County Pricing Training

Social Services Conference
Meridian, Idaho
April 19, 2017
3:15 4:30 pm
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• PRICING QUESTIONS
  • Redact all the personal information - patient’s name, contact information, social security number, etc. If the case has been scanned into SCI, provide the CAT case number and I can access the claims for review.
  • Email pricing questions directly to me. The CAT Fund forwards the email to me. Should they not be available or unable to forward the email when it is received it may slow down the response time.
  • Remember – no question is dumb or stupid. This is a learning process and every question is valid. Much better to ask the question and submit the claim correctly than to have to re-do the claim later and make necessary adjustments, especially if it is a CAT case. Carolyn will thank you.
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http://healthandwelfare.idaho.gov/Providers/MedicaidProviders/MedicaidFeeSchedule/tabid/268/Default.aspx

Prescription drugs are reimbursed by locating the generic or brand description. If the prescription is not on the Myers and Stauffer website, send an email to county pricing trainer with a description of the drug, dosage, tablet, capsule, etc. and NDC if possible.

Please do not contact Myers directly for pharmacy prices. Send an email to me.

National Drug Code (NDC)
Example: 13811-0007-10
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PAYMENTS MADE BY APPLICANT
If applicant paid one provider more than the Medicaid reimbursement rate notify the provider that there will be no additional payment from the county even though the procedure was approved by the county.

If there is more than one claim apply the payment toward claim #1 and any balance toward claim #2 and any other claims for the same provider.

Claim #1 – Medicaid reimbursement is $92 (100 - 92 = $8)
Claim #2 – Medicaid reimbursement is $78 (78 - 8 = $70)

Applicant made a $100 payment to provider. Apply $92 toward first claim and remaining $8 to claim #2. County reimbursement is $70 for the two claims.
Clearly show the calculations.

MEDICAL CLAIMS FORWARDED TO THE CAT FUND
Clearly show the calculations for the county portion and the CAT Fund portion of the medical claim reimbursement, including the 95% adjustment per Idaho Statute

31-3502.(23) "Reimbursement rate" means the unadjusted medicaid rate of reimbursement for medical charges allowed pursuant to title XIX of the social security act, as amended, that is in effect at the time service is rendered. The "reimbursement rate" shall mean ninety-five percent (95%) of the unadjusted medicaid rate

Example:
Total reimbursement $23,456.12 x 95% = $22,283.31
County payment $ 6241.78
CAT payment $16,041.53
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HOSPITAL MEDICAL CLAIMS DOS SPANNING TWO INTERIM RATES
For hospital claim dates with some dates of service under one interim rate and another portion under a different interim rate there are two options to consider:

1. Request a split bill for both dates of service from the provider and apply the appropriate interim rate to DOS; or
2. Calculate the charges for both interim rate dates of service manually and apply the appropriate interim rate to DOS
3. Example: DOS from March 20, 2017 through April 7, 2017. The interim rate is 37% for March but changed to 41% in April. Reimburse March charges at 37% and April at 41%.

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CPT CODES AT $0.00 ON THE FEE SCHEDULE REQUIRE MANUAL PRICING

1. Allowed Amount ($0.00 indicates a Manually Priced Code) Column 4
2. CPT Codes with a $0.00 on the current fee schedule posted online must have the following otherwise the claim will not be reimbursed by the county.
3. Invoice showing the provider cost which will be priced at cost plus 10% and the 95% will not apply.
4. A copy of the MSRP which will be reimbursed at 75% of MSRP.
5. If these items are not attached to the medical claims contact the provider and request them. If they are not provided the claim is rejected for payment.
6. Counties reserve the option to deny reimbursement if the provider does not provide the requested invoices or to reimburse at 40% x 95% of the billed charges.
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PLACE OF SERVICE (POS)

Field “B” of a HCFA-1500 is the place of service field which tells where that particular procedure took place. It is especially beneficial on a lab medical claim when determining if there is a corresponding UB-04.

POS 24 - ASC facility
POS 21 - inpatient
POS 22 - outpatient

POS plays a role when reimbursing a HCFA-1500.

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INCREMENTAL NURSING CODES (INC) 0230 - 0234

Incremental nursing charges billed under Revenue Codes 0230, 0231, 0232, 0233, or 0234 must have documentation in the medical record to support the need for these additional services. Idaho Medicaid adheres to the National Uniform Billing Committee UB-04 Data Specifications Manual definition of these codes which states, “Extraordinary charges for nursing services assessed in addition to the normal nursing charge associated with the typical room and board unit. These codes do not support unbundling of nursing charges from standard room and board.”

New Policy: Medical claims, which include INC charges in the amount of $10,000 or more will need a medical review to determine if payment is appropriate for the counties. It is recommended counties have Idaho Medical Review’s support documentation before denying incremental nursing charges. A medical review relieves the county from making medical decisions.
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PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY LIMITS
Effective January 1, 2017, the yearly capitation rate for Physical Therapy, Occupational Therapy and Speech Therapy visits be increased to $1960.00.

Rev Code 420 Physical Therapy (PT) CPT - $1960
Rev Code 430 Occupational Therapy (OT) CPT - $1960
Rev Code 440 Speech/Language Pathology (SPL) CPT - $1960

NOTE: Physical and Speech are **COMBINED** totals of $1960; Occupational total alone is $1960.

No need to track number of visits, track total reimbursed, not the billed charges.

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BEHAVIORAL HEALTH CHARGES
The amount of payment by a county shall be the Medicaid rate, or pursuant to the provisions of any contract between a provider and an obligated county, or if the facility providing the services is a freestanding mental health facility, then the reimbursement rate will be the medicaid rate, for a hospital as defined by section 39-1301(a), Idaho Code, that provides services within the nearest proximity of the mental health facility. Such costs fixed by the court shall be based upon the time services were provided. *Idaho Code 66-327(a)*

Intermountain Behavioral Health Care is reimbursed at the same interim rate as St. Al's because St. Al's is the closest facility.

Consider contracts with behavioral health care providers
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TC MODIFIER ON OUTPATIENT CLAIMS

Radiology/Imaging – All radiology/imaging charges on an outpatient hospital medical claim are reimbursable at the TC modifier rate even though a TC modifier may not be attached to the CPT code. The radiology/imaging provider submits their charges on a HCFA-1500 for interpreting the procedure.

Lab Charges – Lab charges on an outpatient hospital medical claim are reimbursed by how the claim is billed. Reimburse at the global (base) amount if no modifier or at the TC rate if a TC is used with the CPT code.

For inpatient hospital medical claims both radiology and lab are reimbursed at the percentage interim rate for the hospital.

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MODIFIERS 52 AND 53 REDUCTION

1. Effective for claims with dates of service on and after October 1, 2016, modifiers 52 and 53 will reduce the allowed reimbursement amount by 25%.

2. Modifier 52 – is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia.

3. Modifier 53 – is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services.
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REMEMBER THIS FORMULA? WELL – FORGET IT!

Most lab codes in the 300 series with 80000 series CPT codes are reimbursed by using the following formula after having totaled all codes or one at a time if you prefer: NOTE: 36415 venipuncture is not included in this formula.

Amount ÷ .60 x .62 x 95%

Ex: 18.31 ÷ 60% = 30.52 x 62% = 18.92 (.61 more) x 95% = 17.97

Note: This formula gives the hospital a 3.2% increase (hospital only), do not use to price labs billed on a HCFA.

REIMBURSE LAB CHARGES AT THE MEDICAID ALLOWABLE RATE

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LOWER LEVEL OF CARE – SWING BED FACILITIES

Swing bed hospital rate is $274.98 per day effective January 1, 2017.

Swing bed rates are used to negotiate a lower level of care when a patient no longer requires hospitalization but still requires medical monitoring and no other care is available in the area. If a lower level of care is approved by a medical review, documentation will be provided for negotiations with the hospital.

Idaho Code 31-3502 18(A)e: 18) A. "Necessary medical services" means health care services and supplies that:

(e) Are the most cost-effective service or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results for the person’s illness, injury or disease.
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FIELD 80 OF UB-04-1450

Medical records will give a complete description of procedures. This field is for additional if needed.

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Remarks</td>
<td>Use remarks field to indicate any additional information helpful for claims processing, e.g. injury/accident - how, where, and when injury/accident happened.</td>
</tr>
</tbody>
</table>

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REVENUE CODES 0636 AND 0250

Rolling revenue code 0636 drugs into 0250 revenue code is allowable by Medicaid. The county uses the itemized statements together with the UB-04 to price claims. Any 0636 revenue codes on the itemized are deducted from the total billed on the UB-04 before calculating payment. Revenue code 0636 is not covered on an inpatient medical claim. A hospital may send the below image to support combining 0636 with 0250.
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PROCEDURE WITH 90 DAY GLOBAL

• Major surgical procedures (90-day global period)
• One day of preoperative care so the global period starts the day prior to the surgery.
• Care on the day of the surgery is included in the global period unless the decision to perform the surgery was made during the visit on this day. (See modifier -57).
• There are 92 days in the global surgical period beginning the day before the procedure, the day of the procedure, and the 90 days following it.
• No new treatment plan is needed if Idaho Medical Review has approved 90-global

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EFFICIENT PRICING OF MEDICAL CLAIMS

Sometimes when a hospital receives a county approval, they submit a new hospital claim with added charges that had not previously dropped to billing when the first medical claim was sent. Be aware that you could receive a new medical claim with a higher amount than previously billed. Consider waiting a few days after the approval has been sent for any updated charges before pricing your claim(s).

Even if you do not request a medical review you should still review charges carefully. Question the provider if you think charges are excessive. Errors do happen occasionally with provider billing.