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# ISSUE PAPER —CONNECTICUT MEDICAL ASSISTANCE PROGRAMS (CMAP) ADDENDUM B

## State of Connecticut Hospital Payment Modernization

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## Overview

To support the modernization of hospital payments in the State of Connecticut (CT), the Connecticut Department of Social Services (DSS) will be implementing ambulatory payment classification (APC) grouper software to process outpatient hospital claims. An integral component of the APC process is the assignment of the APC group and the APC status indicator at the procedure code level. The Centers for Medicare and Medicaid Services (CMS) publishes this information in Medicare's Addendum B, a detailed list, by procedure code of APC group, status indicator, relative weight and payment rate, and updates it each quarter. In keeping with one of DSS' goals for the hospital payment modernization project of mirroring Medicare policy, DSS utilized Medicare's Addendum B as the basis of developing the Addendum B for CT Medicaid. There are instances, however, where CT-specific policy is more appropriate. Mercer worked closely with DSS to develop the CT version of Addendum B, which documents the APC groups, status indicators and relative weights adopted by DSS for the APC methodology.

## Discussion

CT Medicaid's APC processing will be based on a customized version derived from Medicare's Addendum B identified as, CMAP Addendum B. The differences between the CMAP Addendum B and the Medicare version of Addendum B primarily involve service coverage. In many cases, DSS pays for services that are not covered by Medicare, for example, contraceptive services (J7300-J7307). There are also some cases where DSS does not cover services covered by Medicare, such as infertility treatments. This paper describes the process used to develop CMAP Addendum B followed by a description of CMAP Addendum B and how the values will be used to process Medicaid outpatient claims once the APC methodology is implemented. A table showing fields, field descriptions, and valid values for CMAP Addendum B can be found in Appendix A.

### Review Process

The initial CMAP Addendum B was created utilizing Medicare's 2015 Addendum B as a starting point; the following steps were completed to customize CMAP Addendum B:

1. Added CT-specific columns: Payment Type and CT Fee Schedule.

2. Inserted default values of “APC” or “No” in the Payment Type field based on the values of the status indicator.
3. Reviewed procedure codes with value of “No” in the Payment Type field to determine if any of these codes are payable under CT Medicaid policy:
   A. The Payment Type field was updated to fee schedule (FS) if the procedure code was determined to be payable via CT fee schedule.
   B. The appropriate fee schedule value was then listed in the CT Fee Schedule field.
      i. An example of this type of update is procedure code V5010 (Assessment for hearing aid). The payment type is FS and the fee schedule value is MEDS – Hearing Aid fee schedule.
4. Reviewed procedure codes with value of “APC” in the Payment Type field to identify any that are in conflict with CT Medicaid policy. If the procedure code was determined to be not payable under CT policy, the Payment Type field was updated to “No”. An example of this type of update is procedure code 89258 (cryopreservation; embryo(s)). While Medicare APCs cover this code, it is not covered in the CT Medicaid program.
5. Identified any additional payment exceptions based on CT payment decisions and updated the Payment Type field to revenue center code (RCC), lab fee schedule if modifier L1 (L1), manually priced (MP), or to be determined (TBD), as appropriate.
6. Published draft of CMAP-Addendum B (formerly CT-Addendum B) on CT Medical Assistance Program website.

Following the publication of the 2015 draft version of CMAP Addendum B, Mercer and DSS completed the following steps to incorporate the CMS 2016 Addendum B changes into CMAP Addendum B:

1. Applied all updates including adding new codes, deleting obsolete codes, and updating existing codes.
2. Evaluated all new codes to determine CT payment decision.
3. Reviewed changes in status indicator values that resulted in a potential change to the payment type field.
4. Updated Payment Type and Fee Schedule fields to reflect changes in payment type and the inclusion of three new payment types, APC-FS, APC-PR and PA and the removal of payment type TBD.
5. Published the Payment Rate field for payable codes with a status indicator of G or K.
6. Removed APC, relative weight and/or payment rate information for codes not paid via APC or not payable for CT Medicaid.

Following the publication of the 2016 draft version of CMAP Addendum B, Mercer and DSS completed the following steps to incorporate any additional changes that were identified as necessary for the July 1, 2016 implementation.

1. Changed the font to grey for APC related fields if the payment type was not equal to APC. This allowed the values to be displayed but reduced confusion that they were applicable.
2. Added a new payment type of FS-CMAP and associated codes identified as payable to CT Medicaid but not on Medicare’s version of Addendum B.
3. Removed the PA payment type.
4. Completed various miscellaneous updates identified by DSS staff members.
5. Changed the name from CT Addendum B to CMAP Addendum B.

### Update Process

Each quarter, DSS will review the procedure codes for which a change to the Medicare Addendum B is identified to determine if an update to CMAP Addendum B is warranted. The updates will be applied retroactively to claims processed since the effective date to allow for variations in the timing of receiving the Medicare information and completing the CT review process.

## Conclusion

CMAP Addendum B provides necessary documentation of CT-specific payment approaches for outpatient hospital services at the procedure code level. The maintenance of this key document will be ongoing each quarter to ensure any changes in Medicare or Medicaid APC payment methodology are taken into consideration.

## Appendix A

### Field Descriptions for CMAP Addendum B

| Field Label | Field Description | Valid Values |
|---|---|---|
| **Procedure Code** | Five digit CPT or HCPCS code. | See CPT or HCPCS manual. |
| **Short Descriptor** | Short description for the procedure code field. | See CPT or HCPCS manual. |
| **Payment Type** | Identifies the payment method used by DSS to determine if and how the procedure code will be reimbursed. | • APC — reimbursed using APC methodology.<br>• APC-FS — APC (packaged) except a claim for a 'non-patient' , then reimbursed based on the Lab fee schedule.<br>• APC-PR — APC reimbursed based on payment rate.<br>• FS — reimbursed based on the CT fee schedule listed in the CT Fee Schedule field.<br>• FS-CMAP — Reimbursed based on the CT fee schedule listed in CT Fee Schedule field. These codes are not on Medicare Addendum B.<br>• L1 — reimbursed based on Lab fee schedule if modifier L1 present on the detail.<br>• MP — manually priced.<br>• No — not covered by CT Medicaid (payment denied).<br>• RCC — reimbursed based on RCC pricing. |
| **Status Indicator** | The status indicator assigned by CMS. If the Payment Type value is APC, the status indicator will process according to CMS/Medicare guidelines. | See Medicare Addendum D1. |

| Field Label | Field Description | Valid Values |
|---|---|---|
| **APC** | The APC group assigned by CMS for that procedure code. | See Medicare Addendum B for APC group and Medicare Addendum A for APC descriptions. |
| **Relative Weight** | The relative weight assigned by CMS for the APC group assigned. | See Medicare Addendum A or Addendum B. |
| **Payment Rate** | For payable procedure codes with a status indicator of G or K, this field is the rate that the procedure code will be reimbursed. | |
| **CT Fee Schedule** | Identifies which fee schedule will be utilized for a given procedure code. Field is blank if service will not be paid using a fee schedule. | See CT Fee Schedule Legend in Appendix B. |

# Appendix B
## CT Fee Schedule Legend

| Label | Fee Schedule Description |
|---|---|
| **Clinic/OP-BH** | Clinic and Outpatient-Behavioral Health (BH) fee schedule. |
| **Clinic/OP-BH if RCC=900 or 91x** | Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a BH RCC (900 or 91x). All other instances are not payable. |
| **Clinic-BH if RCC=919** | Clinic-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 919. All other instances are not covered. |
| **Dialysis** | Clinic-Dialysis fee schedule. |
| **FP/OFOUT** | For 340B providers, use the Clinic-Family Planning fee schedule. For all others providers, use the Physician Office and Outpatient fee schedule. |
| **LAB** | Lab fee schedule. |
| **LAB - ModL1** | Lab fee schedule only if modifier L1 is present. |
| **MEDS - DME** | MEDS-durable medical equipment (DME) fee schedule. |
| **MEDS - Hearing Aid** | MEDS-Hearing Aid/Prosthetic Eye fee schedule. |
| **NDCLOW** | Reimbursed based on the lower of Estimated Acquisition Cost (EAC), Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) for the NDC and units. |
| **OFOUT** | Physician Office and Outpatient fee schedule. |
| **PHRAD** | Physician Radiology fee schedule. |
| **RCC 401** | The procedure code must be billed with RCC 401 and will be reimbursed based on the rate on file for RCC 401. |
| **RCC 403** | The procedure code must be billed with RCC 403 and will be reimbursed based on the rate on file for RCC 403. |
| **RCC 771** | The procedure code must be billed with RCC 771 and will be reimbursed based on the rate on file for RCC 771. |
| **RCC 901** | The procedure code must be billed with RCC 901 and will be reimbursed based on the rate on file for RCC 901. |
| **RCC 953** | The procedure code must be billed with RCC 953 and will be reimbursed based on the rate on file for RCC 953. |
| **Therapy RCCs** | The procedure code must be billed with one of the appropriate therapy RCCs and will be reimbursed based on the rate on file for the RCC. (421,424,431,434,441,444) |