How to Use the Official Connecticut Fee Schedule For Hospitals and Ambulatory Surgical Centers – A Primer for Attorneys

September 15, 2020

10:00 a.m. – 11:00 a.m.

CT Bar Association

Webinar

CT Bar Institute Inc.

CT: 1.0 CLE Credit (General)
NY: 1.0 CLE Credit (AOP)

Seminar Materials Sponsored by

Lawyers' Principles of Professionalism

As a lawyer I must strive to make our system of justice work fairly and efficiently. In order to carry out that responsibility, not only will I comply with the letter and spirit of the disciplinary standards applicable to all lawyers, but I will also conduct myself in accordance with the following Principles of Professionalism when dealing with my client, opposing parties, their counsel, the courts and the general public.

Civility and courtesy are the hallmarks of professionalism and should not be equated with weakness;

I will endeavor to be courteous and civil, both in oral and in written communications;

I will not knowingly make statements of fact or of law that are untrue;

I will agree to reasonable requests for extensions of time or for waiver of procedural formalities when the legitimate interests of my client will not be adversely affected;

I will refrain from causing unreasonable delays;

I will endeavor to consult with opposing counsel before scheduling depositions and meetings and before rescheduling hearings, and I will cooperate with opposing counsel when scheduling changes are requested;

When scheduled hearings or depositions have to be canceled, I will notify opposing counsel, and if appropriate, the court (or other tribunal) as early as possible;

Before dates for hearings or trials are set, or if that is not feasible, immediately after such dates have been set, I will attempt to verify the availability of key participants and witnesses so that I can promptly notify the court (or other tribunal) and opposing counsel of any likely problem in that regard;

I will refrain from utilizing litigation or any other course of conduct to harass the opposing party;

I will refrain from engaging in excessive and abusive discovery, and I will comply with all reasonable discovery requests;

In depositions and other proceedings, and in negotiations, I will conduct myself with dignity, avoid making groundless objections and refrain from engaging I acts of rudeness or disrespect;

I will not serve motions and pleadings on the other party or counsel at such time or in such manner as will unfairly limit the other party's opportunity to respond;

In business transactions I will not quarrel over matters of form or style, but will concentrate on matters of substance and content;

I will be a vigorous and zealous advocate on behalf of my client, while recognizing, as an officer of the court, that excessive zeal may be detrimental to my client's interests as well as to the proper functioning of our system of justice;

While I must consider my client's decision concerning the objectives of the representation, I nevertheless will counsel my client that a willingness to initiate or engage in settlement discussions is consistent with zealous and effective representation;

Where consistent with my client's interests, I will communicate with opposing counsel in an effort to avoid litigation and to resolve litigation that has actually commenced;

I will withdraw voluntarily claims or defense when it becomes apparent that they do not have merit or are superfluous;

I will not file frivolous motions;

I will make every effort to agree with other counsel, as early as possible, on a voluntary exchange of information and on a plan for discovery;

I will attempt to resolve, by agreement, my objections to matters contained in my opponent's pleadings and discovery requests;

In civil matters, I will stipulate to facts as to which there is no genuine dispute;

I will endeavor to be punctual in attending court hearings, conferences, meetings and depositions;

I will at all times be candid with the court and its personnel;

I will remember that, in addition to commitment to my client's cause, my responsibilities as a lawyer include a devotion to the public good;

I will endeavor to keep myself current in the areas in which I practice and when necessary, will associate with, or refer my client to, counsel knowledgeable in another field of practice;

I will be mindful of the fact that, as a member of a self-regulating profession, it is incumbent on me to report violations by fellow lawyers as required by the Rules of Professional Conduct;

I will be mindful of the need to protect the image of the legal profession in the eyes of the public and will be so guided when considering methods and content of advertising;

I will be mindful that the law is a learned profession and that among its desirable goals are devotion to public service, improvement of administration of justice, and the contribution of uncompensated time and civic influence on behalf of those persons who cannot afford adequate legal assistance;

I will endeavor to ensure that all persons, regardless of race, age, gender, disability, national origin, religion, sexual orientation, color, or creed receive fair and equal treatment under the law, and will always conduct myself in such a way as to promote equality and justice for all.

It is understood that nothing in these Principles shall be deemed to supersede, supplement or in any way amend the Rules of Professional Conduct, alter existing standards of conduct against which lawyer conduct might be judged or become a basis for the imposition of civil liability of any kind.

--Adopted by the Connecticut Bar Association House of Delegates on June 6, 1994

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Emily Casey presenting:

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Questions and Answers – 5 mins.

Faculty Biography

Emily R. Casey, Esq.

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Practice

Attorney Emily R. Casey practices primarily in the areas of Workers' Compensation, Medicaid Revenue Recovery and Medicaid Audit & Compliance.

Profile

Ms. Casey joined the firm of Tobin, Carberry, O'Malley, Riley & Selinger in 2013. She has worked in the Healthcare law section of the firm for seven years and represents thirteen client hospitals. Since the implementation of the *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers* in 2015, Ms. Casey has represented her clients at many hearings before the Workers' Compensation Commission on the issue of the correct reimbursement of hospital bills. Prior to joining the firm, Ms. Casey worked as a consultant for Immigration and Customs Enforcement (ICE) in connection with a criminal investigation conducted by the Southern District of New York of a suspected major stolen antiquities dealer. From 2004 to 2009, Ms. Casey was a contract archaeologist and worked as a crew chief for a cultural resource management firm.

Education

Ms. Casey graduated cum laude from Drew University in 2004 with a Bachelor of Arts Degree in both Anthropology and Classical Studies. She also attended Yale University where she received a Master's Degree in Archaeological Studies in 2008. Ms. Casey went on to earn her Law degree from the DePaul University College of Law in 2012, with a certificate in Arts and Museum Law. Ms. Casey served as a senior law student in the DePaul Technology and Intellectual Property Clinic. Ms. Casey clerked at the Chicago History Museum in 2011, focusing on intellectual property, trademark licensing issues, employment and health care law. She served on the board of the National Cultural Heritage Moot Court Competition in 2010 to 2012. She was a Senior Service Award recipient in 2012 for her exceptional service to the DePaul University Community. In 2012, Ms. Casey clerked at the firm of Ladas & Parry LLP.

Professional Memberships/Associations

Ms. Casey admitted to practice in Connecticut, and is a member of the American, Connecticut and New London Bar Associations.

How to Use the *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers*

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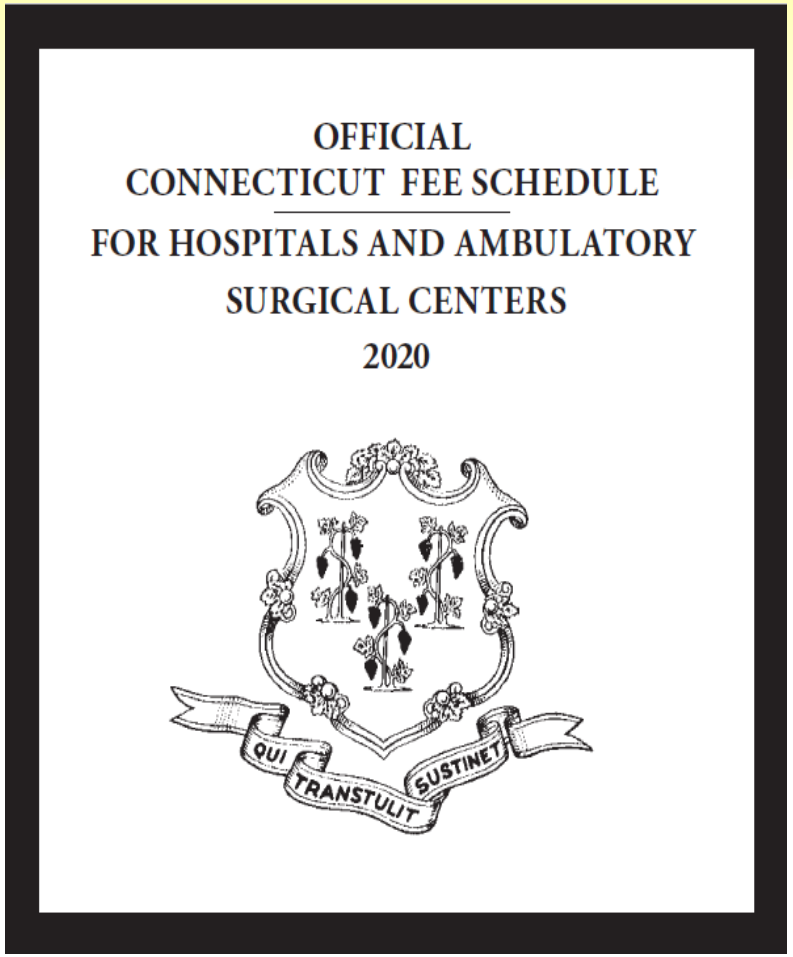
Pursuant to C.G.S. §31-294d (as amended by Public Act 14-167) the Workers' Compensation Commission established the Fee Schedule

The Fee Schedule is Medicare-based and follows Medicare's formulas and rules, with some CT specific exceptions



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The Hospital Fee Schedule

- Applies to all dates of service rendered on and/or after April 1, 2015
- Based on the date of service, not the date of injury
- The Fee Schedule runs from April 1st to March 31st of every year

Inpatient and Outpatient Reimbursement:

- The Inpatient rate is **174%** of the Medicare rate payable to that facility on the date of service
- The Outpatient and Hospital-based Ambulatory Surgery rate is **210%** of the Medicare rate payable to that facility on the date of service
- The Non-Hospital based Ambulatory Surgery rate is **195%** of the Medicare rate payable in the same CBSA (Core Based Statistical Area) on the date of service

Hospital bills must be paid according to the Fee Schedule unless a different rate is negotiated between the parties (i.e. PPO contract or single-case agreement)

Time Limits

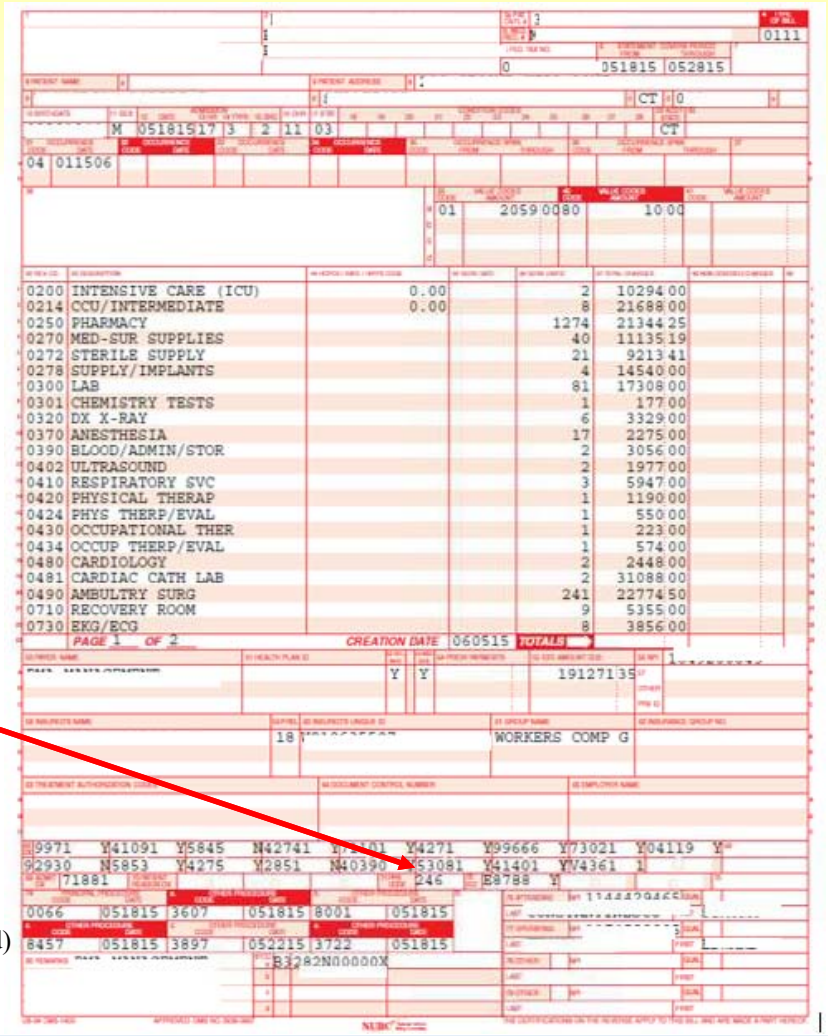
- Bills must be submitted within **180 days** of service
- Payors must pay within **60 days** of receipt of bill
  - Payment made after **60 days** must include interest at the rate of **1.5% per month**
- Hospitals have **60 days** to request a reconsideration
  - After 60 days requests to review will not be considered unless the parties agree otherwise

Inpatient Admissions

- For inpatient cases Medicare uses the DRG or diagnostic related group system which groups each case on the basis of the primary diagnosis.
- The DRG code and admission information are then put into Medicare's PC Pricer tool following instructions located online at the CMS Medicare website
- CT Specific Rule – once you have Medicare's DRG calculation you then multiply that amount by 174% to get the Fee Schedule rate due

Inpatient Admissions

- The DRG code is located in Form Locator (FL) box 71 on the UB-04



UB-04 for an Inpatient Admission (redacted)

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Inpatient Admissions

07/05/2019 FY 2018 INPATIENT PROSPECTIVE PAYMENT (IPPS) PAYMENT RESULTS

CALCULATOR VERSION: C19.0

CLAIM RETURN CODE: 14 - Paid normal DRG payment with perdiem days = or > GM ALOS.

** PROVIDER DETAILS **		** CLAIM DETAILS **		** PPS FACTORS & ADJUSTMENTS **	
PROVIDER #:	070022	PATIENT ID:		OP/CAR CCR:	0.2750/0.0120
PSF EFF DATE:	03/15/2019	DRG:	299	OP/CAR DSH:	0.1682/0.0000
PROVIDER TYPE:	07	DISCHARGE DATE:	04/06/2019	OPERATING IME:	000000.242002089
GEO/STD CBSA:	35300/ 07	LENGTH OF STAY	003	CAPITAL IME:	000000.199435340
RECLASS CBSA:	35004	CHARGES:	$22,096.88	NAT LABOR%:	0.6830
				NAT NLABOR%:	0.3170
				NAT LABOR:	6.2700
				NAT NLABOR:	9.8100
** CAPITAL AMOUNTS **		** OPERATING AMOUNTS **		INP WAGE INDX:	01.3348
				INP PR WAGE:	00.0000
				INP DRG WGHT:	01.4504
				INP GM ALOS:	03.9
C-FSP:	$812.05	O-FSP:	$10,061.66	TRANSFER ADJ:	0.0000
C-OUTLIER:	$0.00	O-HSP:	$0.00	READMIT ADJ:	0.9897
C-DSH:	$0.00	O-Outlier:	$0.00	VBP ADJ:	1.00050255150
C-IME:	$161.95	O-DSH:	$423.09	BUNDLE %:	0.000
		O-IME:	$2,434.94	EHR RED IND:	
		UNCOMP CARE:	$741.04	HAC RED IND:	N
		READMIT:	$103.64CR	COST OUTLIER:	$0.00
** OTHER PPS AMOUNTS **		VBP:	$5.06		
		NEW TECH:	$0.00		
HAC ADJ:	$0.00				
LOW VOLUME:	$0.00	~~~~~~~~~~~~~~~~~~~~			
PASS THRU AMT:	$596.61	* *			
ISLET ADD-ON:	$0.00	* TOTAL PAYMENT *			
EHR ADJ:	$0.00	* *			
BUNDLE ADJ:	$0.00	* $15,132.76 *			
MA-HSP:	$0.00	~~~~~~~~~~~~~~~~~~~~			

PC Pricer calculation example

The total Medicare payment rate is then multiplied by 174% for CT

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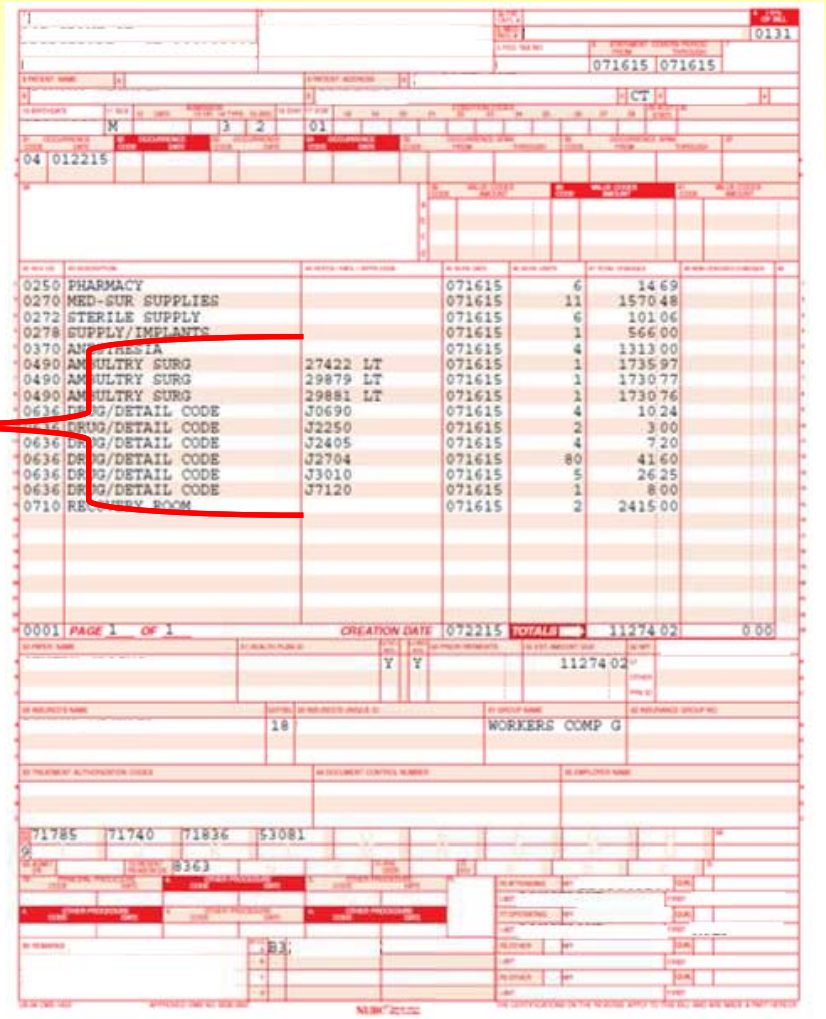
Outpatient Admissions

- Outpatient cases are more complicated to calculate
- Need to have an understanding of CPT/HCPCS codes and status indicators
  - CPT = Current Procedural Terminology
  - HCPCS = Healthcare Common Procedure Coding System

Outpatient Admissions

- The CPT codes are located in FL box 44 on the UB-04



UB-04 for an Outpatient Admission (redacted)

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Outpatient Admissions

- Unlike inpatient cases that use the Medicare website, outpatient cases need the Fee Schedule which already includes the 210% markup in the amounts listed

- Each CPT code will have a status indicator which tells you if it will be paid or bundled into the other codes

Outpatient Admissions

- Medicare bundles codes together so not every CPT code will have a reimbursable amount

CPT Code	Billed Charge	Status Indicator	Amount Due Per Index Group D	Calculated Reimbursement Amount
73610	$750.00	Q1	$150.00	$0.00
73630	$750.00	Q1	$150.00	$0.00
99285	$2,000.00	J2	$3,000.00	$3,000.00
Totals	$3,500.00			$3,000.00

*Reimbursement amounts are for example purposes only

Outpatient Admissions

Hospital Outpatient Core Based Statistical Area Table

Hospitals within Connecticut have been identified by CMS, based on the name and location, and have been assigned to a core based statistical area (CBSA).

The Hospital Outpatient CBSA Table includes the following columns:

- Provider/Organization Name
  - The providers/organizations are listed alphabetically
- Provider Number
  - The provider number is needed for inpatient pricing (see the Hospital Inpatient section for PC Pricer instructions).
- CBSA Name
  - CBSA name will be blank for rural areas
- Index Group
  - Each city or area is assigned to one of six CBSA areas
  - For purposes of this table and the hospital outpatient and hospital-based ASC fee schedule each CBSA is identified by an index group: A, B, C, D, E, or F

NOTE: Some provider organizations are in new index groups for 2020. Please check the index group.

Provider/Organization Name	Provider Number	CBSA Name (Blanks are Rural)	Index Group
Bridgeport Hospital	070010	Bridgeport-Stamford-Norwalk, CT	E
Bristol Hospital	070029	Hartford-West Hartford-East Hartford, CT	A
Charlotte Hungerford Hospital	070011		D
Connecticut Hospice Inc,the	070038	New Haven-Milford, CT	F
Danbury Hospital	070033	Bridgeport-Stamford-Norwalk, CT	C
Day Kimball Hospital	070003	Worcester, MA-CT	A
Greenwich Hospital Association -	070018	Bridgeport-Stamford-Norwalk, CT	E
Griffin Hospital	070031	New Haven-Milford, CT	F
Hartford Hospital	070025	Hartford-West Hartford-East Hartford, CT	A
Hebrew Home And Hospital Inc	070040	Hartford-West Hartford-East Hartford, CT	A
Hospital Of Central Connecticut, The	070035	Hartford-West Hartford-East Hartford, CT	A
John Dempsey Hospital	070036	Hartford-West Hartford-East Hartford, CT	B

In order to look up the CPT codes you need to know which Index Group the hospital falls into

Outpatient Admissions

Index Groups

Status Indicator

Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers — Outpatient Facility

HOSPITAL OUTPATIENT AND HOSPITAL-BASED ASC FEE SCHEDULE — **60000–69990**

Effective April 1, 2020

CODE	DESCRIPTION	SI	INDEX GROUP A	INDEX GROUP B	INDEX GROUP C	INDEX GROUP D	INDEX GROUP E	INDEX GROUP F	RELATIVE WEIGHT	DEVICE %
69667	REPAIR ROUND WINDOW FISTULA	J1	$6,142.75	$6,301.16	$6,338.13	$6,343.74	$6,354.30	$6,663.87	32.4198	1.50%
69670	MASTOID OBLITERATION SEPARATE PROCEDURE	J1	$11,375.44	$11,668.80	$11,737.25	$11,747.64	$11,767.20	$12,340.48	60.0365	4.70%
69676	TYMPANIC NEURECTOMY	J1	$6,142.75	$6,301.16	$6,338.13	$6,343.74	$6,354.30	$6,663.87	32.4198	1.50%
69700	CLOSURE POSTAURICULAR FISTULA MASTOID SPX	J1	$3,164.47	$3,246.07	$3,265.12	$3,268.01	$3,273.45	$3,432.92	16.7012	2.80%

CPT Codes

Reimbursement Rates

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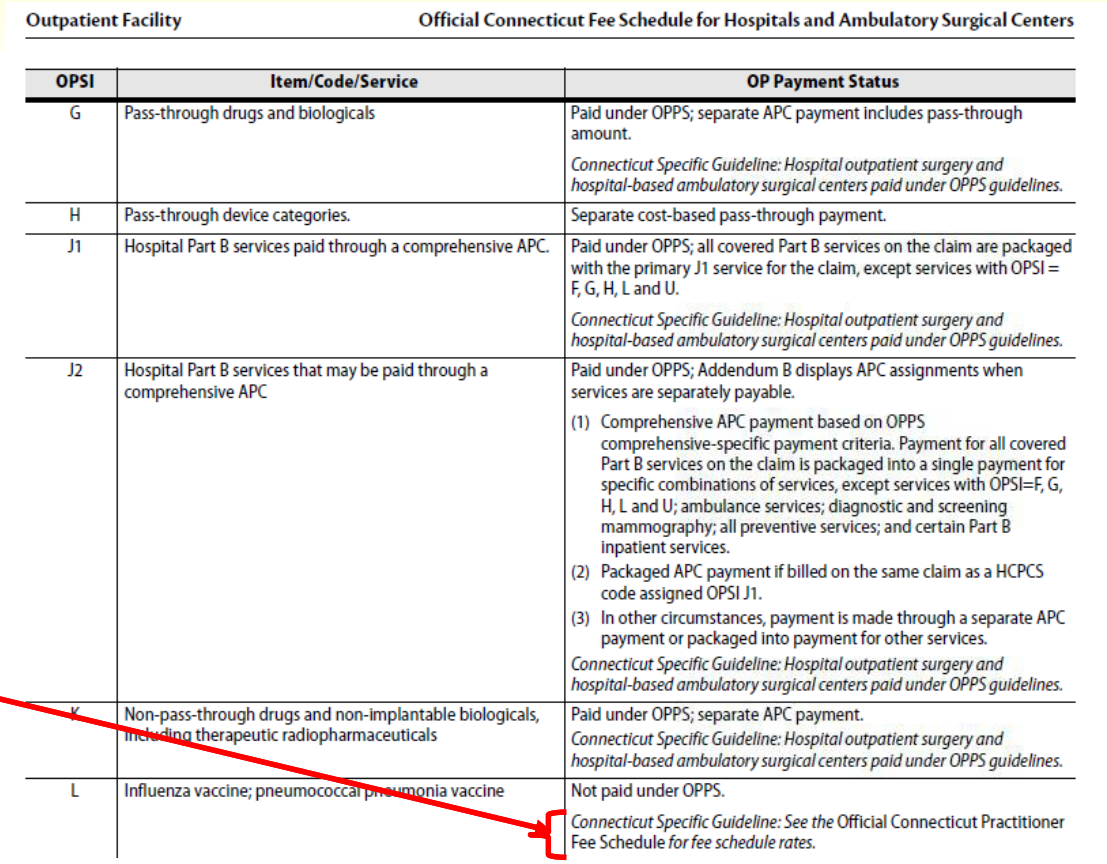
Outpatient Admissions

- Status Indicators tell you if the code is payable or bundled
- CT specific guidelines apply
  - Example: L codes are paid per the Practitioner Fee Schedule



Outpatient Facility — **Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers**

OPSI	Item/Code/Service	OP Payment Status
G	Pass-through drugs and biologicals	Paid under OPPS; separate APC payment includes pass-through amount. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
H	Pass-through device categories.	Separate cost-based pass-through payment.
J1	Hospital Part B services paid through a comprehensive APC.	Paid under OPPS; all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPSI = F, G, H, L and U. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
J2	Hospital Part B services that may be paid through a comprehensive APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPSI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. (2) Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI J1. (3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
K	Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals	Paid under OPPS; separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
L	Influenza vaccine; pneumococcal pneumonia vaccine	Not paid under OPPS. *Connecticut Specific Guideline: See the* Official Connecticut Practitioner Fee Schedule *for fee schedule rates.*

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Hospital Fee Schedule vs. Practitioner Fee Schedule

- All hospital bills have to be calculated per the Hospital Fee Schedule, but it will direct the payor to the Practitioner Fee Schedule for the reimbursement amount on some services

- Services payable per the Practitioner Fee Schedule on hospital bills:
  - Physician Services/Professional Fees
  - Outpatient Physical Therapy
  - Outpatient Occupational Therapy
  - Radiology
  - Pathology

The *Official Connecticut Practitioner Fee Schedule*, as it pertains to hospitals, applies to all physician services and all outpatient physical therapy, occupational therapy, radiology, and pathology. It does not apply to any services which flow from an emergency room visit. It does not apply to inpatient hospital services or any other hospital services. See the *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers* for further information regarding hospital and ASC billing and reimbursement.

Procedures with no Medicare Rate

CT Specific Rule = the parties shall negotiate the reimbursement rate

If negotiation is not successful, the parties may request a hearing with the Commission

Procedures with no Medicare Rate

Examples of codes with no rates: E1 and C codes

OPSI	Item/Code/Service	OP Payment Status
E1	Items, codes and services: • Not covered by any Medicare outpatient benefit category • That are not covered by Medicare based on statutory exclusion • Not reasonable and necessary	Not paid under OPPS. *Connecticut Specific Guideline: Where there is no Medicare rate for the procedure, the parties shall negotiate the reimbursement rate.*
C	Inpatient procedures	Not paid under OPPS. *Connecticut Specific Guideline: Where there is no Medicare rate for the procedure, the parties shall negotiate the reimbursement rate.*

PPO Contracts

- Critical to know terms and who is entitled to the discount
- Many PPO agreements incorporate the Fee Schedule rate so you have to calculate the rate first in order to see how the PPO applies

PPO Discounts

Typically three types of discounts:

1. Discount off of Billed Charges
2. Discount off of Fee Schedule rate
3. Discount off of Billed Charges OR Fee Schedule rate, whichever is lesser

PPO Discounts

1. Discount off of Billed Charges

Only a copy of the bill is necessary to take the discount

No Fee Schedule rate calculation needed, but the discount must be taken off of the full billed charges

PPO Discounts

Example: PPO Discount 10% off of Billed Charges

CPT Code	Billed Charge	Status Indicator	Amount Due Per Index Group D	Calculated Reimbursement Amount
73610	$750.00	Q1	$150.00	$0.00
73630	$750.00	Q1	$150.00	$0.00
99285	$2,000.00	J2	$3,000.00	$3,000.00
Totals	$3,500.00			$3,000.00
10% Discount	$350.00			
Total Due	**$3,150.00**			

Here it would not matter that the Fee Schedule rate is lesser

PPO Discounts

2. Discount off of Fee Schedule rate

Must calculate what is due pursuant to the Fee Schedule

The discount must be taken off of the Fee Schedule rate – the billed charges do not factor in the calculation

PPO Discounts

Example: PPO Discount 10% off of Fee Schedule Rate

CPT Code	Billed Charge	Status Indicator	Amount Due Per Index Group D	Calculated Reimbursement Amount
73610	$750.00	Q1	$150.00	$0.00
73630	$750.00	Q1	$150.00	$0.00
99283	$2,000.00	J2	$3,000.00	$3,000.00
Totals	$3,500.00			$3,000.00
			10% Discount	$300.00
			Total Due	**$2,700.00**

Here it would not matter what the billed charges were

PPO Discounts

3. **Discount off of Billed Charges OR Fee Schedule rate, whichever is lesser**

Must know the billed charges and the calculated Fee Schedule rate

The discount must be taken off of the whole billed charges or the whole Fee Schedule rate – cannot pick and choose which line is paid at which rate

PPO Discounts

Example: PPO Discount 10% off of Billed Charges OR Fee Schedule Rate, whichever is lesser

CPT Code	Billed Charge	Status Indicator	Amount Due Per Index Group D	Calculated Reimbursement Amount
73610	$750.00	N	$150.00	$0.00
73630	$750.00	N	$150.00	$0.00
99283	$2,000.00	J2	$3,000.00	$3,000.00
Totals	$3,500.00			$3,000.00

Billed Charges	$3,500.00
Fee Schedule Rate	$3,000.00

10% Discount off of Fee Schedule as it is lesser

Discount	$300.00
Total Due	**$2,700.00**

Examples of Common Mistakes

Incorrect PPO calculation – picking and choosing line by line

10% Discount off of FS or BC, whichever is lesser

CPT Code	Billed Charge	Fee Schedule Rate	Paid Amount
73610	$750.00	$0.00	$0.00
73630	$750.00	$0.00	$0.00
99283	$2,000.00	$3,000.00	$1,800.00
Total			$1,800.00

Examples of Common Mistakes

Down-coding with no support or explanation

Reviewers making coding adjustments are required to provide supporting evidence and the rationale for their conclusions to the facility at the time payment is made based on the reduced amount. The material provided should indicate both the billed code and the code on which payment is made.

	CPT Code Billed	Changed CPT Code
	99285	99283
Reimbursement Amount	$1,283.55	$568.21

Examples of Common Mistakes

Issuing late payment without interest –
if paid after 60 days of receipt interest at 1.5% is mandatory

> Payers must remit payment within 60 days of receipt of appropriate documentation for compensable claims. Payment made after the 60th day must include interest payment at the rate of 1.5 percent per month.

Examples of Common Mistakes

Vaccine Administration Bundling

CPT Code	Description	Status Indicator	Billed Charge	Fee Schedule Rate	Paid Amount
90715	Drug	N	$351.52	-	$0.00
J0690	Drug	N	$15.26	-	$0.00
J2270	Drug	N	$63.74	-	$0.00
90471	Vaccine Admin	S	$21.00	$134.82	$21.00
Totals			$451.52	$134.82	$21.00

Examples of Common Mistakes

- Not contacting the provider to negotiate codes with no Medicare rate
- Payment or denial issued with no attempt to contact provider

Messages	
323	THE MAXIMUM DAILY LIMIT FOR PHYSICAL THERAPY HAS BEEN REACHED.
356	THIS ALLOWANCE WAS BASED ON THE FEE SCHEDULE AMOUNT.
616	THIS CODE HAS A STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS.
618	THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
619	THIS SERVICE DOES NOT HAVE A MEDICARE RATE PER THE STATE GUIDELINES THE PARTIES SHALL NEGOTIATE THE REIMBURSEMENT RATE.
630	THIS SERVICE IS PACKAGED WITH OTHER SERVICES PERFORMED ON THE SAME DATE AND REIMBURSEMENT IS BASED ON A SINGLE COMPOSITE APC RATE.
PP1	PRICING APPLIED VIA PRIME HEALTH SERVICES. FOR INQUIRIES, PLEASE CONTACT 866-348-3887.

Official
Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers

Effective April 1, 2020

Introduction

The materials contained in this directive are general guidelines for reviewers, payers, and facilities for compensable claims payable under Connecticut Workers' Compensation. The intent of issuing this directive is to clarify billing and payment rules and to facilitate the processing of claims. Please note that surgical billing is based on a surgical package as defined by the Centers for Medicare and Medicaid Services (CMS).

These guidelines are not all-encompassing due to the individualized nature of medical treatment and care. If it is the opinion of the hospital or ambulatory surgical center (ASC) that the guidelines do not adequately or appropriately address a specific patient's medical care or treatment needs due to the severity, intensity, complexity, or other medically relevant circumstances of the injury or illness, the facility providing the service is advised to contact the payer (i.e., workers' compensation carrier) to discuss the appropriate treatment and billing process. This directive will be reviewed and updated periodically.

The 2020 *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers* is established, published, and updated annually by the Chairman pursuant to Connecticut General Statutes Sec. 31-294d(d) and in accordance with Public Act 14-167. This fee schedule will also include rules established by the Chairman regarding services not covered by Medicare, rules governing billing and payment time frames, as well as additional payment issues relating to hospitals and ambulatory surgical centers.

Where there is no Medicare rate for the procedure, the parties shall negotiate the reimbursement rate. If negotiation is not successful, parties may request a hearing with the Commission; however, treatment shall proceed pending same.

Background

Medicare uses its Outpatient Prospective Payment System (OPPS) methodology to pay for many hospital and ASC services. However, not all allowable outpatient services are paid using OPPS. Some items may be paid under a different system, considered bundled or packaged, or not paid at all. On August 1, 2000, the Centers for Medicare and Medicaid Services (CMS) began using the OPPS, which was authorized by section 1833(t) of the Social Security Act (the Act) as amended by section 4533 of the Balanced Budget Act of 1997.

Under the OPPS, hospitals and ASCs are paid specific predetermined payment rates for services that are calculated based on grouping outpatient services into ambulatory payment classifications (APCs). Services within an APC are similar clinically and require comparable resources. Each APC is assigned a relative payment rate based on the median cost of the services within that classification. The payment rates are initially determined on a national basis; however, the rates actually paid to hospitals and ASCs in an area will vary, depending on the area's wage level. To adjust for wage differences across geographic areas, the labor-related portion of the payment rate (50 percent) is wage adjusted, using the individual hospital's wage index.

Some incidental items and services will be packaged into the APC payment. No separate payment is made for packaged services because the cost of these items is included in the APC payment for the service of which they are a primary part. Supplies, anesthesia, recovery room, and certain drugs are considered to be a primary part of a surgical procedure and payment for these items is packaged into the APC payment.

Medicare's outpatient prospective payment system (OPPS) is based on packaging (a similar concept to bundling). As such, it is inappropriate to apply per-line payments (as may be a part of a Preferred Provider Organization (PPO) arrangement) with the packaged payment amounts, especially where Medicare considers the item or service to be packaged or included with the primary service. Unless otherwise specified in a contract between a provider and payer, the "lessor of" language should not be used selectively to negate Medicare's packaged payment. However, it is appropriate to sum all of the charges for items included in the package (typically items with N or Qx (x = 1, 2, 3, or 4) status indicators) and compare the total charges for all items in the package with the payment amount to determine the total payment. For example:

Code	Status Indicator	Billed Amt	CT Payment
99285	J2	$1,000	$1,250
J3486	N	$100	$0
G0378	N	$50	$0

Numbers are for example purposes only.

It would not be appropriate to pay the $1,000 billed amount for 99285 and then use the $0 payment amounts for J3486 and G0378 for a total payment of $1,000. However, it would be appropriate to sum the billed charges for all three items

($1,150) and pay that lesser amount instead of the Connecticut Fee Schedule payment of $1,250.

Additionally, claims for a patient's inpatient stay must include all outpatient diagnostic services and admission-related outpatient non-diagnostic services provided by the admitting hospital or an entity that is wholly owned or operated by the admitting hospital on the date of a patient's inpatient admission or within three days immediately preceding the date of a patient's inpatient admission. In addition, hospitals must not separately bill these as outpatient services.

This 2020 *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers* establishes the Medicare-based inpatient and outpatient formulae and rules as required under Public Act No. 14-167.

Rates

The 2020 *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers* will publish Medicare-based formulae established by the Workers' Compensation Commission Chairman as follows:

- The hospital inpatient rate shall be 174 percent of the Medicare rate payable to that facility on the effective date of this fee schedule (see the Hospital Inpatient section)
- The hospital outpatient and hospital-based ambulatory surgery rate shall be 210 percent of the Medicare rate payable to that facility as published in this fee schedule
- The non-hospital-based ambulatory surgery rate shall be 195 percent of the hospital-based outpatient Medicare rate payable in the same core based statistical area (CBSA) as published in this fee schedule

Prospective Payment System

A prospective payment system (PPS) is a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service. The payments for ASCs and outpatient hospitals are based upon the prospective payment system (PPS).

Rules

In order to implement the above-referenced fee schedule the following rules shall apply:

A. Claims for services must be submitted within 180 days after the date of service to be considered for payment. Claims submitted after this period are not payable unless the facility can demonstrate that claims jurisdiction was at issue (e.g., claims where compensability was at issue).

B. Payers must remit payment within 60 days of receipt of appropriate documentation for compensable claims. Payment made after the 60th day must include interest payment at the rate of 1.5 percent per month.

C. Facilities have 60 days following receipt of payment to request a review by payer and such requests may be accompanied by additional supporting documentation. Any requests to review made after such 60-day period will not be considered unless parties agree otherwise.

D. Payment for implants, devices, and hardware is included as part of the appropriate percentage above Medicare for the procedure (the applicable inpatient, outpatient, or ambulatory surgery rate established by this fee schedule). Requests for additional reimbursement for implants, devices, and hardware shall be by exception only. The exception is if the applicable percentage of the Medicare amount for the implant, device, and hardware does not cover the invoice cost, then the invoice cost can be presented and will be reimbursed at 130 percent of invoice less the applicable percentage of the Medicare amount for the implant, device, and hardware already included in the fee.

   All hardware, equipment, and materials for installing and implementing an implantable device, including but not limited to screws and anchors, are considered a part of the device, not a separate device. If an item has a stand-alone medical function, it is considered a separate device. If it is used solely to support the functioning of another piece of equipment, then it is not a separate device.

   Implantable devices are not paid separately except in the rare circumstance where an implant is particularly costly for some legitimate reason. In such circumstances, claims should be accompanied by a copy of the invoice for the device.

E. The reimbursement rate for services rendered will be in accordance with this fee schedule unless a different rate is negotiated between the parties.

F. This fee schedule will apply to dates of service on and after April 1, 2020. Procedures that are represented by new American Medical Association (AMA) 2020 *Current Procedural Terminology* (CPT®) codes are payable at the fees set forth in this publication for dates of service January 1, 2020 forward.

General Guidelines

A. The Connecticut Workers' Compensation Commission has developed this fee schedule to provide a comprehensive resource to health care facilities in the workers' compensation community. Fees in this fee schedule should be used to bill for services performed on or after April 1, 2020 regardless of the date of injury. Procedures that are represented by new 2020 CPT codes are payable at the fees set forth in this publication for dates of service January 1, 2020 forward. The Medicare PC Pricer will be used for inpatient services. The Medicare PC Pricer, normally posted by CMS October 1, will go into effect for Connecticut Workers' Compensation the following April 1 and will remain in effect through March 31 of the subsequent year. If a new PC Pricer has not been released, the existing version will remain in effect until a new version is published or additional information is provided by the Connecticut Workers' Compensation Commission. See the Hospital Inpatient section.

B. The 2020 editions of *Current Procedural Terminology* (CPT®); *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM); *International Classification of Diseases, Tenth Revision, Procedure Coding System* (ICD-10-PCS); HCPCS Level II; and Medicare Severity Diagnosis Related Groups (MS-DRG), are the standards for reporting until the Chairman of the Workers' Compensation Commission adopts a later edition or has indicated where a variation is to be used.

C. Payers are required to designate the party to receive claim information and supporting documentation from the facilities. The designee is responsible for ensuring that all parties who have need for the information are provided with appropriate copies. Facilities are only required to submit the complete set of documentation once. If documentation is incomplete, the facility is required to submit the missing information. The facility can charge a reasonable rate if the complete documentation has been submitted and the payer requests it again.

D. Payment calculations must be according to the guidelines published by the Workers' Compensation Commission Chairman and as published in this fee schedule unless the facility has entered into a contract that provides for an alternative payment method.

E. Evidence of fraudulent or abusive claim submission by facilities, or fraudulent or abusive claim review by payers or managed care organizations, should be referred to the Chairman. The Chairman may refer such reports to the appropriate professional societies and enforcing authorities for facilities or to the Department of Insurance for payers and managed care organizations.

F. Reviewers may recommend non-payment for medical services provided for illnesses or injuries unrelated to compensable workers' compensation claims.

G. Reviewers making coding adjustments are required to provide supporting evidence and the rationale for their conclusions to the facility at the time payment is made based on the reduced amount. The material provided should indicate both the billed code and the code on which payment is made.

H. Inpatient hospital bills must be submitted using a UB-04 form or electronic form 837i. Payment for the technical component will only be made for diagnostic tests following Medicare guidelines.

I. Outpatient hospital bills must be submitted using the most current electronic 837i or 837p format, the paper UB-04, or the CMS-1500 form (version 02/12). Supporting documentation where required should also be submitted.

J. Outpatient claims must be submitted with CPT, HCPCS, and ICD-10-CM codes; inpatient claims must be submitted with ICD-10-CM and ICD-10-PCS codes; literal definitions may be included.

K. The 2020 *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers* applies to inpatient hospital services, outpatient services and surgical centers, and ASCs. Where there is no Medicare rate for the procedure, the parties shall negotiate the reimbursement rate. See the *Official Connecticut Practitioner Fee Schedule*, as it pertains to all physician services and all outpatient physical therapy, occupational therapy, and pathology. See the inpatient section for specific guidelines for reimbursement of inpatient services.

L. The National Correct Coding Initiative (NCCI) Edits and Medically Unlikely Edits (MUEs) will be used to determine appropriate coding for outpatient hospital and ASC claims. A current list of NCCI edits and MUEs can be found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

Additional Requirements

Connecticut Workers' Compensation for the most part, follows CMS's rules, policies and guidance for Medicare claims. Some of these items are included here so that providers are clear about Connecticut expectations.

Therapy

Reporting the number of units for timed codes, such as code 97530 Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes, should follow Medicare instructions.

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

1 unit = 8 mins. to < 23 mins.

2 units = 23 mins. to < 38 mins.

3 units = 38 mins. to < 53 mins.

4 units = 53 mins. to < 68 mins.

5 units = 68 mins. to < 83 mins.

6 units = 83 mins. to < 98 mins.

7 units = 98 mins. to < 113 mins.

8 units = 113 mins. to < 128 mins.

The pattern remains the same for treatment in excess of two hours.

Modifiers

This partial list of modifiers may affect facility reimbursement. For a full list of modifiers see page 10.

CT Computed tomography services furnished using equipment that does not meet each of the attributes of the national electrical manufacturers association (NEMA) XR-29-2013 standard

Hospitals and suppliers must append modifier CT to scans to identify computed tomography (CT) scans that are furnished on equipment that does not meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013. The applicable CPT codes that identify CT services are 70450–70498, 71250–71275, 72125–72133, 72191–72194, 73200–73206, 73700–73706, 74150–74178, 74261–74263, and 75571–75574. As mandated by the Protecting Access to Medicare Act (PAMA) of 2014, this modifier will result in a payment reduction for the applicable CT services when the service is paid separately.

Chairman's Note: When modifier CT is used, the payment is the lesser of billed charges or 95 percent of the allowable.

ER Items and services furnished by a provider-based, off-campus emergency department.

This modifier is to be reported with every claim line for outpatient hospital services furnished in an off-campus, provider-based emergency department. Critical access hospitals (CAH) would not be required to report this modifier. In 2020, this modifier has no effect on reimbursement.

FX X-ray taken using film

Hospitals are required to append modifier FX on claims for imaging services that are taken using film. The payment under the OPPS for imaging services that would otherwise be made (without application of this reduction and before application of any other adjustment) will be reduced beginning in 2017 and continuing during subsequent years.

Chairman's Note: The use of this modifier will result in a payment reduction of 20 percent for the X-ray services taken using film when the service is paid separately.

FY X-ray taken using computed radiography technology/cassette-based imaging

Hospitals must append modifier FY to images captured using computed radiography technology. Computed radiography technology is defined in section 1848(b)(9)(C) of the Social Security Act as cassette-based imaging which utilizes an imaging plate to create the image involved. The payment for such services furnished during calendar years 2017 through 2022 will be reduced by 7 percent, and for services furnished during 2023 or a subsequent year, payments for such will be reduced by 10 percent. When payment for an imaging service taken using computed radiography imaging is packaged into the payment for another item or service under the OPPS, no separate payment for the X-ray service is made and the amount of the payment reduction for a packaged X-ray service would be $0.

Chairman's Note: The use of this modifier will result in a payment reduction of 7 percent in years 2017–2022 for the X-ray services taken using computed radiography technology when the service is paid separately.

JG Drug or biological acquired with 340B drug pricing program discount.

For 2020, hospital drugs are discounted by 22.5 percent. This does not apply to pass-through drugs (OPSI G), vaccines, OPSI L, and critical access hospitals (CAH), rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals.

PN Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital

Chairman's Note: This modifier is not adopted at this time.

PO Excepted service provided at an off-campus, outpatient, provider-based department of a hospital

Chairman's Note: This modifier is not adopted at this time.

TB Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes.

Used to identify drugs excluded from the 340B discount.

Corneal Tissue Transplant

HCPCS Level II code V2785 Processing, preserving and transporting corneal tissue, must be reported with a CPT code representing a cornea transplant procedure for the same service date or the line item will be rejected. Code V2785 should not be reported in any other circumstances. Allowable corneal transplant procedures are:

65710 Keratoplasty (corneal transplant); anterior lamellar

65730 Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)

65750 Keratoplasty (corneal transplant); penetrating (in aphakia)

65755 Keratoplasty (corneal transplant); penetrating (in pseudophakia)

65756 Keratoplasty (corneal transplant); endothelial

65765 Keratophakia

65767 Epikeratoplasty

Also, any successor or new code describing a new type of corneal transplant procedure that uses eye-banked corneal tissue.

Comprehensive APC

A comprehensive APC provides a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

CPT and HCPCS Level II codes assigned to comprehensive APCs are designated with outpatient Status Indicator (OPSI) J1 Hospital Part B services paid through a comprehensive APC. OPSI J1 indicates that all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under OPPS:

- Major OPPS procedure codes (OPSIs P, S, T, V)
- Lower ranked comprehensive procedure codes (OPSI J1)
- Non-pass-through drugs and biologicals (OPSI K)
- Blood products (OPSI R)
- DME (OPSI Y)
- Therapy services (HCPCS codes with OPSI A reported on therapy revenue centers)

The following services are excluded from comprehensive APC packaging:

- Brachytherapy sources (OPSI U)
- Pass-through drugs, biologicals and devices (OPSIs G or H)
- Corneal tissue, CRNA services, and Hepatitis B vaccinations (OPSI F)
- Influenza and pneumococcal pneumonia vaccine services (OPSI L)
- Ambulance services
- Mammography
- Certain preventive services

The payment for a comprehensive claim is based on the rate associated with either the J1 service or the specific combination of J2 services. J1 services are assigned to comprehensive APCs. Payment for all adjunctive services reported on the same claim as a J1 service is packaged into payment for the primary J1 service. When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service. When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family.

When a J1 service and a J2 service are reported on the same claim, the single payment is based on the rate associated with the J1 service, and the combination of the J1 and J2 services on the claim does not make the claim eligible for a

complexity adjustment. Note that complexity adjustments will not be applied to discontinued services (reported with modifier 73 or 74).

Laboratory

OPSI Q4 is defined as a conditionally packaged laboratory service if billed on the same claim as a HCPCS code assigned OPSI J1, J2, S, T, V, Q1, Q2, or Q3, otherwise it is separately paid.

If the codes on a 013X bill are all OPSI Q4, which are only laboratory HCPCS codes, they will be paid as listed in the *Official Connecticut Practitioner Fee Schedule*.

High-cost pathology services (Level 3 and 4 pathology) are assigned OPSI Q2 (T packaging) to avoid packaging this subset into lower cost and non-primary services frequently billed with some of the services. Level 3 and 4 pathology services will be packaged only when they are billed with a surgical service. Pathology services are routine tests that are typically performed ancillary or adjunctive to another primary service, most commonly surgery. Other pathology services will be paid according to the *Official Connecticut Practitioner Fee Schedule*.

Outpatient Facility

Hospital Outpatient and Hospital-Based Ambulatory Surgery Fee Schedule and Non-Hospital-Based Ambulatory Surgery Fee Schedule

How to Use this Fee Schedule

The Hospital Outpatient and Hospital-based ASC Fee Schedule and the Non-hospital-based ASC Fee Schedule include codes with reimbursement values for services rendered in the outpatient hospital.

Hospitals within Connecticut have been assigned to a core based statistical area (CBSA) based on their name and location. The Hospital Outpatient and Hospital-based ASC Fee Schedule and Non-hospital-based ASC Fee Schedule chapters include a list of facilities and the wage index group to which it is assigned. For purposes of this fee schedule, each hospital outpatient CBSA is identified by an index group: A, B, C, D, E, or F. Each non-hospital-based ASC wage index group is assigned to the index group AA, BB, CC, DD, or EE.

Column Headings

- Icon—the following icons are used:
  - ● Designates a code that is new for 2020
  - ▲ Designates a code that has changed in official description for 2020
  - # Identifies codes that are resequenced in the 2020 CPT book but are printed in numeric order in this publication
- CPT/HCPCS Code
- Description—48 character description is used, refer to the 2020 versions of either the CPT or HCPCS Level II book for a full description of the code
- SI—Outpatient Prospective Payment Status Indicators (OPSI) (Hospital outpatient and hospital-based ASC only)
- Index Group A/AA
- Index Group B/BB
- Index Group C/CC
- Index Group D/DD
- Index Group E/EE
- Index Group F
- Relative Weight—Relative weight of the CPT or HCPCS code. The relative weight is used to determine the primary procedure in a multiple procedure claim
- Device % —The CMS average device cost as a percentage of the procedure's cost as derived in the CMS APC offset file
- Multiple Procedure—Multiple Procedure Payment Reduction (MPPR) identifies those codes subject to MPPR with a Y, those paid at full allowable with an N, and blank if MPPR is not applicable (Non-hospital-based ASC only)

Billing and Payment Procedures

Unless otherwise specified by these rules, hospitals and ambulatory surgical centers (ASCs) are to follow appropriate policies as established by CMS.

Definitions

Clinic Codes—HCPCS Level II codes are used to describe hospital clinic visits, replacing the 992xx series codes. These should be paid under HCPCS Level II code G0463.

HCPCS and CPT Codes—HCPCS is most accurately used as the acronym for the entire Healthcare Common Procedure Coding System. The federal government refers to all procedure codes as the HCPCS system. Two levels of codes are contained in the HCPCS code sets.

Level I—This coding system contains only the American Medical Association's (AMA) *Physicians' Current Procedural Terminology* (CPT) codes. CPT codes are used by physicians, facility outpatient departments, and ASCs to code ambulatory, laboratory, radiology, and other diagnostic services. The AMA updates codes annually with periodic updates as necessary.

Level II—Developed by CMS, and commonly referred to as HCPCS. This code set contains alphanumeric codes for physician and non-physician services not included in the CPT coding system. HCPCS Level II covers such things as ambulance services, durable medical equipment, and orthotic and prosthetic devices. CMS updates this code set quarterly.

HCPCS/CPT codes are required for all outpatient hospital services unless a specific exception exists in the CMS manual instructions. Codes are required for surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take-home surgical dressings, therapies, preventative services, blood and blood products, and most drugs.

National Correct Hospital Outpatient PPS NCCI Coding Initiative Edits—The CCI edits are part of the Outpatient Code Editor that determines payment for OPPS Services.

Column 1/Column 2 Correct Coding Edits apply to code combinations where one of the codes is a component of a more comprehensive code. Payment is allowed only for the comprehensive code.

Part-time Emergency Room Visits—There are HCPCS codes to describe hospital emergency visits provided in part-time dedicated emergency departments that are not open 24 hours per day, seven days per week. The G codes will be paid as hospital clinic visits.

Revenue Codes—Hospitals are to report the HCPCS codes under the revenue center where they were performed. Unless otherwise specified, there is no separate payment for revenue code only (no HCPCS reported) charges.

Payment Modifiers for Outpatient Hospital and ASC Services

A modifier indicates that a service or procedure performed has been altered by some specific circumstance but has not changed its definition or code. The modifying circumstance shall be identified by the appropriate modifier following the procedure code. The two-digit modifier should be placed after the usual procedure number.

Modifiers approved for ambulatory surgery center (ASC) and hospital outpatient use, as referenced by the AMA, are applicable to the 2020 *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers*. Note that the modifiers are for outpatient services only.

The modifiers listed below are CPT modifiers published by the American Medical Association and HCPCS modifiers developed by CMS. Facilities submitting workers' compensation billing shall use only the modifiers set out in this fee schedule.

CPT Modifiers

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department, or Preventive Medicine Services** codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code. **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating

circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc.). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

91 Repeat Clinical Diagnostic Laboratory Test
In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

HCPCS Level II Modifiers

CO Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

CQ Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant

CT Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard
Chairman's Note: When modifier CT is used, the payment is the lesser of billed charges or 95 percent of the allowable.

E1 Upper left, eyelid

E2 Lower left, eyelid

E3 Upper Right, eyelid

E4 Lower right, eyelid

ER Items and services furnished by a provider-based, off-campus emergency department.
This modifier is to be reported with every claim line for outpatient hospital services furnished in an off-campus, provider-based emergency department. Critical access hospitals (CAH) would not be required to report this modifier. In 2020, this modifier has no effect on reimbursement.

F1 Left hand, second digit

F2 Left hand, third digit

F3 Left hand, fourth digit

F4 Left hand, fifth digit

F5 Right hand, thumb

F6 Right hand, second digit

F7 Right hand, third digit

F8 Right hand, fourth digit

F9 Right hand, fifth digit

FA Left hand, thumb

FX X-ray taken using film
Chairman's Note: The use of this modifier will result in a payment reduction of 20 percent for the X-ray services taken using film when the service is paid separately.

FY X-ray taken using computed radiography technology/cassette-based imaging
Chairman's Note: The use of this modifier will result in a payment reduction of 7 percent in years 2017-2022 for the X-ray services taken using computed radiography technology when the service is paid separately.

GG Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day

GH Diagnostic mammogram converted from screening mammogram on same day

JG Drug or biological acquired with 340B drug pricing program discount.
For 2020, hospital drugs are discounted by 22.5 percent. This does not apply to pass-through drugs (OPSI G), vaccines, OPSI L, and critical access hospitals (CAH), rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals.

LC Left circumflex coronary artery

LD Left anterior descending coronary artery

LM Left main coronary artery

LT Left side (used to identify procedures performed on the left side of the body)

PN Non-excepted items and services used to identify and pay non-excepted items and services billed on an institutional claim

Chairman's Note: This modifier is not adopted at this time

PO Excepted service provided at an off-campus, outpatient, provider-based department of a hospital

Chairman's Note: This modifier is not adopted at this time

QM Ambulance service provided under arrangement by a provider of services

QN Ambulance service furnished directly by a provider of services

RC Right coronary artery

RI Ramus intermedius coronary artery

RT Right side (used to identify procedures performed on the right side of the body)

T1 Left foot, second digit

T2 Left foot, third digit

T3 Left foot fourth digit

T4 Left foot, fifth digit

T5 Right foot, great toe

T6 Right foot, second digit

T7 Right foot, third digit

T8 Right foot, fourth digit

T9 Right foot, fifth digit

TA Left foot, great toe

TB Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes.
Used to identify drugs excluded from the 340B discount.

XE Separate encounter

XP Separate practitioner

XS Separate structure

XU Unusual non-overlapping service

Determining Payment

The hospital outpatient and hospital-based ambulatory surgery rate shall be 210 percent of the Medicare rate payable to that facility as published in this fee schedule.

The non-hospital-based ambulatory surgery rate shall be 195 percent of the hospital-based outpatient Medicare rate payable in the same CBSA as published in this fee schedule.

Where there is no Medicare rate for a procedure, the parties (facility and payer) shall negotiate the reimbursement rate. If negotiation is not successful, the hospital and the payer may request a hearing with the Commission; however, treatment shall proceed pending same.

To assist facilities and payers, the Connecticut Workers' Compensation Commission provides fee schedules containing essential components to determine hospital outpatient and ASC payments. The fee schedules contain precalculated payments based on hospital and ASC assigned wage indexes. The schedules are also available as data files.

To determine an outpatient hospital and hospital-based ASC payment:

A. There are currently six hospital wage index groups in Connecticut. These are labeled A through F. Hospitals are assigned to a wage index group based on their wage index as reported in the Inpatient Prospective Payment System Impact File. To determine a hospital's wage index group, see the corresponding column in the included wage index tables.

B. Once the hospital's index group has been identified, the payment for a service will be listed in the appropriate index group column in the Hospital Outpatient and Hospital-based ASC fee schedule.

C. Some items are not paid, are paid in certain circumstances, or are discounted. See Outpatient Prospective Payment Status Indicators (OPSI) section in the Hospital Outpatient and Hospital-based ASC Fee Schedule.

To determine a non-hospital-based ASC payment:

A. There are currently five ASC wage index groups in Connecticut. These are labeled AA through EE. ASCs are assigned to a wage index group based on their wage index as reported in the Outpatient Prospective Payment System. To determine an ASC's wage index group, see the corresponding column in the wage index tables.

B. Once the ASC's index group has been identified, the payment for a service will be listed in the appropriate index group column in the ASC fee schedule.

C. Some items are not paid, are paid in certain circumstances, or are discounted.

Implantable Device Payments

Implantable orthotic and prosthetic devices and implantable DME are paid under the OPPS when billed with the appropriate HCPCS and revenue codes.

Payment for implants, devices, and hardware is included as part of the appropriate percentage above Medicare for the procedure (the applicable inpatient, outpatient, or ambulatory surgery rate established by this fee schedule). Requests for additional reimbursement for implants, devices, and hardware shall be by exception only. The exception occurs when the applicable percentage of the Medicare amount for the implant, device, and hardware does not cover the invoice cost. In those circumstances the invoice cost can be presented and will be reimbursed at 130 percent of invoice less the applicable percentage of the Medicare amount for the implant, device, and hardware already included in the fee.

All hardware, equipment, and materials for installing and implementing an implantable device, including, but not limited to, screws and anchors, are considered a part of the device, not a separate device. If an item has a stand-alone medical function, it is considered a separate device. If it is used solely to support the functioning of another piece of equipment, then it is not a separate device.

Implantable devices are not paid separately except in the rare circumstance where an implant is particularly costly for some legitimate reason. In such circumstances, claims should be accompanied by a copy of the invoice for the device.

The Medicare values for the implant, device, or hardware for outpatient hospital can be found in the Device % column of the outpatient hospital fee schedules.

Medicare does not separately reimburse non-implantable orthotic and prosthetic devices by an OPPS hospital when associated with a procedure code that has an OPSI of J1 or J2. Payment is packaged into the payment for the procedure. Report the HCPCS code on the UB04 or 837i.

For items and services not associated with a procedure code that has an OPSI of J1 or J2, payment for non-implantable orthotic and prosthetic devices furnished by an OPPS hospital or hospital-based ASC is made under Medicare's Durable Medical Equipment, Prosthetic, Orthotic, and Supply (DMEPOS) fee schedule when billed with the appropriate HCPCS and revenue code. Non-implantable DME furnished by an OPPS hospital or hospital-based ASC should be billed on the CMS-1500 form. Payment will be made under the DMEPOS fee schedule. Following is a link to the Medicare DMEPOS fee schedule: https://www.cms.gov/medicare/medicare-fee-for-service-payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule

Implementation and Examples

If a request for additional reimbursement for implants, devices, and hardware is made, use the following methodology to determine the amount of the additional payment, if any:

1. Determine the principal procedure on the claim. This will be the highest weighted procedure. For reference, procedure relative weights are included in the Hospital Outpatient and Hospital-based ASC and Non-hospital-based ASC fee schedules.

2. Determine the allowed payment for this procedure based on appropriate rules.

3. Sum the invoice costs for the applicable implants, devices, and hardware.

4. From the Device % column, apply the Medicare percentage listed to the allowed payment calculated in Number 2.

5. If the invoice costs are less than the calculation in Number 4, no additional payment is made. If the invoice costs are greater, follow the steps below to determine the total payment.

6. From the allowed payment calculated in Number 2, subtract the Medicare percentage amount calculated in Number 4. This will be the Medical Payment.

7. Multiply the invoice costs summed in Number 3 by 1.3. This will be the Device Payment.

8. Add the Medical Payment (Number 6) and the Device Payment (Number 7). This will be the allowed payment for this procedure.

Example:

- Procedure is CPT code 29806 Arthroscopy, shoulder, surgical, capsulorrhaphy. Hospital is wage index group A. This is the only procedure on the claim.
- From the Hospital Outpatient Fee Schedule, payment for wage index group A is $14,028.85.
- Payment for this Medicare device is considered packaged with the payment for the procedure 29806.
- Total invoice costs are $5,000.00.
- From the Device % offset column, Medicare device allocation is 22.70 percent (converted to a multiplier of ".2270" by moving the decimal point two places). Thus,

CT Payment	$14,028.85
Medicare Device	x .2270
CT Device Allocated	$3,184.55

- Invoice cost ($5,000.00) is greater than the allocation ($3,023.46); therefore, additional payment is made.

CT Allowed	$14,028.85
CT Device	-$3,184.55
Medical Payment	$10,844.30
Device costs	$5,000.00
CT Additional	x 1.3
Device Payment	$6,500.00
Medical Payment	$10,844.30
Device Payment	+$6,500.00
Total Payment	$17,344.30

Hospital Outpatient and Hospital-based ASC Fee Schedule

The Hospital Outpatient and Hospital-based ASC Fee Schedule includes the following tables:

Outpatient Prospective Payment Status Indicators (OPSI)

OPSI determine how payments are calculated, whether items are paid, and which reimbursement methodology is used. OPSIs are included in the data column labeled SI. For the 2020 *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers* the hospital OPSI will be used for both outpatient hospital and hospital-based ASC reporting and payment. When referenced in the OPSIs, please consult CMS for APC payment policy. See: Addenda D1 at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-P

NOTE: OPSIs are not applicable to non-hospital-based ASCs.

OPSI	Item/Code/Service	OP Payment Status
(Blank)		*Connecticut Specific Guideline: Where there is no Medicare rate for the procedure, the parties shall negotiate the reimbursement rate.*
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance services • Separately payable clinical diagnostic laboratory services • Separately payable non-implantable prosthetics and orthotics • Physical, occupational, and speech therapy • Diagnostic mammography • Screening mammography	Not paid under OPPS. *Connecticut Specific Guideline: See the* Official Connecticut Practitioner Fee Schedule *for fee schedule rates.*
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available *Connecticut Specific Guideline: These services should be reported with another HCPCS code that describes the service.*
C	Inpatient procedures	Not paid under OPPS. *Connecticut Specific Guideline: Where there is no Medicare rate for the procedure, the parties shall negotiate the reimbursement rate.*
D	Discontinued codes	Not paid under OPPS.
E1	Items, codes and services: • Not covered by any Medicare outpatient benefit category • That are not covered by Medicare based on statutory exclusion • Not reasonable and necessary	Not paid under OPPS. *Connecticut Specific Guideline: Where there is no Medicare rate for the procedure, the parties shall negotiate the reimbursement rate.*
E2	Items and services for which pricing information and claims data are not available	Not paid under OPPS. Status may change as data is received by CMS. *Connecticut Specific Guideline: Where there is no Medicare rate for the procedure, the parties shall negotiate the reimbursement rate.*
F	Corneal tissue acquisition; certain CRNA services, and hepatitis B vaccines	Not paid under OPPS. *Connecticut Specific Guideline: See the* Official Connecticut Practitioner Fee Schedule *for fee schedule rates.*

OPSI	Item/Code/Service	OP Payment Status
G	Pass-through drugs and biologicals	Paid under OPPS; separate APC payment includes pass-through amount. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
H	Pass-through device categories.	Separate cost-based pass-through payment.
J1	Hospital Part B services paid through a comprehensive APC.	Paid under OPPS; all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPSI = F, G, H, L and U. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
J2	Hospital Part B services that may be paid through a comprehensive APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPSI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. (2) Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI J1. (3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
K	Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals	Paid under OPPS; separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
L	Influenza vaccine; pneumococcal pneumonia vaccine	Not paid under OPPS. *Connecticut Specific Guideline: See the* Official Connecticut Practitioner Fee Schedule *for fee schedule rates.*
M	Items and services not billable to the Medicare Administrative Contractor (MAC)	Not paid under OPPS. *Connecticut Specific Guideline: See the* Official Connecticut Practitioner Fee Schedule *for fee schedule rates.*
N	Items and services packaged into APC rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
P	Partial hospitalization	Paid under OPPS, per diem APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
Q1	STV packaged codes	Paid under OPPS. Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI of S, T, or V. (2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made though a separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*

OPSI	Item/Code/Service	OP Payment Status
Q2	T packaged codes	Paid under OPPS. Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI T. (2) In other circumstances, payment is made through a separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
Q3	Codes that may be paid through a composite APC	Paid under OPPS. Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
Q4	Conditionally packaged laboratory tests	Paid under OPPS or the *Official Connecticut Practitioner Fee Schedule.* (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned published OPSI J1, J2, S, T, V, Q1, Q2 or Q3. (2) In other circumstances, laboratory tests should have an SI=A and payment is made under the practitioner fee schedule. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines. Non-packaged laboratory tests are reimbursed under the practitioner fee schedule. See the* Official Connecticut Practitioner Fee Schedule.
R	Blood and blood products	Paid under OPPS, separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
S	Procedure or service, not discounted when multiple	Paid under OPPS, separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
T	Procedure or service, multiple reduction applies	Paid under OPPS, separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
U	Brachytherapy sources	Paid under OPPS; separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
V	Clinic or emergency department visit	Paid under OPPS, separate APC payment. *Connecticut Specific Guideline: Hospital outpatient surgery and hospital-based ambulatory surgical centers paid under OPPS guidelines.*
Y	Non-implantable durable medical equipment	Not paid under OPPS. All institutional Providers other than home health agencies bill to a DME MAC. *Connecticut Specific Guideline: See the* Official Connecticut Practitioner Fee Schedule *for fee schedule rates.*

Hospital Outpatient Core Based Statistical Area Table

Hospitals within Connecticut have been identified by CMS, based on the name and location, and have been assigned to a core based statistical area (CBSA).

The Hospital Outpatient CBSA Table includes the following columns:

- Provider/Organization Name
  - The providers/organizations are listed alphabetically
- Provider Number
  - The provider number is needed for inpatient pricing (see the Hospital Inpatient section for PC Pricer instructions).
- CBSA Name
  - CBSA name will be blank for rural areas
- Index Group
  - Each city or area is assigned to one of six CBSA areas
  - For purposes of this table and the hospital outpatient and hospital-based ASC fee schedule each CBSA is identified by an index group: A, B, C, D, E, or F

NOTE: Some provider organizations are in new index groups for 2020. Please check the index group.

Provider/Organization Name	Provider Number	CBSA Name (Blanks are Rural)	Index Group
Bridgeport Hospital	070010	Bridgeport-Stamford-Norwalk, CT	E
Bristol Hospital	070029	Hartford-West Hartford-East Hartford, CT	A
Charlotte Hungerford Hospital	070011		D
Connecticut Hospice Inc,the	070038	New Haven-Milford, CT	F
Danbury Hospital	070033	Bridgeport-Stamford-Norwalk, CT	C
Day Kimball Hospital	070003	Worcester, MA-CT	A
Greenwich Hospital Association -	070018	Bridgeport-Stamford-Norwalk, CT	E
Griffin Hospital	070031	New Haven-Milford, CT	F
Hartford Hospital	070025	Hartford-West Hartford-East Hartford, CT	A
Hebrew Home And Hospital Inc	070040	Hartford-West Hartford-East Hartford, CT	A
Hospital Of Central Connecticut, The	070035	Hartford-West Hartford-East Hartford, CT	A
John Dempsey Hospital	070036	Hartford-West Hartford-East Hartford, CT	B
Johnson Memorial Hospital	070008	Hartford-West Hartford-East Hartford, CT	A
Lawrence & Memorial Hospital	070007	Norwich-New London, CT	F
Manchester Memorial Hospital	070027	Hartford-West Hartford-East Hartford, CT	A
Masonicare Health Center	070039	New Haven-Milford, CT	F
Middlesex Hospital	070020	Hartford-West Hartford-East Hartford, CT	A
Midstate Medical Center	070017	New Haven-Milford, CT	F
Milford Hospital, Inc	070019	New Haven-Milford, CT	F
Norwalk Hospital	070034	Bridgeport-Stamford-Norwalk, CT	C
Rockville General Hospital	070012	Hartford-West Hartford-East Hartford, CT	A
Saint Mary's Hospital	070016	New Haven-Milford, CT	F
Sharon Hospital	070004		D
St Francis Hospital & Medical Center	070002	Hartford-West Hartford-East Hartford, CT	A
St Vincent's Medical Center	070028	Bridgeport-Stamford-Norwalk, CT	E
Stamford Hospital	070006	Bridgeport-Stamford-Norwalk, CT	E
Waterbury Hospital	070005	New Haven-Milford, CT	F
William W Backus Hospital	070024	Norwich-New London, CT	F
Windham Comm Mem Hosp & Hatch Hosp	070021	Worcester, MA-CT	C
Yale-New Haven Hospital	070022	New Haven-Milford, CT	F

Hospital Outpatient and Hospital-based ASC Fee Schedule

The Hospital Outpatient and Hospital-based ASC Fee Schedule includes codes with reimbursement values for services rendered in the outpatient hospital.

The data includes the following columns (for a complete description of the columns, see How to Use this Fee Schedule):

- Icons—for new code, changed description, or resequenced code
- CPT/HCPCS Code
- Description
- SI—OPSI
- Index Group A
- Index Group B
- Index Group C
- Index Group D
- Index Group E
- Index Group F
- Relative Weight
- Device %

Reimbursement is determined based upon the index group from the Hospital Outpatient CBSA Table.

Hospital Inpatient

Inpatient Prospective Payment System (IPPS)

The Connecticut Workers' Compensation Commission has developed this fee schedule to provide a comprehensive resource to health care facilities in the workers' compensation community. Fees in this fee schedule should be used to bill for services performed on or after April 1, 2020 regardless of the date of injury.

Please note that the 2020 editions of *Current Procedural Terminology (CPT®); International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM); *International Classification of Diseases, Tenth Revision, Procedure Coding System* (ICD-10-PCS); HCPCS Level II; and Medicare Severity Diagnosis Related Groups (MS-DRG) are the standards for reporting until the Chairman of the Workers' Compensation Commission adopts a later edition or has indicated where a variation is to be used.

A prospective payment system (PPS) is a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service.

Medicare provides general free educational overviews of its inpatient (IPPS) prospective payment system as a part of its Medicare Learning Network (MedLearn). The MedLearn product catalog is available from the following link: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index

NOTE: For General Guidelines related to inpatient services, please see the Introduction.

Background

Generally, acute care hospitals receive Medicare IPPS payment on a per discharge or per case basis for inpatient stays. The claim for the patient's inpatient stay must include all outpatient diagnostic services and admission-related outpatient nondiagnostic services provided by the admitting hospital or an entity that is wholly owned or operated by the admitting hospital on the date of a patient's inpatient admission or within three days immediately preceding the date of a patient's inpatient admission. In addition, hospitals must not separately bill these services.

Discharges are assigned to diagnosis-related groups (DRG), a classification system that groups similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay. The patient's principal diagnosis and up to 24 secondary diagnoses that may include comorbidities or complications will determine the DRG assignment. Similarly, DRG assignment can be affected by up to 25 procedures furnished during the stay. Other factors that may influence DRG assignment include a patient's gender, age, or discharge status disposition.

The Centers for Medicare and Medicaid Services (CMS) reviews the DRG definitions annually to ensure that each group continues to include cases with clinically similar conditions that require comparable amounts of inpatient resources. When the review shows that subsets of clinically similar cases within a DRG consume significantly different amounts of resources, CMS may reassign them to a different DRG with comparable resource use or create a new DRG.

This 2020 *Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers* establishes the Medicare-based inpatient and outpatient formulae and rules as required under Public Act No. 14-167.

The Medicare PC Pricer will be used for inpatient services. The Medicare PC Pricer, normally posted by CMS October 1, will go into effect for Connecticut Workers' Compensation the following April 1 and will remain in effect through March 31 of the subsequent year. If a new PC Pricer has not been released, the existing version will remain in effect until the new version is published or additional information is provided by the Connecticut Workers' Compensation Commission.

Rules

In order to implement the above-referenced fee schedule, the following rules shall apply:

A. Payers must remit payment within 60 days of receipt of appropriate documentation for compensable claims. Payment made after the 60th day must include interest payment at the rate of 1.5 percent per month.

B. Facilities have 60 days following receipt of payment to request a review by payer and such requests may be accompanied by additional supporting documentation. Any requests to review made after such 60-day period will not be considered unless the facility and the payer parties agree otherwise.

C. Payment for implants, devices, and hardware is included as part of the appropriate percentage above Medicare for the procedure (the applicable inpatient, outpatient, or ambulatory surgery rate established by this fee

schedule). Requests for additional reimbursement for implants, devices, and hardware shall be by exception only. The exception is if the applicable percentage of Medicare amount for the implant, device, and hardware does not cover the invoice cost, then the invoice cost can be presented and will be reimbursed at 130 percent of invoice less the applicable percentage of the Medicare amount for the implant, device, and hardware already included in the fee.

D. The reimbursement rate for services will be in accordance with this fee schedule unless a different rate is negotiated between the facility and the payer parties.

E. This fee schedule will apply to dates of service on and after April 1, 2020.

Inpatient Implantable Device Payments

Implantable Device Payments

Implantable orthotic and prosthetic devices and implantable DME are paid under the IPPS when billed with the appropriate revenue codes.

Payment for implants, devices, and hardware is included as part of the appropriate percentage above Medicare for the procedure (the applicable inpatient, outpatient, or ambulatory surgery rate established by this fee schedule). Requests for additional reimbursement for implants, devices, and hardware shall be by exception only. The exception occurs when the applicable percentage of the Medicare amount for the implant, device, and hardware does not cover the invoice cost. In those circumstances the invoice cost can be presented and will be reimbursed at 130 percent of invoice less the applicable percentage of the Medicare amount for the implant, device, and hardware already included in the fee.

All hardware, equipment, and materials for installing and implementing an implantable device, including but not limited to screws and anchors, are considered a part of the device, not a separate device. If an item has a stand-alone medical function, it is considered a separate device. If it is used solely to support the functioning of another piece of equipment, then it is not a separate device.

The Medicare values for the implant, device, or hardware for inpatient services can be found in the Inpatient Device Amount Schedule. This schedule is the device average charge by MS-DRG as a percentage of the average total claim charge as calculated from the 2018 MedPAR (CMS inpatient) data file for Connecticut acute care hospitals.

Implementation and Examples

If a request for additional reimbursement for implants, devices, and hardware is made, use the following methodology to determine the amount of the additional payment, if any:

1. Determine the MS-DRG for the claim.
2. Using the PC Pricer tool, determine the allowed payment based on appropriate rules.
3. Sum the invoice costs for the applicable implants, devices, and hardware.
4. From the IP Device Amount Schedule, apply the Medicare percentage listed to the allowed payment calculated in Number 2.
5. If the invoice costs are less than the calculation in Number 4, no additional payment is made; if the invoice costs are greater, follow the steps below to determine the total payment.
6. From the allowed payment calculated in Number 2, subtract the Medicare percentage amount calculated in Number 4; this will be the Medical Payment.
7. Multiply the invoice costs summed in Number 3 by 1.3; this will be the Device Payment.
8. Add the Medical Payment (Number 6) and the Device Payment (Number 7). This will be the allowed payment for this procedure.

Example (using Medicare version 2020.0 PC Pricer data):

- Hospital is Yale-New Haven (provider number 070022), MS-DRG 460 Spinal Fusion
- Yale-New Haven's payment for this MS-DRG would be $72,321.29
- Total invoice costs are $35,000.00
- From IP Device Amount Schedule, Medicare device allocation is 34.70%; thus,

CT Payment	$72,321.29
Medicare Device	x .3470
CT Device Allocated	$25,095.49

- Invoice cost ($35,000) is greater than the allocation ($25,095.49); therefore, additional payment is made

CT Allowed	$72,321.29
CT Device	-$25,095.49
Medical Payment	$47,225.80
Device costs	$35,000.00
CT Additional	x 1.3
Device Payment	$45,500.00
Medical Payment	$47,225.80
Device Payment	+$45,500.00
Total Payment	$92,725.80

Determine Inpatient Hospital Payment

Preparing to Determine a Payment

To simplify the complexities of determining a payment under Medicare's IPPS system, the Connecticut Workers' Compensation Commission has adopted Medicare's PC Pricer as the standard for determining reimbursements. ***Other software solutions are acceptable as long as they produce the same results.***

The Medicare PC Pricer, normally posted by CMS October 1, will go into effect for Connecticut Workers' Compensation the following April 1 and will remain in effect through March 31 of the subsequent year. If a new PC Pricer has not been released, the existing version will remain in effect until a new version is published or additional information is provided by the Connecticut Workers' Compensation Commission.

Note: There is at least a six-month offset between Medicare's implementation of an inpatient rule and the effective date of this fee schedule. Therefore, it may be necessary to change the year when using the PC Pricer. In this case, use the day and month of the claim, but replace the year of the claim with the year for the PC Pricer. You will find the year of the PC Pricer in the date range displayed at the top of the screen.

Besides the PC Pricer software, two additional elements are required to determine a payment:

A. The hospital's provider certification number (often called the CCN or OSCAR number). A current list of Connecticut hospital provider numbers may be found in the hospital list as a part of the Hospital Outpatient and Hospital-based ASC Fee Schedule.

B. The claim's MS-DRG assignment. Many hospitals' billing systems will provide the MS-DRG assignment as a part of the UB-04 claim. It is typically located in FL 71 (PPS Code) on the UB-04 claim.

Payers (and others) who wish to verify the MS-DRG assignment for the claim will need an appropriate grouping software package. The current URL for the Medicare grouper software is:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

Third-party vendors such as Optum, 3M, and others also have software available which will assign the MS-DRG to the claim.

The current version of the PC Pricer tool may be downloaded here:

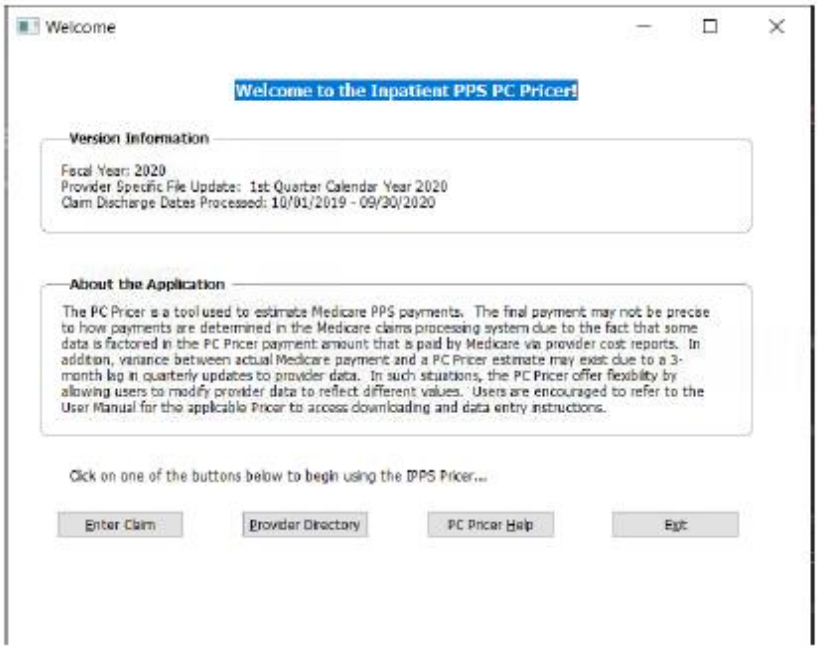
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html

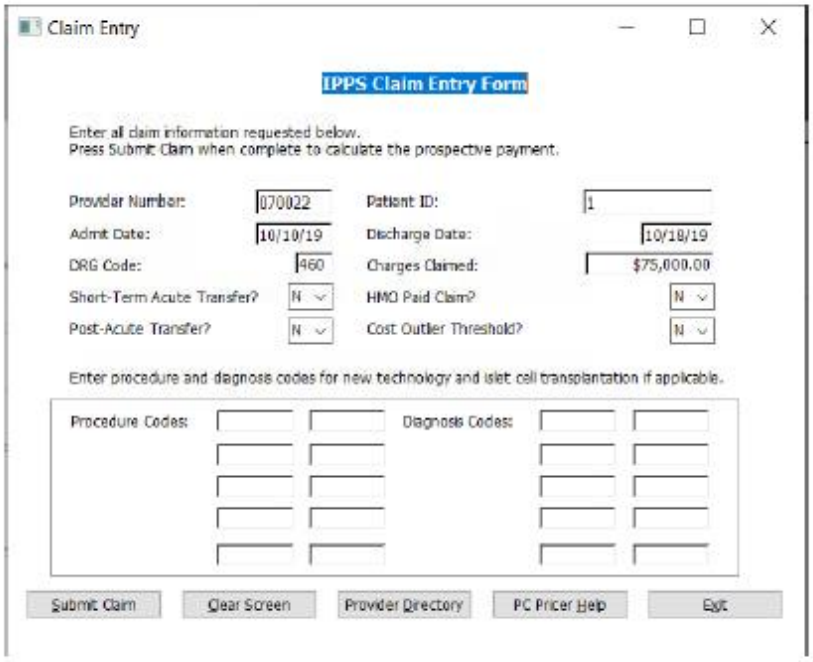
Guidelines for downloading and executing the PC Pricer can be downloaded here:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/Guidelines.html

The following illustration is a sample of the PC Pricer as found on the CMS website.

NOTE: These illustrations and calculations are for example purposes only and do not reflect current reimbursement.





The PC Pricer instructions are included below:

Data Entry and Calculation Steps for the Inpatient PPS PC Pricer—From the welcome screen above (top image), select Enter Claim. The IPPS Claim Entry Form will appear.

PROVIDER NUMBER—Enter the six-digit OSCAR (also called CCN) number present on the claim.

Note: The National Provider Number (NPI) on the claim (if submitted by the hospital) is not entered in this field. Please note that depending on NPI billing rules, a hospital may only submit their NPI number without their OSCAR number. Should this occur, contact the billing hospital to obtain its OSCAR number as the PC Pricer software cannot process using an NPI.

PATIENT ID—Not required, but the patient's ID number on the claim can be entered.

ADMIT DATE—Enter the admission date on the claim FL 12 (the FROM date in Form Locator (FL) 6 of the UB-04).

DISCHARGE DATE—Enter the discharge date on the claim (the THROUGH date in FL 6 of the UB-04). **Note:** There is at least a six-month offset between Medicare's implementation of an inpatient rule and the effective date of this fee schedule. Therefore, it may be necessary to change the year when using the PC Pricer. In this case, use the day and month of the claim, but replace the year of the claim with the year for the PC Pricer.

DRG—Enter the DRG for the claim. The DRG is determined by the Grouper software or may be on the UB-04 claim form in FL 71.

CHARGES CLAIMED—Enter the total covered charges on the claim.

SHORT TERM ACUTE CARE TRANSFER—Enter 'Y' if there is a Patient Status Code 02 on the claim. Otherwise, enter 'N' (or tab). Pricer will apply a transfer payment if the length of stay is less than the average length of stay for this DRG.

HMO PAID CLAIM—N/A for IHS/CHS. Enter 'N' (or tab). HMOs must enter 'Y.'

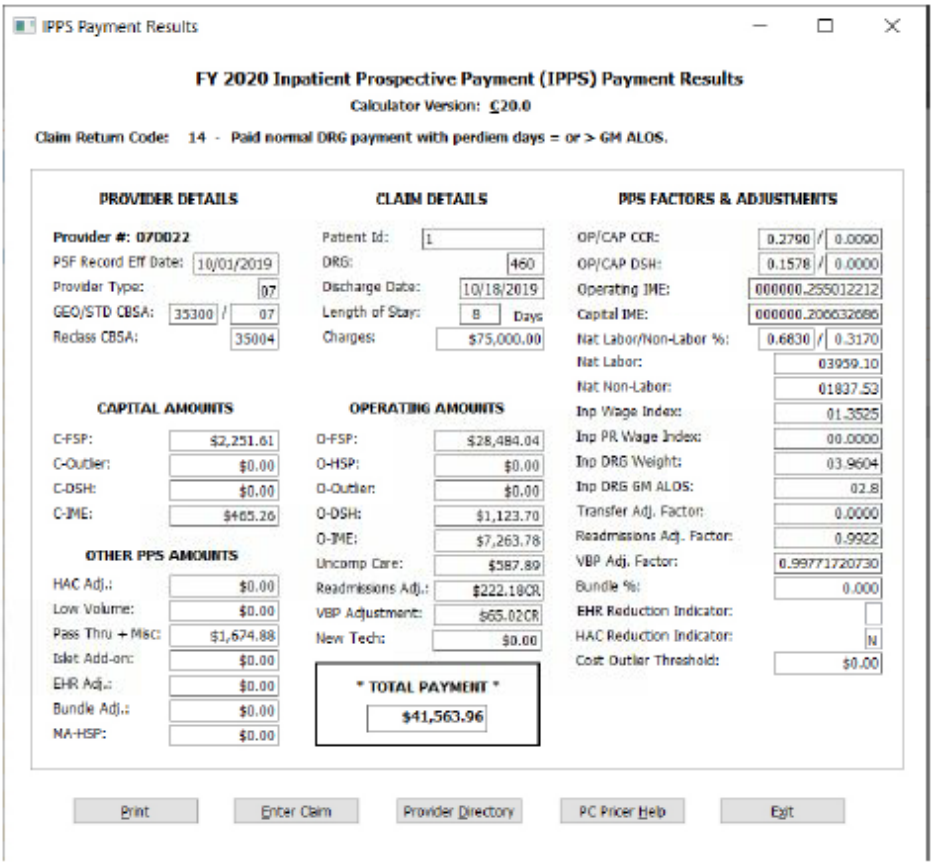
POST ACUTE TRANSFER—Enter 'Y' if one of the following Patient Status Codes is present on the claim: 03, 05, 06, 62, 63, or 65. Pricer will determine if the postacute care transfer payment will apply depending on the length of stay and the DRG.

COST OUTLIER THRESHOLD—Enter 'N' (or tab) if the cost outlier threshold is not applicable for the claim. For the cost outlier threshold, enter 'Y.'

For all of the remaining new technology fields, enter the procedure and diagnosis code if there is a procedure code on the claim that is defined within the International Classification of Diseases, Tenth Revision, Clinical Modification. Otherwise, enter 'N' (or tab).

Certain new technologies provide for an additional payment.

The following screen is an example of what will appear. Note that some fields may have 0 values depending on the inputs entered in the prior screen.



A Note on Pass-through Payments in the PC Pricer

There are certain hospital costs that are excluded from the IPPS payment and are paid on a reasonable cost basis. Pass-through payments under Medicare FFS are usually paid on a bi-weekly interim basis based upon cost determined via the cost report (or data received prior to cost report filing). It is computed on the cost report based upon Medicare utilization (per diem cost for the routine and ancillary cost/charge ratios). In order for the PC Pricer user to estimate what the pass-through payments are, it uses the pass-through per diem fields that are outlined in the provider specific file.

Pass-through estimates should be included when determining the Connecticut workers' compensation payment.

Determining the Final Payment

To determine the Connecticut workers' compensation payment, multiply the TOTAL PAYMENT field result above by 1.74 to calculate the payment.

In the above example, the TOTAL PAYMENT is reported as:

	$41,563.96
Multiplied by	x 1.74
Connecticut Workers' Compensation Payment	$72,321.29