EGID
CY2018 Outpatient Hospital Reimbursement
Fee Modeling for Cases with CMS J1 Status Indicators Using CMS J1 Methodology

Introduction

Under the CMS Hospital Outpatient Prospective Payment System OPPS, CPT codes assigned a J1 modifier in the CMS OPPS Addendum B are assigned to a comprehensive APC (C-APC). The single payment for the C-APC includes all services and items included on the outpatient claim. There are a few carve-out items that receive separate reimbursement. The C-APC is assigned based on the primary CPT code with a J1 modifier. A **complexity adjustment** is made for certain combinations of primary and secondary CPT codes.

EGID Application of CMS Policy

A) EGID will be applying similar bundling logic to its outpatient hospital claims beginning Jan. 1, 2019. Claims with at least one CPT code that have a CMS J1 status indicator will be bundled into a single unit reimbursement for the primary J1 CPT code. The following procedure/items will be bundled into the payment for the primary procedure:
   - Secondary procedures in the CPT range 10000-69999 or 92900-93999 (with or without a J1 status indicator).
   - Units for the primary J1 procedure beyond 1.
   - Services that are typically bundled for hospital outpatient surgery claims under EGID's April 2018 Outpatient Fee Schedule. Examples include: NC – non-covered services, UB-revenue code items without a vaild-CPT code, and CPT codes that are assigned a $0 fee.
   - Implants that are billed with just a UB-revenue code are not paid separately and are bundled into the J1 procedure fee.
   - All other items, procedures or services that CMS does not specifically carve-out as a pass-through for J1 reimbursement (i.e., most lab, radiology, drugs and supplies will be bundled into the J1 procedure reimbursement).

B) The following items will be paid separately in accordance with the CMS methodology:
   - Diagnostic and screening mammograms.
   - Preventive services as defined in 42 CFR410.2.
   - Ambulance services.
   - Items, procedures or services that have a CMS OPPS Status Indicator of F, G, H, L or U.
     - F is for corneal tissue acquisition cost, certain CRNA services, and Hepatitis B vaccines.
     - G is for pass-through drugs and biologicals.
     - H is for pass-through devices.
     - L is for influenza and pneumococcal pneumonia vaccines.
     - U is for brachytherapy sources.

Steps to Model J1 Reimbursement Using EGID Approach

- Determine if the claim has a unit or units billed with a CPT code with CMS J1 status indicator. If it does go to the next step; otherwise, the claim will be reimbursed under the standard EGID hospital outpatient payment methodology.

- Determine if the claim has multiple units of J1 procedure or procedures. If there is only one unit billed with one J1 CPT code, then the claim is a single procedure claim. The fee on the EGID hospital outpatient fee schedule will be the J1 reimbursement. All other services will be packaged and not paid separately unless the item is listed under B above. If the items are separately payable, then the EGID Hospital Outpatient Fee Schedule is referenced.

- If the claim has multiple J1 units or J1 CPTs, then determine which CPT code has the highest CMS ranking. Use the CMS OPPS Addendum J schedule to determine the CPT ranking or the attachment. **The lowest numerically ranked CPT code is defined as the primary CPT code** for the claim. If there is not a **complexity adjustment,** the EGID Hospital Outpatient Fee Schedule will be the J1 reimbursement. All other services or procedures **will be bundled and not reimbursed separately** even if there is a separate fee assigned on the EGID Hospital Outpatient Fee Schedule unless it is a carve out item mentioned in B above.

- Determine if the claim should have a **complexity adjustment.** Generally, CMS established the procedure oriented APCs with different levels of groups of surgeries. For example, APCs 5191-5194 are for endovascular procedures and there is an APC for each of the four levels of complexity. Certain combinations of procedures will receive a complexity adjustment to the next highest APC within the same family of procedures. The combinations of CPT codes and the next highest APC assigned are included in the CMS Addendum J or the attachment.

    - Use the table name CMS Complexity Adj APC Lookup to determine if the primary CPT **with any of its secondary CPTs** (or a second unit of the primary) are in the table and then therefore receive a complexity adjustment (i.e., the next highest level APC assignment).

    - If the CPT combination is included in the CMS Complexity Adj APC Lookup, then lookup the new APC Assignment (i.e., the Complexity Adjustment Assigned APC) in the next table – the excerpt from the CMS Addendum A with the EGID tier fees added to it. The higher payment is the new bundled fee for the multiple procedures on the claim. Note that many claims will not receive a complexity adjustment as it is only for a certain combination of CPT codes.

    - The bundling rules for other procedures and services will apply the same as described in above.