details	Costs	Charges	Regular Payments	Outlier Payments	Total Payments	Regular Payments	Outlier Payments	Total Payments from OPPS Model	Difference from Model 0	Assumption of New Pmts Under Provider-Based Billing	Final Total Payments	Difference from Model 0	Pct Difference from Model 0
Brattleboro Memorial Hospital	56,209	4,488,026	13,223,411	3,064,844	21,886	3,086,730	2,900,638	29,141	2,929,780	-156,950	\$367,444	\$3,297,224	\$210,494	6.8%
Central Vermont Med Ctr	99,084	10,543,850	26,733,900	7,237,851	6,467	7,244,317	6,340,144	9,074	6,349,218	-895,099	\$796,300	\$7,145,518	-\$98,799	-1.4%
Copley Hospital	49,487	5,097,162	11,274,414	2,986,952	194,020	3,180,972	2,634,310	253,714	2,888,025	-292,947	\$362,207	\$3,250,232	\$69,260	2.2%
Fletcher Allen Health Care	258,908	32,363,731	102,676,813	22,223,709	33,582	22,257,291	19,500,356	60,378	19,560,734	-2,696,557	\$2,453,248	\$22,013,982	-\$243,309	-1.1%
Gifford Medical Center	42,550	4,619,337	10,680,549	1,965,960	132,949	2,098,909	1,567,069	187,502	1,754,570	-344,339	\$220,053	\$1,974,623	-\$124,286	-5.9%
Grace Cottage Hospital	11,825	865,460	1,624,361	394,506	0	394,506	305,563	0	305,563	-88,943	\$38,323	\$343,886	-\$50,620	-12.8%
Mt. Ascutney Hospital	13,469	1,659,525	3,637,714	749,392	12,824	762,216	643,423	21,590	665,013	-97,203	\$83,404	\$748,417	-\$13,799	-1.8%
North Country Hospital	64,150	9,251,663	18,762,245	4,178,017	54,724	4,232,741	3,675,549	105,053	3,780,602	-452,139	\$474,152	\$4,254,754	\$22,013	0.5%
Northeastern Vt Reg Hosp	51,636	6,099,354	13,139,496	2,990,587	134,097	3,124,685	2,602,182	209,534	2,811,716	-312,969	\$352,637	\$3,164,353	\$39,668	1.3%
Northwestern Medical Center	100,498	9,048,343	19,017,115	6,515,692	2,542	6,518,234	5,650,687	4,415	5,655,102	-863,132	\$709,246	\$6,364,348	-\$153,886	-2.4%
Porter Medical Center	52,313	4,380,682	10,987,413	2,925,399	28,958	2,954,357	2,496,968	49,352	2,546,320	-408,037	\$319,352	\$2,865,672	-\$88,685	-3.0%
Retreat Health Care	1,216	323,449	934,284	323,218	0	323,218	323,193	0	323,193	-25	\$40,534	\$363,727	\$40,509	12.5%
Rutland Regional Med Ctr	129,412	17,492,441	36,298,903	9,732,178	17,015	9,749,192	8,529,576	43,251	8,572,828	-1,176,364	\$1,075,178	\$9,648,006	-\$101,186	-1.0%
Southwestern Vt Health Care	92,514	9,967,252	20,529,870	6,039,641	28,743	6,068,385	5,342,514	39,972	5,382,486	-685,899	\$675,055	\$6,057,541	-\$10,844	-0.2%
Springfield Hospital	58,636	5,923,934	11,972,380	3,233,908	4,403	3,238,311	2,786,654	25,942	2,812,596	-425,715	\$352,747	\$3,165,343	-\$72,968	-2.3%
All In State Hospitals	1,081,907	122,124,209	301,492,868	74,561,854	672,210	75,234,064	65,298,826	1,038,918	66,337,746	-8,896,318	8,319,879	74,657,625	-576,439	-0.8%
Dartmouth-Hitchcock Med Ctr	98,004	24,993,062	59,777,714	10,308,567	332,679	10,641,246	9,352,594	547,581	9,900,175	-741,071	\$1,241,650	\$11,141,825	\$500,579	4.7%
All Other Out-of-State Hosp	61,502	8,332,801	19,930,163	3,691,469	160,343	3,851,811	3,289,866	206,237	3,496,103	-355,708	\$438,471	\$3,934,574	\$82,763	2.1%
All Hospitals	1,241,413	155,450,072	381,200,745	88,561,890	1,165,232	89,727,121	77,941,286	1,792,736	79,734,024	-9,993,097	10,000,000	89,734,024	6,903	0.0%

