A New Hospital Outpatient Payment Method for New Mexico Medicaid

Frequently Asked Questions

The New Mexico Medicaid program will move to a new method of paying for hospital outpatient services based on a simplified Medicare APC method. Our goals are to implement a new method that is sustainable, increases fairness, reduces administrative burden, rewards economy and improves transparency.

This document provides questions and answers about the new method. We invite additional questions and we welcome suggestions. The Division is working with a hospital advisory group on questions of payment policy, implementation and provider education.

Please note that details of the payment method shown in this document remain subject to change before the implementation date. If so, an update will be available to hospitals.

FAQs #1, #8, #12, #20, #24 and #25 have been updated since the last release.

OVERVIEW QUESTIONS

1. When will the new method be implemented?

The new payment methodology will be implemented November 1, 2010 for claims with dates of service on or after that date.

2. What change is being made?

The Division will change its current payment method, a fee schedule for certain services (i.e. clinical laboratory and radiology) and a cost-to-charge ratio for all other services, to a new method using a simplified “APC Fee Schedule” for all hospital outpatient services. The simplified “APC Fee Schedule” is based on, but not identical to, the Medicare Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs).

3. What providers and services will be affected by the simplified APC fee schedule?

The new method will apply to all hospital outpatient services provided by general acute care hospitals and rehabilitation hospitals.

The new method will apply to hospital outpatient fee-for-service claims billed on paper, electronically or via the web portal, and includes the UB-04 claim type and ANSI ASC X12N 837 Institutional transaction.

Outpatient services provided by Indian Health Service facilities, psychiatric hospitals, community mental health centers, dialysis clinics, physician offices, and other non-hospitals are unaffected.

If a hospital bills for a “provider-based” physician clinic, then the APC fee schedule will apply to
facility services (UB-04 claim form/ANSI ASC X12N 837 Institutional transaction), but not to physician services (CMS-1500 claim form/ANSI X12N 837 Professional transaction).

4. How much money is affected?

For the period January through June 2009, Medicaid fee-for-service payments to hospitals for outpatient care were approximately $32.5 million, before tax, third party liability, copay, patient liability, and cost settlement. The future volume of services affected by the APC fee schedule will depend on trends in utilization and on the number of people remaining in the Medicaid fee-for-service program.

The $32.5 million figure excludes payments for Medicare crossover claims, payments for Medicaid managed care patients, and psychiatric hospitals.

5. How does the current payment method work?

The Division’s current payment method is primarily a cost-based reimbursement method, using a fee schedule for certain services.

- Fee schedule for laboratory services
- Fee schedule for radiology services (effective December 1, 2009)
- Interim hospital outpatient reimbursement rate for all other eligible services with a year-end cost settlement process

Effective with dates of services beginning December 1, 2009, the hospital outpatient interim reimbursement rate was set at the final outpatient cost to charge ratio established during the most recent cost settlement or at fifty percent (50%) if the most recent cost settlement year was more than 2 fiscal years prior to the facility’s current fiscal year. If the provider is out of state and there is no cost settlement, the interim outpatient rates were also set at fifty percent (50%).

6. Why change to the new payment method?

The Division has 6 reasons:

- **Reward hospital efficiency.** In principle, the current cost-based method penalizes hospitals that reduce the cost of care. Although the lack of rebasing mitigates the perverse incentive, this is not a principle followed by leading purchasers of hospital care in 2010.

- **Align payment methodology for New Mexico Medicaid with prevailing payment methodologies (e.g. Medicare, private payers).** Going forward, the Division needs a method that can be sustained over time, with adaptations as appropriate to promote access to quality care and reduce unnecessary expenditures.

- **Improve the Division’s understanding of what it is purchasing.** It is currently very difficult to understand how much Medicaid is paying for services. Medicaid wishes to implement a payment method that will improve purchasing clarity.

- **Reduce unnecessary expenditures where appropriate.** The current method results in different hospitals being paid sharply different amounts for similar care.
- **Reduce reliance on cost reports and cost settlements.** The current method, involving cost reporting and year-end settlement processes, is burdensome. In particular, the lag time between provision of outpatient services and final settlement - which has ranged to several years - hinders financial planning efforts by both hospitals and the Division.

- **Improve revenue predictability for hospitals and financial planning efforts for the Division.**

**PAYMENT CALCULATIONS**

7. **What will be the basic approach?**

The basic approach is quite simple. The allowed charge amount will be based on the CPT/HCPCS code reported on the claim line. If a claim line is reported without a CPT/HCPCS code, the service will be considered packaged with $0.00 allowed charge amount. If a claim line is reported with a CPT/HCPCS code and the service is considered covered, the allowed charge amount will be based on the fee schedule and the allowed units.

8. **What are the exceptions to the basic approach?**

To minimize complexity, the Division is making only 4 exceptions to the basic approach, as follows.

- **Bilateral procedures.** The allowed charge amount for CPT/HCPCS codes reported with modifier 50 will be adjusted by 150% or 200% according to Medicare OPPS rules for bilateral procedures.

- **Discounted payment for multiple procedures.** If a claim contains multiple lines with procedure codes that have APC status indicator “T” (significant procedure subject to discounting) then the highest procedure in terms of the billed amount will be paid at 100% of the fee, the second-highest and subsequent ranked procedures in terms of the billed amount will be subject to a 50% discount or cutback percentage according to Medicare OPPS rules for multiple procedures.

- **Packaged services.** Some services will be “packaged,” that is, the fee will be zero because payment is considered packaged into the payment for other services on the claim. Packaging will apply to any services billed with anesthesia or recovery room revenue codes (0370, 0371, 0372, and 0710) and any procedure codes with APC status indicator “N”.

- **Services not covered by Medicare, but covered by Medicaid.** Fees will be developed as needed for services not covered under the Medicare OPPS, but covered by Medicaid.

9. **Where do the APC status indicators come from?**

For almost all services, Medicaid will assign the same APC status indicator to a procedure that Medicare does. In a few cases Medicaid and Medicare may use different APC status indicators because of differences between Medicare and Medicaid coverage policy. For example, Medicaid covers some vaccines that Medicare does not.
10. What will the fees be?

The level of payment is generally the same as Medicare using the Medicare OPPS APC relative weights; Medicare OPPS APC national conversion factor; Medicare clinical laboratory fee schedule; Medicare durable medical equipment, prosthetic, orthotic, and supply fee schedule; and the current New Mexico Medicaid rates for therapies (i.e., physical, occupational, and speech), dental, transportation, certain drugs and biologicals.

A comprehensive fee schedule is available on the Medical Assistance Division’s fee schedule website at [http://www.hsd.state.nm.us/mad/PFeeSchedules.html](http://www.hsd.state.nm.us/mad/PFeeSchedules.html).

**COMPARISON WITH MEDICARE**

11. How does the simplified APC fee schedule compare with Medicare?

Hospitals should find the similarities much more notable than the differences. Under both payers, the payment method essentially will be a fee schedule approach.

12. What are the key differences between the Medicare and Medicaid methods?

- **Outpatient Code Editor.** Medicaid will not use the OCE, although claims will be subject to Medicaid-specific edits as described in question 20.

- **Conditional packaging.** Under Medicare, procedure codes with APC status indicators Q1, Q2 and Q3 are sometimes paid and sometimes packaged, depending on what other codes are on the claim. Medicaid will pay these procedure codes separately in all instances. Payment will be based on Medicare OPPS APC assignment and relative weight.

- **Composite APCs.** Medicare uses “composite APCs” to make bundled payments for certain services. In 2009 this approach was expanded to include certain imaging services. Implementation of composite APCs is complex and, for several APCs, geared specifically to the Medicare program. Due to the complexities, Medicaid will not adopt the concept of composite APCs.

- **Modifier impacts.** Only modifier 50 will affect pricing under Medicaid. At present, the Division is considering the use of modifiers to accommodate special areas, e.g., drugs billed by 340B hospitals.

- **Multiple procedure discounts.** Under Medicare, procedure codes with APC status indicator “T” are subject to multiple procedure discounting. Medicare ranks the procedures from high to low based on the fee schedule amount to determine the procedure to be paid at full price and the procedures to be discounted. Medicaid will apply multiple procedure discounts using the billed amount to rank the procedures.

- **Outliers.** Medicaid will not make outpatient outlier payments

- **Quality reporting.** Medicare reduces payments to hospitals that do not report outpatient quality data. At present, Medicaid has no similar program.
- **Special treatment for some hospital types.** Medicare has special payment provisions for children’s hospitals, cancer hospitals, rural hospitals and critical access hospitals. Medicaid will use the same payment method for all hospitals.

- **Cost-sharing.** Medicare has minimum and maximum coinsurance rates by service. Medicaid is making no changes to its cost-sharing policy.

**COVERAGE AND PAYMENT FOR SPECIFIC SERVICES**

13. What changes, if any, will be made to Medicaid policy on covered services?

Like Medicare, Medicaid covers a very wide range of hospital outpatient services. Differences do exist in coverage policy, in which case the Medicaid policy will continue to apply.

14. What changes, if any, will be made to Medicaid prior authorization policy?

The change in payment methods has no impact on Medicaid prior authorization policy.

15. How will payment be made for lab services?

The fee schedule for clinical laboratory services will be based on the Medicare Clinical Laboratory Fee Schedule (CLAB) similar to the approach used under the Medicare OPPS.

16. How will payment be made for radiology services?

The fee schedule for radiology services will be based on the Medicare OPPS APC status indicator and relative weights including adjustments for bilateral and multiple procedures when applicable, similar to the approach under Medicare OPPS.

17. How will payment be made for physical, occupational, and speech therapy?

Physical, occupational, and speech therapy services will be based on the current New Mexico fee schedule.

18. How will payment be made in other special situations?

These situations include vaccines and immunizations, dental services, ambulance and transportation services and other services where Medicare either does not cover the service in the hospital outpatient setting or pays for it outside the APC payment method. In most cases, Medicaid has simply set a fee for the service. For observation, Medicaid’s existing policy is to pay up to the 24th hour of observation. Payment for observation care will consist of payment by procedure based on an hourly fee, up to the 24th hour, regardless of diagnosis. Observation should be billed using G0378, where the unit of service is explicitly one hour. Other observation codes such as 99217 will have their fees set at zero.
BILLING AND EDITING

19. What billing practices will be important for hospitals to follow?

By intention, the following list is very similar to the list for Medicare:

- **Procedure code billing.** Since claim lines without procedure codes will be packaged (i.e., paid at zero), hospitals should list procedure codes wherever appropriate. Like Medicare, Medicaid will require procedure codes for most revenue codes. As a general rule, hospitals will bill Medicaid in the same manner as they bill Medicare. For those revenue codes, a procedure code may or may not be appropriate but if it is appropriate then the hospital should list it in case it results in payment for that line.

- **Procedure code units.** Hospitals are asked to pay particular attention to billed units, which should be appropriate for the specific CPT or HCPCS code description. Special attention should be paid to therapy codes and drugs billed using J codes or other HCPCS codes.

- **Same-day billing.** Hospitals are expected to bill all services provided on the same day to the same patient on the same claim.

- **Visit levels.** In billing for emergency room and clinic visits (e.g., 99281-99285), hospitals are expected to follow the same guidelines as they do for Medicare. For example, see page 66805 of the November 27, 2007 Federal Register for Medicare guidance on assigning ER visit levels (available at [www.gpoaccess.gov/fr/retrieve.html](http://www.gpoaccess.gov/fr/retrieve.html)). Medicare also has guidance on the definitions of new and established patients in a hospital context.

- **Observation.** Bill observation using code G0378, showing hours as the number of units. See question 18.

- **Claim Adjustment.** Hospitals are responsible for tracking the status of a claim and for determining the need to resubmit a claim. The guidelines for a claim adjustment request are outlined in the New Mexico Medicaid Program Policy Manual Section 8.302.2.11.B. of Chapter 302 which is entitled Medicaid General Provider Policies.

20. What edits will hospital outpatient claims be subject to?

Again by intention, the list is very similar to current practices in the New Mexico claims processing system. In addition to standard edits related to eligibility, enrolled provider, timely filing, valid data values, prior authorization, etc., the following edits will apply to hospital outpatient claims specifically.

- **Covered services.** Both revenue codes and procedure codes are checked to ensure that Medicaid covers specific services in the hospital outpatient department.

- **Maximum units.** Billed units are checked for reasonableness. If the claim is denied then the hospital is asked to correct the units or to justify the medical necessity of the amount of units.

- **National Drug Codes.** Current edits to require NDC codes will continue in place.
Non-covered services. The change in payment method has no impact on Medicaid non-covered services policy.

OTHER QUESTIONS

21. Will hospitals still have to submit cost reports?

Yes. Under the new payment method, the cost settlement process will be discontinued for hospital outpatient services. Cost reports will still be required, however, because they are used for other purposes.

22. Will payments be subject to adjustment after cost reports have been submitted?

No. Payment based on the simplified APC-based fee schedule will be final with no cost settlement.

23. Will the new payment method have any impact on the provider tax calculations?

No.

24. What is Medicaid doing to involve and inform hospitals during the development of the simplified APC-based fee schedule?

- **FAQ.** Updates of this document will be available to hospitals.
- **Financial simulation.** Each hospital has received financial simulation results at the line-specific level. For additional information contact yleana.sanchez@acs-inc.com.
- **Hospital consultation.** Meetings with the New Mexico Hospital Association, hospital representatives and other interested parties were held in January 2010 and August 2010.
- **Training sessions.** Training and presentation of the new payment method was held during the August 2010 meeting.

25. Who can I contact for more information?

- **Technical questions about the APC-based fee schedule.** Yleana Sanchez, Senior Consultant, Payment Method Development, ACS Government Healthcare Solutions, yleana.sanchez@acs-inc.com, (860) 742-2229.

- **Technical questions about the financial simulation.** Yleana Sanchez, Senior Consultant, Payment Method Development, ACS Government Healthcare Solutions, yleana.sanchez@acs-inc.com, (860) 742-2229.

- **Questions about billing and claims processing.** ACS, nmsupport@acs-inc.com, toll free 800-299-7304
Questions about Division policy.

Written comments may be sent to: Devi Gajapathi
Project Manager, Medical Assistance Division
Benefit Services Bureau
New Mexico Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348

E-mail comments may be sent to: Devi.gajapathi@state.nm.us.

However, if you have questions, you may contact Devi Gajapathi at (505) 827-6227