

FREQUENTLY ASKED QUESTIONS — TRANSITION TO AMBULATORY PAYMENT CLASSIFICATION (APC)

State of Connecticut Hospital Payment Modernization

April 28, 2016

Policy Topics

What is the implementation date for the APC payment methodology?

July 1, 2016.

What version of the APC grouper will be used at implementation?

The current plan is to implement with IOCE Version 17.x, where x represents the release number. It is not yet known if it will be release 0 or release 1.

Will a statewide conversion factor be used?

Yes, most hospitals will be paid based on a statewide conversion factor. There may be some exceptions to this policy.

Will the conversion factor be wage adjusted?

Yes, Medicare wage indices **prior** to reclassification will be applied to the statewide conversion factor.

Will behavioral health (BH) services be excluded from the APC methodology?

Yes, revenue center codes 90x, 91x and 953 will all be excluded from the APC methodology. Please see the APC Policy Exclusions and Behavioral Health Services issue papers for additional information.

Will BH services continue to be paid using the BH revenue center code rates?

The State of Connecticut will shift to paying for routine BH services based on procedure codes, rather than revenue center codes, to allow level of payment to better match level of service. Other BH services (e.g., intermediate care programs) will be paid using revenue center codes that are billed with the appropriate procedure code. Please see the APC Policy Exclusions and Behavioral Health Services issue papers for additional information. A policy transmittal providing more guidance on billing for BH services will be forthcoming.

Will other services be excluded from the APC methodology?

Yes, please see the APC Policy Exclusions issue paper for additional information.

How will lab services be paid?

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 for based on the lab fee schedule used to price lab services provided to non-patients. Please see the CT Addendum B and the associated issue paper for specific lab code information.

Can emergency room practices bill directly — not through the hospital?

Yes, effective July 1, 2016, providers will be required to bill professional services provided in the emergency department directly to the MMIS using the professional claim.

How will outpatient professional services be reimbursed?

Most professional services delivered by a hospital based provider are reimbursed based on the physician fee schedule. The current physician fee schedules can be accessed and downloaded from Connecticut Medical Assistance Program's (CMAP) web site, www.ctdssmap.com.

Can the hospital practitioner groups bill for outpatient professional BH services?

Most outpatient BH services in the hospital setting are considered an all-inclusive service; therefore, they must be billed on the UB-04 by the hospital and the professional fees should not be submitted separately. The only BH services that will be reimbursed separately are:

a) Emergency Department evaluation provided by licensed clinical social worker (LCSW), psychiatrists, psychiatric advanced practice registered nurses (APRNs) or psychologist, and b) the professional component of electroshock treatment billed by psychiatrists or psychiatric APRNs. The professional services will be paid based on the applicable provider fee schedule, which can also be accessed on the CMAP website, following the directions above, with the exception of selecting the psychologist fee schedule or the BH Clinician for reimbursement of LCSW services.

Will the policy for observation services be changing?

Yes, as noted in the APC Policy Changes issue paper, new criteria will be used for observation services. The Connecticut Department of Social Services will be following Medicare policy for observation and will be issuing a provider bulletin regarding the new criteria.

How will outliers be handled?

Please see the Outpatient Outliers issue paper.

Data Topics

What time period of data was used for conversion factor development?

The base data used for the conversion factor calculation was outpatient claims with dates of service from May 1, 2014 through December 31, 2014, paid through April 10, 2015.

Was the data or analysis annualized?

No.

Are Medicare crossover claims included in the analytical data set?

No.

How was third party liability (TPL) handled in the analytical data set?

The analytical data set includes claims where Medicaid was not primary. For these (and all claims), "Medicaid Allowed", not the final payment amount, was used for the Fiscal Impact Model. As the APC system goes into effect, the TPL adjudication approach will continue unchanged – except the Medicaid allowed will be based on APC methods.

Was the base data adjusted for policy changes?

Yes, please see the APC Policy Changes issue paper.

What cost to charge ratios were used for determining the current payment amounts in the Fiscal Impact Model?

The Medicaid allowed amount from the analytical data set was used in the determination of current payment amounts. Claims from May 1, 2014 through June 30, 2014 are based on percent of charges from the FFY11 cost report and claims from July 1, 2014 through December 31, 2014 are based on percent of charges from the FFY12 cost report.

What cost to charge ratios were used for determining outlier payments?

For each hospital an overall outpatient cost to charge ratio was calculated using information from the Medicare cost report with a fiscal year ending in 2014. The charge and cost data was obtained from Worksheet D, Part V.

Is there an issue paper explaining how the estimated impact of unbundling professional claims was calculated?

Yes, please see the Professional Services issue paper.

What year Addendum B was used for the APC claim detail file?

The 2014 grouper and Addendum B were used in order to match to the claims data time period.

Which grouper was used for the data analysis?

The 2014 3M APC Medicare grouper was used. In addition, results from the 2013 grouper were evaluated to help inform and improve the data analysis.

Why wasn't the current grouper version used?

The 2014 grouper was used in order to match to the claims data time period. Using a grouper version that does not match the time frame of the data set could potentially increase the error rate because a more recent grouper version reflects coding guidelines not available when the 2014 claims were billed.

Was there any impact related to composite APCs?

Our review of the claims data confirmed that composite APCs were assigned to claims. The composite APCs were assigned based on 2014 data and the 2014 version of the grouper software and values.

Can the hospitals get detailed claim files containing the data used in the APC conversion factor calculation?

Yes, detailed claims files containing the hospital-specific outpatient APC data used to calculate the conversion factor was provided to each hospital.

Can the hospitals get the Patient Account Number or Medicaid Recipient ID fields for the APC claim detail file?

Yes, upon request, DSS will provide hospitals with a supplemental file that contains Patient Account Number, Medicaid Recipient ID and ICN that can be linked to the detailed claim file.

Additional Resources

Connecticut Department of Social Services Reimbursement Modernization:

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

Connecticut Medical Assistance Program:

www.ctdssmap.com