

## PROVIDER BULLETIN

May 1, 2008

### Highlights:

- OVHA's new outpatient payment system takes effect
- OVHA's OPPTS versus Medicare OPPTS
- Latest on the inpatient payment system

### New Outpatient Payment System

OVHA's new outpatient prospective payment system takes effect with services provided as of May 1, 2008. A new fee schedule for hospitals as well as an updated Billing Manual is provided on the EDS website under Downloads and Manuals. The fee schedule was developed using the Medicare OPPTS Addendum B effective January 1, 2008 as the basis. This fee schedule will be updated annually in line with changes to Medicare's Addendum B. The fees on OVHA's fee schedule are derived from three sources.

- Medicare OPPTS- If OVHA covers the service, then the payment to hospitals is the national median value as shown on the Medicare OPPTS Addendum B effective 01/01/08.
  - Hospitals with Sole Community Hospital status in Medicare as well as all Vermont Critical Access Hospitals will receive a 7.1% upward adjustment to the published fee for any service that is paid in the Medicare OPPTS. This adjustment does not apply to non-OPPTS services.
  - There are a few services paid in the Medicare OPPTS that are not covered by the OVHA in the hospital setting. These are listed on page 3.
- Medicare Clinical Lab Fee Schedule (CLAB) – Effective 05/01/08, hospitals will receive the maximum fee allowable under CLAB. This is a change in reimbursement for hospitals only.
- OVHA's Fee Schedule – Hospitals are paid for services covered by OVHA that do not have a fee in either the Medicare OPPTS or Medicare CLAB using OVHA's fee schedule to non-hospital providers. These services have been incorporated into the hospital-only fee schedule as well.

There are some situations where OVHA covers a service for which no fee is available. These services will be paid using a hospital-specific cost-to-charge ratio (CCR) multiplied by covered charges. The CCR used for payment is the same CCR used to calculate outlier payments for both inpatient and outpatient services. The most recent CCR from each hospital's 09/30/06 Medicare Cost Report Worksheet C is used. The hospital-specific CCRs will be updated annually along with other OPPTS-related changes.

## OVHA's OPPTS versus Medicare's OPPTS

OVHA has adopted all provisions of the Medicare OPPTS with the following exceptions:

- OVHA is using the national median fees on Addendum B (SCH and CAH) hospitals receive the 7.1% upward adjustment). There is no wage-adjusted portion on non-wage adjusted portion to the rate.
- OVHA is packaging observation services with OPPTS primary procedures (status indicators S, T, V or X). There are no exceptions for certain conditions as there are in Medicare (e.g. for congestive heart failure). Alternatively, OVHA will pay for observation separately when there is no primary procedure on the claim whereas Medicare will not. OVHA will pay the observation line on the claim using the hospital's CCR, provided that the G0378 HCPCS appears on the labor room or observation room revenue code detail line and the number of hours in observation appears in the units field (value cannot be zero). There is no maximum limit on this payment as there had been in the past (limit was the hospital's med/surg per diem rate).
- Although hospitals may report them on their claims, OVHA is not utilizing modifiers for pricing purposes. The most significant impact of this policy is for bilateral procedures. Instead of billing one detail line with one unit of service and modifier 50 (to indicate 150% of the standard fee), hospitals should bill the service on two separate lines and each line should have a unit of 1. The modifier 50 can remain on the first line if you wish but it will not be factored into pricing at all. Since most bilateral procedures have a Medicare Status Indicator 'T', the effect on pricing is the same as if the modifier was recognized – namely, pricing will be 150% of the fee for the two lines combined.
- All notional median fees in the Medicare OPPTS Addendum B effective 01/01/08 are used as the fees on OVHA's hospital fee schedule except for a small number of HCPCS which are not covered by OVHA. There are also a few codes still under review by OVHA for decisions on coverage. See page 3 and 4 for the lists.

The CPT/HCPCS on Addendum B with their Medicare status indicator have been crosswalked to OVHA's five pricing action codes (PAC).

- PAC 9: Not covered by OVHA
- PAC O: Paid using Medicare OPPTS national median fee
- PAC N: Packaged service with a Medicare OPPTS service
- PAC M: Paid using a fee from OVHA's fee schedule (including lab)
- PAC P: Paid using the hospital's CCR

The crosswalk appears on page 5.

<b><i>HCPCS with a fee in the Medicare OPPS that are not covered by OVHA</i></b>				
<b>HCPCS Code</b>	<b>Short Descriptor</b>	<b>SI</b>	<b>APC</b>	<b>National Median</b>
D0277	Vert bitewings-seven to eight	S	0330	583.93
D0460	Pulp vitality test	S	0330	583.93
D4264	Bone replace graft each add	S	0330	583.93
D4268	Surgical revision procedure	S	0330	583.93
D4273	Subepithelial tissue graft	S	0330	583.93
D4381	Localized delivery antimicro	S	0330	583.93
D5911	Facial moulage sectional	S	0330	583.93
D5912	Facial moulage complete	S	0330	583.93
D5983	Radiation applicator	S	0330	583.93
D5984	Radiation shield	S	0330	583.93
D5985	Radiation cone locator	S	0330	583.93
D5987	Commissure splint	S	0330	583.93
D6920	Dental connector bar	S	0330	583.93
D7940	Reshaping bone orthognathic	S	0330	583.93
D9930	Treatment of complications	S	0330	583.93
G3001	Admin + supply, tositumomab	S	0330	1747.11

***HCPCS with a fee in the Medicare OPPS that are still under review by OVHA  
(assume non-covered for now)***

<b>HCPCS Code</b>	<b>Short Descriptor</b>	<b>SI</b>	<b>APC</b>	<b>National Median</b>
90585	Bcg vaccine, precut	K	9137	119.31
C9237	Inj, lanreotide acetate	K	9237	24.13
C9240	Injection, ixabepilone	K	9240	64.54
C9354	Veritas collagen matrix, cm2	G	9354	11.77
C9355	Neuromatric nerve cuff, cm	G	9355	227.26
J1568	Octagam injection	K	0943	33.49
J1569	Gammagard liquid injection	K	0944	31.35
J1571	HepaGam B IM injection	K	0946	58.69
J1572	Flebogamma injection	K	0947	32.31
J1573	Hepagam B intravenous, inj	K	1138	58.69
J1743	Idursulfase injection	G	9232	455.03
J2323	Natalizumab injection	G	9126	7.51
J2724	Protein C concentrate	K	1139	12.08
J2778	Ranibizumab injection	G	9233	406.18
J2791	Rhophylac injection	K	0945	5.28
J3488	Reclast injection	G	0951	216.61
J7321	Hyalgan/supartz inj, per dose	K	0873	101.09
J7322	Synvisc injection, per dose	K	0874	176.48
J7323	Euflexxa injection, per dose	K	0875	109.82
J7324	Orthovisc injection, per dose	K	0877	169.75
J7347	Integra matrix tissue	K	1140	32.46
J7348	Tissuemend tissue	G	9351	92.31
J7349	Primatrix tissue	G	1141	40.86
J7501	Azathioprine parenteral	K	0887	48.08
J7525	Tacrolimus injection	K	9006	138.38
J9303	Panitumumab injection	G	9235	82.87
Q2009	Fosphenytoin, 50mg	K	7028	3.56
Q2017	Teniposide, 50mg	K	7035	279.35
Q3025	IM inj interferon beta 1-a	K	9022	121.15

**Crosswalk of Count of HCPCS by Medicare Status Indicator to OVHA's Pricing Action Code**

<b>Medicare Status Indicator</b>	<b>Medicare- Short Descriptor</b>	<b>Non-Covered</b>	<b>Pay with Medicare OPPS Fee</b>	<b>Packaged Item not separately payable</b>	<b>Pay with Medicare Lab or OVHA's Published Fee Schedule</b>	<b>Pay Using Hospital CCR</b>	<b>Total HCPCS</b>
A	Paid under fee schedule other than OPPS	158	0	0	2,148	289	2,595
B	Not recognized by OPPS	84	0	0	190	86	360
C	Inpatient procedures	15	0	8	6	1,695	1,724
D	Discontinued codes	140	0	0	0	0	140
E	Not covered- statutory exclusion	472	0	0	375	152	999
F	Corneal tissue, vaccines	1	0	0	5	0	6
G	Pass-through drugs & biologicals	9	12	0	0	0	21
H	Pass-through devices	0	0	0	1	25	26
K	Non pass-through drugs, radiopharms	21	281	0	0	0	302
L	Flu, pneumonia vaccine	1	0	0	5	1	7
M	Services not billed to fiscal intermediary	28	0	0	636	39	703
N	Packaged Services	8	0	1,028	0	0	1,036
P	Partial Hospitalization	2	0	0	0	0	2
Q	Packaged services paid separate certain cond.	0	166	0	0	0	166
S	Significant procedure, not discounted	16	856	0	0	0	872
T	Significant procedure, discounted when multiple	0	3,675	0	0	0	3,675
V	Clinic or ED visit	0	29	0	0	0	29
X	Ancillary services	0	442	0	0	0	442
Y	Non-implantable DME	33	0	0	542	117	692
	<b>Total HCPCS</b>	<b>988</b>	<b>5,461</b>	<b>1,036</b>	<b>3,908</b>	<b>2,404</b>	<b>13,797</b>

### Latest on the Inpatient Payment System

- EDS's coding logic for neonate DRG cases to pay an additional \$100 per day in addition to the DRG payment is now in place. We are reviewing all claims since the implementation of the DRGs to determine which claims are eligible for the additional payment. Hospitals will receive an adjusted payment for these cases.
- The logic to pay for awaiting placement days separate from the DRG payment is also in place. Only a few claims have met this criteria so far. We will also be making an adjusted payment for these cases.
- OVHA has put in a clarification request to CMS as to how hospitals should bill OVHA when a patient loses Medicaid eligibility during an inpatient stay. There is still not a final decision from CMS on this matter.
- If a patient exhausts their Medicare coverage during an inpatient stay, OVHA will pay the coinsurance and deductible for the Medicare-covered days and a separate DRG payment for the days where Medicaid is primary payor. The DRG payment will be prorated based on the number of Medicaid-covered to total days on the claim.
- OVHA is beginning the analysis to migrate to MS-DRG Grouper Version 26. There will be meetings in the next few months with the hospitals to discuss this transition.