



**Employees Group Insurance Department  
Outpatient Facility Reimbursement**

**September 30, 2015**

# Outpatient Background

- Outpatient reimbursement was last reviewed in 2008
- Surgical codes (CPT 10000-69999) and covered revenue codes are reimbursed using percentage of billed charges
  - Urban: 60% of billed charges
  - Rural: 70% of billed charges
- Most remaining codes have an established Allowable Fee ranging from 125% to 300% of Medicare
- No lesser of billed charges or Allowable Fee on a line or claim level
- No multiple procedure discounting
- The Department of Corrections (DOC) utilizes EGID's reimbursement methodology

# Objectives and Analysis

- Primary Objective:
  - Evaluate whether EGID's payment levels for outpatient hospital services are in alignment with common industry practices
    - No changes in methodology for injectables, per diem, commonly-billed dialysis codes
- Analytical Steps:
  - Retained external consulting services to assist in data analysis and identify reimbursement options that are consistent with industry practices
  - Reviewed EGID's utilization, reimbursement levels and historical cost trends
    - Outpatient cost increases are disproportionate to utilization and case mix changes
    - Over 50% of outpatient reimbursement is at a percentage of billed charges

## Objectives and Analysis (continued)

- Assessed current EGID reimbursement levels in the context of:
  - Commercial payer ranges
  - Actual EGID line item (procedure level) versus case level allowed amounts
  - Medicare payment levels and policies
    - Under Medicare’s Outpatient Prospective Payment System (OPPS) certain charges are “packaged” and not reimbursed at a line item level
    - Medicare discounts secondary and tertiary procedures at 50%

## Task Force Process

- Established an outpatient task force and presented the following proposed reimbursement changes in December, 2014
  - CPT 10000-69999:
    - 170% urban/180% rural of Medicare (National Addendum B amounts)
    - Discontinued payment of packaged services (as indicated by Medicare Status Indicators)
  - C-Codes (that are not packaged)
    - 170% urban/180% rural of Medicare
  - Continue with no multiple procedure discount
  - No changes to 7xxxx and 9xxxx series codes
  - Continue with urban/rural differential
  - No outlier payment

## Task Force Process – (continued)

- Most common task force feedback:
  - Establish tiers, similar to the inpatient tiers
  - Continue reimbursement for implants and high cost drugs (revenue codes 274-278, 279, 636)
    - Cost plus approach, OR
    - Percent of billed charges approach with annual cap on chargemaster increases
  - Establish fee schedule with inflation factor rather than tying rates to Medicare
  - Establish different markups over Medicare for different service lines, i.e., higher markup for higher cost services such as orthopedics
  - Larger urban/rural differential
  - Exclude Critical Access Hospitals and Sole Community Hospitals from methodology and continue to pay % of billed charges
  - Phase-in Medicare percentages over three years

## Task Force Process – (continued)

- In order to be responsive to the task force concerns, EGID and its consultant conducted additional data analyses and benchmarking
  - July, 2015 revised proposal incorporated many of the task force recommendations
- Remaining task force concerns
  - Reductions are too large
    - EGID response
      - Shifting from a charge-based reimbursement approach to a fee schedule approach will have a larger impact on facilities that have the highest charges
      - The analysis sought to balance out the impact as much as possible but the ability to do so for facilities with high charges was limited
    - The fully phased-in rates will be among the lowest compared to other Oklahoma commercial payers
      - EGID response
        - Analysis indicates that aggregate reimbursement under the revised proposal will be within close range of market levels

## Task Force Process – (continued)

- The proposal does not account for high cost devices, drugs or specialty services that some facilities provide
  - EGID response
    - The Medicare OPPS is based on resource costs and accounts for high cost devices and drugs within the Ambulatory Payment Classification (APC) rates, which are reviewed and updated annually
    - EGID will follow most of Medicare’s policy regarding package and payment; however, selected implant-related revenue codes will continue to be reimbursed at a percent of billed charges
    - In addition, Medicare uses multiple procedure discounting (MPD); EGID’s proposal does not include MPD, which would result in additional reductions
    - The vast majority of outpatient services billed to EGID are routine surgical procedures

## Task Force Process – (continued)

- Some facilities are calculating a different financial impact than the EGID models
  - EGID response
    - Facilities may be calculating the impact using different assumptions regarding inflation, Medicare rate increases, and/or their anticipated charge master increases
    - Facilities may have misunderstood the pro-forma fee schedule that was provided during the task force process; many codes that are currently allowed at 60%/70% will remain that way when indicated by the Status designation of BR (i.e. G0378)
    - Detailed claim examples provided during the task force process focused only on changes in allowables for those codes where there was a proposed methodology change
- EGID thanks the task force members for their time and consideration during this process

# Revised Proposal

- Create same Tiers as Inpatient
  - Tier 1 – Network urban facilities with greater than 300 beds
  - Tier 2 – All other urban and non-network facilities
  - Tier 3 – Critical Access Hospitals (CAH), Sole Community Hospitals (SCH), Indian, Military and VA Facilities
  - Tier 4 – All other network rural facilities
    - For inpatient, Tier 4 remains frozen until Tier 2 base rate exceeds Tier 4, which is estimated to be in 2023. At that time both inpatient and outpatient Tier 4 will be moved to Tier 2.
- Phase in changes over three years
  - January 1, 2016
  - April 1, 2017
  - April 1, 2018

## Revised Proposal – (continued)

- Code ranges allowed as a tier-specific % of Medicare:
  - Surgery and other procedures within 10000 – 69999 that are not packaged by Medicare
  - Cardiovascular and other procedures within 92900 – 93999 that are not packaged by Medicare
  - HCPCS Cxxxx codes that are not packaged by Medicare

Tier	01/01/2016	04/01/2017	04/01/2018
1	220%	205%	180%
2	210%	195%	170%
3	230%	215%	200%
4	220%	205%	190%

## Revised Proposal – (continued)

- Revenue codes

- Covered revenue codes that are currently allowed at 60%/70% of billed charges (generally, Medicare packaged revenue codes) will initially be allowed at a reduced % of billed charges and then phased out

Tier	01/01/2016	04/01/2017	04/01/2018
All	25%	10%	no payment

- Covered implants will be allowed at the CPT/HCPCS allowable fee, or if no CPT/HCPCS code exists then revenue codes 275, 276, 278, and 279 will be allowed at 30%/35% of billed charges

Tier	01/01/2016	04/01/2017	04/01/2018
1	30%	30%	30%
2	30%	30%	30%
3	35%	35%	35%
4	35%	35%	35%

## Revised Proposal – (continued)

- No phase-in for colonoscopy services; allowables will begin at fully phased-in levels effective 01/01/2016
  - CPT/HCPCS codes

Tier	01/01/2016	04/01/2017	04/01/2018
1	180%	180%	180%
2	170%	170%	170%
3	200%	200%	200%
4	190%	190%	190%

- Revenue codes associated with colonoscopy procedures currently allowed at 60%/70% will initially be allowed at a reduced % of billed charges and then phased out

Tier	01/01/2016	04/01/2017	04/01/2018
All	25%	10%	no payment

## Revised Proposal – (continued)

- No methodology changes to 7xxxx, 8xxxx, and 9xxxx series codes
- No changes to injectables, dialysis, per diem
- No multiple procedure discount
- Clinical edits will still apply
- Plan provisions and limitations regarding non-covered services will still apply

## Revised Proposal – (continued)

- Timing of fee schedule updates:
  - The fee schedule for January 1, 2016 implementation will be based on the July 1, 2015 National Addendum B amounts
    - Will be posted on the provider website after September 30, 2015
  - January 1, 2016 – update for adds, changes and deletes
  - April 1, 2016 – comprehensive update based on the January 1, 2016 National Addendum B amounts
  - July 1, 2016, October 1, 2016, and January 1, 2017 – updates for adds, changes and deletes
  - April 1, 2017 – comprehensive update based on the January 1, 2017 National Addendum B amounts
  - July 1, 2017, October 1, 2017, and January 1, 2018 – updates for adds, changes and deletes
  - April 1, 2018 – comprehensive update based on the January 1, 2018 National Addendum B amounts

## Impact of Proposed Changes

- While most hospitals will experience an increase at the line (procedure) level, they may experience overall reductions in case level payments.
  - Primarily due to phase-out of codes considered packaged by Medicare
- Greater impact for hospitals with relatively high charges
- Fully phased-in payment levels will result in a per case payment that is within range of Oklahoma commercial payer levels.

# Time Line

Item	Date
Public Hearing	09/30/15
Public Hearing Written Comments Due	10/09/15
Final Recommendations Posted on Website	10/27/15
Implementation of First Phase	01/01/16
Implementation of Second Phase	04/01/17
Implementation of Third Phase	04/01/18