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ISSUE PAPER — PHARMACY REVENUE CENTER CODE 636

State of Connecticut Hospital Payment Modernization

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Overview

Reliable procedure code data is an essential component of the analytical dataset for development of the Ambulatory Payment Classification (APC) conversion factor. To support the implementation of APCs, provider bulletin 2014-06 was issued by the State of Connecticut Department of Social Services requiring valid procedure codes be billed for certain revenue center codes (RCCs). Due to a flaw in the implementation of this system change, a subset of claim details was missing procedure code data. As a result, the analytical dataset was missing procedure codes for a significant number of pharmacy line items in RCC 636 — primarily for 340B providers.

To address the missing procedure code data, a methodology was applied to line items with missing procedure codes for claim details with RCC 636. Questions that surfaced during the May 26, 2016 APC update meeting for hospitals resulted in a more in-depth review of this methodology and ultimately identified the need for a methodology revision. This issue paper describes the original methodology applied, the revised methodology and the impact of the revised approach.

In addition to RCC 636, other RCCs posted an edit code due to missing procedures, however for all but RCC 636 and 637 an appropriate methodology for handling those line items could not be identified and those line items were excluded from the analysis. Only 98 line items with RCC 637 were impacted by the original methodology. The revised methodology described below was not applied to RCC 637 because the data indicates the original methodology was appropriate for those line items.

Methodology

The analytical dataset was organized into various tables based on a number of criteria including status indicators, edit codes and RCCs. One of these tables was the Not APC Payable table. Originally, the Not APC Payable table contained approximately 100,000 line items with RCC 636 and a blank procedure code. Under APC implementation, it is expected that line items with RCC 636 will be billed with a valid procedure code, therefore an assumption as to how the correctly billed line items would process and pay was necessary.

Original Methodology

For any line item that had an RCC of 636 and a blank procedure code, the line item was moved to the APC table and assigned a status indicator of “N” (packaged).

This approach considered the fact that nearly all line items previously in the APC table with an RCC of 636 were assigned a status indicator of “N”. However, this approach failed to recognize that a significant portion of the line items with RCC 636 were also assigned to other Not APC Payable status indicators, including status indicator “K”.

Revised Methodology

A revised methodology was developed taking into consideration the distribution of line items with RCC 636 across all status indicators — both APC Payable and Not APC Payable. For the hospitals with complete data, a distribution of costs by status indicator was constructed. Instead of assuming the blank data represented only packaged claims with status indicator “N”, the blank data was then redistributed among the status indicators at the same ratios as seen for hospitals with complete data.

The effect of this improved approach is a more reasonable fiscal impact for those hospitals with missing procedure code data for RCC 636. For those hospitals, the original method had understated future payments associated with changing to the APC system.

As a result of the improved approach, approximately $22 million in allowed payments under the current model moved from the APC Payable table back to the Not APC Payable table. Removing this amount from the APC Target payments resulted in a decrease to the conversion factor.

An additional impact is related to the increased number of status indicator “K” claims. For these Not APC Payable claims, the Medicare fee schedule is somewhat lower than the prior method. In the spirit of revenue neutrality, the theoretical reduction in payments arising from this shift, have been added back into the APC Target.

Results

The revised approach for handling blank procedure codes for RCC 636 improves the model’s ability to estimate future payments for 340B hospitals, reducing losses incorrectly attributed to the excessive packaging assumption previously made for these hospitals.

By improving the method, more claims are positively identified for explicit payment and are removed from assumed “packaged” status. As such, the payment target for the APC claims is reduced (as is the conversion factor) to the extent that these claims are not explicitly priced with status indicator “K”.

Finally, with the additional status indicator “K” claims being priced at Medicare fee schedules (slightly lower than current allowed payments), some of these same dollars remain unspent and are moved back to the APC Target via a target adjustment.