Connecticut Medical Assistance Program PB 2014-88

Policy Transmittal 2014-35 December 2014

Roderick L. Bremby, Commissioner

Effective Date: January 1, 2015

Contact: Barbara Fletcher @ 860-424-5136

TO: Hospitals and Physicians

RE: Billing for Emergency Department Services

In response to providers' inquiries and in order to clarify the Department of Social Services' billing requirements, the purpose of this policy transmittal is to notify hospitals and physicians that the current billing policies and procedures for emergency department physicians will remain in place until further guidance is issued. Specifically, those policies and procedures will not be modified until the Department modernizes its outpatient hospital reimbursement methodology using Ambulatory Payment Classifications pursuant to section 17b-239(d)(2) of the Connecticut General Statutes. That change is tentatively scheduled for implementation in mid-2016.

In the 2014 legislative session, the General Assembly passed Public Act (PA) 14-160. Subsection (e) of PA 14-160 provides for separate reimbursement for emergency department physicians, but only at rates that result in no additional costs to the State. Subsection (j) directs the Department to submit written notice to the Connecticut General Assembly's Human Services and Appropriations Committees if it is unable to implement the provisions of subsection (e).

In accordance with subsection (j) of PA 14-160, the Department has notified the Committees of cognizance that it is unable to implement subsection (e) for the reasons described in the attached Issue Brief.

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Responsible Unit: DSS, Division of Health Services, Medical Policy and Regulations, Barbara Fletcher, Supervisor, Medical Policy at (860) 424-5136

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Department of Social Services

Issue Brief: Direct Medicaid Billing by Emergency Department Physicians

November 2014

Conclusion

After careful analysis, the Department is unable to implement direct Medicaid reimbursement for hospital emergency department (ED) physicians on January 1, 2015 because:

- The change would require large payment reductions to hospitals and other physicians in order to reimburse ED physicians directly while keeping budget neutrality, as required.
- The Department is unable to estimate the fiscal impact accurately due to likely changes in billing practice that cannot be quantified.
- The federal Centers for Medicare & Medicaid Services (CMS) advised that it would be challenging to unbundle physician payments in the ED without unbundling physician payments in all outpatient hospital settings.

Background

Subsection 1(e) of Public Act 14-160 provides for direct Medicaid reimbursement for emergency department physicians for professional services provided in the ED on and after January 1, 2015, with rates established to ensure budget neutrality. Subsection 1(j) provides that if the Department cannot implement this change by January 1, 2015, the Department must notify the Human Services and Appropriations Committees explaining the reasons why the change cannot be implemented by that date and the date when the Department will be able to implement the change.

Services provided in the ED are either an emergency service or an urgent service. For an emergency service, the hospital bills two procedure codes: Revenue Center Code (RCC) 450 (the facility component) and RCC 981 (the professional component). For urgent services, the hospital bills RCC 456 (bundled code for both the facility and professional components).

Analysis

Emergency services. In theory, the Department could remove RCC 981 from the hospital fee schedule and allow ED physicians to bill for professional services using the physician fee schedule. However, instead of the hospital billing only RCC 981, the physician could bill multiple Current Procedural Terminology (CPT) codes on the physician fee schedule, in addition to the CPT code for the ED visit. Estimating the volume and cost of those additional procedures is enormously difficult and any estimate (based on assumptions and guesses) is unlikely to be accurate.

Urgent services. In order to keep the change budget neutral, the Department would need to ensure that the total payments for both the facility and professional services of an urgent visit are not greater

than the current bundled fee of $57. In practice, in order to unbundle this payment into separate payments for the hospital and the physician, the Department would need to drastically reduce either the payment to the hospital for RCC 456, payments to all physicians for related services on the physician fee schedule, or both. Such large reductions are not feasible because the Department needs to make sure Medicaid members have access to hospital and physician services.

Outpatient Hospital Modernization. As part of the Hospital Modernization project, the Department will restructure its payment methodology for outpatient hospitals using the Ambulatory Payment Classification (APC) payment system, similar to Medicare. Implementing the APC system will include unbundling physician services for all outpatient hospital services, as part of a comprehensive analysis to ensure that the changes are budget neutral to the state and ensure proper access to hospital and physician services.

CMS Guidance: CMS has advised that it would be challenging to reimburse ED physicians directly without making direct payments to physicians for all outpatient hospital professional services. CMS needs to approve any change in Medicaid reimbursement methodology through a Medicaid State Plan Amendment.

Timeline

For the reasons described above, the Department is unable to implement separate reimbursement of hospital ED physicians on January 1, 2015. The Department will be able to implement this change as part of the implementation of outpatient hospital modernization using the APC system (currently targeted for mid-late 2016).