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1 Overview

This chapter provides an overview of this manual and how to contact Optum. It contains the following sections:

- Introduction to This Guide
- Intended Audience
- Organization of This Guide
- Document Conventions
- About Optum
- Contact Us
  - Corporate Address
  - Need Assistance? Contact Optum Client Services
  - Optum Client Portal
  - Found an Error in This User’s Guide?
1.1 Introduction to This Guide

The EASYGroup™ User’s Guide contains all the essential information the user will need to be able to work with all EASYGroup™ components. Consider this guide your textbook, a ready reference source should you forget a procedure or encounter a problem.

1.1.1 Intended Audience

This guide is directed to:
- Claims Specialists
- Information Technology Personnel
- System Administrators
- Supervisors

This guide assumes that the reader has a working knowledge of C and/or COBOL language syntax and file structures. All EASYGroup™ COBOL components utilize standard COBOL, using a compiler that conforms to INCITS/ISO/IEC 1989-2002 standard, “High” level specifications. The COBOL file types used are SEQUENTIAL and INDEXED.

1.2 Organization of This Guide

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1.3 Document Conventions

This guide uses the following conventions:

- Any screen fields, buttons, tabs, or other controls that you can manipulate are printed in **bold** type. Keys that you press on the keyboard are also printed in **bold** type. For example:
  - Press the *Exit* button.
  - Press the *Enter* key.

- Keyboard keys that you must press simultaneously are printed in **bold** type and separated by a plus (+) sign. For example:
  - Press *Ctrl + C*.

- Links embedded in the text that you can select to jump to another section are in orange. For example:
  - Mappers

- Field names for the C Platform and filenames are italicized. For example:
  - *pricer_rtn_code*
  - *EASYGroup.exe*

- Field names for the COBOL Platform are in all caps. For example:
  - *PRCR-RTN-CODE*

- Field description titles are printed in **bold** type:
  - **NICU Accreditation Indicator**

- Legislation titles are italicized. For example:
  - *Balanced Budget Act of 1997*

- CMS Transmittals will be written in the following format:
  - CMS Transmittal No. R2220CP (*Update - Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2012*)

1.4 About Optum

Optum is a health services business dedicated to making the health system work better for everyone. At Optum, we help modernize the health ecosystem, by bringing inter-operable and connected technology, real-time information, streamlined administration and managed compliance, risk, and costs.
1.5 Contact Us

1.5.1 Corporate Address

Optum
11000 Optum Circle
Eden Prairie, MN. 55344
T 1 + (888) 445-8745
www.optum.com

1.5.2 Need Assistance? Contact Optum Client Services

We welcome you as a valued client. Please contact Optum Client Services using one of the methods detailed below.

When opening a ticket with Optum Client Services you will be issued a ticket number. These ticket numbers correlate to individual issues. If you are experiencing multiple issues, it is recommended that you obtain individual ticket numbers.

When calling Optum Client Services regarding a previously opened ticket, have your ticket number available. If you misplaced or did not receive a ticket number, please ask the technician to provide it to you.

Optum Client Services Phone: 800-999-DRGS (3747)

1. Calls are answered in the order that they are received. If there is a high call volume, calls are held in a queue until a technician becomes available.
2. Calls classified as an industry expert category (i.e., case and reimbursement, logic encoder, etc.) will be escalated to Optum experts.
3. Technicians are available 24/7.

After selecting Option 6 for Technical Support you will hear the following choices:

Table 1-2: Technical Support Options

<table>
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<td>For password reset, login issues, or expiration error.</td>
</tr>
<tr>
<td>Option 2</td>
<td>For all other issues.</td>
</tr>
</tbody>
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Email: OptumClientServices

1. Include name and number and detailed description of product issue.
2. Response time to email is generally within a few business hours.
3. Service technician has ability to do prior research before calling back.
1.5.3 Optum Client Portal

For access to announcements, user documentation, notices, release schedules, and much more please visit the Optum Client Portal.

1.5.4 Found an Error in This User’s Guide?

Please feel free to contact our EASYGroup™ Documentation team with any errors you may have found within this user’s guide:

EASYGroup_Documentation

We welcome feedback from our clients.
2 Introduction

This chapter provides an introduction to the EASYGroup™ product suite. It contains the following sections.

Note
Please note that you may or may not license all of the EASYGroup™ components. Please refer to the Optum Client Portal for access to user documentation for the components you currently license.

- Introduction to EASYGroup™
  - Editors
  - Analyzers
  - Groupers
  - Pricers
  - Mappers
  - Data Files
  - Fee Schedule Data Files
  - Rate Files
  - Rate Manager
- EASYGroup™ Component Architecture
2.1 Introduction to EASYGroup™

Note
Please refer to the applicable sections of this user’s guide for further information on each EASYGroup™ component listed below. The below section outlines the core EASYGroup™ components only. For information relating to the EASYGroup™ platforms (i.e., the Optimizer, the Server, the Web Service, etc.) please refer to the Interfacing With EASYGroup™ Guide.

2.1.1 Editors
Editors examine claims for data entry errors and inconsistencies. EASYGroup™ Editors have been designed to improve the accuracy of data that will determine grouping and pricing of the claim. Some examples of the types of edits that are performed are as follows:

- Invalid Diagnosis Codes
- Invalid Procedure Codes
- Invalid Patient Age
- Invalid Patient Sex

The EASYGroup™ product suite contains 5 different Editors:

- Date-Sensitive Code (DSC) Editor
- Ambulatory Code Editor™ (ACE)
- Local Coverage Determination (LCD) Editor (C Only)
- EASYEdit™ (COBOL Only)
- Physician Editor

2.1.2 Analyzers
Analyzers work seamlessly with EASYGroup™ Editors, Mappers, Groupers, and Pricers to examine claims for coding errors or inconsistencies. Analyzers can be configured to apply a set of rules to claims and adjust payment amounts, or simply to output information about each claim. The EASYGroup™ product suite includes the following Analyzer:

- V01 EDC Analyzer™:
  The V01 EDC Analyzer™ is used to evaluate outpatient emergency department claims (Medicare, Medicaid, and Commercial) for correct coding, dated October 01, 2015 or later.
2.1.3 Groupers

Groupers assign patients to groups containing similar clinical characteristics and similar levels of resource usage. These assignments are driven by diagnosis and procedure codes. Within EASYGroup™ there are multiple types of Groupers. There are Groupers for use with inpatient care settings, outpatient care settings, and specialized care settings, such as home health agencies, rehabilitation facilities, etc.

2.1.4 Pricers

Pricers contain reimbursement calculations and payment rules. Pricers allow for some commercial modifications of payment rules. They perform the standard calculation of:

\[ \text{Base Rate} \times \text{Weight} \]

Pricers also perform hospital-specific adjustments and calculations for outliers, short stays, long stays, and transfer adjustments. There are Pricers for use with inpatient care settings, outpatient care settings, commercial care settings, and specialized care settings, such as skilled nursing facilities, rehabilitation facilities, physicians, etc.

2.1.5 Mappers

Mappers are a collection of programs and files that map or translate ICD-9-CM or ICD-10-CM/PCS codes from a specified time period or version to a selected target version. Mapping allows the coding conventions for one time period to be used with DRG assignment software based on a different time period's coding conventions. For example, the Mapper can be used to map V34 ICD-10-CM codes (effective October 01, 2016) to codes effective in a previous time period or version, such as V33 (effective October 01, 2015). With such mapping, V34 codes can be submitted to a V33 DRG Grouper.

The EASYGroup™ product suite contains three different Mappers:
- ICD-9 Mapper (referred to simply as the “Mapper”)
- ICD-10 Mapper
- Alternate ICD-10 Mapper

2.1.6 Data Files

The EASYGroup™ Data Files have been designed to streamline the update process by separately distributing important pricing data for certain inpatient and outpatient payment systems, as well as the Physician Payment System. These data-only products dispense such files as the Code Table File. For further information please refer to Chapter 9.

2.1.7 Fee Schedule Data Files

The Medicare Fee Schedule Data Files support APC, ASC, ESRD, HHA, and the SNF Payment Systems, as well as the Physician Payment System. The
payment rates contained in the applicable fee schedule data files are published annually by the Centers for Medicare & Medicaid Services (CMS). Effective at the start of each calendar quarter (January 01st, April 01st, July 01st, and October 01st). CMS may update payment rates in one or more categories. Therefore, these fee schedule data files will generally be released every quarter for each payment system.

The Medicaid Fee Schedule Data Files support New York, Virginia, Washington, and Wisconsin outpatient payment systems. The New York, Washington, and Wisconsin Outpatient Fee Schedule Data File distributions include all published Medicaid fee schedule rates. The Virginia Outpatient Fee Schedule Data Files distribution includes published Medicaid fee schedule rates for vaccines that are part of the Vaccine for Children (VFC) program in the state of Virginia. For further information please refer to Chapter 10.

2.1.8 Rate Files

Within EASYGroup™ there are two types of rate files available:

- State Rate Files (including TRICARE)
- National Medicare Provider Rate Files (NMPRFs)

The State Rate Files are developed by Optum and are a comprehensive source of hospital-specific Medicaid and TRICARE (outpatient and inpatient) reimbursement information. They contain all the specific information or rate variables needed to calculate hospital reimbursements under the Medicaid and TRICARE Payment Systems. The information contained in these files can be loaded in Rate Manager for use with EASYGroup™ and are compatible with Web.Strat™.

The NMPRFs are a comprehensive source of provider-specific Medicare reimbursement information. These products contain all the rate variables needed to calculate reimbursement under the appropriate Medicare Payment Systems (including Physician). The information contained in these files is compatible with EASYGroup™ Medicare Pricers (available in COBOL or C) and can also be used with Optum reimbursement management products: Web.Strat™, ECM Pro™ Web Services, EASYGroup™ Web Service, and EASYGroup™ Server (available for Windows®).

2.1.9 Rate Manager

Rate Manager is a Microsoft® Windows® application that is used to define editing, grouping, mapping, and pricing rules by facility, contract, and effective date. Rate Manager allows these customized rules to be exported to rate files which are then transferable to other systems.

Note

Please refer to the Rate Manager User’s Guide for further information.
2.2 EASYGroup™ Component Architecture

Below is a diagram of the EASYGroup™ components and how they interact with each other.

Figure 2-1. EASYGroup™ Component Architecture

In the above diagram you can see that the Optimizer is the “brain” of the EASYGroup™ system. The Optimizer and its control programs send signals to each main component depending on which component it needs to call. The Optimizer receives information from the user’s claims processing system and then calls the Grouper, Analyzer (if needed), Pricer, Editor (if needed), and Mapper (if needed) based on user-defined rules.

The user-defined rules for grouping, analyzing, pricing, mapping, and editing are specific to a facility (i.e., hospital or provider), payer (i.e., line of business or provider contract) and period of time. These rules are stored in data files which also contain data to drive the claims processing functions. The Optimizer relies on Rate Manager to set-up and maintain these files.

When calling the Optimizer, the user can specify which functions should be performed for the patient record being processed. Choices include options to Edit, Analyze, Group, Map, and Price.
3 Editors

This chapter provides an introduction to the EASYGroup™ Editors. It contains the following sections:

• Introduction to EASYGroup™ Editors
• Ambulatory Code Editor™ (ACE)
  - Features Supported
• Date-Sensitive Code (DSC) Editor
  - Features Supported
• Local Coverage Determination (LCD) Editor
  - Features Supported
• EASYEdit™ Editor
  - Features Supported
• Physician Editor
  - Features Supported
• Medicaid Outpatient Editor (MOE)
  - Features Supported
3.1 Introduction to EASYGroup™ Editors

The EASYGroup™ product suite contains a few different types of Editors. Your EASYGroup™ system will require a different Editor depending on the payment system you are using to process your claims. This chapter will explain each type of Editor that is available.

3.1.1 Ambulatory Code Editor™ (ACE)

The Ambulatory Code Editor™ (ACE) is designed to evaluate and ensure the accuracy of outpatient claims data, including HCPCS Level I (CPT®-4) and Level II procedure codes and their associated modifiers are billed. At a minimum, all services provided to a single patient on a single date by a single provider should be assembled and passed together to ACE. ACE will not provide accurate results if services provided on the same date to the same patient are split into two sets of ACE input. However, ACE can accept multi-date claims as input. These batch or cycle bills are divided into single day segments, with most edits applied separately to each day. ACE then assembles the edit results from each service date and returns all errors.

3.1.1.1 Features Supported

- **Outpatient Code Edits (OCEs):**
  
  OCEs are designed to examine the validity, accuracy, and appropriateness of hospital outpatient services. These edits are applied by the Medicare Fiscal Intermediaries (FIs) to all hospital outpatient claims. Failure to pass these edits may result in reduced payment or non-payment of the claim.

  The extensive OCE Edits include:

  - **Validity Edits:** Identify invalid or inappropriate diagnosis codes, HCPCS procedure codes, modifiers, service dates, age or sex. Also examined are conflicts between diagnosis and procedure codes and the patient’s age and sex.

  - **Units Edits:** Identify service units that are clinically impossible or unreasonable for the service billed.

  - **Medicare Program Edits:** Identify services never paid by the Medicare program, services only covered under certain medical conditions, service/site limitations, and inpatient procedures.

  - **OCE Correct Coding Initiative (CCI) Edits:** Identifies sets of codes which are not eligible for payment when presented together on a single claim and for a single service date. These edits are based on the National Correct Coding Initiative (NCCI).

  - **Partial Hospitalization and Mental Health Edits:** There are a substantial number of OCE Edits devoted to mental health claims, in particular those claims involving the partial hospitalization per diem payment benefit. These edits identify which claims are eligible for the per diem payment and apply maximum payment limits to mental health services.
Correct Coding Initiative (CCI) Edits:

Outpatient claims data can also be evaluated using the National Correct Coding Initiative (NCCI). The NCCI edits were developed by Medicare to promote the utilization of correct coding methodologies in outpatient settings and to curtail improper coding practices that lead to inappropriate increased payment. The NCCI provides a set of rules governing complex coding situations, and specifies when certain combinations of codes are inappropriate. The NCCI was originally developed for evaluating physician-based coding practices.

The NCCI analyzes each possible pair of HCPCS codes and looks for combinations of codes that cannot be billed together for one of the reasons listed below. A modifier can be appended to a HCPCS Level I or Level II code to indicate that a service or procedure was altered by specific circumstances. In some cases, the addition of a modifier will indicate that a combination of procedure codes is appropriate under those circumstances.

The NCCI edits are divided into the following categories:

- **Essential Services**: Services essential to the procedure should not be separately coded.

- **Separate Procedure**: Some procedures, although they can be performed separately, are generally included in other more comprehensive procedures. One code is a CPT® separate procedure and should not be reported.

- **Most Extensive Procedure**: Code only the most extensive service for the same site.

- **“With” and “Without” Services**: “With” and “Without” codes should not be used together.

- **Anesthesia Included in Surgical Procedures**: Anesthesia administered by the operating physician should not be reported.

- **Laboratory Panels**: Individual laboratory tests that make up a comprehensive panel of tests should not be reported separately.

- **Sequential Procedures**: Report the code for the completed service only.

- **Standard Preparation or Monitoring Services**: Do not code services integral to the procedure.

- **CPT® Coding Manual Guidelines**: Codes should not be reported together per CPT® Coding Manual instructions or guidelines.

- **CPT® Procedure Code Definition**: Codes should not be reported together per CPT® Procedure Code definitions.

- **Misuse of Column 2 Code with Column 1 Code**: These services are not typically performed together.

- **Mutually Exclusive Codes**: Codes indicate mutually exclusive services.
- Designation of Sex Procedures: Codes indicate a sex conflict.

- Medically Unlikely Edits (MUEs):
  A MUE (Medically Unlikely Edit) is a Unit of Service (UOS) edit for a
  HCPCS/CPT® code for services rendered by a single provider/supplier to
  a single beneficiary on the same date of service. The typical MUE is the
  maximum UOS that is reported for a HCPCS/CPT® code on the vast
  majority of appropriately reported claims. CMS developed MUEs to reduce
  the paid claims error rate for Part B claims.

  MUEs are a part of the National Correct Coding Initiative (NCCI) to
  promote correct coding methodologies. The NCCI policies are based on
  coding conventions developed by nationally recognized organizations and
  are updated annually or quarterly.

  MUEs were generally developed using biological considerations (number
  of limbs or organs, etc). MUEs adjudicate on units billed per line of service.
  CMS began applying MUEs to Part B claims in January 2007. However,
  none of the edits were made publicly available until October of 2008 out of
  concern for abuse. Some MUEs still remain confidential.

  There are two sets of MUEs:

  - Facility Claims: If a facility submits a Part B claim which contains (for a
    particular HCPCS code) a unit value that is higher than the facility MUE
    maximum value for that code, CMS denies payment for that code. The
    MUEs are applied by Medicare Administrative Contractors/Fiscal
    Intermediaries (MACs/FIs) to hospital outpatient claims prior to running
    them through the OCE. All facility outpatient claims which are subject to
    the OCE edits are also subject to the MUEs.

  - Professional Claims: For professional claims, units that exceed the MUE
    maximums are ignored and payment for the affected service is capped
    at the MUE unit maximum times the unit price.

  Note
  ACE also supports National Medicaid CCI/MUE, and certain state-specific
  CCI/MUEs.

3.1.1.2 Additional ACE Functionality
In addition to editing claims, the Ambulatory Code Editor™ (ACE) also
assigns APCs and Payment Statuses to HCPCS codes or groups of HCPCS
codes, using rules found in Medicare’s Outpatient Code Editor (OCE).
Explanation for some of this additional functionality is provided below.

- Conditional Packaging:
  Effective January 01, 2007, CMS introduced conditionally packaged codes
  with an interim Payment Status of Q (Packaged Service Subject to
  Separate Payment Based on Payment Criteria). Effective January 01,
  2009, CMS replaced the interim Payment Status Q with the better
differentiated interim Payment Statuses Q1 (STVX - Packaged Services/STV - Packaged Services), Q2 (T-Packaged Services), and Q3 (Services That May be Paid Through a Composite APC). Effective January 01, 2011, CMS expanded the definition of Payment Status Q3 to include Critical Care Packaged Services. Effective January 01, 2012, CMS expanded the definition of Payment Status Q3 to include Cardiac Care Packaged Services. All services that are assigned to one of these interim Payment Statuses are separately payable only under certain circumstances.

**Note**

Optum APC Assistant™ is a comprehensive, web-based resource containing all the latest APC regulatory information to successfully navigate through the OPPS. If you do not license APC Assistant™, please contact Optum Client Services (1-800-999-DRGs [3747]).

- Q1 (STV - Packaged Services):
  Services with a Payment Status of Q1 are payable only if there is no other service on the claim with a Payment Status of S (Procedure or Service, Not Discounted When Multiple), T (Procedure or Service, Multiple Reduction Applies), or V (Clinic or Emergency Department Visit). If there is no Payment Status S, T or V service on the claim, the Q1 service will be assigned to a payable payment status and an APC, and will be separately payable. If there is a Payment Status S, T or V service on the claim, the Payment Status Q1 service will be assigned a Payment Status of N (Packaged/Incidental Service) with no APC, and will not be separately payable.

**Note**

Prior to January 01, 2017, the evaluation of Q1 services was done at the service date level, rather than the claim level, so that the Payment Status S, T or V service would need to have the same service date in order to trigger packaging of the Q1 service. Prior to January 01, 2016, a Payment Status X (Ancillary Service) service would also cause packaging of any Q1 service, but Payment Status X was discontinued as of January 01, 2016.

- Q2 (T-Packaged Services):
  Services with a Payment Status of Q2 are payable only if there is no other service present on the claim with a Payment Status of T. If there is no Payment Status T service present on the same claim as a Q2 service, the Q2 service will be assigned a Payment Status and an APC and will be separately payable. If there is a Payment Status T service present on the same claim as a Q2 service, the Q2 service will be assigned a Payment Status of N, a zero APC, and will not be payable. A complete list of all T-
packaged services is available on the **Procedures** page within APC Assistant™.

- **Q3 (Services That May be Paid Through a Composite APC):**
  Services with a Payment Status of Q3 are paid or packaged using a complex set of rules.

- **Q3 (Critical Care Packaged Services):**
  Certain ancillary services that are billed on or after January 01, 2011, and on the same claim as procedure code 99291, *Critical care, evaluation and management of the critically ill or critically injured patient; first 30 - 74 minutes*, will be packaged (Payment Status of N and an APC of zero) and they will not be separately paid. If these services are not provided on the same claim as procedure code 99291, they will be assigned a Payment Status of S, an APC, and they will be separately payable. If Modifier 59, XE, XP, XS, or XU are billed on the same claim as procedure code 99291, these ancillary services will be separately paid instead of packaged.

**Note**
Modifiers XE, XP, XS, and XU are valid after January 01, 2015.

- **Q3 (Cardiac Care Packaged Services):**
  **Effective January 01, 2012 - December 31, 2014,** if procedure codes 33249, *insert pace-defibrillator w/ lead*, and 33225, *L ventric pacing lead add-on*, are submitted on the same date of service, code 33249 will have its Payment Status Indicator changed from Q3 to T and will be assigned to APC 00108, and code 33225 will be packaged (i.e., assigned a Payment Status Indicator of N and an APC of zero). When code 33225 has been packaged in this way, use of the FB and FC modifier on this line item will be ignored during offset reduction.

  If there is more than one Payment Status Q1 or Q2 service on the same day with no other service that is separately payable, the Q1 or Q2 service with the highest rate will be assigned a Payment Status, and an APC will be paid. All other services will be assigned a Payment Status of N, an APC of zero, and will not be payable.
Example:

A claim with a single service date and the following procedure codes:

Table 3-1: Q3 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Interim Pay Status</th>
<th>Final Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>36591</td>
<td>Collections of blood</td>
<td>00000</td>
<td>Q1</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>55400</td>
<td>Vasovasostomy</td>
<td>00183</td>
<td>T</td>
<td>Paid</td>
<td></td>
</tr>
<tr>
<td>0126T</td>
<td>IMT Study</td>
<td>00000</td>
<td>Q1</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>74440</td>
<td>Vasography radiological supervision and interpretation</td>
<td>00000</td>
<td>Q2</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

- Q4 (Conditionally Packaged Laboratory Services)

Effective January 01, 2016, clinical laboratory procedure codes billed on UB-04 Bill Type of 013X (Hospital, Outpatient) claims, that are assigned to Payment Status Indicator Q4 (Conditionally Packaged Laboratory Services) will be packaged and will not be separately payable, if billed on the same claim as a procedure code assigned to Payment Status Indicator J1, J2, S, T, V, Q1, Q2, or Q3.

If a clinical laboratory procedure code assigned to Payment Status Indicator Q4 is billed in one of the below-listed scenarios, the Payment Status Indicator will be re-assigned to Payment Status Indicator A (Services Paid Under Fee Schedule or Other Prospectively Determined Rate) and will be paid off of the Clinical Laboratory Fee Schedule:

- Billed on a UB-04 Bill Type 012X (Hospital Inpatient, Part B) claim without Condition Code of W2 (Duplicate of Original Bill)
- Billed on a UB-04 Bill Type 014X (Hospital, Lab for Non-Patients) claim
- Billed on a UB-04 Bill Type 013X claim with:
  Modifier L1 (Separately Payable Lab Test) prior to January 01, 2017 OR
  A procedure code assigned to Payment Status Indicators Q3, S, T, or V is billed on the same claim with a Line Override (override; HCT-OVERRIDE) value of 2 (External Line Item Rejection/Denial (Ignore)) and no other payable services are billed OR
  Billed alone (except for any laboratory tests)
• Comprehensive APC Packaging:

Per the OPPS CY 2015 Final Rule, CMS adopted a Comprehensive APC policy. CMS created Comprehensive APCs to pay for high cost (typically device-dependent) services using a single payment for the entire hospital visit. Under this new policy, payment will be provided for the primary service. All other services reported on the same claim (with a few exceptions) will be considered related to the delivery of the primary service and will be packaged into the payment for that service. The primary service will be assigned to a Comprehensive APC and Payment Status Indicator J1 or J2. Most other services on the claim will be packaged and assigned to Payment Status Indicator N. Under certain circumstances, complexity adjustments may then be applied resulting in the assignment of a higher complexity Comprehensive APC and a larger single payment. This policy only applies to claims with a UB-04 Bill Type of 013X (Hospital, Outpatient) and to claims with a UB-04 Bill Type of 012X (Hospital, Inpatient Part B) with Condition Code W2 (Duplicate of Original Bill).

- Primary Services:

Primary services are identified with a Payment Status Indicator. If a single primary service is billed on a claim, it will be assigned to the Comprehensive APC and will be payable. If multiple primary services are billed on the same claim, the primary service with the highest rank is assigned to the Comprehensive APC and is payable. All lower ranked primary services are packaged and are not payable.

- Complexity Adjustments:

When a claim meets at least one of the following requirements it will be eligible for an additional complexity adjustment:

- Two or more units of an eligible primary service are billed.
- An eligible primary service is billed with an additional eligible primary service (also called a secondary service).
- An eligible primary service is billed with an eligible add-on service.

If one of these requirements is met, the Comprehensive APC that has already been assigned to the primary service will be changed to the next highest ranked Comprehensive APC in the same clinical family, resulting in a larger single claim payment. When a secondary service or an add-on service is discontinued as indicated by Modifier 52, 73, or 74, the complexity adjustment will not be applied. When a primary service has been performed bilaterally as indicated by Modifier 50, the service will count as two units when applying the complexity adjustment.
- **Packaged Services:**

The following types of services, which are not normally packaged under the OPPS, will be packaged if billed on a Comprehensive APC claim:

**Table 3-2: Packaged Services**

<table>
<thead>
<tr>
<th>Procedure Type</th>
<th>Payment Status Indicator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major OPPS procedures, E&amp;M services, and therapy services not provided under a plan of care (i.e., therapy services not reported with Revenue Code 042X, 043X, or 044X or Modifier GN, GO, or GP)</td>
<td>P, S, T, and V</td>
</tr>
<tr>
<td>Lower Ranked Comprehensive APC procedures</td>
<td>J1</td>
</tr>
<tr>
<td>Non-pass-through drugs and biologicals</td>
<td>K</td>
</tr>
<tr>
<td>Blood products</td>
<td>R</td>
</tr>
<tr>
<td>DME</td>
<td>Y</td>
</tr>
</tbody>
</table>

- **Services Not Packaged:**

The following types of services are excluded from Comprehensive APC packaging and will be paid separately even if billed on a Comprehensive APC claim:

**Table 3-3: Services Not Packaged**

<table>
<thead>
<tr>
<th>Procedure Type</th>
<th>Payment Status Indicator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brachytherapy sources</td>
<td>U</td>
</tr>
<tr>
<td>Pass-through drugs, biologicals, and devices</td>
<td>G and H</td>
</tr>
<tr>
<td>Corneal tissue, CRNA services, and Hepatitis B vaccinations</td>
<td>F</td>
</tr>
<tr>
<td>Influenza and pneumococcal pneumonia vaccine services</td>
<td>L</td>
</tr>
<tr>
<td>Ambulance services, mammography services, therapy services provided under a plan of care (i.e., therapy services reported with Revenue Code 042X, 043X, or 044X or Modifier GN, GO, or GP), preventive services, and other items paid by fee schedule</td>
<td>A</td>
</tr>
<tr>
<td>New technology services</td>
<td>S and T</td>
</tr>
</tbody>
</table>

- **Important Notes:**

Procedures that are not allowed on OPPS claims (services assigned to Payment Status Indicator B, C, E1, E2, or M) are edited as usual even when billed on a Comprehensive APC claim.
DME services that are billable only to the DMERC (services assigned to Payment Status Indicator Y) are packaged as part of the Comprehensive APC. OCE Edit 061 is not applied to these services.

Primary services performed bilaterally as indicated by Modifier 50 that are assigned to a Comprehensive APC are not subject to bilateral procedure discounting.

Primary services that have been terminated as indicated by Modifier 52 or 73 that are assigned to a Comprehensive APC are subject to terminated procedure discounting.

When a primary service is billed with multiple units and assigned to a Comprehensive APC, the units will be ignored during payment calculations.

• Skin Substitute Logic:

  Effective April 1, 2012 through December 31, 2013, a skin substitute product must be billed on the same date of service as a skin substitute application procedure to be eligible for payment. If a skin substitute product is billed without a skin substitute application procedure on the same date of service, the skin substitute product will be assigned a Payment Status of N (Packaged/Incidental Service), a zero APC, and will not be eligible for payment.

  When billed on the same date of service, both the skin substitute application procedure and the skin substitute product will be assigned their standard Payment Status, APC, and APC Rate, and will both be eligible for payment.

  If a skin substitute application procedure is billed without a skin substitute product on the same date of service, the skin substitute application procedure will be assigned to its standard Payment Status, APC, and APC Rate, and will be eligible for payment.

  Effective January 01, 2014, skin substitutes are split into two categories: high cost and low cost. A low cost skin substitute application procedure must be billed with a low cost skin substitute product on the same day, and a high cost skin substitute application procedure must be billed with a high cost skin substitute product on the same day, or else the skin substitute application procedure line will receive OCE Edit 087.

  When a (high/low) skin substitute application procedure is billed on the same day as a (high/low) skin substitute product, the skin substitute application procedure will be assigned its standard Payment Status, APC, and APC Rate and will be eligible for payment. The skin substitute product will be assigned a Payment Status of N (Packaged/Incidental Service), a zero APC, and will not be eligible for payment.

  Example: A January 1, 2014 claim billed with high cost skin substitute procedure code 15271, Skin Sub Graft Trnk/Arm/Leg, and high cost skin substitute product code Q4101, Apigraf, will result in procedure code
15271 being assigned Payment Status Indicator T (Procedure or Service, Multiple Reduction Applies), and APC 00328 (Level III Skin Repair).

A complete list of all skin substitute application procedures and products is available on the APC Assistant™ Procedures page.

- **Line Items Without HCPCS Codes:**

Medicare has determined that only certain revenue codes are acceptable for use under OPPS. Claim lines that do not contain a HCPCS code, but that do contain a revenue code will be assigned to one of the following four groups based on the revenue code:

- **Packaged:** These revenue codes can be included on claims without HCPCS codes and the charges for these revenue codes will be included in the pricing calculations for outlier payments and hold harmless adjustments. A Payment Status Indicator of N (Packaged/Incidental Service) is assigned to these claim lines. Note that these claim lines do not participate in the assignment of OCE Edits 027 and 047.

- **Non-Covered:** These revenue codes cannot be included on claims without HCPCS codes, so any charges for these revenue codes will not be included in the pricing calculations for outlier payments and hold harmless adjustments. A Payment Status Indicator of E (Non-covered Service) is assigned to these claim lines.

- **Not Allowed:** For certain bill types, these revenue codes cannot be included on claims without HCPCS codes, so any charges for these services will not be included in the pricing calculations for outlier payments and hold harmless adjustments. A Payment Status Indicator of B (Not Allowed Under OPPS) is assigned to these claim lines.

- **Other:** These revenue codes are considered to be outside the scope of the APC payment system. Charges for these revenue codes will not be included in the pricing calculations for outlier payments and hold harmless adjustments. A Payment Status Indicator of Z (Valid Revenue Code, Blank HCPCS, No Other Status Indicator Assigned) is assigned to these claim lines.

If the revenue code is invalid, OCE Edit 041 is assigned to the claim line and, beginning with V5.0 of the OCE, a Payment Status of W (Invalid HCPCS, or Blank HCPCS and Invalid Revenue Code) is also assigned.

- **Assignment of APC 00977 or 00375 to Inpatient-Only Procedures:**

Procedures with Payment Status of C (Inpatient Procedures) will not generally be paid for by CMS when provided on an outpatient basis. Effective January 1, 2003, CMS created modifier CA, which indicates that the patient died before being admitted as an inpatient. From January 1, 2003 to December 31, 2003, APC 00977 (New Technology - Level VIII) and a Payment Status Indicator of S are assigned to inpatient-only procedures with a modifier CA. These procedures are then eligible for payment based on the APC 00977 rates. All other services on that day are
assigned a Payment Status Indicator of N, and an APC of zero. Effective January 1, 2004, these procedures are assigned to APC 00375 (Ancillary Services Patient Expires) instead of APC 00977, with a Payment Status Indicator of S. All other services on that day are assigned a Payment Status Indicator of N, and an APC of zero.

Effective January 1, 2015 when a claim is billed with Payment Status J1 and also contains an inpatient only procedure along with Payment Status of C and a modifier CA, the procedure is assigned to APC 00375 (Ancillary Services Patient Expires), with a Payment Status Indicator of S. All other services on that day are assigned a Payment Status Indicator of N, and an APC of zero.

- “Sometimes” Therapy Services:

  Effective January 01, 2006, CMS designated certain wound care services as “Sometimes Therapy.” Depending on how these services are billed, they will be paid either with an APC rate or a physician fee schedule rate. If these services are reported with therapy modifiers GP, GO, GN, or with therapy Revenue Codes 42X, 43X, or 44X (for physical, occupational, or speech therapy), then they will be assigned a Payment Status of A (Fee Schedule or Other Methodology) and paid under the Physician Fee Schedule. If these services are not reported with one of the aforementioned therapy modifiers or revenue codes, then they will be paid with an APC rate. The following HCPCS codes are subject to this alternate pricing logic:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>92520</td>
<td>Laryngeal Function Studies</td>
<td>January 1, 2010</td>
<td></td>
</tr>
<tr>
<td>97597</td>
<td>Active Wound Care &lt; 20 CM</td>
<td>January 1, 2006</td>
<td></td>
</tr>
<tr>
<td>97598</td>
<td>Active Wound Care &gt; 20 CM</td>
<td>January 1, 2006</td>
<td></td>
</tr>
<tr>
<td>97602</td>
<td>Wound Care Non-Selective</td>
<td>January 1, 2006</td>
<td></td>
</tr>
<tr>
<td>97605</td>
<td>Negative Pressure Wound Therapy, &lt; 50 CM</td>
<td>January 1, 2006</td>
<td></td>
</tr>
<tr>
<td>97606</td>
<td>Negative Pressure Wound Therapy, &gt; 50 CM</td>
<td>January 1, 2006</td>
<td></td>
</tr>
<tr>
<td>97607</td>
<td>Neg Pre Wound &lt;= 50 sq cm</td>
<td>January 1, 2015</td>
<td></td>
</tr>
<tr>
<td>97608</td>
<td>Neg Pre Wound &gt; 50 sq cm</td>
<td>January 1, 2015</td>
<td></td>
</tr>
<tr>
<td>97610</td>
<td>Low Frequency Non-Thermal US</td>
<td>January 1, 2014</td>
<td></td>
</tr>
<tr>
<td>0183T</td>
<td>Low Frequency, Non-Contact, Non-Thermal Ultrasound, Including Topical Application(s), When Performed, Wound Assessment, and Instruction(s) for Ongoing Care, Per Day</td>
<td>January 1, 2009</td>
<td>December 31, 2013</td>
</tr>
</tbody>
</table>
• Observation Services:

Effective January 01, 2008 through December 31, 2013, observation services are paid for under the Observation Composite APCs 08002 and 08003. Effective January 1, 2014, observation services are paid for under the Observation Composite APC 08009. These Composite APCs are further described in the Descriptions of Conditional APCs chapter.

Prior to January 01, 2008, CMS paid separately for outpatient observation services only under very limited circumstances. For example, outpatient observation services were only separately payable if the patient was diagnosed with chest pain, asthma, or heart failure. Observation service hours should be reported using HCPCS code G0378 and direct admission to observation should be reported using HCPCS code G0379. G0378 should always be reported for observation services, regardless of whether the claim meets separate payment criteria. Before January 1, 2008, G0378 and G0379 were assigned to interim Payment Status Indicator Q (Packaged Service Subject to Separate Payment Under OPPS Payment Criteria). If these services met the criteria for separate payment, then they would be assigned to a Payment Status of S (for G0378) or V (for G0379) and an APC of 0339 (for G0378) or an APC of 0604 (for G0379). If the requirements for separate payment were not met, then the observation services would be packaged and assigned a Payment Status of N (Packaged/Incidental Services).

• Line-Level Override Functionality:

Line-level override functionality applies to claims with service dates on or after January 1, 2012. The line-level override functionality is for clients that use external Editors (e.g., Optum CES® Facility Editor) and is used to determine when a claim line has been rejected or denied by an external Editor.

To utilize the line-level override functionality, set the existing Line-Level Override field, to a 2 (External Line Item Rejection/Denial (Ignore)) or 5 (External Line Item Rejection/Denial (Consider)).

Claim lines submitted with a Line-Level Override value of 2 or 5 will be flagged as errors and ignored during regular OCE editing. Where possible, APCs and Payment Status Indicators will still be returned. Claim lines that are submitted with a Line-Level Override value of 5 will be considered

Table 3-4: Procedure Codes Subject to Alternate Pricing Logic

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0456</td>
<td>Neg Pre Wound &lt;= 50 sq cm</td>
<td>January 1, 2013</td>
<td>December 31, 2014</td>
</tr>
<tr>
<td>G0457</td>
<td>Neg Pre Wound &gt; 50 sq cm</td>
<td>January 1, 2013</td>
<td>December 31, 2014</td>
</tr>
</tbody>
</table>
during the grouping, packaging, and discounting of other claim lines. Claim lines that are submitted with a Line-Level Override value of 2 will be ignored during the grouping, packaging, and discounting of other claim lines.

**Note**
Please note that to utilize this new functionality in ACE, the Extended Structure Switch (ext_blk_sw; ECB-EXT-BLK-SW) field located in the ECB [ezg_cntl_block] structure for C and the ECB-EZG-CNTL-BLOCK structure for COBOL, must be set to a 1 (Enable).

When a claim line is submitted with a Line-Level Override value of 2 or 5, error 99999 (Line Item Denial From External Editor) will be issued in the Procedure Errors field, and the Highest Procedure Disposition field will be set to 02 (Claim Contains Line Item Denial).

• Group Only Editor Request:

A Group Only Editor Request applies to claims with a from date on or after January 01, 2012. The Group Only Editor request allows clients that use external Editors (e.g., Optum CES® Facility Editor) to bypass most OCE and CCI editing in ACE, but utilize ACE for its grouping, packaging, and discounting functionality. The Group Only Editor Request will bypass all OCE Edits and the practitioner CCI Edits 101 through 113, except for OCE Edit 023 (Invalid Date (Claim Returned to Provider (RTP))).

3.1.2 Date-Sensitive Code (DSC) Editor

The DSC Editor is made up of a collection of programs designed to evaluate the accuracy of diagnosis and procedure codes at the time health care services were delivered (e.g., according to the patient’s dates of service or hospitalization). All current and previous codes, including code deletions and expansions, are supported. Codes are evaluated for validity, with reasons for invalid codes suggested (e.g., missing necessary fourth or fifth digits, unnecessary digits, non-specific, or vague). In addition, the appropriateness of codes for the patient’s age and sex are examined. All Medicare Code Edits (MCEs), as defined by CMS, are included within the DSC Editor.

3.1.2.1 Features Supported

• The DSC Editor verifies the validity of Present on Admission (POA) indicators.

**Note**
Please refer to Appendix F for more information on POA.

• Evaluates claims for Hospital-Acquired Conditions (HACs). The DSC Editor determines whether or not a HAC is present on a claim by doing the following:
- Checks for HAC-eligible diagnosis and procedure codes on the claim.
- Checks for POA indicators of N or U for HAC-eligible diagnosis codes.

If a HAC with appropriate POA indicators is found on the claim, the DSC Editor outputs information on what HAC has been found, and the potential impact of that HAC on DRG assignment.

3.1.2.2 Technical Setup for HACs
The following items are needed to properly implement HAC functionality in the DSC Editor:
- Optimizer V1006 or later
- DSC Editor V0810 or later
- 5010 Interface
- POA indicators for each diagnosis code on the claim
- Configuration File - optional

3.1.2.3 HAC-Related Output
The following HAC-related output fields are returned in the MEB_DX [mce_dx_edits] structure for C and the MEB2-MCE-EDITOR-BLOCK2 structure for COBOL:

Hospital-Acquired Condition Eligibility/Impact field (haceligible, MEB2-DX-HAC-ELIGIBLE):

- 00 = Code is not subject to HAC
- 01 = Code is HAC eligible; another CC/MCC is present (DRG may not be affected)
- 02 = Code is HAC eligible, but is not a CC/MCC (DRG may not be affected)
- 03 = Code is HAC eligible; no other CC/MCC is present (DRG may be affected)

Hospital-Acquired Condition field (hac, MEB2-DX-HAC):

- 0001 = Foreign Object Retained After Surgery
- 0002 = Air Embolism
- 0003 = Blood Incompatibility
- 0004 = Pressure Ulcer Stages III and IV
- 0005 = Falls and Trauma
- 0006 = Catheter-Associated Urinary Tract Infection (UTI)
- 0007 = Vascular Catheter-Associated Infection
- 0008 = Surgical Site Infection (SSI), Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
- 0009 = Manifestations of Poor Glycemic Control
- 0010 = Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures
- 0011 = Surgical Site Infection (SSI) Following Bariatric Surgery for Obesity
- 0012 = Surgical Site Infection (SSI) Following Certain Orthopedic Procedures
- 0013 = Surgical Site Infection (SSI) Following Cardiac Implantable Electronic Device (CIED)
0014 = Iatrogenic Pneumothorax with Venous Catheterization
9999 = Hospital-Acquired Condition

CC/MCC Indicator field (ccmccind, MEB2-DX-CCMCCIND):

- 0 = Not a CC or MCC for DRG assignment
- 1 = CC for DRG assignment
- 2 = MCC for DRG assignment

The following HAC-related output field is returned in the DX [dx_entry] structure for C or the DCB-DX-CODE-BLOCK structure for COBOL:

Present on Admission Bypassed field (poa_bypassed, DCB-POA-BYPASSED):

**Note**
Please refer to the Input & Output Parameter Blocks User's Guide for further information on the values returned in this field.

**Example:**

An example Hospital-Acquired Condition (HAC) claim contains the following diagnosis codes and POA indicators:

- Principal Diagnosis: 430, POA = Y
- Secondary Diagnosis: 836.4, POA = N

For this claim, the DSC Editor will output the following information in the MEB_DX [mce_dx_edits] structure for C or the MEB2-MCE-EDITOR-BLOCK2 structure for COBOL, and the DX [dx_entry] structure for C or the DCB-DX-CODE-BLOCK structure for COBOL:

Table 3-5: DSC Editor Output

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>HAC Eligibility/Impact</th>
<th>HAC</th>
<th>CC/MCC Indicator</th>
<th>Present on Admission Bypassed</th>
</tr>
</thead>
<tbody>
<tr>
<td>430</td>
<td>00</td>
<td>0000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>836.4</td>
<td>03 (HAC eligible; no other CC/MCC is present)</td>
<td>0005 (Falls and Trauma)</td>
<td>1 (CC)</td>
<td>1 (Eligible for bypass)</td>
</tr>
</tbody>
</table>

3.1.3 Local Coverage Determination (LCD) Editor

**Note**

The LCD Editor is only available on the C Platform.

The LCD Editor requires the following input fields, all of which are available on a standard hospital outpatient UB-04 claim:

- Admit and discharge dates
• Provider (facility or physician) identifier
• Patient age and sex
• Diagnosis codes
• Line item services (identified by CPT® or HCPCS procedure codes)
• Service dates

The LCD Editor evaluates the HCPCS codes on the claim for validity based on the service dates and checks for Medicare coverage of each service on an outpatient basis. It then uses the provider identifier to select the appropriate set of Local Coverage Determinations (LCDs). Each line item service on the claim is evaluated to determine if the service meets the medical necessity requirements documented on the policies.

The LCD Editor returns the following information (for further information refer to the Input & Output Parameter Blocks User's Guide):

• Any line item service that is not covered by Medicare on an outpatient basis.
• Each line item service that has diagnoses that are not covered by Medicare on the claim.
• Each line item service that has statutorily excluded diagnoses.
• Each line item service that is inconsistent with the patient’s age or sex.
• Each line item service that does not have a required secondary diagnosis on the claim.
• Each line item service that does not have a required associated procedure on the claim.

For each line item that violates a Local Coverage Determination (LCD), the LCD Editor returns a short description of the policy, the date the policy was first implemented, the date of the most recent update to the policy, and the policy identifier for each LCD or National Coverage Determination (NCD) that contains a comprehensive description of the requirements.

### 3.1.3.1 LCD Editor Data Files

The LCD Editor relies on a set of data files which contain the coding and editing rules used to validate the input claims. These data files that contain the FI, carrier, or MAC edits are updated monthly.

**Important**

The LCD data files contain one year of data.

<table>
<thead>
<tr>
<th>File Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>fi.dat</td>
<td>Assigns Fiscal Intermediary, carrier, or MAC based on provider (hospital or physician) identifier. This is a customizable file.</td>
</tr>
</tbody>
</table>
Please refer to the EASYGroup™ Technical Reference User’s Guide for all file layouts.

The LCD rules change frequently, therefore each data file update should be installed as soon as it is received. In each case, the update file should replace the current file.

For fi.dat, refer to the EASYGroup™ Installation User’s Guide for more details on customizing this file.

### 3.1.3.2 Features Supported

- **Overview of LCDs:**

  Medicare will only pay for services that meet specific medical necessity standards. Medicare defines medical necessity as a determination that a service is “reasonable and necessary” for the diagnosis or treatment of an illness or injury. In 1998, Medicare implemented Local Medical Review Policies (LMRPs), which were designed to identify services that do not meet medical necessity guidelines. LMRPs specify whether certain services are reasonable and necessary as implemented by a Fiscal Intermediary (FI) or carrier. LMRPs also include provisions for coding, benefit category, and statutory exclusion.

  Based on the *Final Rule* published in the November 11, 2003 *Federal Register*, Medicare contractors had to transition all medical necessity guidelines from the LMRP format to the LCD format. Only the LMRP information related to reasonable and necessary provisions was to be mapped to a corresponding LCD. LMRP information related to coding, category, and statutory exclusions had to be removed or published in a

---

<table>
<thead>
<tr>
<th>File Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>mac.dat</td>
<td>Used in conjunction with FI.dat to assign a MAC ID based on provider (hospital or physician) identifier.</td>
</tr>
<tr>
<td>fq.dat</td>
<td>External Editor file containing frequency restriction rules.</td>
</tr>
<tr>
<td>codes.dat</td>
<td>Validates HCPCS codes and identifies services not covered by Medicare.</td>
</tr>
<tr>
<td>index.dat</td>
<td>Identifies each local coverage determination.</td>
</tr>
<tr>
<td>i10pairs.dat</td>
<td>Identifies ICD-10-CM diagnosis codes required to support certain services.</td>
</tr>
<tr>
<td>i10sd.dat</td>
<td>Identifies ICD-10-CM supporting diagnosis codes required to support certain services.</td>
</tr>
<tr>
<td>ap.dat</td>
<td>Identifies associated procedures required to support certain services.</td>
</tr>
<tr>
<td>i10stdx.dat</td>
<td>Identifies ICD-10-CM diagnosis codes denied by Medicare for statutory reasons.</td>
</tr>
<tr>
<td>url.dat</td>
<td>Reserved to identify URL containing alternate site for medical necessity policy documentation.</td>
</tr>
</tbody>
</table>
These changes were implemented to streamline medical necessity requirements, and to reduce the number of appeals based on coding provisions. All LMRPs had to be converted to the new LCD format, effective January 1, 2006.

If an ordered test or service is found to be medically unnecessary based on a National Coverage Determinations (NCD) or LCD, the patient must be asked to sign an Advanced Beneficiary Notice (ABN). The ABN informs the patient that if the services are denied, he or she will be responsible for the bill. If an ABN is not completed before the test is performed, the provider may not bill the patient for these services. Without the use of software, it is difficult for hospitals and other providers to determine if a service is medically necessary based on the diagnoses and procedure information available, and to flag instances when an ABN should be obtained.

- Overview of NCDs:

  NCDs identify the circumstances under which particular services will be considered “covered” by Medicare. They describe the clinical circumstances and settings under which particular services are reasonable and necessary or are not reasonable and necessary on a national basis.

- Part A and Part B Edits:

  **Note**
  
  During 2011-2014, Medicare modified the management of local coverage determinations from a network of Fiscal Intermediaries (FIs) and carriers to a much smaller and consolidated set of Medicare Administrative Contractors (MACs).

  Hospital outpatient claims are subject to LCD Part A edits as implemented by the hospital’s MAC (previously FI). Physician claims are subject to LCD Part B edits as implemented by the physician’s MAC (previously Carrier). Part A and Part B LCD edits for the same state or locality are similar or identical for some services. In other cases, the MAC may implement an existing requirement differently for the facility claims than for the physician claims.

  Every hospital and physician sends claims to the designated MAC (previously FI or Carrier), based on where the facility or physician’s office is located. In each state, there is only one MAC. All MACs serve more than one state.

  The LCD Editor can provide Part A edits, or Part B edits, or both. The selection of which set of edits to apply to a particular claim is based on the provider or facility identifier that is submitted with the claim. This provider or facility identifier is assigned to the appropriate jurisdiction in the Data File (fi.dat). This file is designed to be customized by the user.
3.1.4 EASYEdit™ Editor

**Note**

EASYEdit™ is only available on the COBOL Platform.

EASYEdit™ is a knowledge-based edit and audit tool for assessing and correcting data describing a patient’s contact with the health care system. EASYEdit™ examines the entire set of services provided during a single inpatient episode of acute care and includes:

- Medicare Code Edits (MCEs)
- ICD-9/ICD-10 Diagnosis and Procedure Code Verification and Compatibility Edits
- Code Sequencing Edits
- DRG/Reimbursement Edits
- Line-Level Edits

**3.1.4.1 Features Supported**

EASYEdit™ utilizes a collection of extensive clinical, coding, and reimbursement edits that assure coding accuracy, and offer suggested coding changes, which might affect Diagnostic-Related Group (DRG) or Ambulatory Payment Classification (APC) assignment, and therefore reimbursement. Some of these edits do not identify pronounced coding errors, but instead recommend items to be further explored in the medical record or other documentation.

EASYEdit™ requires that specific data elements be present in order to insure all applicable edits are performed. Edits are assigned by calling the edit control program.

- **Line-Level Editing**

EASYEdit™ also features line-level editing for multiple procedure codes on outpatient claims provided they have the same date of service. Line-level Revenue Code and Modifier edits are also available within EASYEdit™.

3.1.5 Physician Editor

The Physician Editor performs the Medicare CCI edits and MUE edits. Included with the Physician Editor are editing logic files, which are regularly updated for new and terminated codes and coding rules. The Physician Editor also contains basic claim validation edits to ensure that accurate HCPCS Level I (CPT®-4) and Level II procedure codes are coded. The Physician Editor is designed to be used with sets of codes describing services provided to a single patient during a single visit.

The Physician Editor utilizes the `physedit.dat` (for C) or the `phycode.dat` (for COBOL) table (which contains all valid procedure codes, diagnosis codes, Modifiers, and edits, as well as MUE maximums), the `physcci.dat` (for C) or the
phycci.dat (for COBOL) table (which contains all physician CCI code pairs), and the MUE Data File (mue.dat) (which contains the MUE Adjudication Indicator fields).

Note
For further information on the above-mentioned tables please refer to the EASYGroup™ Technical Reference Guide.

3.1.5.1 Features Supported

• Physician Edits

The Physician Editor performs CCI, MUE, and basic claims validation edits, including:

- Invalid Date
- Date Out of Range
- Invalid Age
- Invalid Sex
- Invalid Diagnosis Code
- Diagnosis and Age Conflict
- Diagnosis and Sex Conflict
- Invalid Procedure Code
- Procedure and Sex Conflict
- Invalid Modifier

Note
For a complete list of all of the applicable Physician Edits, please refer to the Descriptions of Physician Edits section of this user's guide.

Each of the Physician Edits are assigned to a disposition. The following dispositions are used by the Physician Editor:

- 01 = Claim Contains Line Item Rejections
- 02 = Claim Contains Line Item Denials
- 03 = Claim Suspension
- 04 = Claim Returned to Provider (RTP)

• Acceptable Level of Error Functionality

The user has the ability to specify an Acceptable Level of Error for each claim in the accept_if field in the PCB1 [patient_claim_data] structure in C and the PCB1-ACCEPT-IF field in the PCB1-PATIENT-CLAIM-BLOCK1 structure in COBOL. If a claim contains an Edit with a disposition that exceeds that pre-established Acceptable Level of Error, the Physician Editor issues claim-level Editor Return Code 10 (Final Disposition Exceeds Maximum Acceptable Level
of Error) in the `edtr_rtn_code` field in the PEB1 [pe_edit_block1] structure in C and the PEB1-RTN-CODE field in the PEB1-PHY-EDIT-BLOCK1 structure in COBOL.

- **Line Item Override Functionality**

Individual claim lines that a user chooses to bypass, such as claim lines already identified as being in error by an external Editor (e.g., Optum iCES® Professional Editor), can be flagged with a 1 (External Line Item Denial) in the `override` field in the LINE [line_entry] structure in C and the HCT-OVERRIDE field in the HCT-HCPCS-CODE-TBL structure in COBOL. This will inform the Physician Editor to ignore this claim line during editing.

- **Status Codes**

The Physician Editor assigns one of the below Status Codes to each claim line. These are output in the `scode` field in the PEB3 [pe_op_edits] structure for C and the PEB3-POE-SCODE field in the PEB3-PHY-EDIT-BLOCK3 structure for COBOL:

  - A = Active Code
  - B = Bundled Code
  - C = Carriers Price the Code
  - D = Deleted Code
  - E = Excluded from Physician Fee Schedule by Regulation
  - F = Deleted/Discontinued Code
  - G = Not Valid for Medicare Purposes
  - H = Deleted Modifier
  - I = Not Valid for Medicare Purposes
  - J = Anesthesia Service
  - M = Measurement Code
  - N = Non-Covered Service
  - P = Bundled/Excluded Code
  - R = Restricted Coverage
  - T = Injections
  - X = Statutory Exclusion

- **Claim-Level Output**

The Physician Editor outputs the following claim-level data in the PEB1 [pe_edit_block1] structure in C and the PEB1-PHY-EDIT-BLOCK1 structure in COBOL:

  - Editor Return Code
  - Editor Version
- Editor Release Version
- Number of Claim Edits
- Number of Diagnosis Edits
- Number of Procedure Edits
- Total Number of Edits
- Overall Claim Disposition
- Summary of All Claim Dispositions
- Highest Claim Edit Disposition
- Claim Edits

• Diagnosis-Level Output

The Physician Editor outputs the following data for each diagnosis code in the PEB2 [pe_dx_edits] structure in C and the PEB2-PHY-EDIT-BLOCK2 structure in COBOL:

- Highest Diagnosis Edit Disposition
- Number of Edits for This Diagnosis
- Diagnosis Edits

• Line-Level Output

The Physician Editor outputs the following data for each procedure code in the PEB3 [pe_op_edits] structure in C and the PEB3-PHY-EDIT-BLOCK3 structure in COBOL:

- Highest Procedure Edit Disposition
- Number of Edits for This Procedure
- Procedure Edits
- Medically Unlikely Edit (MUE) Maximum
- MUE Adjudication Indicator
- Column 1 Code for CCI Edit
- CCI Edit Type
- Status Code

Note
For further information on the above-mentioned inputs and outputs for the Physician Editor, please refer to the Input & Output Parameter Blocks User’s Guide.
3.1.6 Medicaid Outpatient Editor (MOE)

**Note**
The Medicaid Outpatient Editor (MOE) is only available on the C Platform.

The MOE is used by the New Mexico Medicaid APC Payment System. The New Mexico Medicaid APC Payment System uses editing rules that do not follow the standard outpatient editing rules used by the Ambulatory Code Editor™ (ACE). While the MOE was developed to be a solution for the New Mexico Medicaid APC Payment System it also has the ability to support other Medicaid payment systems in the future.

This component evaluates the accuracy of outpatient visit and service data and ensures accurate and valid HCPCS Level I (CPT®-4) and Level II procedure codes and associated modifiers are billed. In addition to validating HCPCS Level I and Level II codes based on the date of patient service, MOE includes the National Medicaid Correct Coding Initiative (CCI) Edits and Medically Unlikely Edits (MUEs). Included with MOE are date-sensitive procedure code and modifier data files, as well as CCI and MUE editing files, which are regularly updated for new and terminated codes and coding rules.

### 3.1.6.1 Features Supported

- **Correct Coding Initiative (CCI) Edits:**

  Outpatient claims data can also be evaluated using the National Correct Coding Initiative (NCCI). The NCCI edits were developed by Medicare to promote the utilization of correct coding methodologies in outpatient settings and to curtail improper coding practices that lead to inappropriate increased payment. The NCCI provides a set of rules governing complex coding situations, and specifies when certain combinations of codes are inappropriate. The NCCI was originally developed for evaluating physician-based coding practices.

  The NCCI analyzes each possible pair of HCPCS codes and looks for combinations of codes that cannot be billed together for one of the reasons listed below. A modifier can be appended to a HCPCS Level I or Level II code to indicate that a service or procedure was altered by specific circumstances. In some cases, the addition of a modifier will indicate that a combination of procedure codes is appropriate under those circumstances.

  The NCCI edits are divided into the following categories:

  - **Essential Services:** Services essential to the procedure should not be separately coded.
  - **Separate Procedure:** Some procedures, although they can be performed separately, are generally included in other more comprehensive procedures. One code is a CPT® separate procedure and should not be reported.
- **Most Extensive Procedure**: Code only the most extensive service for the same site.
- **“With” and “Without” Services**: “With” or “Without” codes should not be used together.
- **Anesthesia Included in Surgical Procedures**: Anesthesia administered by the operating physician should not be reported.
- **Laboratory Panels**: Individual laboratory tests that make up a comprehensive panel of tests should not be reported separately.
- **Sequential Procedures**: Report the code for the completed service only.
- **Standard Preparation or Monitoring Services**: Do not code services integral to the procedure.
- **CPT® Coding Manual Guidelines**: Codes should not be reported together per CPT® Coding Manual instructions or guidelines.
- **CPT® Procedure Code Definition**: Codes should not be reported together per CPT® Procedure Code definitions.
- **Misuse of Column 2 Code with Column 1 Code**: These services are not typically performed together.
- **Mutually Exclusive Codes**: Codes indicate mutually exclusive services.
- **Designation of Sex Procedures**: Codes indicate a sex conflict.

**Medically Unlikely Edits (MUEs):**

A MUE is a Unit of Service (UOS) edit for a HCPCS/CPT® code for services rendered by a single provider/supplier to a single beneficiary on the same date of service. The typical MUE is the maximum UOS that is reported for a HCPCS/CPT® code on the vast majority of appropriately reported claims. CMS developed MUEs to reduce the paid claims error rate for Part B claims.

MUEs are a part of the NCCI to promote correct coding methodologies. The NCCI policies are based on coding conventions developed by nationally recognized organizations and are updated annually or quarterly.

MUEs were generally developed using biological considerations (number of limbs or organs, etc). MUEs adjudicate on units billed per line of service. CMS began applying MUEs to Part B claims in January 2007. However, none of the edits were made publicly available on October of 2008 out of concern for abuse. Some MUEs still remain confidential.

There are two sets of MUEs:

- **Facility Claims**: If a facility submits a Part B claim which contains (for a particular HCPCS code) a unit value that is higher than the facility MUE maximum value for that code, CMS denies payment for that code. The MUEs are applied by the Medicare Administrative Contractors (MACs) to hospital outpatient claims.
- **Professional Claims:** For professional claims, units that exceed the MUE maximums are ignored and payment for the affected service is capped at the MUE unit maximum times the unit price.

*The MOE only applies the facility claim MUEs.*
4  Analyzers

This chapter provides an introduction to the EASYGroup™ Analyzers. It contains the following sections:

**Note**
For further information please refer to the Implementation Plan Guide.

- Introduction to EASYGroup™ Analyzers
- V01 EDC Analyzer™
  - Features & Functionality
    - The EDC Analyzer™ Objective
    - The EDC Analyzer™ Advantage
    - Optum Algorithm Methodology
    - Calculating the Visit Level
    - Configuration File Override Option
    - Optum EDC Analyzer™ Worksheet
- Analyzer Logging
  - Savings Results Log Text File
4.1 Introduction to EASYGroup™ Analyzers

Analyzers work seamlessly with EASYGroup™ Editors, Mappers, Groupers, and Pricers to examine claims for coding errors or inconsistencies. Analyzers can be configured to apply a set of rules to claims and adjust payment amounts, or simply to output information about each claim.

4.1.1 V01 EDC Analyzer™

Note
Please note that the V01 EDC Analyzer™ is only supported in Rate Manager V1707.01 and higher.

4.1.2.1 Features & Functionality

Optum is very excited to offer the EASYGroup™ V01 EDC Analyzer™, which is the first of its kind, and can be used to evaluate outpatient emergency department claims (Medicare, Medicaid, and Commercial) for correct coding, dated October 01, 2015 or later. The V01 EDC Analyzer™ is available on the Windows®/C and COBOL Platforms and can be accessed directly through the EASYGroup™ Optimizer or through the ECM Pro™ Outpatient Web Service, the EASYGroup™ Web Service, the EASYGroup™ Server, or Optum Exchange PPS (OEPPS).

- The EDC Analyzer™ Objective

Emergency department visits should be coded based on hospital resource utilization which is dictated by the patient’s clinical condition and the treatment provided. There are five visit levels that the emergency department can choose from when submitting claims. These visit levels are represented by the procedure codes shown below in Table 4-1.

Table 4-1: Procedure Codes and Corresponding Levels for Emergency Department (ED) Claims

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Explanation</th>
<th>ED Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281/G0380</td>
<td>Used for very simple and limited services. The presenting problem is usually self-limited or minor.</td>
<td>Level 1</td>
</tr>
<tr>
<td>99282/G0381</td>
<td>Typically assigned for an acute episodic illness and/or minor injury evaluation. The presenting problem is of low to moderate severity.</td>
<td>Level 2</td>
</tr>
<tr>
<td>99283/G0382</td>
<td>Generally requires additional facility resources including x-ray, laboratory testing or additional nursing time. The presenting problem is of moderate severity.</td>
<td>Level 3</td>
</tr>
<tr>
<td>99284/G0383</td>
<td>For encounters associated with acute illness or injury that requires prolonged evaluation and typically diagnostic studies, repeat nursing evaluations, or other therapeutic interventions. The presenting problem is high severity requiring urgent evaluation.</td>
<td>Level 4</td>
</tr>
</tbody>
</table>
Visit Level 1 is the least resource-intensive for the facility and Visit Level 5 is the most resource-intensive. Per CMS guidelines (CY 2008 OPPS Final Rule (Medicare and Medicaid Programs; Interim and Final Rule) published in the Federal Register on November 27, 2007) the facility must bill the visit level that most reasonably relates to the intensity of hospital resources used in the treatment of the patient.

Increasingly, facilities are submitting emergency department claims with higher visits levels (visit levels 4 and 5).

Without access to each patient’s medical record, it is difficult for Payers and Providers to systematically determine if the visit level submitted on each claim is appropriate. Inappropriate coding can lead to improper reimbursement. The V01 EDC Analyzer™ has been designed to assist Payers and Providers by evaluating each emergency department visit level, in the context of other claim data, to determine if it reasonably relates to the intensity of hospital resources.

**The EDC Analyzer™ Advantage**

Optum has developed an objective methodology (“the algorithm”) to determine if the visit level submitted on emergency department claims is appropriate. The algorithm determines the appropriate and fair level of facility reimbursement for outpatient emergency department services. Since, the algorithm uses only data contained on the claim itself (i.e., diagnosis codes, procedure codes, patient age, and patient gender) it can be incorporated into the claims adjudication process.

The V01 EDC Analyzer™ processes all applicable claim inputs and, based on user-defined configuration settings, may suggest a more appropriate emergency department visit code and associated reimbursement, based on the those inputs.
Certain claims are excluded from visit level recalculation by the algorithm:

- Claims for patients who received critical care services
- Claims with certain diagnosis codes (refer to the EDC Analyzer™ Definitions Manual for a list)
- Claims for patients under the age of two years
- Claims with a discharge disposition of other than 01 (Discharged to Home or Self-Care) or 07 (LAMA or Left Against Medical Advice)
- Claims spanning more than two days
- Claims with more than one emergency department visit code (99281 – 99285 and G0380 – G0384), in certain circumstances
- Claims with an invalid or ambiguous gender (Condition Code = 45)
- Claims with an invalid age
- Claims with a length of stay of zero
- Claims with certain specialty service revenue codes (0760, 0761, 0762, or 0769)

Clients have the ability to enable/disable and customize the impact the V01 EDC Analyzer™ has on claims. Clients may configure the V01 EDC Analyzer™ to alter the reimbursement amount when a change in visit level is identified. Clients also have the ability to apply the algorithm only to claims that have certain starting visit levels and only to claims where the visit level has changed by a user-specified number of levels. All configurations can be made for a given facility, paysource, and effective date by utilizing Rate Manager.

- **Optum Algorithm Methodology**

  There are three main steps of the Optum algorithm:

  - **Step 1 (Standard Costs)**

    Reviews all reason for visit diagnosis codes and assigns a Proportional Standard Cost Allocation (PSCA) weight to each code taking into consideration the age and gender of the patient. If multiple PSCAs are assigned to a claim, the V01 EDC Analyzer™ takes the highest PSCA and uses that to assign a weight value to the claim. If no PSCAs are assigned to a claim, the claim is excluded from further analysis by the EDC Analyzer™.

    Standard cost weights were calculated by analyzing the typical amount of facility resources utilized for each presenting problem and include the costs associated with:

    - Nursing and ancillary staff time (for a routine arrival, triage, registration, basic patient/family communications, and a routine discharge)
    - The room
• Creation of a medical record

• Coding and billing

  - **Step 2 (Extended Costs)**

    Reviews all line-level services on the claim to identify diagnostic services that fall into each of the following categories:
    
    - Laboratory tests
    - X-ray tests (film)
    - EKG/RT/other diagnostic tests
    - CT/MRI/ultrasound tests

    Each category carries an extended cost weight. The V01 EDC Analyzer™ adds together the weights for each *unique* category of services found on the claim to determine the overall extended cost weight.

    Extended cost weights were calculated for each category based on the level of emergency department resources (including staff time) typically expended to note orders, communicate with the patient and staff, and follow up as needed.

  - **Step 3 (Patient Complexity Costs)**

    Reviews all principal, secondary, and external cause of injury diagnosis codes on the claim; looking for complicating conditions or circumstances that may impact the level of facility resource utilization, and assigns a weight to each complicating diagnosis code that is found. The highest weighted diagnosis code on the claim is used to determine the overall patient complexity cost weight. If a reason for visit diagnosis code is also billed as a principal or secondary diagnosis code they are excluded from acting as complicating conditions during this step.

    Patient complexity cost weights were developed for each complicating condition or circumstance by analyzing the additional services typically provided to patients with that complicating condition or circumstance.

• **Calculating the Visit Level**

  All three weights mentioned above are used in combination to assign the final visit level (Level 1, 2, 3, 4 or 5) to the claim. Depending on the processing option used and the configuration options chosen by the user for a given facility, paysource, or effective date, the revised visit level may be used later in EASYGroup™ processing for editing, grouping, and pricing. The following configuration options are available:

  - **EDC Analyzer™ Starting Visit Level Option**

    With this option, clients can choose which claims should be analyzed by the V01 EDC Analyzer™ based on the billed or “starting” visit level. For example, clients can choose to only analyze claims with a billed visit level of 5 (i.e., claims that are billed with procedure code 99285 or G0384).
- **EDC Analyzer™ Visit Level Change Option**

With this option, clients can choose which claims will receive an alternate visit level based on the number of visit level changes calculated by the algorithm. For example, clients can choose to only analyze claims where the calculated visit level is two levels higher/lower than the billed visit level.

- **EDC Analyzer™ Action**

Clients have the ability to control the impact the V01 EDC Analyzer™ will have on claim reimbursement. Clients can choose to apply or not to apply the V01 EDC Analyzer™ changes to reimbursement, or to only apply changes when the visit level is decreased. The following options are available:

  - Report results but **do not return** the revised emergency department E&M visit code as the one to be used for reimbursement
  
  - Report results and **return** the revised emergency department E&M visit code as the one to be used for reimbursement
  
  - Report results but do not return the revised emergency department E&M visit code as the one to be used for reimbursement unless the revised visit level is lower than the billed visit level

- **Configuration File Override Option**

For modeling purposes, an option has been added to EASYGroup™ that will allow the three facility-level V01 EDC Analyzer™ options mentioned above to be overridden at the claim-level. This allows clients to model various combinations of the above three options with previously processed claims, to understand the impact that the options may have on claim reimbursement.

- **Optum EDC Analyzer™ Worksheet**

The V01 EDC Analyzer™ outputs informational data in worksheet format to help clients understand the V01 EDC Analyzer™ output, particularly when a visit level change is identified. The EDC Analyzer™ Worksheet indicates exactly what impact the V01 EDC Analyzer™ had on a claim.

### 4.1.3 Analyzer Logging

- **Savings Results Log Text File**

The EASYGroup™ Analyzers will log savings results in a text file titled, `EDCyyymmdd-sequence number.log` or `EAMyyymmdd-sequence number.log`. This text file will log savings results for Optum reporting purposes and will be written to the default destination path of the Analyzer (`C:\EASYGroup\EZGLogs\`). Clients may change the destination path of the text file by modifying the `fileName` variable located in the `nLog.config` file (as shown below in Figure 4-1).

The `ezgcomm` file manages the communication from the Analyzer to a customized instance of the open-source nLog utility. nLog writes data to the...
log files, manages log file sizes, and archives the logs when they reach a size limit.

To accommodate this feature, the Analyzer utilizes the commercially available NLog program (NLog.dll) which has been configured for the EASYGroup™ Analyzers. The NLog program runs as a Windows® Service (EZGLogger.exe).

NLog: Copyright© 2004-2020 Jaroslaw Kowalski, Kim Christensen, Julian Verdurmen. All rights reserved.

If/when the savings results log text file reaches the maximum file size allowed (default 50 MB) then the text file will be closed and a new file will be created. Clients may change the maximum file size allowed by modifying the archiveAboveSize variable located in the nLog.config file (as shown below in Figure 4-1). The archiveAboveSize variable value is in bytes (1,048,576 Bytes = 1 MB). Periodically, these log text files will need to be transmitted to Optum for reporting purposes. After a file has been transmitted to Optum, that specific file can be archived or deleted by the client. Optum will work with each client to establish a delivery schedule and process for these log files.
Figure 4-1. nLog.config File

```xml
<?xml version="1.0" encoding="utf-8" ?>
<nlog xmlns="http://www.nlog-project.org/schemas/NLog.xsd"
     xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
     autoReload="true"
     throwExceptions="true">
  <targets>
    <target name="EzgLogFile"
      layout="${message}"
      xsi:type="File"
      fileName="${basedir}/logs/ezg${date:format=yyyyMMdd}.log"
      archiveEvery="Day"
      archiveAboveSize="52428800"
      archiveNumbering="Sequence"
      maxArchiveFiles="8"
      archiveFileName="${basedir}/logs/ezg${date:format=yyyyMMdd}-{####}.log"
      concurrentWrites="false"
      keepFileOpen="false" />
    <target name="EdcLogFile"
      layout="${message}"
      xsi:type="File"
      fileName="${basedir}/logs/edc${date:format=yyyyMMdd}.log"
      archiveEvery="Day"
      archiveAboveSize="52428800"
      archiveNumbering="Sequence"
      maxArchiveFiles="8"
      archiveFileName="${basedir}/logs/edc${date:format=yyyyMMdd}-{####}.log"
      concurrentWrites="false"
      keepFileOpen="false" />
    <target name="EamLogFile"
      layout="${message}"
      xsi:type="File"
      fileName="${basedir}/logs/eam${date:format=yyyyMMdd}.log"
      archiveEvery="Day"
      archiveAboveSize="52428800"
      archiveNumbering="Sequence"
      maxArchiveFiles="8"
      archiveFileName="${basedir}/logs/eam${date:format=yyyyMMdd}-{####}.log"
      concurrentWrites="false"
      keepFileOpen="false" />
  </targets>
  <rules>
    <logger name="Eam" writeTo="EamLogFile" minlevel="Debug" />
    <logger name="Edc" writeTo="EdcLogFile" minlevel="Debug" />
    <logger name="Ezg" writeTo="EzgLogFile" minlevel="Debug" />
  </rules>
</nlog>
```
5 Groupers & Readers

This chapter provides an introduction to the EASYGroup™ Groupers & Readers. It contains the following sections:

• Introduction to EASYGroup™ Groupers & Readers
• Ambulatory Payment Classification (APC) Groupers
  - Features Supported
• Ambulatory Patient Group (APG) Groupers
  - Features Supported
• Diagnostic Related Group (DRG) Groupers
  - Features Supported
• Inpatient Rehabilitation Facility (IRF) Grouper
  - Features Supported
• End Stage Renal Disease (ESRD) Reader
• Home Health Agency (HHA) Home Health Resource Group (HHRG) Reader (Prior to January 01, 2020)
• HHA Patient-Driven Groupings Model (PDGM) Reader (Effective January 01, 2020)
• Skilled Nursing Facility (SNF) Resource Utilization Group (RUG) Reader (On or Prior to October 01, 2019)
• SNF Reader (Effective October 01, 2019)
5.1 Introduction to EASYGroup™ Groupers & Readers

The EASYGroup™ product suite contains several different types of Groupers and Readers. Your EASYGroup™ system will utilize a different Grouper or Reader depending on the type of clinical procedure classification you need to process. You may only need to process one type of grouping, such as Ambulatory Payment Classifications (APCs) or you may need to use the APC Grouper, as well as the Inpatient Rehabilitation Facility (IRF) Grouper. This chapter will explain each type of Grouper or Reader that is available, and will give an overview of each type of assignment process. Groupers are collections of C and COBOL language programs and files that are used to assign the different types of grouping classifications.

Important

5.1.1 Ambulatory Payment Classification (APC) Groupers

The APC Groupers are used to assign the APCs in Hospital Outpatient Departments (HOPDs) and Ambulatory Surgical Centers (ASCs). As required by the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999, Medicare will make major structural/logic changes to the APC assignment process, as needed, every January 1st. There are two types of APC Groupers. They are as follows:

• Ambulatory Payment Classification (APC) Grouper
• Ambulatory Surgical Center (ASC) Grouper

5.1.1.1 APC Assignment Process

APCs generally represent groups of outpatient services that are clinically similar and have comparable patterns of resource use. The APCs are mutually exclusive categories that describe the full range of services that are paid under Medicare’s hospital Outpatient Prospective Payment System (OPPS) as well as Medicare’s Ambulatory Surgical Center Prospective Payment System (ASC PPS), when applicable. There are separate APCs for significant procedures, medical visits, ancillary services, transitional pass-throughs, and new technologies.

5.1.1.2 Features Supported

• Significant Procedure APCs

This category includes traditional ambulatory surgeries, as well as a variety of other procedures and tests, such as strapping and cast application, chemotherapy administration, transfusions, nuclear medicine, magnetic resonance imaging, and Computerized Axial Tomography (CAT) scans. These
APCs are divided into two groups: (1) those that are always paid in full, and (2) those that may be eligible for multiple procedure discounting.

- **Medical APCs**

  This category includes APCs for low, middle, and high-level clinic or emergency department visits, as well as APCs for critical care and interdisciplinary team conference. Medical APCs are assigned using Evaluation and Management (E/M) codes that indicate site of service and level of intensity. Generally, medical visit APCs (with the exception of the critical care APC) will not be assigned on the same day that a surgical procedure was performed. If “significant, separately identifiable evaluation and management services” are performed on the same day as a surgical procedure, a Modifier of 25 must be placed on the E/M code in order for a medical APC to be assigned. Without Modifier 25, only surgical APCs will be assigned to the case.

- **Ancillary Service APCs**

  The ancillary service category includes APCs for simple and complex pathology services, plain film radiological procedures, immunology tests, immunizations, simple and complex pulmonary tests, allergy tests and injections, and electrocardiograms.

- **Transitional Pass-Through APCs**

  The hospital Outpatient Prospective Payment System (OPPS) provides a transitional pass-through payment for specific innovative and generally expensive medical devices, drugs, and biologicals. Items eligible for this transitional pass-through include orphan drugs (as designated by the Food and Drug Administration (FDA)), current drugs, biologic agents, and brachytherapy devices used in cancer treatment, current radiopharmaceutical drugs and biological products used in nuclear medicine for diagnostic monitoring or therapeutic purposes, and new medical devices, drugs, and biologic agents, whose costs are not insignificant in relation to APC payment amounts.

- **New Technology APCs**

  This category includes APCs for new technologies not eligible for the transitional pass-through. These APCs are based on cost alone and are used to temporarily categorize emergent technologies until they can be assigned to the most appropriate “clinically-related” APC. It is anticipated that new items will be assigned to these APCs for a period of at least two years, but no more than three years. There are two sets of new technology APCs, one for new technology services and one for new technology devices.

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*CMS Medicare Claims Processing Manual*, Ch.12 - Physicians/Non-physician Practitioners [Sec. L., p. 73], HDC Inc. for OSORA.
• Composite APCs (APC Grouper Only)

Introduced in 2008, Composite APCs provide a single payment for several independent services when they are furnished on the same date of service. Composite APCs are intended to establish APC payment rates for combinations or “bundles” of services that are frequently furnished together. When a claim is eligible for a Composite APC, the designated primary service in the composite definition is paid based on the Composite APC, and all other services in the composite definition are packaged. Charges for packaged items within the Composite APC are bundled into the claim line that contains the primary service and these reallocated charges are taken into consideration during outlier calculations.

For Composite APC assignment, groups of services are assigned to a single APC if specific criteria are met. Addendum B of the OPPS Final Rule assigns Payment Status Indicator “Q(#)” to specific services which may be packaged or separately payable or part of a Composite APC, based on other services on the same service date. The Outpatient Code Editor (OCE) overwrites Payment Status Indicator “Q(#)” with either a packaged or payable payment status based on other information on the claim. The complex logic for handling these “Q(#)” codes is maintained in the EASYGroup™ Ambulatory Code Editor™ (ACE). The APC Grouper assumes any submitted Payment Status Indicator “Q(#)” service is separately payable and assigns the appropriate native APC and payment status; it does not package these services, nor does it assign Composite APCs. For Composite APC assignment and for evaluation of Payment Status Indicator “Q(#)” items for packaged and payable decisions, use ACE.

Note
For further information on ACE refer to Chapter 3.

• Skin Substitute Logic (ASC Grouper Only)

Effective April 1, 2012, a skin substitute product code must be billed on the same date of service as the skin substitute application procedure code, to be eligible for payment. If a skin substitute product code is billed without a skin substitute application procedure code, on the same date of service, the skin substitute product code will be assigned a Payment Status Indicator of N1 (Packaged Service/Item; No Separate Payment Made), a zero APC, and will not be eligible for payment.

When billed on the same date of service, both the skin substitute application procedure code and the skin substitute product code will be assigned the standard Payment Status Indicator and standard APC, and will both be eligible for payment.

If a skin substitute application procedure code is billed without a skin substitute product code, on the same date of service, the skin substitute application procedure code will be assigned to its standard Payment Status Indicator and standard APC, and will be eligible for payment.
Note
The APC Grouper assumes all skin substitute product codes are separately payable and it will assign the appropriate APC and Payment Status Indicator. The APC Grouper will not package these services, nor does the APC Grouper handle skin substitute logic. For skin substitute logic, ACE is required. For further information on ACE refer to Chapter 3.

APC assignment is based upon Health Care Financing Administration Common Procedure Coding System (HCPCS) codes, but only those HCPCS codes that represent services paid under the PPS are assigned to APCs. Each eligible HCPCS code is assigned to a single APC, and for any outpatient visit, multiple APCs may be assigned. The following types of services (and their associated HCPCS codes) are not included in the composite prospective payment system and are not assigned to APCs:

- Services paid under a fee schedule
- Inpatient services
- Non-covered services
- Incidental procedures

APCs are assigned by calling the APC Grouper using the input parameters. The APC Grouper accepts as input a set of services provided to a single patient by a single provider on a single date of service. Each set of input data should contain a single service date and have a variable number of HCPCS procedure codes and (as appropriate) modifiers.

The APC Grouper assigns a Payment Status Indicator to each HCPCS code and when appropriate, an APC. Payment Status Indicators describe how Medicare pays for a particular service when it is provided in the hospital outpatient setting. When an APC is assigned, the Payment Status Indicator identifies APC type, as listed above. When an APC is not assigned, the Payment Status Indicator details whether the service is covered in the outpatient setting and if so, how it is paid for by Medicare.

Note
APC input and output fields are described in the Input and Output Parameter Blocks User's Guide.
5.1.2 Ambulatory Patient Group (APG) Groupers

**Note**
For information on the APG Grouper which is used with the 3M™ Grouper Plus System (GPS) please refer to Chapter 7.

APG Groupers are used to assign the Ambulatory Patient Groups (APGs). APGs are to outpatient care what the Diagnostic Related Groups (DRGs) are to inpatient care. Under an outpatient payment system they serve as the basic unit of payment. There are two types of APG Groupers. They are as follows:

- APG V2.0 (C and COBOL Platform)
- APG V2.1 (C Platform Only)

**5.1.2.1 APG Assignment Process**

APGs describe an outpatient visit or simply a contact between a patient and a health care professional. The visit may be for a procedure, a medical evaluation, or an ancillary service. APGs are applicable to all outpatient settings, including same day surgical units, hospital emergency rooms, and outpatient clinics. They describe facility costs, not professional costs.

The APG Grouper assigns each HCPCS Level I and Level II code to one of the following procedure APG categories:

- Significant procedure or therapy
- Ancillary test or procedure
- Incidental procedure or service
- Medical visit indicator
- Mental illness/substance abuse or counseling indicator
- Error APG

Patients not assigned to a significant procedure or therapy APG may be placed into a medical APG. Assignment to a medical APG is based on the patient’s principal diagnosis code, which is considered the reason for the encounter or visit (RVDX diagnosis code). In addition, to be assigned to a medical APG an Evaluation and Management (E/M) code must be entered for the patient. All codes considered to be E/M codes by the APG Grouper are assigned to a single Medical Visit Indicator APG (APG 422).

APGs are assigned by calling the APG Grouper. This program then accesses the appropriate APG Grouper data files and uses internal logic to set the APG output fields. These data files contain specially coded information required by the APG Grouper, including the diagnostic and procedure information needed for APG assignment. Note that each patient record is eligible for assignment to multiple APGs.
Note
APG input and output fields are described in the Input and Output Parameter Blocks User’s Guide.

5.1.2.2 Features Supported
• APG Assignments Specific to Several State or Private Payers
• Automatic Diagnosis and Procedure Code Mapping

The V2.0 APG Grouper was originally developed using Fiscal Year (FY) 1995 (V12) ICD-9-CM diagnosis codes and Calendar Year (CY) 1995 HCPCS procedure codes. V2.1 of the APG Grouper was originally developed to utilize diagnosis and procedure coding conventions for 2004 (V21). Both APG Groupers have been enhanced to accept all current codes and to “backward” map these codes into diagnoses and/or procedures recognized by the conventions of their particular Grouper versions. This mapping occurs automatically and is transparent to the user. All current codes can be passed to the APG Grouper and these codes will be placed into the correct APGs.

Note
The APG Grouper does not accept pre-1995 codes for V2.0 or pre-2004 codes for V2.1. It does not “forward” map these codes into diagnoses and procedures recognized by the APG Grouper. The APG Grouper mapping capability is for “backward” mapping only.

• Multi-Payer Ancillary Packaging
Ancillary procedure APGs are often packaged for payment with significant procedure or medical APGs. When an ancillary APG is packaged, no additional payment is received for the APG. The APG Grouper has been designed to support the concurrent use of multiple state and/or payer-specific ancillary packaging routines.

• Multi-Payer Significant Procedure Consolidation
Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for payment purposes. This collapsing is accomplished through use of a “consolidation list,” which identifies each significant procedure APG and the APGs which are integrally related to it. The procedures in these related APGs can be performed with relatively little additional effort and should therefore be consolidated with the initial APG. No significant procedure consolidation list is part of the standard APG Grouper. Many individual states and/or payers, however have developed such consolidation lists for local use. The APG Grouper has been designed to support the concurrent use of multiple state and/or payer-specific consolidation lists.
5.1.3 Diagnostic Related Group (DRG) Groupers

The DRG Groupers are used to assign Diagnostic Related Groups (DRGs). DRGs are the basic unit of payment for inpatient care. There are several types of DRG Groupers. They are as follows:

- Medicare DRG Grouper
- ICD-10 Medicare DRG Grouper
- All-Patient Diagnosis Related Group (AP-DRG) Grouper
- TRICARE/CHAMPUS DRG Grouper
- ICD-10 TRICARE DRG Grouper
- North Carolina Medicaid Grouper (prior to October 1, 2012)
- Wisconsin Medicaid Grouper
- ICD-10 Wisconsin Medicaid Grouper
- Ohio Medicaid Grouper (prior to July 1, 2013)

Note
For information on APR-DRG Groupers please refer to Chapter 7.

5.1.3.1 DRG Assignment Process

DRGs are assigned by calling the appropriate DRG Grouper. The Grouper then accesses the appropriate data files and uses internal logic to set the DRG output fields. These data files contain specially coded information required by the DRG Grouper, including diagnostic and procedure information, Complication/Comorbidity (CC) exclusions, and Major Complication/Comorbidity (MCC) exclusions.

Note
DRG input and output fields are described in the Input and Output Parameter Blocks User’s Guide.

5.1.3.2 Features Supported

- Hospital-Acquired Conditions (HACs): Medicare

In the Deficit Reduction Act of 2005, congress mandated that Medicare establish a program to reduce reimbursement for certain conditions that are acquired during a hospital stay. Beginning October 1, 2008, if a claim contains a diagnosis code representing one of the Hospital-Acquired Conditions (HACs), as defined by Medicare, plus a Present on Admission (POA) indicator of N (not present at the time of inpatient admission) or a POA indicator of U (documentation is insufficient to determine if condition is present on admission), then that diagnosis code will not be considered a Complication/Comorbidity (CC) or Major Complication/Comorbidity (MCC) during MS-DRG (Medicare Severity-Diagnosis Related Group) assignment.
All of the diagnosis codes representing the selected conditions are considered to be Complications/Comorbidities (CC) or Major Complications/Comorbidities (MCC) by the Medicare DRG Grouper. Demoting these codes to non-CC status may cause assignment to a less complex DRG, with corresponding lower reimbursement to the hospital. However, DRG assignment for the claim may not be affected by excluding these codes if other CCs or MCCs are present on the claim and the CC or MCC is not related to the principal diagnosis.

HACs will be evaluated by the Medicare DRG Grouper via the HAC Editor. The DRG Grouper will internally invoke the Editor to check claims for HACs and will use HAC-related output from the Editor in the final DRG assignment. The Medicare DRG Grouper contains a direct link to the HAC Editor.

- Hospital-Acquired Conditions (HACs) and/or Health Care-Acquired Conditions (HCACs): Medicaid & Other Government Agencies

Since the inception of the Medicare HAC program in October of 2008, many state Medicaid programs and other government agencies have adopted similar HAC programs. Most of these HAC programs are identical to the Medicare HAC program with the exception of the program effective date. There are a few HAC programs that are either less or more comprehensive than the Medicare HAC program.

Some states (refer to Table 5-1) have adopted Health Care-Acquired Condition (HCAC) programs per the Medicaid Program: Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions Final Rule, published in the June 6, 2011 Federal Register. The Medicaid HCAC Program is identical to the Medicare HAC program, with the exception of HAC #10 (Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) following certain orthopedic procedures), which will not be applied for cases that meet one of the following criteria:

- Pediatric patients
- Obstetric patients which are defined as patients with a primary or secondary diagnosis code that indicates pregnancy

HACs/HCACs will be evaluated by the appropriate DRG Grouper via the HAC Editor. The DRG Grouper will internally invoke the HAC Editor to check claims for HACs/HCACs and will use HAC/HCAC-related output from the HAC Editor in the final DRG assignment. Table 5-1 below lists available payment systems and the appropriate DRG Grouper that contains a direct link to the HAC Editor:

Table 5-1: Medicaid and Other Payment Systems with HAC/HCAC Grouping Functionality

<table>
<thead>
<tr>
<th>Payment System</th>
<th>Grouper Version</th>
<th>HAC/HCAC</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia Medicaid (C Only)</td>
<td>TRICARE V24</td>
<td>HAC</td>
<td>November 1, 2010</td>
</tr>
<tr>
<td>Illinois Medicaid (C Only)</td>
<td>Medicare V12</td>
<td>HCAC</td>
<td>July 1, 2012</td>
</tr>
</tbody>
</table>
The HAC/HCAC functionality in the above-listed Groupers is optional and can be turned on or off using Rate Manager, for any facility, paysource, or time period. Make sure the check box for HAC is checked in the appropriate rate calculator screen of Rate Manager. Alternatively, this functionality can be directly set in the Optimizer using the appropriate Editor Requests (edit_req for C, ECB-EDIT-HAC-SW for COBOL) field for HAC in the ECB [ezg_cntl_block] structure for C, or the ECB-EZG-CNTL-BLOCK structure for COBOL.

Table 5-1: Medicaid and Other Payment Systems with HAC/HCAC Grouping Functionality

<table>
<thead>
<tr>
<th>Payment System</th>
<th>Grouper Version</th>
<th>HAC/HCAC</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana Medicaid (C Only)</td>
<td>AP-DRG V18</td>
<td>HAC</td>
<td>October 1, 2009 - June 30, 2012</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCAC</td>
<td>July 1, 2012</td>
</tr>
<tr>
<td>Iowa Medicaid (C Only)</td>
<td>ICD-10 Medicare V33</td>
<td>HAC</td>
<td>October 1, 2015</td>
</tr>
<tr>
<td>Kansas Medicaid (C Only)</td>
<td>Medicare V30 and higher</td>
<td>HCAC</td>
<td>July 1, 2013</td>
</tr>
<tr>
<td>Kentucky Medicaid (C Only)</td>
<td>Medicare V24</td>
<td>HAC</td>
<td>July 1, 2010 - June 30, 2011</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCAC</td>
<td>July 1, 2011</td>
</tr>
<tr>
<td>Michigan Medicaid</td>
<td>Medicare V28 and higher</td>
<td>HAC</td>
<td>July 1, 2011</td>
</tr>
<tr>
<td>Nebraska Medicaid (C Only)</td>
<td>AP-DRG V27</td>
<td>HAC</td>
<td>July 1, 2011</td>
</tr>
<tr>
<td>New Jersey Medicaid</td>
<td>AP-DRG V24 and higher</td>
<td>HAC</td>
<td>April 1, 2011</td>
</tr>
<tr>
<td>New Mexico Medicaid (C Only)</td>
<td>Medicare V27 and higher</td>
<td>HCAC</td>
<td>May 1, 2010</td>
</tr>
<tr>
<td>North Carolina Medicaid (C Only)</td>
<td>North Carolina Medicaid V27 and higher</td>
<td>HCAC</td>
<td>January 1, 2011</td>
</tr>
<tr>
<td>Texas Medicaid (C Only)</td>
<td>Medicare V28 and higher</td>
<td>HAC</td>
<td>September 1, 2010</td>
</tr>
<tr>
<td>(prior to September 1, 2012)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRICARE</td>
<td>TRICARE V27 and higher</td>
<td>HAC</td>
<td>October 1, 2009</td>
</tr>
<tr>
<td>Virginia Medicaid (C Only)</td>
<td>AP-DRG V23 and higher</td>
<td>HAC</td>
<td>January 1, 2010 - June 30, 2012</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCAC</td>
<td>July 1, 2012</td>
</tr>
<tr>
<td>Washington HCA</td>
<td>AP-DRG V26</td>
<td>HAC</td>
<td>January 1, 2010</td>
</tr>
<tr>
<td>Washington Medicaid</td>
<td>AP-DRG V23</td>
<td>HCAC</td>
<td>January 1, 2010</td>
</tr>
<tr>
<td>Wisconsin Medicaid (C Only)</td>
<td>Wisconsin Medicaid V26 and higher</td>
<td>HAC</td>
<td>March 1, 2010</td>
</tr>
</tbody>
</table>
• ICD-9-CM Code Mapping from Different Time Periods

Each October 1st, the ICD-9-CM coding system is updated. Codes are added, deleted, and expanded. Generally, ICD-9-CM updates are associated with a specific time period and are referred to by version, for example: V28 was effective, October 1, 2010.

Note
For further information on the Mapper please refer to the Mappers section of this user’s guide.

The DRG Groupers contain a direct link to the Mapper, for users who have licensed both the Mapper and the Grouper.

• ICD-10 DRGs

The Health Insurance Portability and Accountability Act (HIPAA) legislation mandated the adoption of ICD-10-CM and ICD-10-PCS coding for inpatient discharges on or after October 1, 2015. Optum offers DRG assignment for claims coded in either ICD-9-CM or ICD-10-CM/PCS.

• New York Modifications to the AP-DRG V14 Grouper

New York State modified the AP-DRG V14 Grouper so that diagnosis code 998.59 (Other Postoperative Infection) was not recognized as a Major Complication/Comorbidity (MCC). To invoke New York-specific modifications to the AP-DRG V14 Grouper (known as AP-DRG V14.1), set the Grouper Option Flag field to 1 (option_flag in the ECB [ezg_cntl_block] or the ECB-OPTION-FLAG in the ECB-EZG-CNTL-BLOCK) prior to invoking the AP-DRG Grouper. There are no New York-specific modifications to the AP-DRG Grouper prior to or after V14.

Note
For Rate Manager users, select the New York AP-DRG option for Grouper Type and 14 for Grouper Version.

In addition to New York State, the AP-DRG Grouper V14 modifications are also used by Washington Medicaid.

• Special Instructions for Ohio Medicaid Grouper (C Only) (prior to July 1, 2013)

For Ohio Medicaid, DRGs 388 through 390 are assigned a fourth digit based on level or type of nursery (1, 2, or 3) and DRGs 425 through 437 are assigned a fourth digit of “1” if the patient was treated in a distinct part psychiatric unit. These fourth digits cause a different set of weights to be used in pricing.

The Ohio Medicaid Grouper handles all Ohio-specific DRG modifications, including the fourth digits discussed above, when the nursery level is passed on the claim level. The Ohio Medicaid Pricer also has additional functionality.
to assign the fourth digit when the nursery level is passed on the facility level. Refer to Appendix B for further information.

- Birth Weight Imputation

The AP-DRG Grouper requires a birth weight value in grams for any neonate (i.e., any patient less than 29 days old).

If a birth weight value in grams is not available, the AP-DRG Grouper may be able to impute the birth weight from the patient’s diagnosis using the rules outlined below:

Table 5-2: Birth Weight Imputation

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>Imputed Birth Weight Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>76401, 76411, 76421, 76491, 76501, 76511</td>
<td>&lt; 500 grams</td>
</tr>
<tr>
<td>76402, 76412, 76422, 76492, 76502, 76512</td>
<td>500 - 749 grams</td>
</tr>
<tr>
<td>76403, 76413, 76423, 76493, 76503, 76513</td>
<td>750 - 999 grams</td>
</tr>
<tr>
<td>76404, 76414, 76424, 76494, 76504, 76514</td>
<td>1000 - 1249 grams</td>
</tr>
<tr>
<td>76405, 76415, 76425, 76495, 76505, 76515</td>
<td>1250 - 1499 grams</td>
</tr>
<tr>
<td>76406, 76416, 76426, 76496, 76506, 76516</td>
<td>1500 - 1749 grams</td>
</tr>
<tr>
<td>76407, 76417, 76427, 76497, 76507, 76517</td>
<td>1750 - 1999 grams</td>
</tr>
<tr>
<td>76408, 76418, 76428, 76498, 76508, 76518</td>
<td>2000 - 2499 grams</td>
</tr>
<tr>
<td>76409, 76419, 76429, 76499, 76509, 76519</td>
<td>&gt; 2499 grams</td>
</tr>
<tr>
<td>None of the Diagnosis Codes Listed Above</td>
<td>&gt; 2499 if birth weight is 9999 0 if birth weight is not entered</td>
</tr>
<tr>
<td>ONLY ONE of the following codes: 76400, 76410, 76420, 76490, 76500, 76510</td>
<td>0 grams</td>
</tr>
<tr>
<td>Diagnosis Codes from Two or more Birthweight Ranges</td>
<td>0 grams</td>
</tr>
</tbody>
</table>

The AP-DRG Grouper contains an option to automatically impute birth weight. To use this option, set the Birth Weight in Grams field in the PCB2.ICD [ip_claim_data] structure for C or the PCB2-ICD-IP-CLAIM-DATA structure for COBOL to 9999 prior to invoking either Grouper.

In the absence of birth weight or imputed birth weight, the case will be assigned to DRG 470 (Ungroupable) in the AP-DRG Grouper when birth weight is required for DRG grouping.

5.1.4 Inpatient Rehabilitation Facility (IRF) Grouper

On January 01, 2002, CMS implemented a Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities and units (IRFs). Prior to that date, IRFs were paid reasonable costs limited by a facility-specific target amount per discharge (Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rules). Under the IRF PPS, services are paid using prospectively determined rates. Payments are case-based (per discharge), and include both inpatient operating (routine and ancillary) costs, as well as capital costs. New providers
were paid 100% of the IRF PPS payment in year one and existing providers could have elected to be paid a fully prospective rate in 2002.

Payment under the IRF PPS is case-based (per discharge). Facilities receive a single payment for each rehabilitation stay, which is based on information from an admission assessment that must be completed by day four of the rehabilitation stay. Payment involves assignment to a distinct Case-Mix Group (CMG) and use of a weighting factor to account for variations in patient acuity. Separate payments are calculated for each CMG with additional case and facility level adjustments applied. The IRF Grouper is designed to help IRFs comply with the requirements of the IRF PPS.

5.1.4.1 IRF Patient Classification
For payment purposes, each IRF patient stay is classified into a CMG-based on the following variables, which are collected during the admission assessment:

- Impairment Group
- Functional Status
- Age

Patients receiving a full course of treatment are first classified into 21 major groups called Rehabilitation Impairment Categories (RICs), based upon their primary reason for treatment. RICs are then subdivided into CMGs using functional status and age.

CMS has determined that the presence of certain comorbidities (i.e., patient conditions that are secondary to the patient’s principal diagnosis or impairment group) have a major effect on the costs of furnishing inpatient rehabilitation care. To account for these resource differences, CMS has identified four levels of comorbidity for payment purposes. The IRF Grouper evaluates each submitted diagnosis and determines the appropriate comorbidity tier for the diagnosis:

A = Not a commodity or comorbidity excluded for RIC
B = High cost comorbidity
C = Medium cost comorbidity
D = Low cost comorbidity

Finally, a Health Insurance Prospective Payment System (HIPPS) code is assigned to the case. This code is in the format “XYYYY” where “X” is the comorbidity tier for the case (highest comorbidity level identified) and “YYYY” is the assigned CMG. CMGs will be updated periodically to reflect changes in treatment patterns, technology, number of discharges, and other factors affecting the relative use of resources.

Alternatively, the HIPPS code can be taken from the claim line, instead of being calculated from the impairment group, functional status, and age. The HIPPS code is reported on the claim line with Revenue Code 0024. The IRF Grouper can extract the CMG from this claim line. In this situation all that
would be needed is the claim information to process, instead of the IRF assessment data.

5.1.4.2 Features Supported

- **CMG/HIPPS Assignment From Assessment Data**
  1. Call/invoke the IRF Grouper.
  2. Pass all claim information, including the impairment group, motor scores, and age.
  3. The IRF Grouper will assign the appropriate CMG and HIPPS code.

- **CMG/HIPPS Assignment From the HIPPS Code**

  **Note**
  This option is only available with the Optimizer (V1006 and higher).

  1. Call/invoke the IRF Grouper.
  2. Pass all claim information, including HIPPS codes. HIPPS codes must be passed with a Revenue Code of 0024.
  3. The IRF Grouper will extract the CMG and HIPPS code from the claim.

  **Note**
  IRF input and output fields are described in the Input and Output Parameter Blocks User’s Guide.

5.1.5 End Stage Renal Disease (ESRD) Reader

The ESRD Reader facilitates claims processing within EASYGroup™ through EditGroupPrice and GroupPrice functionality.

**Note**
Although there is no grouping logic within the ESRD Reader, it is still required for claims processing.

5.1.6 Home Health Agency (HHA) Home Health Resource Group (HHRG) Reader (Prior to January 01, 2020)

For claims with discharge dates prior to January 01, 2020, the HHA HHRG Reader searches UB-04 Bill Types 0322, 0327, 0329, 032Q, 0332, 0337, 0339, and 033Q claims for Revenue Code 0023 (HIPPS Code) and extracts the HHRG and Non-Routine Supplies Code from the HIPPS code on that line. In addition, for claims with UB-04 Bill Types 0327, 0329, 032Q, 0337, 0339, or 033Q and a valid Treatment Authorization Code, the HHA HHRG Reader compares the submitted HIPPS code to the services that were actually provided to the patient. If the HHA HHRG Reader finds a discrepancy between the HIPPS code and the services provided, it will use the submitted
Treatment Authorization Code to derive a more appropriate HIPPS code and, therefore a more appropriate HHRG for the patient.

**Note**

Effective October 01, 2013, UB-04 Bill Types 033X (where X = any value) have been discontinued.

The HHA HHRG Reader is not a Grouper and does not derive HIPPS codes and HHRGs from the Outcome and Assessment Information Set (OASIS) data.

### 5.1.7 HHA Patient-Driven Groupings Model (PDGM) Reader (Effective January 01, 2020)

Effective for periods of care beginning on or after January 01, 2020, the HHRG, previously used in reimbursement calculation of HHA claims, has been replaced with the PDGM. The PDGM HIPPS code is a 5 character case-mix group that better reflects clinical and patient characteristics affecting payment by taking into account admission source and admission timing, principal and other diagnoses, as well as functional impairment. Similar to HHRGs, each PDGM HIPPS code holds a specific weight which is used to adjust the standard rate.

The purpose of the HHA PDGM Reader is to validate the HIPPS code billed on the claim and output an alternative PDGM HIPPS code, if the claim data is inconsistent with what was billed.

#### 5.1.7.1 HIPPS Codes

Position 1 of the PDGM HIPPS is based on two pieces of information (as outlined below) where values range from 1 to 4. Values 1 - 4 represent an early community, early institutional, late community, and late institutional claim respectively.

- **Admission Source** is defined as community or institutional. It is institutional if the patient was discharged from an acute care hospital within 14 days of the start of this period of care. This is identified with UB-04 Occurrence Code 61, where the occurrence date is the Discharge Date from the acute care facility; or
- The patient was discharged from an acute care, long term care, or inpatient psychiatric, rehabilitation, or skilled nursing facility or unit within 14 days of the home health admission. This is identified with UB-04 Occurrence Code 62.
- **Otherwise,** it is community. Admission timing is defined as early or late:
  - Early is defined as the first 30-day period of care which is determined by comparing the From Date to the Admit Date. When the dates match it is defined as early.
Late is defined as a subsequent 30-day period of care which is determined by comparing the From Date to the Admit Date. When the dates do not match it is defined as late.

Position 2 of the PDGM represents the clinical grouping and is based on the principal diagnosis code. There are 12 clinical groups which are assigned an alphabetical PDGM value ranging from A - L.

Table 5-3: Clinical Groupings

<table>
<thead>
<tr>
<th>Clinical Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Medication Management Teaching &amp; Assessment (MMTA) - Other</td>
</tr>
<tr>
<td>B</td>
<td>Neurology/Stroke- Rehabilitation</td>
</tr>
<tr>
<td>C</td>
<td>Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Care</td>
</tr>
<tr>
<td>D</td>
<td>Complex Nursing Interventions</td>
</tr>
<tr>
<td>E</td>
<td>Musculoskeletal Rehabilitation</td>
</tr>
<tr>
<td>F</td>
<td>Behavioral Health Care</td>
</tr>
<tr>
<td>G</td>
<td>MMTA - Surgical Aftercare</td>
</tr>
<tr>
<td>H</td>
<td>MMTA - Cardiac or Other Circulatory Related Conditions</td>
</tr>
<tr>
<td>I</td>
<td>MMTA - Endocrine Related Conditions</td>
</tr>
<tr>
<td>J</td>
<td>MMTA - Gastrointestinal or Genitourinary Related Conditions</td>
</tr>
<tr>
<td>K</td>
<td>MMTA - Infectious Disease/Neoplasm/Blood-Forming Diseases</td>
</tr>
<tr>
<td>L</td>
<td>MMTA - Respiratory Related Condition</td>
</tr>
</tbody>
</table>

Position 3 of the PDGM HIPPS code is the functional severity level which is assigned based on OASIS data. Valid values include A for low severity, B for medium severity, and C for high severity level.

Position 4 of the PDGM HIPPS code represents the comorbidity adjustment which is determined based on secondary diagnosis codes. Valid values include 1 for no comorbidity adjustment, 2 for low comorbidity adjustment, and 3 for high comorbidity adjustment. High comorbidity is defined as two diagnosis codes on the claim that CMS has defined as associated with a higher resource utilization level. A low comorbidity adjustment is defined as a diagnosis code on the claim that CMS has included in one of the low comorbidity groups. If none of the diagnosis codes on the claim qualify for the low or high comorbidity adjustment criteria then no comorbidity adjustment is assigned.

Position 5 of the PDGM HIPPS code is a placeholder and will be assigned a value of 1.
5.1.7.2 Alternate PDGM HIPPS Code Assignment

Position 1 of the alternate PDGM is assigned based off of UB-04 Occurrence Codes and the From Date and Admit Date of the claim as follows:

- 1 (Early Community) = From Date equals Admit Date and there is no UB-04 Occurrence Code 61 or 62
- 2 (Early Institutional) = From Date equals Admit Date and there is a UB-04 Occurrence Code of 61 or 62
- 3 (Late Community) = From Date does not equal Admit Date and there is no UB-04 Occurrence Code 61 or 62
- 4 (Late Institutional) = From Date does not equal Admit Date and there is an UB-04 Occurrence Code of 61

Position 2 of the alternate PDGM is assigned based off of the principal diagnosis code on the claim. If the diagnosis code is found, the associated clinical grouping is used to assign the appropriate character for position 2.

Position 3 is based off of the OASIS data which the EASYGroup™ software is not able to access; therefore this character will be assigned using the submitted HIPPS code value.

Position 4 of the alternate PDGM is assigned based off of the secondary diagnosis codes on the claim.

- Step 1 - Remove any secondary diagnosis codes that cannot contribute to the comorbidity adjustment. This is determined by comparing the first 3 characters of the secondary diagnosis code with the first 3 characters of the principal diagnosis code, and if they are identical, these codes will not be considered. Each secondary diagnosis code is searched for and if the secondary and principal diagnosis codes have matching first 3 characters, the diagnosis code is excluded.
- Step 2 - Determine if there are any secondary diagnosis codes that are considered a pair and will be assigned a high comorbidity. Two or more secondary diagnosis codes on the claim must be assigned to a high comorbidity pair. If this criteria is met, the character will be set to a value of 3.
- Step 3 - Determine if there are any secondary diagnosis codes that are considered low comorbidity. The secondary diagnosis code must be assigned to one of the low comorbidity subgroups to be considered. If this criteria is met, the character will be set to a value of 2.
- Step 4 - If there are no secondary diagnoses on the claim, or no comorbidity level was assigned, a comorbidity adjustment will not be applied and the character will be set to a value of 1.

Position 5 will always be assigned a value of 1 because it is a placeholder.

When the alternate PDGM HIPPS code generated is not identical to the HIPPS code billed, the Alternate HHRG/PDGM Flag will be set to 1 (Alternate HHRG/PDGM is Available). When the alternate PDGM generated is identical...
to the HIPPS code billed, the Alternate HHRG/PDGM Flag will be set to 0 (No Alternate HHRG/PDGM Available) and the HHRG/First Four Positions of PDGM will be set to the first 4 positions of the billed HIPPS code and the PDGM will be set to all 5 positions of the billed HIPPS code. If the Admit Date is not submitted, an alternate PDGM will not be generated and the Alternate HHRG/PDGM Flag will be set to a value of 2 (No Alternate PDGM Available; Admit Date Not Submitted on the Claim).

5.1.8 Skilled Nursing Facility (SNF) Resource Utilization Group (RUG) Reader (On or Prior to October 01, 2019)

For claims with discharge dates on or prior to October 01, 2019, the SNF RUG Reader is designed to extract a RUG (Resource Utilization Group) from each claims-submitted HIPPS (Health Insurance Prospective Payment System) code reported with a revenue code of 0022. The SNF RUG Reader is not a RUG Grouper and does not calculate RUG values from input clinical data. The SNF RUG Reader’s sole responsibility is to extract a RUG value from submitted claims data.

5.1.9 SNF Reader (Effective October 01, 2019)

For claims with discharge dates after October 01, 2019, the SNF V01 Reader is designed to extract and evaluate each submitted HIPPS (Health Insurance Prospective Payment System) code reported on a SNF Part A claim with Revenue Code 0022. The SNF Reader is not a Grouper and does not calculate HIPPS values from input clinical/assessment data.
6 Pricers

This chapter provides an introduction to the EASYGroup™ Pricers. It contains the following sections:

- Introduction to EASYGroup™ Pricers
- Ambulatory Payment Classification (APC) for Hospital Outpatient Departments (HOPDs) Pricer
  - Features Supported
- Contract Ambulatory Payment Classification (APC) Pricer or APC Pro
  - Features Supported
- New Mexico Medicaid Ambulatory Payment Classification (APC) Pricer
  - Features Supported
- Ambulatory Surgical Center (ASC) Pricer
  - Features Supported
- Contract Ambulatory Surgical Center (ASC) Pricer or ASC Pro
  - Features Supported
- Ambulatory Patient Group (APG) Pricer (C Only)
  - Features Supported
- Diagnosis Related Group (DRG) Pricer
  - Features Supported
- End Stage Renal Disease (ESRD) Pricer
  - Features Supported
- Federally Qualified Health Center (FQHC) Pricer
  - Features Supported
  - Not Currently Supported
- Home Health Agency (HHA) Pricer (Prior to January 01, 2020)
  - Features Supported
  - Not Currently Supported
- HHA Pricer (Effective on or After January 01, 2020)
  - Features Supported
  - Not Currently Supported
- HHA Pricer (Effective on or After January 01, 2020)
  - Features Supported
- Skilled Nursing Facility (SNF) Pricer
- Features Supported
  • Physician Pricer
  - Features Supported
6.1 Introduction to EASYGroup™ Pricers

The EASYGroup™ product suite contains several different types of Pricers. Your EASYGroup™ system will utilize a different Pricer depending on the type of claims you need to process. You may only need to process one type of claim, such as Ambulatory Payment Classifications (APCs) or you may need to use the APC-HOPD Pricer, as well as the Diagnosis Related Group (DRG) Pricer. This chapter will explain each type of Pricer that is available. Pricers are collections of C and COBOL language programs and files that are used to calculate reimbursement.

Important


6.1.1 Ambulatory Payment Classification (APC) for Hospital Outpatient Departments (HOPDs) Pricer

The APC-HOPD Pricer calculates expected reimbursement for eligible outpatient services provided in hospital outpatient departments according to Medicare rules. Pricing is based on APC-specific rates with adjustments for local wage variations. Discounting is included for multiple procedures in some cases. The HOPD rules include pricing for surgical procedures, medical visits, emergency room and critical care services, ancillaries, and per-diem payments for eligible community mental health center patients. The APC-HOPD Pricer includes the calculation of patient co-payment for each APC according to published Medicare rules. Also included is an option to calculate fee schedule pricing via one of the following Medicare fee schedules: Ambulance, Clinical Laboratory Services, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), Rehabilitation Services, Telehealth Services, Outpatient Diabetes Self-Management Services, and Parenteral/Enteral Nutrition (PEN) Services. The system includes geographic variations in fee schedule rates and allows user specification of variable fee schedule payment percentages by the payer and by the patient.

6.1.1.1 Features Supported

The APC-HOPD Pricer performs the following functions:

- Calculates patient-specific reimbursements using the appropriate APC pricing rules.
- Returns pricing flags for each APC, indicating payment rules, discounting, and other adjustments.
- Estimates patient co-payment.
- Supports pricing of critical access Method I claims.
- Pricing for reasonable cost items:
Most hospital outpatient services are paid based on the APC payment system, or based on Medicare’s Clinical Laboratory, DMEPOS, Ambulance, or Physician Fee Schedules. Exceptions have been made for Payment Status F and L services, which are paid based on reasonable hospital cost. These services include:

Payment Status F- Corneal, CRNA, and Hepatitis B:

Table 6-1: Payment Status F

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Code Description</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90739</td>
<td>Hepatitis B Vaccine, Adult Dosage, for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90740</td>
<td>Hepatitis B Vaccine, Dialysis or Immunosuppressed Patient Dosage (3 Dose Schedule), for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90743</td>
<td>Hepatitis B Vaccine, Adolescent (2 Dose Schedule), for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90744</td>
<td>Hepatitis B Vaccine, Pediatric/Adolescent Dosage (3 Dose Schedule), for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90746</td>
<td>Hepatitis B Vaccine, Adult Dosage, for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90747</td>
<td>Hepatitis B Vaccine, Dialysis or Immunosuppressed Patient Dosage (4 Dose Schedule), for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>J0205</td>
<td>Injection, Alglucerase, Per 10 Units</td>
<td>01/01/2003</td>
<td>12/31/2003</td>
</tr>
<tr>
<td>J0256</td>
<td>Injection, Alpha 1 - Proteinase Inhibitor - Human, 10 Mg</td>
<td>01/01/2003</td>
<td>12/31/2003</td>
</tr>
<tr>
<td>J1785</td>
<td>Injection, Imiglucerase, Per Unit</td>
<td>01/01/2003</td>
<td>12/31/2003</td>
</tr>
<tr>
<td>J9300</td>
<td>Gemtuzumab Ozogamicin, 5mg</td>
<td>01/01/2003</td>
<td>12/31/2003</td>
</tr>
<tr>
<td>V2785</td>
<td>Processing, Preserving and Transporting Corneal Tissue</td>
<td>04/01/2010</td>
<td></td>
</tr>
</tbody>
</table>
## Payment Status L - Influenza Vaccine; Pneumococcal Pneumonia Vaccine:

### Table 6-2: Payment Status L

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Code Description</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90630</td>
<td>Influenza Virus Vaccine, Quadrivalent (IIV4), Split Virus, Preservative Free, for Intradermal Use</td>
<td>01/01/2015</td>
<td></td>
</tr>
<tr>
<td>90653</td>
<td>Influenza Vaccine, Inactivated (IIV), Subunit, Adjuvanted, for Intramuscular Use</td>
<td>10/01/2015</td>
<td></td>
</tr>
<tr>
<td>90654</td>
<td>Flu Vaccine No Preserv ID</td>
<td>04/01/2011</td>
<td></td>
</tr>
<tr>
<td>90655</td>
<td>Influenza Virus Vaccine, Split Virus, Preservative Free, When Administered to Children 6-35 Months of Age, for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90656</td>
<td>Influenza Virus Vaccine, Split Virus, Preservative Free, for Use in Individuals 3 Years and Above, for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90657</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Children 6-35 Months of Age, for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90658</td>
<td>Influenza Virus Vaccine, Split Virus, for Use in Individuals 3 Years of Age and Above, for Intramuscular Use</td>
<td>04/01/2010</td>
<td>12/31/2010</td>
</tr>
<tr>
<td>90659</td>
<td>Influenza Virus Vaccine, Whole Virus, for Intramuscular or Jet Injection Use</td>
<td>01/01/2003</td>
<td>03/31/2004</td>
</tr>
<tr>
<td>90660</td>
<td>Influenza Virus Vaccine, Live, for Intranasal Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90661</td>
<td>Influenza Virus Vaccine, Derived From Cell Cultures, Subunit, Preservative and Antibiotic Free, for Intramuscular Use</td>
<td>10/01/2012</td>
<td></td>
</tr>
<tr>
<td>90662</td>
<td>Influenza Virus Vaccine, Split Virus, Preservative Free, Enhanced Immunogenicity Via Increased Antigen Content, for Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90669</td>
<td>Pneumococcal Conjugate Vaccine, 7 Valant, for Intramuscular Use</td>
<td>04/01/2010</td>
<td>12/31/2015</td>
</tr>
<tr>
<td>90670</td>
<td>Pneumococcal Vacc, 13 Val Im</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90672</td>
<td>Flu Vaccine 4 Valent Nasal</td>
<td>01/01/2013</td>
<td></td>
</tr>
<tr>
<td>90673</td>
<td>Influenza Virus Vaccine, Trivalent, Derived From Recombinant DNA (RIV3), Hemagglutinin (HA) Protein Only, Preservative and Antibiotic Free, for Intramuscular Use</td>
<td>01/01/2014</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Code Description</td>
<td>Start Date</td>
<td>End Date</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>90674</td>
<td>Influenza Virus Vaccine, Quadrivalent (cciIV4), Derived From Cell Cultures, Subunit, Preservative and Antibiotic Free, 0.5 ML Dosage, for Intramuscular Use</td>
<td>07/01/2016</td>
<td></td>
</tr>
<tr>
<td>90682</td>
<td>Influenza Virus Vaccine, Quadrivalent (RIV4), Derived From Recombinant DNA, Hemagglutinin (HA) Protein Only, Preservative and Antibiotic Free, For Intramuscular Use</td>
<td>01/01/2017</td>
<td></td>
</tr>
<tr>
<td>90685</td>
<td>Flu Vac No Prsv 4 Val 6-35 M</td>
<td>01/01/2013</td>
<td></td>
</tr>
<tr>
<td>90686</td>
<td>Influenza Virus Vaccine, Quadrivalent, Split Virus, Preservative Free, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use</td>
<td>01/01/2013</td>
<td></td>
</tr>
<tr>
<td>90687</td>
<td>Influenza Virus Vaccine, Quadrivalent, Split Virus, When Administered to Children 6-35 Months of Age, for Intramuscular Use</td>
<td>07/01/2014</td>
<td></td>
</tr>
<tr>
<td>90688</td>
<td>Influenza Virus Vaccine, Quadrivalent, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use</td>
<td>01/01/2013</td>
<td></td>
</tr>
<tr>
<td>90689</td>
<td>Vacc IIV4 No Prsrv 0.25ml im</td>
<td>01/01/2019</td>
<td></td>
</tr>
<tr>
<td>90694</td>
<td>Influenza Virus Vaccine, Quadrivalent (AlIV4), Inactivated, Adjuvanted, Preservative Free, 0.5 ml Dosage, for Intramuscular Use</td>
<td>07/01/2020</td>
<td></td>
</tr>
<tr>
<td>90732</td>
<td>Pneumococcal Polysaccharide Vaccine, 23-valent, Adult or Immunosuppressed Patient Dosage, When Administered to 2 Years or Older, for Subcutaneous or Intramuscular Use</td>
<td>04/01/2010</td>
<td></td>
</tr>
<tr>
<td>90756</td>
<td>Influenza Virus Vaccine Quadrivalent (cciIV4) Derived From Cell Cultures, Subunit, Antibiotic Free, 0.5mL Dosage, for Intramuscular Use</td>
<td>10/01/2017</td>
<td></td>
</tr>
<tr>
<td>G0008</td>
<td>Administration of Influenza Virus Vaccine</td>
<td>01/01/2003</td>
<td>12/31/2005</td>
</tr>
<tr>
<td>G0009</td>
<td>Administration of Pneumococcal Vaccine</td>
<td>01/01/2003</td>
<td>12/31/2005</td>
</tr>
<tr>
<td>Q2033</td>
<td>Influenza Vaccine, Recombinant Hemagglutinin Antigens, for Intramuscular Use (Flublok)</td>
<td>07/01/2013</td>
<td>12/31/2013</td>
</tr>
<tr>
<td>Q2034</td>
<td>Influenza Virus Vaccine, Split Virus, for Intramuscular Use (Agriflu)</td>
<td>07/01/2012</td>
<td></td>
</tr>
<tr>
<td>Q2035</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Afluria)</td>
<td>10/01/2010</td>
<td></td>
</tr>
</tbody>
</table>
The APC-HOPD Pricer offers the following pricing options for Payment Status F and L services:

- **Option 1: Pay Based on a User-Specified Percent of Submitted Charge:**

  Using this option, you can reimburse these services based on the submitted charges times a user-supplied Reasonable Cost Factor, which can be any decimal number between 0.0001 and 9.9999. To reimburse based on submitted charges, set this factor to 1.0000. The Reasonable Cost Factor can be set up using Rate Manager. If you do not use Rate Manager, the Reasonable Cost Factor can be specified in the Hospital Rate Calculator File. The location and format of this field is specified in the EASYGroup™ Technical Reference Guide.

  This will be the default pricing rule for Payment Status F and L services. If no fee schedule rates are set up, the reimbursement will be calculated as the Reasonable Cost Factor times the submitted charges. If the Reasonable Cost Factor is blank or zero, the reimbursement will be based on submitted charges.

  **If you use the Outpatient National Medicare Provider Rate Files (ONMPRF):** For services dated on or after January 1, 2005, the Reasonable Cost Factor for all facilities will be set to the hospital outpatient Ratio of Costs-to-Charges (RCCs).

- **Option 2: Pay Some or All Services Based on a User-Specified Fee Schedule Rate:**

  To pay some or all F and L services based on a user-specified fee schedule amount, please use the following procedure:

  1. Load the standard Fee Schedule Data Files into Rate Manager. These files are available from the Rate Manager OPPS update or the EASYGroup™ Fee Schedule Data Files. For C clients, these files are Q2036 Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluvirin) 10/01/2010

  Q2037 Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluzone) 10/01/2010

  Q2038 Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluzone) 10/01/2010

  Q2039 Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Not Otherwise Specified) 10/01/2010

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Code Description</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2036</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Flulaval)</td>
<td>10/01/2010</td>
<td></td>
</tr>
<tr>
<td>Q2037</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluvirin)</td>
<td>10/01/2010</td>
<td></td>
</tr>
<tr>
<td>Q2038</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluzone)</td>
<td>10/01/2010</td>
<td></td>
</tr>
<tr>
<td>Q2039</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Not Otherwise Specified)</td>
<td>10/01/2010</td>
<td></td>
</tr>
</tbody>
</table>
called fee yyyy.dat, where yyyy represents the calendar year. For COBOL clients, these files are called fsr01yy, where yy represents the 2-digit calendar year.

2. Identify the services for which you wish to set up fee schedule rates. Any services that are not selected for fee schedule pricing will be priced based on submitted charges times the Reasonable Cost Factor (option #1, above).

3. Identify the payment rates for each applicable effective date and service, identified by the appropriate procedure code.

4. Determine whether the fee schedule rates will be standard for all hospitals, or specific for certain facilities or groups of facilities.
   a. If the rates should be standard for all hospitals, the codes can be added to the National carrier with a type of N.
   b. If the codes are not standard across all hospitals, create an appropriate carrier code for each hospital or hospital group with a type of X.

5. Prepare a file to be used with the Rate Manager Fee Schedule Import utility. Please refer to the Rate Manager User's Guide for further information.

6.1.1.2 Not Supported
The APC-HOPD Pricer does not support pricing of Critical Access Method II claims.

6.1.2 Contract Ambulatory Payment Classification (APC) Pricer or APC Pro
The Contract APC Pricer is designed for the commercial/managed care marketplace. It calculates expected reimbursement for services provided in hospital outpatient departments. Pricing is at a line-item level and includes a variety of options.

6.1.2.1 Features Supported
• Lines Assigned to APCs
Price using either an APC-specific rate or a user-supplied base conversion factor times an APC-specific weight.
  • Lines Assigned to HCPCS Codes, but no APC
Price according to a fee schedule (Medicare or user-supplied), a percentage of charges, or do not pay.
  • Lines Without HCPCS Codes
Price using Medicare rules, a percentage of charges, or do not pay.
The Contract APC Pricer also allows the user to adjust for local wage difference, discount surgical procedures, specify payment rules for packaged
items, and limit total payment to a percentage of total claim charges. Co-payment outlier payment and mark-up/discount options are also available.

6.1.3 New Mexico Medicaid Ambulatory Payment Classification (APC) Pricer

The New Mexico Medicaid APC Pricer calculates expected reimbursement for eligible outpatient services based on the New Mexico Medicaid Outpatient Fee Schedule, Payment Status Indicators, and certain 340B drugs. The Payment Status Indicators are assigned based off the New Mexico Medicaid Outpatient Fee Schedule and may vary from Payment Status Indicators assigned by Medicare. Claim lines are required to be billed with the appropriate procedure code and are reimbursed a fee schedule rate based on the procedure code and number of units. For further information please refer to Appendix B.

6.1.3.1 Features Supported

The New Mexico Medicaid APC Pricer performs the following functions:

- Calculates Patient-Specific Reimbursement Using the Appropriate Pricing Rules
- Returns Payment Status Indicators Indicating Payment Rule, Procedure Discount, and Other Adjustments

6.1.4 Ambulatory Surgical Center (ASC) Pricer

The ASC Pricer calculates expected reimbursement for eligible services provided in free-standing Ambulatory Surgical Centers (ASCs) according to Medicare rules. Pricing is based on ASC-specific rates with adjustments for local wage variations. Discounting is included for multiple procedures in some cases. Also included in the ASC Pricer is an option to calculate fee schedule pricing via one of the following categories of free-standing services:

- Surgical procedures
- Office and non-office based procedures
- Brachytherapy sources
- Device-intensive procedures
- OPPS pass-through devices
- Classified and unclassified drugs and biologicals
- New technology intraocular lenses
- Packaged services and items
- Radiology services

Although the fee schedule pricing is set-up to adhere to Medicare’s fee schedule pricing rules, it can be modified by the user to accommodate fee schedules and payment rates for non-Medicare payers or contracts.

6.1.4.1 Features Supported
The ASC Pricer performs the following functions:

- Calculates Patient-Specific Reimbursements Using the Appropriate Pricing Rules
- Returns Payment Status Indicators for Each Indicating Payment Rule, Procedure Discount, and Other Adjustments
- Estimates Patient Co-Payment

**Note**
Refer to Pricing Items Without a Rate below for additional ASC Pricer functionality.

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6.1.5 Contract Ambulatory Surgical Center (ASC) Pricer or ASC Pro

The Contract ASC Pricer is designed for the commercial/managed care marketplace. The Contract ASC Pricer calculates expected reimbursement for eligible services provided in free-standing Ambulatory Surgical Centers (ASCs) based upon Medicare rules. Pricing is based on ASC-specific rates with adjustments for local wage variations. Discounting is included for multiple procedures in some cases. Also included in the Contract ASC Pricer is an option to calculate fee schedule pricing via one of the following categories of free-standing services:

- Surgical procedures
- Office and non-office based procedures
- Brachytherapy sources
- Device-intensive procedures
- OPPS pass-through devices
- Classified and unclassified drugs and biologicals
- New technology intraocular lenses
- Packaged services and items
- Radiology services

Although the fee schedule pricing is set-up to adhere to Medicare’s fee schedule pricing rules, it can be modified by the user to accommodate fee schedules and payment rates for non-Medicare payers or contracts.

**6.1.5.1 Features Supported**
The Contract ASC Pricer performs the following functions:

- Calculates Patient-Specific Reimbursements Using the Appropriate Pricing Rules
- Returns Payment Status Indicators for Each Indicating Payment Rule, Procedure Discount, and Other Adjustments
- Estimates Patient Co-Payment
- Customize and Reimburse Using Additional Payment Status Indicators

The Contract ASC Pricer allows the user to customize and reimburse services using three additional Payment Status Indicators; AX, AZ, and EX. Payment Status Indicator AX will allow the user to pay the assigned service at the fee schedule rate with the option for wage adjustment. Payment Status Indicator AZ will allow the user to pay the assigned service at the fee schedule rate without wage adjustment. Payment Status Indicator EX will allow the user to deny the assigned service for pricing on that visit. Additionally, the Contract ASC Pricer will allow for customization of mark-up/discount by Payment Status Indicator. Co-payment options are also available.

- Pricing Items Without a Rate

Under the Medicare ASC Payment System and the ASC Pro Payment System, ancillary services categorized under “Unclassified Drugs and Biologicals” (Payment Status Indicator K7) are paid at contracted rates and are entered into the Fee Schedule Data Files with a rate of $0.00. Additionally, services that CMS designates as “OPPS Pass-Through Device” (Payment Status Indicator J7) may also not have a rate available, but still be listed as covered by Medicare for this care setting. Finally, commercial users may elect to add services to the fee schedule. The ASC and Contract ASC Pricers offer the pricing options listed below for Payment Status Indicator K7 and J7 services that may not have a rate in the fee schedule. The ASC Pricers do not allow pricing of YY items not reimbursed under both ASC Prospective Payment Systems.

  - Option 1: Pay Based on a User-Specified Percent of Submitted Charge

Using this option, you can reimburse these services based on submitted charges times a user-specified payment percentage, which can be any decimal number between 0.0001 and 9.9999. To reimburse based on submitted charges, set this factor to 1.0000. The payment percentage flag must also be turned on for this type of pricing to occur. These fields (Payment Percentage Rate and Payment Percentage Rate Flag) can be set up using Rate Manager. If you do not use Rate Manager, the fields can be specified in the Hospital Rate Calculator Files. The location and format of these fields are specified in the EASYGroup™ Technical Reference Guide.

This will be the default pricing rule for Payment Status Indicator K7 and J7 services when the corresponding fee schedule rate is set to $0.00 and the Payment Percentage Rate Flag is turned on (i.e., set to 1).

If you use the Ambulatory Surgical Center National Medicare Provider Rate Files (ANMPRF): For services dated on or after January 01, 2008, the Payment Percentage Rate Flag will be turned on (i.e., set to 1), and the Payment Percentage Rate will be set to 1.0000.

  - Option 2: Pay Some or All Services Based on a User-Specified Fee Schedule Rate
To pay some or all Payment Status Indicator K7 and J7 services based on a user-specified fee schedule amount, please use the following procedure:

1. Load the standard fee schedule data files into your Rate Manager. These files are available from Rate Manager or the EASYGroup™ Fee Schedule Data Files. For C clients these files are called: fsascyy.dat or feeascyy.dat, where yy represents the calendar year. For COBOL clients these files are called: fsr01.dat/fst01.dat or fsr02yy.dat, where yy represents the calendar year.

2. Identify the services for which you wish to set up fee schedule rates. Choose from the list of HCPCS codes currently assigned to Payment Status Indicator K7 and J7. Any services that are set to a rate of $0.00 in the fee schedule will be priced based on submitted charges times the payment percentage rate when the Payment Percentage Rate Flag is turned on (option #1, above). No payment will be made if the services are not in the fee schedule.

3. Identify the payment rates for each applicable effective date and service, identified by the appropriate HCPCS code.

4. Determine whether the fee schedule rates will be standard for all hospitals, or specific for certain facilities or groups of facilities.
   a. If the rates should be standard for all hospitals, the codes can be added to the National carrier with a fee type of S.
   b. If the codes are not standard across all hospitals, create an appropriate carrier code for each hospital or hospital group with a fee type of X.

5. Prepare a file to be used with the Rate Manager Fee Schedule Import utility. Please refer to the Rate Manager User’s Guide for further information.

6.1.6 Ambulatory Patient Group (APG) Pricer (C Only)

The APG Pricer is used to calculate hospital-specific APG base rates and visit-specific patient reimbursements. For individual patients, the APG Pricer calculates anticipated base or inlier payments and cost outlier add-ons, when applicable. Packaging and discounting rules are applied, as appropriate.

There are several types of APG Pricers:

- State-Specific Medicaid Pricers
- Medicaid APG Pro Pricer

6.1.6.1 Features Supported

The APG Pricer performs the following functions:

- Calculates hospital-specific APG base rates or conversion factors.
- Calculates patient-specific reimbursements using the appropriate APG pricing rules.
• Returns APG-specific payments, packaging flags, consolidation flags, and discount factors.
• Identifies cost outliers (when applicable) and prices accordingly.

6.1.6.2 APG Pricer Types
Please refer to the APG Pricer Functionality section in Appendix B for a complete listing of the APG Pricer types.

6.1.7 Diagnosis Related Group (DRG) Pricer
The DRG Pricer is used to calculate patient-specific inpatient reimbursements (including inlier, outlier, and transfer payments) by DRG or compatible case-mix measure. There are several types of DRG Pricers:
• State-Specific Medicaid Pricers
• State-Specific Medicaid APR Pricers
• Medicaid APR Pro Pricer
• Medicare DRG Pricer
• TRICARE Pricer
• Inpatient Psychiatric Facility (IPF) Pricer
• Long Term Care (LTC) Pricer
• Contract Multi-Pricer

Note
Please refer to Appendix B for further details on the most of the above-listed Pricers.

6.1.7.1 Features Supported
The DRG Pricer performs the following functions:
• Calculates hospital-specific DRG base rates or conversion factors using rules specific to the pricing scheme you have licensed.
• Calculates patient-specific reimbursements using pre-defined pricing schemes.
• Identifies pricing outliers (e.g., short stay, long stay, and cost outliers), as applicable to the selected pricing scheme.
• Returns DRG-specific values (as applicable) to the selected pricing scheme (e.g., short stay outlier trim, long stay outlier trim, and mean length of stay). By comparing a patient’s length of stay to the trims, patients who have length of stay outliers or are approaching length of stay outlier status can be identified.
• The Medicare DRG Pricer supports Medicare’s Value Based Purchasing (VBP) Program, for qualifying hospitals with claims including discharges on or after October 01, 2012. For each qualifying FY 2013 discharge, the DRG payment will be reduced by 1.0 percent, and a hospital may earn
back a payment percentage that is less than, equal to, or more than the initial 1.0 percent. This VBP factor amount is based on whether or not hospitals meet or exceed performance standards, and each hospital’s value-based payment percentage will be based partly on a Total Performance Score (TPS). This hospital-specific VBP factor is applied to the claim’s base operating DRG, and will either increase or decrease total claim reimbursement.

- The Medicare DRG Pricer supports Medicare’s Hospital Readmissions Reduction Program for FY 2013, effective October 01, 2012. Under this program, certain inpatient hospitals will receive a reduction to their base operating DRG payment amount based on measured excess readmissions. This reduction is equivalent to the base operating DRG payment amount multiplied by the Readmissions Payment Adjustment Factor (RPAF).

### 6.1.7.2 DRG Pricer Types

The following table provides a list of all the DRG Pricer/Payer types:

<table>
<thead>
<tr>
<th>DRG Pricer</th>
<th>Pricer/Payer Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Medicaid Reimbursement Calculations</td>
<td>34</td>
</tr>
<tr>
<td>California Medicaid Reimbursement Calculations</td>
<td>31</td>
</tr>
<tr>
<td>Contract Multi-Pricer Reimbursement Calculations</td>
<td>S</td>
</tr>
<tr>
<td>Florida Medicaid Reimbursement Calculations</td>
<td>30</td>
</tr>
<tr>
<td>Georgia Medicaid Reimbursement Calculations</td>
<td>20</td>
</tr>
<tr>
<td>Illinois Medicaid APR Reimbursement Calculations</td>
<td>29</td>
</tr>
<tr>
<td>Illinois Medicaid Reimbursement Calculations</td>
<td>J</td>
</tr>
<tr>
<td>Indiana Medicaid Reimbursement Calculations</td>
<td>r</td>
</tr>
<tr>
<td>Iowa Medicaid Reimbursement Calculations</td>
<td>43</td>
</tr>
<tr>
<td>Kansas Medicaid Reimbursement Calculations</td>
<td>32</td>
</tr>
<tr>
<td>Kentucky Medicaid APR Reimbursement Calculations</td>
<td>35</td>
</tr>
<tr>
<td>Kentucky Medicaid Reimbursement Calculations</td>
<td>24</td>
</tr>
<tr>
<td>Medicaid APR Pro Reimbursement Calculations</td>
<td>42</td>
</tr>
<tr>
<td>Medicare Inpatient Psychiatric Reimbursement Calculations</td>
<td>19</td>
</tr>
<tr>
<td>Medicare Long Term Care Reimbursement Calculations</td>
<td>v</td>
</tr>
<tr>
<td>Medicare Reimbursement Calculations</td>
<td>A</td>
</tr>
<tr>
<td>Michigan Medicaid Reimbursement Calculations</td>
<td>q</td>
</tr>
<tr>
<td>Nebraska Medicaid APR Reimbursement Calculations</td>
<td>28</td>
</tr>
<tr>
<td>Nebraska Medicaid Reimbursement Calculations</td>
<td>21</td>
</tr>
<tr>
<td>New Jersey Medicaid Reimbursement Calculations</td>
<td>H</td>
</tr>
<tr>
<td>New Mexico Medicaid Reimbursement Calculations</td>
<td>23</td>
</tr>
<tr>
<td>New York Legacy Reimbursement Calculations</td>
<td>F</td>
</tr>
<tr>
<td>New York Medicaid APR Reimbursement Calculations</td>
<td>25</td>
</tr>
</tbody>
</table>
6.1.8 End Stage Renal Disease (ESRD) Pricer

The ESRD Pricer processes claims reimbursement for independent and hospital-based Renal Dialysis Facilities (RDFs). The ESRD Pricer calculates expected Method I reimbursement for eligible kidney dialysis services provided in independent and hospital-based RDFs according to Medicare rules, effective January 01, 2008.

Dialysis pricing is based on patient case-mix, including height, weight, and age; and facility-specific rates with adjustments for local wage variations. Also, included in the ESRD Pricer is an option to calculate fee schedule pricing for certain clinical laboratory services, Durable Medical Equipment (DME) services, physician services, drugs and biologicals, vaccines, and supplies that fall under the umbrella of Medicare ESRD reimbursement. Although the fee schedule pricing is set up to adhere to Medicare’s fee schedule pricing rules, it can be modified by the user to accommodate fee schedules and payment rates for non-Medicare payers or contracts.
6.1.8.1 Bundled ESRD Prospective Payment System (PPS)
The ESRD Pricer reimburses based on Medicare's ESRD Prospective Payment System (PPS), effective January 01, 2011. Additional factors will be considered for the dialysis adjustment including comorbidities, onset of dialysis, training, and low volume facilities. Medicare Part B services and supplies that were formerly separately payable are now bundled into the dialysis payment. These services, and select Part D oral drugs, can create a cost outlier payment when they exceed the predicted per treatment Medicare Allowable Payment (MAP) amount for outlier services, plus the fixed dollar loss amount. Finally, the ESRD Pricer has support for the four year phase-in of the bundled ESRD PPS methodology (which ended effective January 01, 2014), along with services specifically billed with Modifier AY (Item or Service Furnished to an ESRD Patient That is Not for the Treatment of ESRD) to indicate that the treatment is not connected to ESRD.

Note
The ESRD Pricer is intended to price ESRD claims for January 01, 2008 and forward only.

6.1.8.2 Features Supported
The ESRD Pricer performs the following functions:

- Calculates Patient-Specific Reimbursements Using the Appropriate ESRD Pricing Rules
- Estimates Patient Co-Payment
- Pricing for Reasonable Cost Items

Under Medicare’s ESRD composite payment system, most dialysis services are paid based on the composite rate, based on Medicare’s clinical laboratory, Durable Medical Equipment (DME) or physician fee schedule, or based on the Medicare Part B Average Sales Price (ASP) drug pricing file.

Effective January 01, 2011, Medicare migrated to the bundled ESRD Prospective Payment System (PPS). Most dialysis services are reimbursed as part of a bundled payment. Exceptions have been made for the services listed below. For hospital-based renal dialysis facilities, these services are paid based on reasonable hospital cost. For independent renal facilities, vaccines in the list below are paid at the lesser of charge or the fee schedule rate (95% Average Wholesale Price (AWP)), vaccine-administration procedures are paid the fee schedule rate, and blood-related procedures are paid based on charges.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90630</td>
<td>Influenza Virus Vaccine, Quadrivalent (IIV4), Split Virus, Preservative Free, for Intradermal Use</td>
</tr>
<tr>
<td>90653</td>
<td>Influenza Virus Vaccine, Inactivated, Subunit, Adjuvanted, for Intramuscular Use</td>
</tr>
</tbody>
</table>
Table 6-4: ESRD Services Paid Based on Reasonable Cost

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90654</td>
<td>Flu Vaccine, Intradermal, No Preserv</td>
</tr>
<tr>
<td>90656</td>
<td>Flu Vaccine, No Preserv 3</td>
</tr>
<tr>
<td>90657</td>
<td>Flu Vaccine, 3 Yrs, IM</td>
</tr>
<tr>
<td>90660</td>
<td>Flu Vaccine, Nasal</td>
</tr>
<tr>
<td>90661</td>
<td>Influenza Virus Vaccine, Derived From Cell Cultures, Subunit, Preservative and Antibiotic Free, for Intramuscular Use</td>
</tr>
<tr>
<td>90662</td>
<td>Flu Vaccine, Split Virus, No Preserv, Enhanced Immunogenicity, IM</td>
</tr>
<tr>
<td>90669</td>
<td>Pneumococcal Vacc, Ped &lt;5</td>
</tr>
<tr>
<td>90670</td>
<td>Pneumococcal Conjugate Vaccine, 13 Valent, IM</td>
</tr>
<tr>
<td>90672</td>
<td>Influenza Virus Vaccine, Live, Quadrivalent, for Intranasal Use</td>
</tr>
<tr>
<td>90673</td>
<td>Influenza Virus Vaccine, Trivalent, Derived From Recombinant DNA (RIV3), Hemagglutinin (HA) Protein Only, Preservative and Antibiotic Free, for Intramuscular Use</td>
</tr>
<tr>
<td>90674</td>
<td>Influenza Virus Vaccine, Quadrivalent (CClIV4), Derived From Cell Cultures, Subunit, Preservative and Antibiotic Free, 0.5 ml Dosage, for Intramuscular Use</td>
</tr>
<tr>
<td>90682</td>
<td>Influenza Virus Vaccine, Quadrivalent (RIV4), Derived From Recombinant DNA, Hemagglutinin (HA) Protein Only, Preservative and Antibiotic Free, for Intramuscular Use</td>
</tr>
<tr>
<td>90685</td>
<td>Flu Vac No Prsv 4 Val 6-35 M</td>
</tr>
<tr>
<td>90686</td>
<td>Influenza Virus Vaccine, Quadrivalent, Split Virus, Preservative Free, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use</td>
</tr>
<tr>
<td>90687</td>
<td>Influenza Virus Vaccine, Quadrivalent, Split Virus, When Administered to Children 6-35 Months of Age, for Intramuscular Use</td>
</tr>
<tr>
<td>90688</td>
<td>Influenza Virus Vaccine, Quadrivalent, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use</td>
</tr>
<tr>
<td>90689</td>
<td>Influenza Virus Vaccine Quadrivalent (IIIV4), Inactivated, Adjuvanted, Preservative Free, 0.25 ml Dosage, for Intramuscular Use</td>
</tr>
<tr>
<td>90694</td>
<td>Influenza Virus Vaccine, Quadrivalent (AIIV4), Inactivated, Adjuvanted, Preservative Free, 0.5 ml Dosage, for Intramuscular Use</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumococcal Poly Vaccine (PPV)</td>
</tr>
<tr>
<td>90739</td>
<td>Hepatitis B Vaccine, Adult Dosage (2 Dose Schedule), for Intramuscular Use</td>
</tr>
<tr>
<td>90740</td>
<td>Hepb Vacc, Ill Pat 3 Dose IM</td>
</tr>
</tbody>
</table>
Table 6-4: ESRD Services Paid Based on Reasonable Cost

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90743</td>
<td>Hepb Vacc, Adol, 2 Dose IM</td>
</tr>
<tr>
<td>90744</td>
<td>Hepb Vacc Ped/adol, 3 Dose IM</td>
</tr>
<tr>
<td>90746</td>
<td>Hepb Vaccine, Adult, IM</td>
</tr>
<tr>
<td>90747</td>
<td>Hepb Vacc, Ill Pat 4 Dose IM</td>
</tr>
<tr>
<td>90756</td>
<td>Influenza Virus Vaccine, Quadrivalent (CCIIV4), Derived From Cell Cultures, Subunit, Antibiotic Free, 0.5 ML Dosage, for Intramuscular Use</td>
</tr>
<tr>
<td>90655</td>
<td>Preservative Free Split Flu Vaccine Age 6-35 Months</td>
</tr>
<tr>
<td>A4750</td>
<td>Art/venous Blood Tubing</td>
</tr>
<tr>
<td>A4755</td>
<td>Comb Art &amp; Venous Tubing</td>
</tr>
<tr>
<td>G0008</td>
<td>Administration of Flu Virus Vaccine</td>
</tr>
<tr>
<td>G0009</td>
<td>Administration of Pneumococcal Vaccine</td>
</tr>
<tr>
<td>G0010</td>
<td>Administration of Hepatitis Vaccine</td>
</tr>
<tr>
<td>P9010</td>
<td>Whole Blood for Transfus</td>
</tr>
<tr>
<td>P9011</td>
<td>Blood Split Unit</td>
</tr>
<tr>
<td>P9012</td>
<td>Cryoprecipitate-EA Unit</td>
</tr>
<tr>
<td>P9016</td>
<td>RBC Leukocyte Reduced</td>
</tr>
<tr>
<td>P9017</td>
<td>Fresh Frozen Plasma-ea</td>
</tr>
<tr>
<td>P9019</td>
<td>Platelets, Each Unit</td>
</tr>
<tr>
<td>P9020</td>
<td>Platelet Rich Plasma, Each Unit</td>
</tr>
<tr>
<td>P9021</td>
<td>Red Blood Cells Unit</td>
</tr>
<tr>
<td>P9022</td>
<td>Washed Red Blood Cells</td>
</tr>
<tr>
<td>P9023</td>
<td>Plasma, Pooled Multiple Donor/Solvent/Detergent Treated, Frozen, Each Unit</td>
</tr>
<tr>
<td>P9031</td>
<td>Platelets, Leukocytes Reduced, Each Unit</td>
</tr>
<tr>
<td>P9032</td>
<td>Platelets, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9033</td>
<td>Platelets, Leukocytes Reduced, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9034</td>
<td>Platelets, Pheresis, Each Unit</td>
</tr>
<tr>
<td>P9035</td>
<td>Platelets, Pheresis, Leukocytes Reduced, Each Unit</td>
</tr>
<tr>
<td>P9036</td>
<td>Platelets, Pheresis, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9037</td>
<td>Platelets, Pheresis, Leukocytes Reduced, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9038</td>
<td>RBC, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9039</td>
<td>RBC, Deglycerolized, Each Unit</td>
</tr>
<tr>
<td>P9040</td>
<td>RBC, Leukocytes Reduced, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9044</td>
<td>Plasma, Cryoprecipitate Reduced, Each Unit</td>
</tr>
<tr>
<td>P9050</td>
<td>Granulocytes, Pheresis, Each Unit</td>
</tr>
<tr>
<td>P9051</td>
<td>Whole Blood or RBC, Leukocytes Reduced, CMV-Negative, Each Unit</td>
</tr>
</tbody>
</table>
Pricing Items Without a Rate (C Platform Only)

Under the ESRD composite payment system, separately payable miscellaneous or uncategorized services are entered into the ESRD Fee Schedule Data Files with a rate of $0.00.

Under the ESRD bundled prospective payment system, most of these separately payable items are bundled with the dialysis payment. However, select items can appear in the ESRD Fee Schedule Data Files with a rate of $0.00.

Table 6-4: ESRD Services Paid Based on Reasonable Cost

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9052</td>
<td>Platelets, HLA-Matched Leukocytes Reduced, Apheresis/pheresis, Each Unit</td>
</tr>
<tr>
<td>P9053</td>
<td>Platelets, Pheresis, Leukocytes Reduced, CMV-negative, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9054</td>
<td>Whole Blood or RBC, Leukocytes Reduced, Frozen, Deglycerol, Washed, Each Unit</td>
</tr>
<tr>
<td>P9055</td>
<td>Platelets, Leukocytes Reduced, CMV-negative, Apheresis/pheresis, Each Unit</td>
</tr>
<tr>
<td>P9056</td>
<td>Whole Blood, Leukocytes Reduced, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9057</td>
<td>RBC, Frozen/deglycerolized/washed, Leukocytes Reduced, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9058</td>
<td>RBC, Leukocytes Reduced CMV-negative, Irradiated, Each Unit</td>
</tr>
<tr>
<td>P9059</td>
<td>Fresh Frozen Plasma Between 8-24 Hour of Collection, Each Unit</td>
</tr>
<tr>
<td>P9060</td>
<td>Fresh Frozen Plasma, Donor Retested, Each Unit</td>
</tr>
<tr>
<td>Q2034</td>
<td>Influenza Virus Vaccine, Split Virus, for Intramuscular Use (Agriflu)</td>
</tr>
<tr>
<td>Q2035</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Afluria)</td>
</tr>
<tr>
<td>Q2036</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Flulaval)</td>
</tr>
<tr>
<td>Q2037</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluvirin)</td>
</tr>
<tr>
<td>Q2038</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluzone)</td>
</tr>
<tr>
<td>Q2039</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Not Otherwise Specified)</td>
</tr>
</tbody>
</table>
For admissions on or after January 01, 2011, the ESRD Pricer will reimburse select ESRD services that are not administered to the patient for treatment of ESRD. Modifier AY has been established to indicate that the service was not performed for ESRD treatment. Eligible services include laboratory services, drugs and biologicals, and certain supplies, and will be paid outside of the bundled PPS base rate when billed with Modifier AY.

- Option 1: Pay Based on a User-Specified Percent of Submitted Charge

Using Option 1, payment for miscellaneous or uncategorized services can be calculated by multiplying the submitted charges by a user-specified payment percentage that can be defined as any decimal number between 0.0001 and 9.9999. To reimburse based on submitted charges, set this factor to 1.0000. The payment percentage rate flag must be turned on for this type of pricing to occur. These fields (Payment Percentage Rate and Payment Percentage Rate Flag) can be set up using Rate Manager. If you do not use Rate Manager, these fields can be set in the Hospital Rate Calculator File. The location and format of these fields are specified in the EASYGroup™ Technical Reference Guide.

Option 1 will be the default pricing rule for these services when the corresponding fee schedule rate is set to $0.00 and the Payment Percentage Rate Flag is turned on (i.e., set to 1).

If you use the ESRD NMPRF: For ESRD facilities that were in service on or after January 01, 2008, the Payment Percentage Rate Flag will be turned off (i.e., set to 0), and the Payment Percentage Rate will be set to 0.0000.

- Option 2: Pay Some or All Services Based on a User-Specified Fee Schedule Rate

To pay some or all separately payable miscellaneous or uncategorized services based on a user-specified fee schedule amount, please use the following procedure:

1. Load the standard fee schedule data files into Rate Manager. These files are available from Rate Manager or the ESRD Fee Schedule Data Files release. Rates for all drugs and for all other procedure codes are in the Fee Schedule Data Files (fsesrdvv.dat). In these file names, vv represents the calendar year.

2. Identify the services for which you wish to set up fee schedule rates. Any services that are set to a rate of $0.00 in the fee schedule will be priced based on submitted charges multiplied by the Payment Percentage Rate when the Payment Percentage Rate Flag is turned on (refer to Option 1: Pay Based on a User-Specified Percent of Submitted Charge above). No payment will be made if the services are not in the fee schedule.

3. Identify the payment rates for each applicable effective date and service for each of the previously identified procedure codes.
4. Determine whether the fee schedule rates will be standard for all ESRD facilities, or specific for certain facilities or groups of facilities.
   a. If the rates should be standard for all ESRD facilities, the codes can be added to the National carrier with a type of N.
   b. If the codes are not standard across all ESRD facilities, create an appropriate carrier code for each facility or facility group with a type of X.
5. Prepare a file to be used with the Rate Manager Fee Schedule Import utility. Please refer to the Rate Manager User’s Guide for further information.

• Organ Disease Panel Tests
AMCC procedure component codes must be billed separately and cannot be billed as panels. Claims that contain one or more organ disease panel tests will be rejected.

Table 6-5: List of Organ Disease Panel Tests

<table>
<thead>
<tr>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>80047</td>
</tr>
<tr>
<td>80048</td>
</tr>
<tr>
<td>80051</td>
</tr>
<tr>
<td>80053</td>
</tr>
<tr>
<td>80061</td>
</tr>
<tr>
<td>80069</td>
</tr>
<tr>
<td>80076</td>
</tr>
</tbody>
</table>

6.1.9 Federally Qualified Health Center (FQHC) Pricer
The Medicare FQHC Payment System typically involves a single per-diem payment for all covered services, for claims that meet all billing requirements. Additional payments or adjustments may be provided in certain circumstances.

The FQHC Pricer processes each claim line based on the payment codes in Table 6-6. Each payment code must be submitted with a qualifying visit/encounter. Every FQHC claim must contain at least one payment code and associated qualifying visit, to be paid as described below. If additional payment codes are submitted on the same date of service, an additional payment is made under two circumstances: a mental health visit and a medical visit on the same day, or two unrelated medical visits on the same day (if the second payment code represents a medical visit for an established patient and is submitted with distinct procedural modifiers (shown below in Table 6-7). This additional payment is not eligible for the IPPE/AWV adjustment. A FQHC claim can receive up to three payments per day; the initial per-diem payment, including any IPPE/AWV adjustment, plus the
additional payment for any eligible additional medical or mental health service. In all other circumstances, additional payment codes are not paid.

Table 6-6: FQHC Payment Codes

<table>
<thead>
<tr>
<th>Payment Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0466</td>
<td>FQHC Visit, New Patient</td>
</tr>
<tr>
<td>G0467</td>
<td>FQHC Visit, Established Patient</td>
</tr>
<tr>
<td>G0468</td>
<td>FQHC Visit, New Patient/initial Preventive Physical Exam or Annual Wellness Visit</td>
</tr>
<tr>
<td>G0469</td>
<td>FQHC Visit, Mental Health, New Patient</td>
</tr>
<tr>
<td>G0470</td>
<td>FQHC Visit, Mental Health, Established Patient</td>
</tr>
</tbody>
</table>

Table 6-7: Distinct Procedural Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>59</td>
<td>Distinct Procedural Service</td>
<td>October 01, 2014</td>
</tr>
<tr>
<td>XE</td>
<td>Separate Encounter, a Service That is Distinct Because it Occurred During a Separate Encounter</td>
<td>January 01, 2015</td>
</tr>
<tr>
<td>XP</td>
<td>Separate Practitioner, a Service That is Distinct Because it was Performed by a Different Practitioner</td>
<td>January 01, 2015</td>
</tr>
<tr>
<td>XS</td>
<td>Separate Structure, a Service That is Distinct Because it was Performed on a Separate Organ/Structure</td>
<td>January 01, 2015</td>
</tr>
<tr>
<td>XU</td>
<td>Unusual Non-Overlapping Service, the Use of a Service That is Distinct Because it Does Not Overlap Usual Components of the Main Service</td>
<td>January 01, 2015</td>
</tr>
</tbody>
</table>

6.1.9.1 Features Supported

• FQHC Base Payment

The base payment is calculated using a standardized, prospectively-set base payment rate multiplied by the facility-specific Geographic Adjustment Factor (GAF). The GAF values for each participating FQHC are based on the geographic location of the facility, and are published in the Final Rule tables. The FQHC base payment is calculated as follows:

\[
\text{FQHC Base Payment} = \text{Base Payment Rate} \times \text{GAF}
\]

• New Patient/Initial Preventive Physical Exam (IPPE)/Annual Wellness Visit (AWV) Adjustment

The IPPE/AWV adjustment factor only applies to claims that include a medical or mental health visit for a new patient (new to the facility, not new to the provider), an annual wellness visit, or an initial preventive physical
examination. The IPPE/AWV adjustment factor can only be applied once per day.

\[
FQHC \text{ Base Payment} = \text{Base Payment Rate} \times \text{GAF} \times \text{IPPE/AWV Adjustment Factor}
\]

- Charge Cap Adjustment

For each qualifying payment code (i.e., a code listed in Table 6-6 that meets the requirements above), total payment is capped at the submitted charges for all payment codes on the same day. Charges reported on claim lines that do not contain a payment code are not considered when applying the charge cap.

\[
FQHC \text{ Encounter/Visit Payment} = \text{the Lesser of the...}
\]

- FQHC Base Payment Rate

Or

- Billed Charges for All Payment Codes on the Same Day

- Medicare Payment and Co-Payment

The FQHC Pricer splits reimbursement into the Medicare reimbursement amount and the coinsurance amount (i.e., patient co-payment). In general, Medicare pays 80% and the patient pays 20% of each per-diem payment. However, patients pay no coinsurance for preventive services. Therefore, the split between the Medicare payment and the patient obligation varies as described in Table 6-8.

Table 6-8: Payment and Co-Payment

<table>
<thead>
<tr>
<th>Claim Contains Preventive Services</th>
<th>Calculation Number</th>
<th>Medicare Pays</th>
<th>Patient Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>No (claim contains no preventative services)</td>
<td>Calculation 1</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Yes (claim contains only preventative services)</td>
<td>Calculation 2</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Yes (preventive service charges are equal to or greater than the charges for the FQHC payment code)</td>
<td>Calculation 2</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Yes (preventative service charges are less than the charges for the FQHC payment code)</td>
<td>Calculation 3</td>
<td>80% (refer to below)</td>
<td>20% (refer to below)</td>
</tr>
</tbody>
</table>

The payment and co-payment are calculated as follows:

Table 6-9: Payment and Co-Payment Calculations

<table>
<thead>
<tr>
<th>Calculation Description</th>
<th>Calculation Equation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculation 1:</td>
<td>Payment (No Preventive Services) = FQHC Encounter/Visit Payment * 80%</td>
</tr>
<tr>
<td></td>
<td>Co-Payment = FQHC Encounter/Visit Payment * 20%</td>
</tr>
</tbody>
</table>
Per CMS Transmittal No. R252BP, the calculation used for determining the patient co-payment for services paid off the MPFS is calculated as the lesser of 20% of the submitted charges or the calculated line payment.

**Co-Payment:**

\[
20\% \times \text{Lesser of: Line Charges or (Fee Schedule Rate } \times \text{Units)}
\]

- **Telehealth Payment**

If a FQHC claim contains procedure code Q3014, *Telehealth originating site facility fee*, or G2025, *Payment for a Telehealth distant site service furnished by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) only*, billed with Revenue Code 078X (Telemedicine), the claim qualifies for telehealth payment. The telehealth payment is calculated by taking the originating site facility fee and multiplying by the total units. If the total charges are less than the originating site facility fee multiplied by the units, the telehealth payment is capped at charges.

\[
\text{Telehealth Payment = the Lesser of the...}
\]

- Fee Schedule Rate \times \text{Units}

Or

- **Billed Charges for the Telehealth Service**

The FQHC Pricer splits the Telehealth payment into the Medicare reimbursement amount and the coinsurance amount (i.e., patient co-payment). For the Telehealth originating site facility fee Medicare pays 80% and the patient pays 20%.

- **Chronic Care Management (CCM)/Behavioral Health Integration (BHI) Payment**

CCM services are care management and coordination services for Medicare beneficiaries having multiple (two or more) chronic conditions that are expected to last at least 12 months or until the death of the patient. BHI

### Table 6-9: Payment and Co-Payment Calculations

<table>
<thead>
<tr>
<th>Calculation Description</th>
<th>Calculation Equation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calculation 2:</strong> Claim contains only preventive services, or the charges for the preventive services equal or exceed the charges for the FQHC payment code</td>
<td>Medicare Payment = FQHC Encounter/Visit Payment</td>
</tr>
<tr>
<td></td>
<td>Co-Payment = $0.00</td>
</tr>
<tr>
<td><strong>Calculation 3:</strong> Charges for any preventative services are less than the charges for the FQHC payment code</td>
<td>Medicare Payment = (FQHC Encounter/Visit Payment - Preventive Service Charges) \times 80% + Preventive Service Charges</td>
</tr>
<tr>
<td></td>
<td>Co-Payment = (FQHC Encounter/Visit Payment - Preventive Service Charges) \times 20%</td>
</tr>
</tbody>
</table>
services are services for the treatment of patients with primary care and mental or behavioral health conditions. For claims prior to December 31, 2017, that contain procedure code 99490, *Chronic care management services, at least 20 minutes*, the payment for CCM services is based on the Medicare Physician Fee Schedule (MPFS) national average non-facility payment rate multiplied by units. For claims on or after January 01, 2017, that contain procedure code G0511, *General care management services, minimum of 20 minutes per calendar month*, the payment for CCM or BHI services is based on the MPFS national average non-facility payment rate multiplied by units. The payment for CCM or BHI services is calculated as follows:

**CCM or BHI Payment = Fee Schedule Rate * Units**

After the payment calculation, a 80/20 payment/co-payment split is applied. Medicare pays 80% of the calculated line payment and the patient is responsible for 20% of the submitted charges.

- **Collaborative Care Model (CoCM) Payment**

Payment is made for CoCM services when procedure code G0512, *Psychiatric collaborative care model (CoCM) services*, is billed alone or with other services. The payment for CoCM services is calculated as follows:

**CoCM Payment = Fee Schedule Rate * Units**

- **Communication Technology-Based Services Payment**

Payment will be made for communication technology-based services when procedure code G0071, *Virtual communication services*, is billed alone or with other payable services. Payment for communication technology-based services is calculated as follows:

**Communication Technology-Based Services Payment = Fee Schedule Rate * Units**

After the payment calculation, a 80/20 payment/co-payment split is applied. Medicare pays 80% of the calculated line payment and the patient is responsible for 20% of the lesser of the submitted charges or the calculated line payment.

- **Mark-up/Discount Factor**

The FQHC Pricer includes an option to increase or reduce the overall claim payment by a facility-defined factor (Mark-up/Discount Factor). If the Mark-up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-up/Discount Factor.

- **Sequestration Payment**

The *Budget Control Act of 2011* issued a mandatory reduction in Federal spending also known as sequestration. This payment adjustment was applied to all claims after determining coinsurance. The total Medicare payment was multiplied by the Sequester Factor.
• Total Reimbursement
The total reimbursement is calculated using the Medicare payment and the patient co-payment amounts calculated as described above. The total reimbursement is calculated as follows:

\[
\text{Total Reimbursement} = \text{Payment} + \text{Co-Payment}
\]

• Grandfathered Tribal (GFT) FQHCs
GFT FQHCs are paid the lesser of charges or a GFT FQHC base rate. This base rate will not be adjusted by the FQHC Geographic Adjustment Factors (GAFs) or be eligible for the special payment adjustments normally allowed for new patients, patients receiving an Initial Preventative Physical Exam (IPPE) or an Annual Wellness Visit (AWV). In addition, exceptions to the single per diem payment do not apply to these facilities, which means only one visit will be paid per day.

6.1.9.2 Not Currently Supported
The FQHC Pricer does not support the calculation of Medicare Advantage wrap-around payments.

6.1.10 Home Health Agency (HHA) Pricer (Prior to January 01, 2020)
The HHA Pricer reimburses based on the Medicare Home Health Agency Prospective Payment System (HHA PPS), which was mandated by the Balanced Budget Act (BBA) of 1997 and was first implemented on October 01, 2000. The unit of payment for this payment system is a national 60-day episode rate with applicable adjustments. The 60-day episode rate covers all nursing, therapy, home health aid, and medical social services, as well as routine and non-routine medical supplies. Osteoporosis drugs and vaccines are separately payable on a reasonable cost basis.
The HHA Pricer calculates reimbursement and patient co-payment for claims on or after January 01, 2009 with one of the following UB-04 Bill Types: 0322, 0327, 0329, 032Q, 0332, 0337, 0339, 033Q, or 034X. This includes the base episode reimbursement, Partial Episode Payment (PEP) adjustments, Low Utilization Payment (LUPA) adjustments, outlier payments for high-cost claims, and add-on payments for initial and only episode LUPAs. The HHA Pricer only provides reimbursement for patients that are under a home health plan of care. The HHA Pricer also provides fee schedule pricing as is required for non-Medicare payers or contracts.

Note
Effective October 01, 2013, UB-04 Bill Types 033X (where X = any value) have been discontinued.

6.1.10.1 Features Supported
The HHA Pricer performs the following functions:
• 60-Day Episode Payment
The 60-day episode payment is subject to case-mix and wage adjustments based on the patient’s clinical and functional condition, the patient’s service needs, and the site of visit. Patient condition and service needs are documented in the Outcome and Assessment Information Set (OASIS) data collection form. A nurse or therapist from the HHA must administer the OASIS form at the start of each 60-day episode. Data from the OASIS form is then used to assign each patient to a five-digit Health Insurance Prospective Payment System (HIPPS) code, and subsequently a four-digit Home Health Resource Group (HHRG). The first four digits of the assigned HIPPS code are equivalent to the HHRG. The fifth digit of the HIPPS code is an indicator of the amount of non-routine medical supplies that are provided during an episode. Each HHRG has a different weight associated with it, allowing Medicare to pay differently for each home health episode based on patient characteristics and service needs. Each non-routine medical supply indicator has an associated add-on payment amount. The higher the expected use of non-routine supplies, as determined by the OASIS form, the higher the non-routine supply add-on payment.

Under Medicare’s HHA PPS, most home health services are paid for by the wage and case-mix adjusted 60-day episode rate. Exceptions have been made for the below vaccine and osteoporosis drugs, which are paid on a reasonable cost basis.

Table 6-10: Home Health Services Paid Reasonable Cost

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90630</td>
<td>Influenza Virus Vaccine, Quadrivalent (IV4), Split Virus, Preservative Free, for Intradermal Use</td>
<td>August 01, 2015</td>
</tr>
<tr>
<td>90653</td>
<td>Influenza Vaccine, Inactivated, Subunit, Adjuvanted, for Intramuscular Use</td>
<td>November 22, 2013</td>
</tr>
<tr>
<td>90654</td>
<td>Flu Vaccine No Preserv ID</td>
<td>May 09, 2011</td>
</tr>
<tr>
<td>90658</td>
<td>Flu Vaccine Age 3 + Older</td>
<td>January 01, 2009 - December 31, 2010</td>
</tr>
<tr>
<td>90661</td>
<td>Influenza Virus Vaccine, Derived From Cell Cultures, Subunit, Preservative and Antibiotic Free, for Intramuscular Use</td>
<td>November 20, 2012</td>
</tr>
<tr>
<td>90662</td>
<td>Flu Vacc Prsv Free Inc A</td>
<td>October 01, 2010</td>
</tr>
<tr>
<td>90670</td>
<td>Pneumococcal Vacc, 13 VA</td>
<td>October 01, 2010</td>
</tr>
<tr>
<td>90672</td>
<td>Flu Vaccine 4 Valen Nasal</td>
<td>January 01, 2013</td>
</tr>
<tr>
<td>90673</td>
<td>Influenza Virus Vaccine, Trivalent, Derived From Recombinant DNA (RIV3), Hemagglutinin (HA) Protein Only, Preservative and Antibiotic Free, for Intramuscular Use</td>
<td>January 01, 2014</td>
</tr>
</tbody>
</table>
Table 6-10: Home Health Services Paid Reasonable Cost

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90674</td>
<td>Influenza Virus Vaccine, Quadrivalent (CCIV4), Derived From Cell Cultures, Subunit, Preservative and Antibiotic Free, 0.5 ML dosage, for Intramuscular Use</td>
<td>August 01, 2016</td>
</tr>
<tr>
<td>90682</td>
<td>Influenza Virus Vaccine, Quadrivalent (RIV4), Derived From Recombinant DNA, Hemagglutinin (HA) Protein Only, Preservative and Antibiotic Free, for Intramuscular Use</td>
<td>July 01, 2017</td>
</tr>
<tr>
<td>90685</td>
<td>Flu Vac No Prsv 4 Val 6-35 M</td>
<td>June 07, 2013</td>
</tr>
<tr>
<td>90686</td>
<td>Influenza Virus Vaccine, Quadrivalent, Split Virus, Preservative Free, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use</td>
<td>January 01, 2013</td>
</tr>
<tr>
<td>90687</td>
<td>Influenza Virus Vaccine, Quadrivalent, Split Virus, When Administered to Children 6-35 Months of Age, for Intramuscular Use</td>
<td>January 01, 2013</td>
</tr>
<tr>
<td>90688</td>
<td>Flu Vacc 4 Val 3 Yrs Plus IM</td>
<td>August 16, 2013</td>
</tr>
<tr>
<td>90655</td>
<td>Flu Vaccine No Preserv 6</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>90656</td>
<td>Flu Vaccine, No Preserv 3</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>90657</td>
<td>Flu Vaccine, 3 Yrs, IM</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>90660</td>
<td>Flu Vaccine, Nasal</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>90669</td>
<td>Pneumococcal Vacc, Ped &lt;5</td>
<td>January 01, 2009 - December 31, 2015</td>
</tr>
<tr>
<td>90694</td>
<td>Influenza Virus Vaccine, Quadrivalent (AllV4), Inactivated, Adjuvanted, Preservative Free, 0.5 ML dosage, for Intramuscular Use</td>
<td>August 05, 2020</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumococcal Vaccine</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>90739</td>
<td>Hepatitis B Vaccine (HEPB), Adult Dosage, 2 Dose Schedule, for Intramuscular Use</td>
<td>January 01, 2013</td>
</tr>
<tr>
<td>90740</td>
<td>Hepatitis B Vaccine (HEPB), Dialysis or Immunosuppressed Patient Dosage, 3 Dose Schedule, for Intramuscular Use</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>90743</td>
<td>Hepatitis B Vaccine (HEPB), Adolescent, 2 Dose Schedule, for Intramuscular Use</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>90744</td>
<td>Hepatitis B Vaccine (HEPB), Pediatric/Adolescent Dosage, 3 Dose Schedule, for Intramuscular Use</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>90746</td>
<td>Hepatitis B Vaccine (HEPB), Adult Dosage, 3 Dose Schedule, for Intramuscular Use</td>
<td>January 01, 2009</td>
</tr>
</tbody>
</table>
### Table 6-10: Home Health Services Paid Reasonable Cost

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90747</td>
<td>Hepatitis B Vaccine (HEPB), Dialysis or Immunosuppressed Patient Dosage, 4 Dose Schedule, for Intramuscular Use</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>90756</td>
<td>Influenza Virus Vaccine, Quadrivalent (CCIIV4))</td>
<td>January 01, 2018</td>
</tr>
<tr>
<td>J0630</td>
<td>Injection, Calcitonin Salmon, Up to 400 Units</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>J3110</td>
<td>Injection, Teriparatide, 10 Mcg</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>J3490</td>
<td>Unclassified Drugs</td>
<td>January 01, 2009</td>
</tr>
<tr>
<td>Q2033</td>
<td>Influenza Vaccine, Recombinant Himagglutinin Antigens, for Intramuscular Use (Flublok)</td>
<td>July 01, 2013 - December 31, 2013</td>
</tr>
<tr>
<td>Q2034</td>
<td>Influenza Virus Vaccine, Split Virus, for Intramuscular Use (Agriflu)</td>
<td>July 01, 2012</td>
</tr>
<tr>
<td>Q2035</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Afluria)</td>
<td>October 01, 2010</td>
</tr>
<tr>
<td>Q2036</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluvalal)</td>
<td>October 01, 2010</td>
</tr>
<tr>
<td>Q2037</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluvirin)</td>
<td>October 01, 2010</td>
</tr>
<tr>
<td>Q2038</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Fluzone)</td>
<td>October 01, 2010</td>
</tr>
<tr>
<td>Q2039</td>
<td>Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use (Not Otherwise Specified)</td>
<td>October 01, 2010</td>
</tr>
</tbody>
</table>

- **LUPA, PEP, Outlier Adjustments, RAP Claims, and the Value-Based Purchasing (VBP) Adjustment**

Payment adjustments are also made for patients who require four or fewer home health services during a 60-day episode (i.e., LUPA) and for patients who are either discharged from a HHA and then re-admitted to the same HHA or transferred from one HHA to another (i.e., PEP adjustment). Additional payments are made for extremely high cost episodes (i.e., outlier episodes) and initial and only episode LUPAs. In addition, payment adjustments are
made for certain HHAs that meet, or do not meet, published quality standards (i.e., VBP adjustment).

Requests for Anticipated Payment (RAP) claim pricing is also supported, if submitted appropriately on a UB-04 Bill Type 0322 or 0333 claim. RAP reimbursement is calculated at the appropriate percentage, depending on whether it is the first or a subsequent episode. Note that the date of admission must be submitted to allow accurate determination of RAP payment. When the final claim is submitted for full episode payment, the HHA Pricer will not deduct any earlier RAP payments. It is the responsibility of the user and the calling application to back out any earlier RAP payment from the final payment, for each episode.

HHA also supports the VBP adjustment. Under the VBP program, HHAs that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington are eligible for a payment adjustment (increase or decrease) that is determined based on the HHA total performance score (set by the Outcome & Assessment Information Set (OASIS) and the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)) or by submitted claim data. This adjustment applies to UB-04 Bill Type 032X (Home Health, Inpatient Part B) claims with a Thru Date on or after January 01, 2018. The maximum VBP adjustment percentages (increase or decrease) are shown below in Table 6-11. This payment adjustment can be applied to the HHRG payment, the LUPA add-on payment, the outlier payment amounts, the alternate HHRG payment, the alternate LUPA add-on payment, and the alternate outlier payment amounts.

<table>
<thead>
<tr>
<th>Year</th>
<th>Maximum VBP Adjustment Percentage (Increase or Decrease)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>3%</td>
</tr>
<tr>
<td>2019</td>
<td>5%</td>
</tr>
<tr>
<td>2020</td>
<td>6%</td>
</tr>
<tr>
<td>2021</td>
<td>7%</td>
</tr>
<tr>
<td>2022</td>
<td>8%</td>
</tr>
</tbody>
</table>

- Pricing Items Not Included in the HHA Fee Schedule Data Files (C Platform Only)

The HHA Pricer offers the following pricing options for services that are not included in the HHA Fee Schedule Data Files (for UB-04 Bill Type 034X claims):

  - **Option 1: Pay Based on a User-Specified Percent of Submitted Charge:**

Using Option 1, payment for these services can be calculated by multiplying the submitted charges by a user-specified payment percentage that can be
defined as any decimal number between 0.0001 and 9.9999. To reimburse based on submitted charges, set this factor to 1.0000. The Payment Percentage Rate Flag must be turned on for this type of pricing to occur. These fields (Payment Percentage Rate and Payment Percentage Rate Flag) can be set by using Rate Manager. If you do not use Rate Manager, these fields can be set in the Hospital Rate Calculator File. The location and format of these fields are specified in the EASYGroup™ Technical Reference Guide.

Option 1 will be the default pricing rule for these services when the corresponding fee schedule rate is set to $0.00 and the Payment Percentage Rate Flag is turned on (set to 1).

If you use the Home Health Agency National Medicare Provider Rate Files (HHA NMPRF): For home health agencies that were in service on or after January 01, 2009, the Payment Percentage Rate Flag will be turned off (set to 0) and the Payment Percentage Rate will be set to 0.0000.

- **Option 2: Pay Some or All Services Based on a User-Specified Fee Schedule Rate:**

To pay for these services based on a user-specified fee schedule amount, please use the following procedure:

Load the standard fee schedule data files into Rate Manager. These files are available from Rate Manager or the HHA Fee Schedule Data Files release. These files are called `feehhyy.dat` where `yy` represents the calendar year.

1. Identify the services for which you wish to set up fee schedule rates.
2. Identify the payment rates for each applicable effective date and service for each of the previously identified procedure codes.
3. Determine whether the fee schedule rates will be standard for all home health agencies, or specific for certain agencies or groups of agencies.
   a. If the rates should be standard for all home health agencies, the codes can be added to the National carrier with a type of N.
   b. If the codes are not standard across all home health agencies, create an appropriate Carrier code for each facility or facility group with a type of X.
4. Prepare a file to be used with the Rate Manager Fee Schedule Import utility. Please refer to the Rate Manager User’s Guide for further information.

### 6.1.10.2 Not Currently Supported

As supplied by Optum, the HHA Pricer does not calculate reimbursement for HHA claims billed under UB-04 Bill Type 034X (Home Health Services Not Under a Plan of Treatment). Services billed under this UB-04 Bill Type typically include therapy, equipment, supplies, and dressings, provided to patients who are not under a HHA plan of care. Since 2017, negative pressure wound therapy can also be billed under this UB-04 Bill Type. These services are not paid under the HHRGs, and if eligible, are paid via fee schedule. As
delivered, the HHA Fee Schedule Data Files do not include Medicare fee schedule rates for these services.

Clients wishing to pay for UB-04 Bill Type 034X services with fee schedule rates using the HHA Pricer will need to create a custom fee schedule, by:

• Loading the desired fee schedule rates into a fee schedule.
• In Rate Manager, tying that fee schedule to the Provider/Payer IDs where this benefit is to be supported.

Please refer to the Rate Manager product suite documentation for further information.

6.1.11 HHA Pricer (Effective on or After January 01, 2020)

For CY 2020, the HHRG methodology has been replaced with the Patient-Driven Groupings Model (PDGM) case-mix reimbursement. HHA claims with a From Date on or after January 01, 2020 are based on a 30-day period of care instead of a 60-day episode.

6.1.11.1 Features Supported

The HHA Pricer performs the following functions:

• 30-Day Period of Care

The HHA Pricer uses the following new PDGM methodology for claims with a From Date on or after January 01, 2020:

- The national standard rate is multiplied by the PDGM HIPPS case-mix weight and not the HHRG weight.
- For claims that qualify for Partial Episode Payment (PEP), the final reimbursement is multiplied by the proportion of the days of service billed to the 30-day period of care.
- Low Utilization Payment Adjustment (LUPA) is paid when an episode contains fewer therapy visits than the LUPA threshold indicated by the PDGM HIPPS code.
- Non-Routine Supplies (NRS) are a part of the standard national rate, therefore separate payment for NRS is no longer made.
- Initial and subsequent Request for Anticipated Payment (RAP) claims are paid at 20% instead of 60% and 50% respectively.
- Agencies newly enrolled in Medicare on or after January 01, 2019 are no longer paid for RAP claims. If such an agency submits a RAP on or after January 01, 2020, claim-level Pricer Return Code 57 (RAP Claim No Payment) is issued.

• Crossover Claims

Special rules apply to crossover claims that have a From Date prior to January 01, 2020 and a Thru Date on or after January 01, 2020. For these claims the following rules apply:

- Claims are based on a 60-day episode
- Reimbursement is based on the previous HHRG methodology including the CY 2019 HHRG weights
- A CY 2020 transitional 60-day national rate and the CY 2019 HHRG weights are used in the calculation of the base payment
- A CY 2020 transitional NRS rate and the CY 2019 NRS weights are used to calculate the NRS add-on payment
- A CY 2019 Fixed Dollar Loss (FDL) ratio is multiplied by a transitional 60-day national rate to determine if the claim is eligible for outlier add-on payment
- The CY 2020 LUPA per-visit rates are used to calculate LUPA add-on payments
- CY 2020 per-unit rates are used to calculate outlier add-on payments
- CY 2020 rural add-on percentages are used to calculate reimbursement
- CY 2020 wage index, labor portion, and Value-Based Purchasing (VBP) factors are used in the calculation of the base payment

6.1.11.2 Not Currently Supported
As supplied by Optum, the HHA Pricer does not calculate reimbursement for HHA claims billed under UB-04 Bill Type 034X (Home Health Services Not Under a Plan of Treatment). Services billed under this UB-04 Bill Type typically include therapy, equipment, supplies, and dressings, provided to patients who are not under a HHA plan of care. Since 2017, negative pressure wound therapy can also be billed under this UB-04 Bill Type. These services are not paid under the HHRGs, and if eligible, are paid via fee schedule. As delivered, the HHA Fee Schedule Data Files do not include Medicare fee schedule rates for these services.

Clients wishing to pay for UB-04 Bill Type 034X services with fee schedule rates using the HHA Pricer will need to create a custom fee schedule, by:
- Loading the desired fee schedule rates into a fee schedule.
- In Rate Manager, tying that fee schedule to the Provider/Payer IDs where this benefit is to be supported.

Please refer to the Rate Manager product suite documentation for further information

6.1.12 Inpatient Rehabilitation Facility (IRF) Pricer
The IRF Pricer is designed to support payment under Medicare’s Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). On January 1, 2002, CMS implemented a PPS for Inpatient Rehabilitation Facilities and units (IRFs). Under the IRF PPS, services are paid using prospectively determined rates. Payments are case-based (per discharge), and include both inpatient operating (routine and ancillary) costs, as well as capital costs.
Payment under the IRF PPS is case-based (per discharge). Facilities receive a single payment for each rehabilitation stay, which is based on information from an admission assessment that must be completed by day four of the rehabilitation stay. Payment involves assignment to a distinct Case-Mix Group (CMG) and use of a weighting factor to account for variations in patient acuity. Separate payments are calculated for each CMG with additional case and facility level adjustments applied.

6.1.12.1 Features Supported
The IRF Pricer performs the following functions:

- Assigns Five (5) Additional Payment-Specific CMGs
  Generally, the IRF Pricer uses the HIPPS code returned by the IRF Grouper as basis for calculating patient-specific reimbursements. In certain cases, however it assigns five additional CMGs, which are used for payment purposes only. There are four Pricer-generated CMGs for patients that expire, and one CMG for short stay cases (i.e., cases with a length of stay of three days or less).

- Applies Patient-Level Pricing
  The IRF Pricer calculates patient-specific reimbursements by adjusting HIPPS-specific national payment rates by a number of facility-specific factors. National payment rates are adjusted for facilities based on their local wage differences, percentage of low-income patients, costs of providing medical education, and whether the facility is rural. In addition, the IRF Pricer applies special payment rules for transfers, short stays, deaths, and outliers. The IRF Pricer (if applicable) calculates blended payments based on TEFRA and PPS payments.

6.1.13 Skilled Nursing Facility (SNF) Pricer
The SNF Pricer was designed to support payment under Medicare’s Skilled Nursing Facility Prospective Payment System (SNF PPS). The goal of the SNF PPS is to measure the intensity of care and services required for each SNF resident and to translate this measurement into a payment level. To accomplish this, the SNF PPS must incorporate a patient classification system which differentiates residents based on intensity of resource use. The patient classifications used by the SNF PPS are the Resource Utilization Groups (RUGs). Separate payment indices and per diem amounts are calculated for each RUG category.

Note
For further information on the SNF RUG Reader please refer to the Groupers & Readers section of this user’s guide.

6.1.13.1 Features Supported
- Support for Part A Reimbursement
The SNF Pricer calculates estimated reimbursement for SNF Part A stays. Claims are reimbursed using a RUG-specific per diem rate adjusted for local wage differences multiplied by the number of days the patient is classified under that RUG. The total payment is the sum all rates for the patient’s length of stay. Additional pricing adjustments include:

- Urban or rural RUG rates applied accordingly
- AIDS adjustment
- Optional, markup, or discounting on total payment

• Support for Part B Reimbursement

The SNF Pricer allows for the calculation of Part B skilled nursing claims. A beneficiary is eligible for Part B benefits when Part A benefits have been exhausted, or if the beneficiary is moved to a non-Medicare certified area/distinct part unit of a facility, due to a certain skill level of care no longer being required.

The SNF Pricer does not utilize RUGs or per diem payment for Part B reimbursement as these claims are paid based on fee schedule pricing. The SNF Fee Schedule Data File contains rates the Medicare fee schedules. Please refer to Chapter 10 for further information.

Claims are paid the lesser of billed charges compared with the fee schedule rate. Additional pricing adjustments include:

- Optional markup or discounting on total payment.
- Reasonable charge payment and co-payment factors.
- Vaccine reasonable charge factor for vaccine payment.

• Bill Type Distinction

A single claim cannot receive both Part A and Part B reimbursement. As such, the SNF Pricer distinguishes Part A from Part B claims based on the UB-04 Bill Type present on the claim. The SNF Pricer calculates reimbursement for SNF Part A stays based on Bill Types 018X or 021X and Part B claims based on Bill Types 022X and 023X.

• Excluded Revenue Codes

The following table is a list of Medicare-excluded revenue codes for inpatient Part B claims (Bill Type 022X). Line items featuring any of the revenue codes listed below will not be paid if they appear on a claim with a 022X Bill Type.

Table 6-12: SNF Part B Revenue Code Exclusion List

<table>
<thead>
<tr>
<th>010X</th>
<th>011X</th>
<th>012X</th>
<th>013X</th>
<th>014X</th>
<th>015X</th>
<th>016X</th>
<th>017X</th>
</tr>
</thead>
<tbody>
<tr>
<td>018X</td>
<td>019X</td>
<td>020X</td>
<td>021X</td>
<td>022X</td>
<td>023X</td>
<td>024X</td>
<td>0250</td>
</tr>
<tr>
<td>0251</td>
<td>0252</td>
<td>0253</td>
<td>0256</td>
<td>0257</td>
<td>0258</td>
<td>0259</td>
<td>0261</td>
</tr>
<tr>
<td>0269</td>
<td>0270</td>
<td>0273</td>
<td>0277</td>
<td>0279</td>
<td>029X</td>
<td>0339</td>
<td>036X</td>
</tr>
<tr>
<td>0370</td>
<td>0374</td>
<td>041X</td>
<td>045X</td>
<td>0472</td>
<td>0479</td>
<td>049X</td>
<td>050X</td>
</tr>
</tbody>
</table>
If a claim with Bill Type of 022X contains a line with an excluded revenue code, the line will be denied and a return code will be shown.

6.1.14 Physician Pricer

The Physician Pricer calculates Medicare reimbursement for practitioner and supplier claims that are billed on the printed 1500 claim form, or the electronic 837p claim form. These claims typically include individual provider and related ancillary services which are paid under Medicare’s Physician Fee Schedule (MPFS). Some services are paid under other Medicare fee schedules including Clinical Laboratory, DMEPOS, Parenteral and Enteral Nutrition (PEN), Average Sales Price (ASP) (drugs), and Ambulance. They are provided in multiple settings, including physician offices, several types of facilities, the patient’s home, or over the phone. They involve medical doctors and many other types of practitioners, as well as suppliers of ambulance services, DME suppliers, and independent clinical laboratories. Some of the other practitioner types supported by the Physician Pricer include: nurse practitioners, physician assistants, nurse anesthetists, midwives, psychologists, social workers, and physical, occupational, and speech therapists.

6.1.14.1 Features Supported

In many ways, physician pricing is similar to the facility pricing under Medicare’s prospective payment systems. Input data includes patient demographics, diagnosis codes, line item procedure codes, and service data. Pricing rules are updated periodically and are subject to regulation. Pricing involves a base rate, multiplied by a weighting factor, with geographic adjustments, discounting, and other adjustments. Rates for different services are set prospectively, and payment does not usually vary based on submitted charges.

However, there are a number of key differences that make physician pricing unique, such as:

• Claims are submitted on an entirely different claim form.
• There is limited bundling of services.
• There are no case-mix measures (i.e., no DRGs, no APCs, no grouping of patients or services into clinically similar categories).
In all of Medicare’s facility-based payment systems, the basic pricing rules include a standardized base payment rate multiplied by a weighting factor; which is designed to adjust for the complexity of the service, plus some type of adjustment for geographic differences in costs. In physician pricing, there is a base rate, called a conversion factor. This is multiplied by a weighting factor, or Relative Value Unit (RVU); which measures the relative expenses associated with different services. Next, a geographic adjustment factor is applied, or Geographic Practice Cost Index (GPCI). Our basic payment formula becomes: \( \text{Fee Schedule Rate} = \text{Conversion Factor} \times \text{RVU} \times \text{GPCI} \).

The conversion factor and the GPCI adjustment factors are published every year in the *Physician Final Rule*. All other information derives from the Medicare Physician Fee Schedule (MPFS). The MPFS contains each procedure code and modifier combination, the RVUs, and status codes that identify how each service should be paid. It also contains information about surgical bundling and discounting, bilateral pricing, and many other variables that contribute to the complexity of physician payment.

### 6.1.14.2 Provider Identifiers

The Physician Pricer identifies the provider for each service based on the National Provider Identifiers (NPIs) and taxonomy codes submitted on each claim. The NPI and taxonomy used for pricing each service is selected based on the following hierarchy:

- Rendering provider NPI and taxonomy, if available.
- Service facility NPI and taxonomy, if available.
- Billing provider NPI and taxonomy (always required).

Unlike any other EASYGroup™ payment system, multiple NPI and taxonomy records can be used to price a single claim. Every claim line could be reimbursed using a different NPI and taxonomy. Each NPI must be accompanied by an appropriate taxonomy code.

### 6.1.14.3 Zip Codes

The Physician Pricer uses zip code(s) billed on the claim to select the appropriate fee schedule rate for each claim line, as follows:

- If the Place of Service (POS) code is 12 (Home), the service facility zip code is used. This field must contain the zip code of the patient’s home.
- If the service provided is an ambulance service, the ambulance point of pickup zip code field is used. This field must contain the zip code for the point of pickup.

If the POS is any value other than 12 and the service is not an ambulance service, the service facility zip code is used if provided. Otherwise, the billing provider zip code is used. The chosen zip code determines the carrier/locality, as well as the Health Professional Shortage Area (HPSA), and ambulance urban/super-rural/rural designations. If a required zip code is missing or if a provided zip code is invalid, a claim-level Pricer Return Code is issued and payment is denied.
6.1.14.4 Status Codes
For services paid under the MPFS, the Physician Pricer processes each claim line based on the MPFS status code:

- Certain services are priced, while others may be bundled and not priced as described below.
- If the Physician Editor is being used, the status code is assigned by the Physician Editor.
- If the Physician Editor is not being used, the status code is assigned by the Physician Pricer using data from the Fee Schedule Data Files.

Reimbursement rules by status code are summarized as follows (in the following order):

1. Active/Payable Services (Status Codes A, C, R, and Unbundled T)
2. Non-Payable Services (Status Codes B, D, F, G, H, I, M, and N)
3. Services Excluded From the Physician Fee Schedule (Status Code E)
4. Anesthesia Services (Status Code J)
5. Injections and Bundled/Excluded Services (Status Codes T and P)
6. Statutorily Excluded Services (Status Codes X and Unbundled P)

6.1.14.5 Active/Payable Services (Status Codes A, C, R, and Unbundled T)
The Physician Pricer reimburses Status Code A (Active Code) and unbundled Status Code T (Injections) services as described below. If rates have been established for Status Code C (Carriers Price the Code) and R (Restricted Coverage) services, these services are also priced as described below. If rates have not been established for these services, these services are flagged and separate payment is not made.

- **Place of Service (POS):** The Pricer selects either the facility or non-facility rate for each claim line based on the POS code and the service type.
- **Specialty Code:** The Pricer uses taxonomy to determine the Medicare specialty code associated with the practitioner and the percentage of the fee schedule rate that the practitioner should be reimbursed.

Certain specialties are paid a percentage of the fee schedule rate for most services (excluding most diagnostic tests); all others are paid 100%:

### Table 6-13: Specialties Paid a Percentage of the Fee Schedule Rate

<table>
<thead>
<tr>
<th>Specialty Code</th>
<th>Description</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Nurse Practitioner</td>
<td>85%</td>
</tr>
<tr>
<td>71</td>
<td>Registered Dietitian / Nutrition Professional</td>
<td>85%</td>
</tr>
<tr>
<td>80</td>
<td>Licensed Clinical Social Worker</td>
<td>75%</td>
</tr>
<tr>
<td>89</td>
<td>Certified Clinical Nurse Specialist</td>
<td>85%</td>
</tr>
<tr>
<td>97</td>
<td>Physician Assistant</td>
<td>85%</td>
</tr>
</tbody>
</table>
A valid taxonomy must be provided with each billed NPI to derive the specialty code. Missing and invalid taxonomies are flagged with a line-level Pricer Return Code.

- **Bilateral Adjustments**: The Physician Pricer pays 150% of the fee schedule rate for conditionally bilateral procedures that are performed bilaterally. The 150% adjustment is applied if one of the following is true:
  - A procedure is billed on a single claim line with Modifier 50 (Bilateral Procedure) and one unit.
  OR
  - A procedure is billed on a single claim line with two units.
  OR
  - A procedure is billed on two claim lines: one with Modifier RT (Right Side) and one with Modifier LT (Left Side).

The Physician Pricer pays 200% of the fee schedule rate for independently bilateral procedures that are performed bilaterally and billed on a single claim line with Modifier 50 and one unit.

- **Multiple Procedure Discounting**: Discussed in Appendix E.
- **Endoscopic Discounting**: Discussed in Appendix E.
- **Diagnostic Imaging Discounting**: Discussed in Appendix E.
- **Cardiovascular Diagnostic Imaging Discounting**: Discussed in Appendix E.
- **Ophthalmology Diagnostic Imaging Discounting**: Discussed in Appendix E.
- **Therapy Discounting**: Discussed in Appendix E.
- **Co-Surgeon’s and Surgical Assistants**: The Physician Pricer makes adjustments for co-surgeons and surgical assistants as follows:
  - Each co-surgeon participating in the surgical procedure as indicated by Modifier 62 (Two Surgeons) is paid 62.5% of the fee schedule rate.
  - Services of a surgical assistant as indicated by Modifiers AS (Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery), 80 (Assistant Surgeon), 81 (Minimum Assistant Surgeon), or 82 (Assistant Surgeon (When Qualified Resident Surgeon Not Available)) are reimbursed at 16% of the fee schedule rate.

- **Team Surgeons**: The Physician Pricer flags eligible team surgeries with a line-level Pricer Return Code:
  - Only certain procedures are eligible to be reimbursed as a team surgery. Team surgery reimbursement is determined by Medicare on a case-by-case basis (i.e., “paid by report”).
  - When an eligible team surgery procedure code is billed with Modifier 66 (Surgical Team), the claim line is flagged, which tells the user to
manually review and price the line. When a surgery not eligible for team surgery reimbursement is reported with Modifier 66, the claim line is rejected and an error is returned.

- **Additional Surgical Adjustments:** The Physician Pricer makes adjustments to the reimbursement for both minor procedures (with a 10-day global period) and major surgeries (with a 90-day global period) when billed with specific modifiers indicating that the practitioner only provided a portion of the surgical care:

  - **OPPS Imaging Cap:** Limits the reimbursement of the Technical Component (TC) of certain diagnostic imaging procedures to the reimbursement amount paid for those procedures under the Medicare Outpatient Prospective Payment System (OPPS).
  
  - **Radiology Reductions:** Reduces payment when eligible radiology services are reported with Modifier 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) or FX (X-Ray Taken Using Film).
  
  - **Final Pricing Adjustments:** Multiplies the fully adjusted fee schedule rate for each line by units and pays the lesser of that amount or charges.

  **Table 6-14: Modifiers That Indicate Only a Portion of Surgical Care Was Provided**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>Surgical Care Only</td>
<td>Preoperative + Intraoperative</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative Management Only</td>
<td>Postoperative</td>
</tr>
<tr>
<td>56</td>
<td>Preoperative Management Only</td>
<td>Preoperative</td>
</tr>
<tr>
<td>78</td>
<td>Unplanned Return to the Operating/Procedure Room by the Same Physician</td>
<td>Intraoperative</td>
</tr>
<tr>
<td></td>
<td>Following Initial Procedure for a Related Procedure During the Postoperative Period</td>
<td></td>
</tr>
</tbody>
</table>

6.1.14.6 Non-Payable Services (Status Codes B, D, F, G, H, I, M, and N)

- The Physician Pricer bundles and does not provide separate payment for Status Code B (Bundled Code) services.

- The Physician Pricer denies payment for Status Code D (Deleted Code), F (Deleted/Discontinued Code), G (Not Valid for Medicare Purposes), H (Deleted Modifier), I (Not Valid for Medicare Purposes), and N (Non-Covered Services) services.

- The Physician Pricer flags and does not provide separate payment for Status Code M (Measurement Code) services.

6.1.14.7 Services Excluded From the Physician Fee Schedule (Status Code E)
The Physician Pricer will price Status Code E (Excluded From Physician Fee Schedule by Regulation) services using one of two different reimbursement methodologies, based on user configuration:

- If a fee schedule rate is provided, the Physician Pricer pays the minimum of this rate multiplied by units or charges.
- If a fee schedule rate is not provided, the Physician Pricer pays based on reasonable cost. Reasonable cost is calculated as line-level charges multiplied by the user-specified reasonable cost factor.

### 6.1.14.8 Anesthesia Services (Status Code J)

The Physician Pricer reimburses Status Code J (Anesthesia Service) services at the lesser of the rate described below or charges:

- Calculates the anesthesia time units by dividing the anesthesia minutes by 15 and rounding to 1 digit after the decimal.
- Adds the calculated anesthesia time units to the anesthesia base units.

This sum is then multiplied by the anesthesia conversion factor for the appropriate geographic locality. This reimbursement is then reduced by 50% if medical direction is provided and one of the following Modifiers is billed: QK (Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals), QX (CRNA Service: With Medical Direction by a Physician), or QY (Medical Direction of One Certified Registered Nurse Anesthetist (CRNA) by an Anesthesiologist).

**Note**

Please refer to Appendix E for further information on modifiers that affect reimbursement in the Physician Pricer.

### 6.1.14.9 Injections and Bundled/Excluded Services (Status Codes T and P)

The Physician Pricer separately reimburses Status Code T (Injections) and P (Bundled/Excluded Code) services only if not billed on the same day as a Status Code A (Active Code) service.

- Status Code T services are reimbursed using the same rules as Status Code A services (described above).
- Status Code P services are reimbursed using the same rules as Status Code X (Statutory Exclusion) services (described below).

The Physician Pricer bundles and does not provide separate payment for Status Code T and P services if billed on the same day as a Status Code A service.

### 6.1.14.10 Statutorily Excluded Services (Status Codes X and Unbundled P)

The Physician Pricer reimburses Status Code X (Statutory Exclusion) and unbundled Status Code P (Bundled/Excluded Code) services based on the Fee Schedule Type. All Status Code X and unbundled Status Code P services are paid the lesser of the calculated fee schedule rate or charges.
• **Ambulance Services (Fee Schedule Type A):** Ambulance services are paid differently depending on the type of service provided and whether or not the ambulance point of pickup is in a rural, super-rural, or urban area based on the billed zip code.

  - Ground transportation services are reimbursed using the appropriate rural, super-rural, or urban fee schedule rate depending on the point of pickup.
  - Air transportation services are reimbursed using the appropriate rural or urban fee schedule rate depending on the point of pickup.
  - Air mileage services are reimbursed using the appropriate rural or urban fee schedule rate multiplied by the number of miles reported.
  - Ground mileage services are reimbursed using the appropriate rural or urban fee schedule rate multiplied by the number of miles reported. Adjustments are made for the first 17 miles for rural and super-rural points of pickup.
  - Fractional mileage is truncated at the first digit after the decimal place and is used for pricing ground and air ambulance mileage services for trips less than 100 miles.
  - Adjustments are made for certain types of ambulance services if the patient dies prior to transport as indicated by Modifier QL (Patient Pronounced Dead After Ambulance Called).
  - Reimbursement for non-emergency ambulance transports to and from ESRD facilities is reduced by 10%.

• **DMEPOS Services (Fee Schedule Type D):** Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are paid the fee schedule rate multiplied by units. In most cases, one or more modifiers is required for accurate pricing of DMEPOS items. Parenteral and Enteral Nutrition (PEN) services are paid the fee schedule rate multiplied by units.

• **Clinical Laboratory Services (Fee Schedule Type L):** Clinical laboratory services are paid the fee schedule rate multiplied by units. Automated Multi-Channel Chemistry (AMCC) tests and panels are subject to special pricing logic.

**Note**

Please refer to Appendix E for further information on AMCC test pricing logic.

• **Nationally-Priced Services (Fee Schedule Type N):** Part B drugs are paid using either the billed procedure code or National Drug Code (NDC) as follows:

  - If the procedure code has an established fee schedule rate, it is paid that rate multiplied by units.
- If the procedure code does not have an established rate, but the NDC does have an established rate, it is paid the NDC rate multiplied by units.

- User-Defined Services (Fee Schedule Type X): User-defined services are paid the fee schedule rate multiplied by units.

### 6.1.14.11 Bonus (Incentive) Payments

The Physician Pricer optionally estimates bonus or incentive payments on a claim-by-claim basis. Medicare typically pays these payments to practitioners on a retrospective (quarterly) basis.

- **Health Professional Shortage Area (HPSA):** An additional 10% payment is made for professional services performed by physicians in either a primary care or a mental health HPSA, as indicated by the billed zip code or Modifier AQ (Physician Providing a Service in an Unlisted Health Professional Shortage Area (HPSA)).

- **HPSA Surgical Incentive Payment (HSIP):** An additional 10% payment is made for eligible surgeries performed by a general surgeon in a designated primary care HPSA as identified by the billed zip code or Modifier AQ.

- **Primary Care Incentive Payment (PCIP):** An additional 10% payment is made for eligible services if the provider is a primary care practitioner (as determined by the specialty code and percent of primary care services provided in a year).

**Note**
The HSIP and PCIP programs expired effective January 01, 2016.

### 6.1.14.12 Quality Adjustments

The Physician Pricer optionally calculates quality adjustments for the following aspects of the Quality Payment Program (QPP) that was established by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015:

- **Merit Based Incentive Payment System (MIPS) Adjustment:** Practitioners who are eligible to participate in the MIPS will receive a payment adjustment from -4% (penalty) to 4% (bonus) in 2019. This payment adjustment increases until it reaches 9% in 2022 and is based on quality-reporting data that has been submitted by these eligible practitioners. The adjustment is made to the Medicare payment only (adjustments will not be made to the patient co-payment). In addition, these adjustments only apply to services paid off the MPFS and are applied after all other adjustments, but prior to other bonus payments (e.g., HPSA).

### 6.1.14.13 Payment and Co-Payment

The Physician Pricer splits reimbursement into the Medicare reimbursement amount and the coinsurance amount (i.e., patient co-payment). The coinsurance is waived for preventive services as required by Medicare.

### 6.1.14.14 Mark-Up/Discount Factor
The Physician Pricer has an option to increase or reduce the overall claim payment by a practitioner-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the line-level payment is multiplied by the Mark-Up/Discount Factor.

6.1.14.15 Additional Output
The Physician Pricer outputs the following additional line-level data for informational purposes:

- Fee schedule rate used for pricing.
- Fee Schedule Type which explains the Medicare source of the fee schedule rate.
- Pricing Method Indicator which provides information on how the line was priced.

Note

6.1.14.16 Additional Pricer Functionality

- **Line-Level Edits**: Rejects claim lines that have received one or more line-level edits from the Physician Editor. These would include the Medicare NCCI and MUE practitioner or DME edits, as well as basic field validation edits.
- **Line-Level Override**: Rejects claim lines that a user has chosen to bypass, such as lines that have been denied by an external Editor (e.g., Optum CES® Professional Editor). Lines to be rejected can be flagged with the Line Override input field.
- **OIG Sanctions**: Rejects claim lines for practitioners that have been sanctioned by the Office of the Inspector General (OIG).
- **EHR Payment Reductions**: Reduces payment for services by providers that have not demonstrated meaningful use of electronic health records technology.
- **Quality Reporting Reductions**: Reduces payment for services by providers that have not met Medicare’s quality reporting requirements.
- **Modifier edits**: Rejects claim lines billed with one of the following modifiers:
  - Never Event Modifiers PA (Surgical or Other Invasive Procedure on Wrong Body Part), PB (Surgical or Other Invasive Procedure on Wrong Patient), and PC (Wrong Surgery or Other Invasive Procedure on Patient).
  - Modifiers GX (Notice of Liability Issued, Voluntary Under Payer Policy), GY (Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit or, for Non-Medicare Insurers, is Not a Contract
Benefit), or GZ (Item or Service Expected to be Denied as Not Reasonable and Necessary).

- Modifiers RT (Right Side) and LT (Left Side) on the same claim line (where applicable).
- Modifier 50 (Bilateral Procedure) billed with more than one unit.

**6.1.14.17 Not Supported**
The Physician Pricer does not support more than one Place of Service (POS).
This chapter provides an introduction to the EASYGroup™ components that interface with the 3M™ Grouper Plus System (GPS) and the 3M™ Grouper Plus Content Services (GPCS). It contains the following sections:

- EASYGroup™ Components Used With the 3M™GPS/GPCS Overview
  - APG Grouper
  - APR-DRG Grouper
  - TRICARE APC Pricer & Editor
  - Alternate ICD-10 Mapper
- 3M™ GPS & 3M™ GPCS Overview
  - 3M™ GPS
  - 3M™ GPCS

**Note**

All the EASYGroup™ components mentioned in this chapter are for the C Platform only.
7.1 EASYGroup™ Components Used With the 3M™ GPS/GPCS Overview

7.1.1 APG Grouper
The APG Grouper works in conjunction with the 3M™ GPS/GPCS and the 3M™ EAPGs. The APG Grouper is utilized by the following payers:

- Alabama BCBS (effective October 01, 2016)
- Colorado Medicaid (effective July 01, 2018)
- Florida Medicaid (effective July 01, 2017)
- Illinois Medicaid (effective July 01, 2014)
- Massachusetts Medicaid (effective December 30, 2016)
- Nebraska Medicaid (effective January 01, 2020)
- New York Medicaid (effective October 01, 2008)
- Ohio Medicaid (effective July 01, 2017)
- Virginia Medicaid APG (effective January 01, 2014)
- Virginia Medicaid ASC (effective January 01, 2018)
- Washington Medicaid (effective July 01, 2014)
- Wisconsin Medicaid (effective January 01, 2015)

7.1.1.1 APG Assignment Process

Note
The APG Grouper does not assign APGs. The 3M™ GPS/GPCS must be installed/utilized along with the APG Grouper to appropriately assign APGs.

Ambulatory Patient Groups (APGs) are to outpatient care, what the DRGs are to inpatient care. Under an outpatient payment system they serve as the basic unit of payment. There are various other types of APG assignment including, ancillary and drug that certain services may be classified into. APG-based prospective payment systems can also be subject to CCI and MUE edits.

7.1.2 APR-DRG Grouper
The APR-DRG Grouper also works in conjunction with the 3M™ GPS/GPCS. The APR-DRG Grouper is utilized by the following states:

- Arizona Medicaid (effective October 01, 2014)
- California Medicaid (effective July 01, 2013)
- Colorado Medicaid (effective July 01, 2018)
- Florida Medicaid (effective July 01, 2013)
- Illinois Medicaid (effective July 01, 2014)
• Indiana Medicaid (effective October 01, 2015)
• Louisiana Medicaid (effective January 01, 2019)
• Massachusetts Medicaid (effective October 01, 2014)
• Michigan Medicaid (effective October 01, 2015)
• Minnesota Medicaid (effective July 01, 2017)
• Mississippi Medicaid (effective July 01, 2015)
• Nebraska Medicaid (effective July 01, 2014)
• New Jersey Medicaid (effective October 01, 2018)
• New York Medicaid (effective December 01, 2009)
• Ohio Medicaid (effective July 01, 2013)
• Pennsylvania Medicaid (effective July 01, 2010)
• Rhode Island Medicaid (effective July 01, 2018)
• South Carolina Medicaid (effective October 01, 2011)
• Texas Medicaid (effective September 01, 2012)
• Virginia Medicaid (effective October 01, 2014)
• Washington Medicaid (effective July 01, 2014)
• Wisconsin Medicaid (effective January 01, 2017)

7.1.2.1 APR-DRG Assignment Process

Note
The EASYGroup™ APR-DRG Grouper does not assign APR-DRGs. The 3M™ GPS/GPCS must be installed/utilized along with the APR-DRG Grouper to appropriately assign APR-DRGs.

3M™ APR-DRGs are used to assign patient claims data to Diagnosis Related Groups (DRGs) with further classification based on severity of illness and risk of mortality. They are an extended version of the All-Patient DRGs (AP-DRGs) that include four severity-of-illness levels and four risk of mortality levels within each DRG. The severity and mortality subclasses are assigned according to statistical and clinical evaluation of the interactions of multiple comorbidities, age, procedures, and principal diagnosis. Within each base DRG, patients in a particular severity-of-illness level can be expected to consume similar resources and to achieve similar outcomes within the 3M™ APR-DRG assignment. Unlike the MS-DRGs, which focus on the Medicare population, APR-DRGs reflect the complete cross-section of patients seen in an acute care setting. Designed originally for quality initiatives, APR-DRGs have been adopted for reimbursement by select commercial payers and state Medicaid programs.

APR-DRGs are assigned by calling the APR-DRG Grouper in conjunction with the 3M™ GPS/GPCS, using the input parameters detailed in the Input and
Output Parameter Blocks User’s Guide. Note that each patient record is eligible for assignment to one APR-DRG.

### 7.1.2.2 Features Supported

- **Hospital-Acquired Condition (HAC) & Health Care-Acquired Condition (HCAC) Functionality**

  Effective January 01, 2012, the APR-DRG Grouper allows the option to apply the Medicaid HCAC policy in APR-DRG grouping, and also allows the option to apply the Medicare HAC policy in grouping.

  The APR-DRG Grouper supports an option during DRG assignment to exclude diagnosis codes subject to the Medicare HAC or the Medicaid HCAC program that appear on a claim with a POA indicator of N (i.e., not present at time of inpatient admission) or U (i.e., documentation is insufficient to determine if condition is present on admission). Any other valid POA value is ignored. If no POA indicator is submitted, the APR-DRG Grouper defaults the POA indicator to N for grouping purposes. If an invalid POA indicator is submitted, claim-level Grouper Return Code 61 (All Other Errors From External Software) will be issued. Diagnosis codes that are excluded during DRG assignment due to HAC/HCAC eligibility are flagged by the APR-DRG Grouper in the Present on Admission Bypassed (output) field. Diagnosis Codes that are excluded due to HAC/HCAC eligibility receive a Severity of Illness and Risk of Mortality value of C (Excluded Complication of Care).

  The HAC and HCAC functionality in the APR-DRG Grouper is optional and can be turned on or off using Rate Manager or by passing the appropriate Editor Requests (edit_req) field, HAC Version (hac_version) field, and HAC Override ID (hac_override_id) field in the ECB [ezg_cntl_block] structure for any facility, paysource, or time period. If HAC or HCAC functionality is requested, but the HAC Override ID is not provided, the Medicaid HCAC policy is applied.

  **Table 7-1** below lists the available APR-DRG payment systems and the appropriate APR-DRG Grouper that contains a direct link to the HAC Editor:

<table>
<thead>
<tr>
<th>Payment System</th>
<th>Grouper Version</th>
<th>HAC/HCAC</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Medicaid</td>
<td>APR-DRG V31 and higher</td>
<td>HCAC</td>
<td>October 01, 2014</td>
</tr>
<tr>
<td>California Medicaid</td>
<td>APR-DRG V29 and higher</td>
<td>HCAC</td>
<td>July 01, 2013</td>
</tr>
<tr>
<td>Colorado Medicaid</td>
<td>APR-DRG V33 and higher</td>
<td>HCAC</td>
<td>July 01, 2018</td>
</tr>
<tr>
<td>Florida Medicaid</td>
<td>APR-DRG V30 and higher</td>
<td>HCAC</td>
<td>July 01, 2013</td>
</tr>
</tbody>
</table>
7.1.3 TRICARE APC Pricer & Editor

Based on statutory requirements, TRICARE has adopted Medicare’s Prospective Payment System for reimbursement of hospital outpatient services provided to military personnel, veterans, and their families. This new payment system was first implemented on May 01, 2009, and pays for hospital outpatient services based on Ambulatory Payment Classifications (APCs).

<table>
<thead>
<tr>
<th>Payment System</th>
<th>Grouper Version</th>
<th>HAC/HCAC</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois Medicaid APR-DRG</td>
<td>APR-DRG V30 and higher</td>
<td>HCAC</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>Indiana Medicaid APR-DRG</td>
<td>APR-DRG V30 and higher</td>
<td>HCAC</td>
<td>July 01, 2012</td>
</tr>
<tr>
<td>Louisiana Medicaid</td>
<td>APR-DRG V35 and higher</td>
<td>HCAC</td>
<td>January 01, 2019</td>
</tr>
<tr>
<td>Massachusetts Medicaid</td>
<td>APR-DRG V30 and higher</td>
<td>HCAC</td>
<td>October 01, 2014</td>
</tr>
<tr>
<td>Minnesota Medicaid</td>
<td>APR-DRG V33 and higher</td>
<td>HAC</td>
<td>July 01, 2017</td>
</tr>
<tr>
<td>Mississippi Medicaid</td>
<td>APR-DRG V32 and higher</td>
<td>HCAC</td>
<td>July 01, 2015</td>
</tr>
<tr>
<td>Nebraska Medicaid APR-DRG</td>
<td>APR-DRG V31 and higher</td>
<td>HAC</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>New Jersey Medicaid APR-DRG</td>
<td>APR-DRG V34 and higher</td>
<td>HAC</td>
<td>October 01, 2018</td>
</tr>
<tr>
<td>New York Medicaid APR-DRG</td>
<td>APR-DRG V29 and higher</td>
<td>HCAC</td>
<td>January 01, 2012</td>
</tr>
<tr>
<td>Ohio Medicaid APR-DRG</td>
<td>APR-DRG V30 and higher</td>
<td>HCAC</td>
<td>July 01, 2013</td>
</tr>
<tr>
<td>Pennsylvania Medicaid APR-DRG</td>
<td>APR-DRG V27 and higher</td>
<td>HCAC</td>
<td>July 01, 2012</td>
</tr>
<tr>
<td>Rhode Island Medicaid</td>
<td>APR-DRG V34 and higher</td>
<td>HAC</td>
<td>July 01, 2018</td>
</tr>
<tr>
<td>South Carolina Medicaid</td>
<td>APR-DRG V28 and higher</td>
<td>HAC</td>
<td>October 01, 2011</td>
</tr>
<tr>
<td>Texas Medicaid</td>
<td>APR-DRG V30 and higher</td>
<td>HAC</td>
<td>September 01, 2010</td>
</tr>
<tr>
<td>Virginia Medicaid APR-DRG</td>
<td>APR-DRG V31 and higher</td>
<td>HCAC</td>
<td>October 01, 2014</td>
</tr>
<tr>
<td>Washington Medicaid APR-DRG</td>
<td>APR-DRG V31 and higher</td>
<td>HAC</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>Wisconsin Medicaid APR-DRG</td>
<td>APR-DRG V33 and higher</td>
<td>HCAC</td>
<td>January 01, 2017</td>
</tr>
</tbody>
</table>
TRICARE uses Medicare coding and APC assignment rules in most cases, with modifications to accommodate the TRICARE benefit structure, which is based on the health needs of the military population. TRICARE has adopted a proprietary APC methodology developed by 3M™. This methodology is based on the Medicare’s OPPS, but with select differences.

TRICARE OPPS claims are processed by the EASYGroup™ TRICARE APC Editor and the TRICARE APC Pricer, in conjunction with the 3M™ GPS/GPCS and TRICARE Outpatient Pricer Tables, using the input parameters detailed in the Input and Output Parameter Blocks User’s Guide.

The TRICARE APC Payment System does not utilize the Maximum Acceptable Level of Error function. TRICARE APC uses 3M™ pricing programs.

7.1.3.1 APC Assignment Process

**Note**

The TRICARE APC Editor does not assign APCs or apply TRICARE OCE edits. The TRICARE APC Pricer does not assign TRICARE outpatient APC reimbursement. The 3M™ GPS/GPCS must be installed/utilized along with the TRICARE APC Payment System to appropriately assign APCs, apply edits, and calculate reimbursement.

For further information on the APC assignment process please refer to Chapter 5.

7.1.3.2 Features Supported

• Significant Procedure APCs:

  This category includes traditional ambulatory surgeries, as well as a variety of other procedures and tests, such as strapping and cast application, chemotherapy administration, transfusions, nuclear medicine, magnetic resonance imaging and Computerized Axial Tomography (CAT) scans. These APCs are divided into two groups: (1) those that are always paid in full, and (2) those that may be eligible for multiple procedure discounting.

• Medical APCs:

  This category includes APCs for low, middle, and high-level clinic or emergency department visits, as well as APCs for critical care and interdisciplinary team conference. Medical APCs are assigned using Evaluation and Management (E/M) codes that indicate site of service and level of intensity. Generally, medical visit APCs (with the exception of the critical care APC) will not be assigned on the same day that a surgical procedure was performed. If “significant, separately identifiable evaluation and management services” are performed on the same day as a surgical procedure, a modifier of 25 must be placed on the E/M code in order for a medical APC to be assigned. Without the 25 modifier, only surgical APCs will be assigned to the case.
• Ancillary Service APCs:

The ancillary service category includes APCs for simple and complex pathology services, plain film radiological procedures, immunology tests, immunizations, simple and complex pulmonary tests, allergy tests and injections, and electrocardiograms.

• Transitional Pass-Through APCs:

The TRICARE Outpatient PPS provides a transitional pass-through payment for specific innovative and generally expensive medical devices, drugs, and biologicals. Items eligible for this transitional pass-through include orphan drugs, as designated by the Federal Drug Administration (FDA); current drugs, biologic agents, and brachytherapy devices used in cancer treatment; current radiopharmaceutical drugs and biological products used in nuclear medicine for diagnostic monitoring, or therapeutic purposes; and new medical devices, drugs and biologic agents, whose costs are “not insignificant” in relation to APC payment amounts.

• New Technology APCs:

This category includes APCs for new technologies not eligible for the transitional pass-through. These APCs are based on cost alone and are used to temporarily categorize emergent technologies until they can be assigned to the most appropriate “clinically-related” APC. It is anticipated that new items will be assigned to these APCs for a period of at least two years, but no more than three years. There are two sets of new technology APCs, one for new technology services and one for new technology devices.

• Composite APCs:

Composite APCs provide a single payment for several independent services when they are furnished on the same date of service. Composite APCs are intended to establish APC payment rates for combinations or “bundles” of services that are frequently furnished together. When a claim is eligible for a composite APC, the designated primary service in the composite definition is paid based on the composite APC, and all other services in the composite definition are packaged. Charges for packaged items within the composite APC are bundled into the claim line that contains the primary service and these reallocated charges are taken into consideration during outlier calculations.

CMS Medicare Claims Processing Manual, Ch.12 - Physicians/Non-physician Practitioners [Sec. L., p. 73],
HDC Inc. for OSORA.

7.1.4 Alternate ICD-10 Mapper

Please refer to Chapter 8 for information on the Alternate ICD-10 Mapper.
7.2 3M™ GPS & 3M™ GPCS Overview

Note
The 3M™ GPS, the 3M™ GPCS, and the 3M™ Enhanced Ambulatory Patient Grouping System (EAPGs) are proprietary products of 3M™ Health Information Systems.

7.2.1 3M™ GPS
The 3M™ GPS contains the tables and programs needed to assign a group. The 3M™ GPS must be licensed with the following EASYGroup™ products:
- APG Grouper
- APR-DRG Grouper
- Alternate ICD-10 Mapper
- TRICARE APC Pricer
- TRICARE APC Editor

7.2.1.1 Licensing Information
Please contact your Optum Client Manager for information.

7.2.1.2 Overview
The 3M™ GPS is a locally installed, Java™-based application that integrates with other systems to receive current federal and state regulations. The 3M™ GPS performs editing, grouping, and pricing functions for claims that are paid using APR-DRG, AP-DRG, APG, or TRICARE APC methodologies.

The 3M™ GPS enables third-party software vendors, Payers/Providers, consultants, and analytics companies to embed regulatory content into their own applications. This approach allows clients integrated access to valuable content or allows them to analyze and report on data for their own clients.

7.2.1.3 Installation Steps
Please refer to the EASYGroup™ Installation Guide for hardware/software requirements, installation steps, and other technical details.

7.2.1.4 Architecture
The below diagram is an example of the EASYGroup™ environment with web services and the 3M™ GPS.
7.2.2 3M™ GPCS

3M™ released the 3M™ GPCS as an upgrade and alternative to the 3M™ GPS. The cloud-based 3M™ GPCS may be used in place of the locally installed 3M™ GPS to perform editing, grouping, and pricing functions for claims that are paid using APR-DRG, AP-DRG, APG, or TRICARE APC methodologies. Clients can contact Optum Client Services to inquire about moving to this new product.

The 3M™ GPCS must be licensed with the following EASYGroup™ products:

- APG Grouper V1710.00 or higher
- APR-DRG Grouper V1710.00 or higher
- TRICARE APC Editor V1710.00 or higher
- TRICARE APC Pricer V1710.00 or higher
- Alternate ICD-10 Mapper V1710.00 or higher

7.2.2.1 Licensing Information

Payer clients may continue to utilize the 3M™ GPS if they do not wish to move to the 3M™ GPCS at this time. Payer clients that wish to migrate to the 3M™ GPCS may access the 3M™ GPS and GPCS from the same environment. Provider clients will need to migrate to the 3M™ GPCS in the near future; this deadline will be outlined in future release documentation. Clients may run the 3M™ GPCS for a trial period and will be able to revert back to the 3M™ GPS if they wish.
License fees for the 3M™ GPCS are the same as the 3M™ GPS; however clients will need to receive an updated contract, please contact your Optum Client Manager for further information.

7.2.2.2 Overview
To help businesses faced with intense IT resource burdens and time constraints, 3M™ offers the same essential regulatory and 3M™ proprietary content (available through the 3M™ GPS) delivered through SOAP-based web services and a cloud environment. The 3M™ GPCS leverages web technology to deliver content with increased timeliness and reduced maintenance. The 3M™ GPCS provides secure access to grouping, pricing, editing, and classifications and the content can be viewed from many different workflows.

7.2.2.3 Cloud Content Benefits
A standard interface call over the web allows clients access to current content in a real-time, cloud environment. There are many benefits to switching to the 3M™ GPCS, including:

- Reduced IT maintenance, no local installation, and ease of implementation using industry-standard, SOAP-based web services.
- Java™ by Oracle® is not required.
- Includes a configuration utility (i.e., the GPCS Wizard) to manage required certificates and environmental variables (refer to below sections for more information)

7.2.2.4 Migration Steps
Please refer to the EASYGroup™ Installation Guide for migration steps, required interface changes, hardware/software requirements, and other technical details.

Note
 Clients will be required to install certificates to use the 3M™ GPCS. Please refer to the EASYGroup™ Installation Guide for steps on how to obtain these certificates.

7.2.2.5 Architecture
The below diagram is an example of the EASYGroup™ environment with web services and the 3M™ GPCS.
Figure 7-2. EASYGroup™/3M™ GPCS Example Architecture
8 Mappers

This chapter provides an introduction to the EASYGroup™ Mappers. It contains the following sections:

- Overview of EASYGroup™ Mappers
  - ICD-9 and ICD-10 Mappers
  - Additional ICD-10 Mapper Functionality
  - Alternate ICD-10 Mapper
  - Dual Mapping for ICD-9-CM Procedure Code 00.50
8.1 Overview of EASYGroup™ Mappers

The EASYGroup™ product suite contains the ICD-9 Mapper (simply referred to as the “Mapper”), the ICD-10 Mapper, and the Alternate ICD-10 Mapper (C Platform Only).

The Mapper components map or translate the ICD-9-CM and ICD-10-CM/PCS codes from a specified source time period or version to a selected target version. Mapping allows the coding conventions for one time period to be used with DRG assignment software based upon a different time period’s coding conventions. For example, the Mapper can be used to map Version 34 (source) ICD-9-CM codes (effective October 01, 2016) to codes effective in a previous time period or version, such as Version 33 (effective October 01, 2015). With such a mapping, Version 34 codes can be input to a Version 33 DRG Grouper.

8.1.1 ICD-9 and ICD-10 Mappers

Each October 1st the ICD-9-CM and ICD-10-CM/PCS coding systems are updated. Codes are added, deleted, and expanded. Generally, ICD-9-CM and ICD-10-CM/PCS updates are associated with a specific time period and are referred to by version, for example:

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Time Period (Effective Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>October 01, 2016</td>
</tr>
<tr>
<td>33</td>
<td>October 01, 2015</td>
</tr>
<tr>
<td>32</td>
<td>October 01, 2014</td>
</tr>
<tr>
<td>31</td>
<td>October 01, 2013</td>
</tr>
<tr>
<td>30</td>
<td>October 01, 2012</td>
</tr>
<tr>
<td>29</td>
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<td>28</td>
<td>October 01, 2010</td>
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<tr>
<td>27</td>
<td>October 01, 2009</td>
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<td>26</td>
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</tr>
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<td>17</td>
<td>October 01, 1999</td>
</tr>
<tr>
<td>16</td>
<td>October 01, 1998</td>
</tr>
<tr>
<td>15</td>
<td>October 01, 1997</td>
</tr>
</tbody>
</table>
Source diagnosis and procedure codes are input to the Mapper. The Mapper then uses internal logic and specially designed data files to convert source codes to diagnosis and procedure codes that are valid or appropriate for the target version or time period.

Mapping functionality is optional and can be turned on or off, using Rate Manager, for any facility, paysource, or time period. Make sure the check box for Mapping is checked in the appropriate rate calculator screen of Rate Manager. Alternatively, this functionality can be directly set in the Optimizer using the ICD-9/ICD-10 Mapping Flag (map_flag, ECB-MAP-FLAG) field in the ECB [ezg_cntl_block] structure for the C Platform or the ECB-EZG-CNTL-BLOCK structure for the COBOL Platform (if applicable).

### 8.1.2 Additional ICD-10 Mapper Functionality

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of ICD-10-CM and ICD-10-PCS coding for inpatient discharges on or after October 01, 2015. Prior to this cut-off date, providers and payers of healthcare services prepared systems and software to accommodate this new coding system. Optum offers code mapping for claims coded in either ICD-9-CM or ICD-10-CM/PCS.

The ICD-10 Mapper accepts both ICD-9 and ICD-10 coded claims. The coding versions cannot be mixed on one claim. This means that the admit diagnosis, the principal diagnosis, and all secondary diagnoses are coded entirely in either ICD-9-CM or ICD-10-CM, and any inpatient procedures are coded entirely in either ICD-9-CM or ICD-10-PCS. The first “live” version of ICD-10 Mapping code sets was V33 and was effective for inpatient claims with discharge dates on or after October 01, 2015.

The ICD-10 Mapper maps each incoming code individually to one or more target codes. It also includes the following functionality:

- **Backward Mapping**: Today’s ICD-10 codes can be translated backwards in time to any prior supported data version for ICD-10 or ICD-9. Backward mapping can be done using the standard rules that are supplied with the ICD-10 Mapper, or custom rules can be defined and incorporated.

- **Forward Mapping**: Older codes can be translated into newer equivalent ICD-9 or ICD-10 codes. Forward mapping rules within the ICD-9 code-set are included with the ICD-10 Mapper. Sample forward mappings from ICD-9 to ICD-10, or from ICD-10 to ICD-10, are supplied with the ICD-10 Mapper for testing purposes only. Clients wishing to forward map actual

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Time Period (Effective Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>October 01, 1996</td>
</tr>
<tr>
<td>13</td>
<td>October 01, 1995</td>
</tr>
<tr>
<td>12</td>
<td>October 01, 1994</td>
</tr>
</tbody>
</table>

---

Table 8-1: ICD-9-CM and ICD-10-CM/PCS Coding Systems
claims for modeling purposes should customize these rules to meet their business requirements.

- **Legacy Grouper Support**: The ICD-10 Mapper contains ICD-9-CM to ICD-9-CM forward and backward mapping rules to support legacy Grouper versions.

- **Mapping Override Functionality**: Mapping override functionality to re-assign select CMS mapping decisions to better model DRG-based contracts. Two external data files (*mapfile.dat* and *maprule.dat*) are required for valid claims processing when the ICD-10 Mapper is in use.

- **Import Functionality**: Import functionality to incorporate custom mapping rules for claims adjudication and reimbursement modeling. Custom mapping rules can be imported into Rate Manager.

### 8.1.3 Alternate ICD-10 Mapper

The Alternate ICD-10 Mapper is for use with AP-DRGs. The original ICD-10 Mapper maps each incoming code individually, without consideration of the other codes or data on the claim, and is restricted to mapping diagnosis codes to diagnosis codes, and procedure codes to procedure codes. The Alternate ICD-10 Mapper works in conjunction with the 3M™ GPS to provide the following additional features:

- Map combinations (or clusters) of incoming codes to single or multiple target codes. This is important where two or more ICD-10 codes are needed together to identify the appropriate target code(s).

- Map diagnosis codes to procedures and procedure codes to diagnosis codes. This is important in clinical areas (such as obstetrics and rehabilitation) where ICD-10 coding involves procedure codes, and ICD-9 coding involves diagnosis codes, or the reverse.

#### 8.1.3.1 Backward Mapping

Today's ICD-10 codes can be translated backwards in time to FY 2010 (V27 AP-DRGs) and prior.

#### 8.1.3.2 Forward Mapping

Not supported at this time.

### 8.1.4 Dual Mapping for ICD-9-CM Procedure Code 00.50

Most ICD-9 mapping handled by the Mapper is one-to-one (i.e., one ICD-9-CM diagnosis or procedure code maps to only one other ICD-9-CM diagnosis or procedure code). However, as of October 01, 2002 (FY 2003), there was one ICD-9-CM procedure code (00.50, *Card resynch pacemkr*) that mapped to two procedure codes. These two procedure codes are as follows:

- 37.70, *Insert pacemakr lead NOS*
- 37.80, *Insert pacemaker dev NOS*

As a result of this unique dual mapping, claims coded with ICD-9-CM procedure code 00.50 that are evaluated for DRG assignment, using a
Grouper created prior to FY 2003 (typically Grouper Version 19 or earlier), will be subject to special mapping logic. To accommodate this logic, users must do the following when submitting claims with procedure code 00.50:

1. Enter procedure code 00.50 on the claim in the appropriate position.
2. Code all other necessary procedure codes on the claim and then add special placeholder procedure code 0000 at the end of the block of procedure codes.

If procedure code 00.50 is entered either (1) without code 0000 or (2) with code 0000, but without code 0000 as the last procedure code on the claim, the user will receive Optimizer Return Code 95 (Parameter Error). Please refer to the EASYGroup™ Technical Reference Guide for further information on Optimizer Return Codes.
9 Data Files

This chapter provides an introduction to the EASYGroup™ Data Files. It contains the following sections:

• Introduction to EASYGroup™ Data Files
• Data Files - Inpatient
  - Colorado Inpatient Data Files
  - Florida Inpatient Data Files
  - Indiana Inpatient Data Files
  - Inpatient Data Files
  - Louisiana Inpatient Data Files
  - Massachusetts Inpatient Data Files
  - Minnesota Inpatient Data Files
  - Mississippi Inpatient Data Files
  - New Jersey Inpatient Data Files
  - Rhode Island Inpatient Data Files
  - SNF Data Files
  - Virginia Inpatient Data Files
  - Wisconsin Inpatient Data Files
• Data Files - Outpatient
  - Alabama Blue Cross Blue Shield (BCBS) Outpatient Data Files
  - APG Grouper Data Files
  - Colorado Outpatient Data Files
  - ESRD Data Files
  - Florida Outpatient Data Files
  - HHA Data Files
  - Illinois Outpatient Data Files
  - Nebraska Outpatient Data Files
  - New Mexico Outpatient Data Files
  - New York Outpatient Data Files
  - Ohio Outpatient Data Files
  - Outpatient Data Files
  - Virginia ASC Data Files
  - Virginia Outpatient Data Files
• Physician Data Files
9.1 Introduction to EASYGroup™ Data Files

The following EASYGroup™ Data Files have been created to streamline the update process. For further information please refer to the EASYGroup™ Technical Reference Guide.

9.1.1 Data Files - Inpatient

9.1.2.1 Colorado Inpatient Data Files
The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Colorado Inpatient Code Table Data File (codeco2.dat).

The Colorado Inpatient Code Table Data File includes the discharge disposition or admit sources that are considered transfers and the UB-04 Bill Types that are considered non-covered.

9.1.3.2 Florida Inpatient Data Files
The Florida Inpatient Data Files distribute the Florida Inpatient Code Table Data File (codefl2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Florida Inpatient Code Table Data File.

The Florida Inpatient Code Table Data File includes the discharge status codes that are considered transfers and the UB-04 Bill Types that are considered non-covered.

9.1.4.3 Indiana Inpatient Data Files
The Indiana Inpatient Data Files distribute the Indiana Inpatient Code Table Data File (codein2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Indiana Inpatient Code Table Data File.

The Indiana Inpatient Code Table File includes the discharge status codes that are considered transfers, diagnosis codes that are billed with certain mental health codes that do not receive per diem payments, and the UB-04 Bill Types that are considered non-covered.

9.1.5.4 Inpatient Data Files
The Inpatient Data Files distribute the Inpatient Code Table Data File (codedrg.dat) and contains data only. The Pricer performs pricing operations using the data stored in the Inpatient Code Table Data File.

The Inpatient Code Table File includes the rates for blood clotting factors on claims that contain a Hemophilia diagnosis code, COVID-19 diagnosis codes, and services eligible for new technology add-on payments.

9.1.6.5 Louisiana Inpatient Data Files
The Louisiana Inpatient Data Files distributes the Louisiana Inpatient Code Table File (codela2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Louisiana Inpatient Code Table File.
The Louisiana Inpatient Code Table File includes the discharge dispositions that are considered transfers, the UB-04 Bill Types that are considered non-covered, the day factors used to determine the cumulative factor for psychiatric per diem payments, and the revenue codes used to identify post-acute care claims.

9.1.7.6 Massachusetts Inpatient Data Files
The Massachusetts Inpatient Data Files distribute the Massachusetts Inpatient Code Table Data File (codema2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Massachusetts Inpatient Code Table Data File.

The Massachusetts Inpatient Code Table File includes the discharge status codes that are considered transfers and the UB-04 Bill Types that are considered non-covered.

9.1.8.7 Minnesota Inpatient Data Files
The Minnesota Inpatient Data Files distribute the Minnesota Inpatient Code Table Data File (codemn2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Minnesota Inpatient Code Table Data File.

The Minnesota Inpatient Code Table Data File includes the discharge dispositions that are considered transfers and the UB-04 Bill Types that are considered non-covered.

9.1.9.8 Mississippi Inpatient Data Files
The Mississippi Inpatient Data Files distribute the Mississippi Inpatient Code Table Data File (codems2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Mississippi Inpatient Code Table Data File.

The Mississippi Inpatient Code Table File includes the discharge status codes that are used for transfer and interim claim pricing and the UB-04 Bill Types that are considered non-covered.

9.1.10.9 New Jersey Inpatient Data Files
The New Jersey Inpatient Data Files distribute the New Jersey Code Table Data File (codenj2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the New Jersey Inpatient Code Table Data File.

The New Jersey Inpatient Code Table Data File includes the discharge dispositions that are considered transfers, the UB-04 Bill Types that are considered non-covered, revenue codes, and occurrence span codes related to ALC days.
9.1.11.10 Rhode Island Inpatient Data Files
The Rhode Island Inpatient Data Files distribute the Rhode Island Code Table Data File (coderi2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Rhode Island Inpatient Code Table Data File.

The Rhode Island Inpatient Code Table Data File includes the discharge dispositions that are considered transfers, the UB-04 Bill Types that are considered non-covered, the UB-04 Bill Types that are interim, and partial eligibility occurrence codes.

9.1.12.11 SNF Data Files
The SNF Data Files distribute the SNF Code Table Data File (codesnf.dat; code03.dat). The SNF Pricer performs pricing operations using the data stored in the SNF Code Table Data File.

The SNF Code Table Data File includes a list of film x-ray services subject to payment reductions when billed with Modifier FX (X-Ray Taken Using Film) and contains a list of procedure codes eligible for the Modifier CT (CT Scanner Does Not Meet NEMA Standards) reduction. In addition, the SNF Code Table Data File includes zip code/carrier locality data for pricing of ambulance services

9.1.13.12 Wisconsin Inpatient Data Files
The Wisconsin Inpatient Data Files distribute the Wisconsin Inpatient Code Table Data File (codewi2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Wisconsin Inpatient Code Table Data File.

The Wisconsin Inpatient Code Table File includes the discharge status codes that are used for transfer claim pricing and the UB-04 Bill Types that are considered non-covered.

9.1.14.13 Virginia Inpatient Data Files
The Virginia Inpatient Data Files distribute the Virginia Inpatient Code Table Data File (codeva2.dat) and contains data only. The Medicaid APR Pro Pricer performs pricing operations using the data stored in the Virginia Inpatient Code Table Data File.

The Virginia Inpatient Code Table Data File includes the discharge status codes that are considered transfers and the UB-04 Bill Types that are considered non-covered.

9.1.15 Data Files - Outpatient

9.1.16.1 Alabama Blue Cross Blue Shield (BCBS) Outpatient Data Files
The Alabama BCBS Outpatient Data Files distribute the Alabama APG Code Table Data File (codeal3.dat) and contains data only. The Medicaid APG Pro
Pricer performs pricing operations using the data stored in the Alabama APG Code Table Data File.

The Alabama APG Code Table File includes the policy adjustments and data to correctly price Alabama BCBS outpatient claims.

9.1.17.2 APG Grouper Data Files
The APG Grouper Data Files distribute the APG Grouper Table (eapgdata.dat) and contains data only. The APG Grouper performs grouping operations using the data stored in the APG Grouper Table.

The APG Grouper Table contains the state-specific user keys, grouper version numbers, and payer exceptions.

9.1.18.3 Colorado Outpatient Data Files
The Colorado Outpatient Data Files distribute the Colorado Outpatient Code Table Data File (codeco1.dat) and contains data only. The Medicaid APG Pro Pricer performs pricing operations using the data stored in the Colorado Outpatient Code Table Data File.

The Colorado Outpatient Code Table File includes modifiers and procedure codes required for managing the Colorado Medicaid APG reimbursement methodology.

9.1.19.4 ESRD Data Files
The ESRD Data Files product distributes the ESRD Code Table Data File (codesrd.dat; code05.dat). This ESRD Code Table Data File includes:

- A list of valid vaccine codes that are paid based on reasonable cost for hospital-based Renal Dialysis Facilities (RDFs) that are paid based on the lower of the actual charge, or 95% of the Average Wholesale Price (AWP) for independent RDFs. The co-payment is waived for these vaccine codes.
- A list of valid comorbidity diagnosis codes.
- A list of outlier eligible National Drug Codes (NDCs) along with associated rates.

9.1.20.5 Florida Outpatient Data Files
The Florida Outpatient Data Files distribute the Florida Outpatient Code Table Data File (codefl1.dat) and contains data only. The Medicaid APG Pro Pricer performs pricing operations using the data stored in the Florida Outpatient Code Table Data File.

The Florida Outpatient Code Table includes Modifier JW (Drug Amount Discarded/Not Administered to Any Patient) which indicates discarded drugs.

9.1.21.6 HHA Data Files
The HHA Data Files distribute the HHA Code Table Data File (codehha.dat; code06.dat). The HHA Pricer performs pricing operations using the data stored in the HHA Code Table Data File. The HHA Code Table Data File includes the following:
• List of valid vaccine codes that are paid at a reasonable cost on UB-04 Bill Type 034X (Home Health, Other) claims
• List of valid Core Based Statistical Areas (CBSAs) with associated wage index values and rural indicators, and
• List of Federal Information Processing Standards (FIPS) state and county codes with associated rural indicators

9.1.22.7 Illinois Outpatient Data Files
The Illinois Outpatient Data Files distribute the Illinois Outpatient Code Table Data File (codeil1.dat) and contains data only. The Illinois Medicaid APG Pricer performs pricing operations using the data stored in the Illinois Outpatient Code Table Data File.

The Illinois Outpatient Code Table File includes a complete list of the Ambulatory Procedures Listing (APL) codes (prior to July 01, 2020), revenue codes required to identify devices eligible for the cost outlier add-on payment for high cost devices, and non-covered revenue codes.

9.1.23.8 Nebraska Outpatient Data Files
The Nebraska Outpatient Data Files distribute the Nebraska Outpatient Code Table Data File (codene1.dat) and contains data only. The Medicaid APG Pro Pricer performs pricing operations using the data stored in the Nebraska Outpatient Code Table Data File.

The Nebraska Outpatient Code Table File includes APG Types required for managing the Nebraska Medicaid APG reimbursement methodology.

9.1.24.9 New Mexico Outpatient Data Files
The New Mexico Outpatient Data Files distribute the New Mexico Outpatient Code Table Data File (codenm1.dat) and contains data only. The New Mexico Medicaid APC Pricer performs pricing operations using the data stored in the New Mexico Outpatient Code Table Data File.

The New Mexico Outpatient Code Table File includes covered revenue codes required for managing the New Mexico Medicaid APC reimbursement methodology.

9.1.25.10 New York Outpatient Data Files
The New York Outpatient Data Files distributes the New York Outpatient Code Table Data File (codeny1.dat) and the Enhanced New York Medicaid APG Zip Code File (zipny.dat) which contain data only. The New York Medicaid APG Pricer (prior to October 01, 2019) and the Enhanced New York Medicaid APG Pricer (effective October 01, 2019) performs pricing operations using the data stored in the New York Outpatient Code Table Data File.

The New York Outpatient Code Table Data File includes procedure codes, diagnosis codes and rate codes. The Enhanced New York Medicaid APG Zip Code File contains the zip code and locator code information which is used to determine the base and capital rates for a given facility location.
9.1.26.11 Ohio Outpatient Data Files
The Ohio Outpatient Data Files distribute the Ohio Outpatient Code Table Data File (codeoh1.dat). The Medicaid APG Pro Pricer performs pricing operations based on data stored in the Ohio Outpatient Code Table Data File.

9.1.27.12 Outpatient Data Files
The Outpatient Data Files distribute the APC Code Table Data File (codeapc.dat; code01.dat). The APC-HOPD Pricer and Contract APC Pricer perform pricing operations using the data stored in the APC Code Table Data File. The APC Code Table Data File includes zip code/carrier locality data for pricing of ambulance services, as well as additional data.

9.1.28.13 Virginia ASC Data Files
The Virginia ASC Data Files distributes the Virginia Medicaid ASC Code Table Data File (codeva4.dat). The Medicaid APG Pro Pricer performs pricing operations using the data stored in the Virginia Medicaid ASC Code Table Data File.

The Virginia Medicaid ASC Code Table Data File includes Modifier UD (340B Drugs) which indicates when a drug is billed under the 340B Program.

9.1.29.14 Virginia Outpatient Data Files
The Virginia Outpatient Data Files distributes the Virginia Outpatient Code Table Data File (codeva1.dat). The Medicaid APG Pro Pricer performs pricing operations using the data stored in the Virginia Outpatient Code Table Data File.

The Virginia Outpatient Code Table Data File includes procedure code G0378, Hospital observation service, per hour, which is used to price observation claims and Modifier UD (340B Drugs) which is used to bill 340B drugs.

9.1.30 Physician Data Files
The Physician Data Files distribute the Physician Code Table Data File (codephys.dat; code09.dat) and contains data only. The Physician Pricer performs pricing operations using the data stored in the Physician Code Table Data File.

The Physician Code Table Data File includes data for zip codes, taxonomy codes, Place of Service (POS) codes, select procedure codes, and National Drug Code (NDC) pricing.
10 Fee Schedules

This chapter provides an introduction to the EASYGroup™ Fee Schedule Data Files. It contains the following sections:

• Fee Schedule Data Files Overview
  - Alabama BCBS Outpatient Fee Schedule Data Files
  - APC Fee Schedule Data Files
  - ASC Fee Schedule Data Files
  - Colorado Outpatient Fee Schedule Data Files
  - ESRD Fee Schedule Data Files
  - FQHC Fee Schedule Data Files
  - HHA Fee Schedule Data Files
  - Iowa Outpatient Fee Schedule Data Files
  - Physician Fee Schedule Data Files
  - SNF Fee Schedule Data Files
  - Massachusetts Outpatient Fee Schedule Data Files
  - Nebraska Outpatient Fee Schedule Data Files
  - Michigan ASC Fee Schedule Data Files
  - Michigan Outpatient Fee Schedule Data Files
  - New Mexico Outpatient Fee Schedule Data Files
  - New York Outpatient Fee Schedule Data Files
  - Ohio Outpatient Fee Schedule Data Files
  - Virginia ASC Fee Schedule Data Files
  - Virginia Outpatient Fee Schedule Data Files
  - Washington Outpatient Fee Schedule Data Files
  - Wisconsin Outpatient Fee Schedule Data Files

• Fee Schedule Change Reports
10.1 Fee Schedule Data Files Overview

Please refer to Chapter 2 for an overview of the Fee Schedule Data Files. The sub-sections below describe the different types of Fee Schedule Data Files Optum has available.

10.1.1 Alabama BCBS Outpatient Fee Schedule Data Files

The Alabama BCBS Outpatient Fee Schedule Data Files include the following data for each unique procedure code, carrier/locality, start date, and end date combination:

- Fee Schedule Type:
  - M = Alabama BCBS Outpatient Fee Schedule
  - X = Other Fee Schedule (user-defined)
- Fee Schedule Rate
- Fee Flag

10.1.2 APC Fee Schedule Data Files

The APC Fee Schedule Data Files distribution includes published Medicare fee schedule rates for the following categories of Hospital Outpatient Department (HOPD) services:

- Clinical laboratory services
- Durable Medical Equipment, Prosthetics, Orthotics, Surgical Supplies and Dressings (DMEPOS)
- Rehabilitation therapy
- National rates for parenteral/enteral nutrition services (beginning January 1, 2002)
- Ambulance services (beginning April 1, 2002)
- Screening mammography services
- Telehealth services (beginning October 1, 2001)
- Outpatient diabetes self-management services

These covered services are published annually by CMS.

Within each fee schedule data file, separate payment rates are published by CMS for every Medicare carrier. To identify the payment rates that are applicable for a particular hospital, for every fee schedule except ambulance services, you must select the carrier that is appropriate for that hospital. Refer to the Fee Schedule Carriers Worksheet attached to the Medicare OPPS Rate Variables Worksheet (RVW) for a complete list of carrier codes for each of the Medicare fee schedules. Payment rates for ambulance services are based on the location of the ambulance point-of-pickup. The zip code identifying this point-of-pickup, which is entered on the patient claim, is required for ambulance fee schedule pricing, and is used to determine payment rates.
10.1.3 ASC Fee Schedule Data Files
The ASC Fee Schedule Data Files distribution for use with ASC Pricers encompass all covered services for Medicare free-standing ambulatory surgical centers, effective January 01, 2008. The ASC Fee Schedule Data Files contain the following categories of free-standing ambulatory surgical services:

- Surgical procedures
- Non office-based procedures
- Brachytherapy source
- Device-intensive procedures
- OPPS pass-through devices
- Drugs/biologicals
- New technology intra-ocular lens
- Packaged services and items
- Office-based procedures
- Radiology services
- Unclassified drugs/biologicals

These covered services are published annually by CMS.

10.1.4 Colorado Outpatient Fee Schedule Data Files
The Colorado Outpatient Fee Schedule Data Files distribution, for use with the Medicaid APG Pro Pricer, is used to identify carve out codes used by the state of Colorado. The Colorado Outpatient Fee Schedule Data Files include the following data for each unique procedure code, carrier/locality, start date, end date, and modifier combination:

- Fee Schedule Type:
  - M = Colorado Outpatient Fee Schedule
  - X = Other (user-defined)
- Special Payment Flag

10.1.5 ESRD Fee Schedule Data Files
The ESRD Fee Schedule Data Files distribution for use with the ESRD Pricer encompasses separately payable services for Medicare-participating renal dialysis facilities, effective January 01, 2008. The ESRD Fee Schedule Data Files contain the following categories of outpatient dialysis services:

- Clinical laboratory services
- Drugs/biologicals
- Physician services
• Telehealth Services
• Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

10.1.6 FQHC Fee Schedule Data Files
The FQHC Fee Schedule Data Files distribution for use with the FQHC Pricer encompasses separately payable services for Medicare FQHCs, effective January 01, 2016. The FQHC Pricer uses the FQHC Fee Schedule Data Files to reimburse the following categories of separately payable services:
• Chronic Care Management (CCM)/Behavior Health Integration (BHI)
• Collaborative Care Model (CoCM) Services
• Communications Technology-Based Services
• Telehealth Services

10.1.7 HHA Fee Schedule Data Files
The HHA Fee Schedule Data Files distribution for use with the HHA Pricer encompasses separately payable services for Medicare home health agencies, effective January 01, 2009. The HHA Fee Schedule Data Files contain certain vaccine codes and osteoporosis drugs.

10.1.8 Iowa Outpatient Fee Schedule Data Files
The Iowa Outpatient Fee Schedule Data Files distribution for use with the Contract APC Pricer encompasses Iowa Medicaid-specific fee schedule rates.

10.1.9 Physician Fee Schedule Data Files
The Physician Fee Schedule Data Files distribution includes published fee schedule rates and other data for the following categories of physician services:
• Clinical laboratory services
• Durable Medical Equipment, Prosthetics, Orthotics, Surgical Supplies and Dressings (DMEPOS)
• Physician services
• National rates for Parenteral/Enteral Nutrition (PEN) services
• Ambulance services
• Telehealth services
• Average Sales Price (ASP) drug pricing services
These covered services are published annually by CMS.

10.1.10 SNF Fee Schedule Data Files
Clients licensing the Medicare SNF Payment System will require SNF Fee Schedule Data Files to correctly process Part B claims. The SNF Fee
Schedule Data Files distribution includes published Medicare fee schedule rates for the following categories of services available in the skilled nursing facility environment:

- Clinical laboratory services
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- National rates for parenteral/enteral nutrition services
- Ambulance services
- Telehealth services
- Physician fee schedule
- Part B drug services

These covered services are published annually by CMS. Medicare physician fee schedule items that are not applicable to SNF have been excluded.

Within each fee schedule data file, separate payment rates are published by CMS for every Medicare carrier. To identify the payment rates that are applicable for a particular provider, for every fee schedule except ambulance services, you must select the carrier that is appropriate for that provider. Refer to the Fee Schedule Carriers Worksheet attached to the Medicare SNF RVW for a complete list of carrier codes for each of the Medicare fee schedules. Payment rates for ambulance services are based on the location of the ambulance point-of-pickup. The zip code identifying this point-of-pickup, which is entered on the patient claim, is required for ambulance fee schedule pricing, and is used to determine payment rates.

10.1.11 Massachusetts Outpatient Fee Schedule Data Files

The Massachusetts Outpatient Fee Schedule Data Files distribution, for use with the Medicaid APG Pro Pricer, encompasses Medicaid fee schedule rates applicable to facility outpatient claims otherwise paid under the EAPGs in the state of Massachusetts.

The Massachusetts Outpatient Fee Schedule Data Files include the following data for each unique procedure code, carrier/locality, start date, end date, and modifier combination:

- Fee Schedule Rate
- Fee Schedule Type:
  - M = Massachusetts Medicaid Fee Schedule
  - X = Other (user-defined)
- Special Payment Flag
- Fee Flag
- AMCC Indicator
- AMCC Component Count
• Codes Not Included in AMCC Bundling

10.1.12 Michigan ASC Fee Schedule Data Files
The Michigan ASC Fee Schedule Data Files product is a custom fee schedule which consists of selected components of the Medicare ASC Payment System coupled with Michigan Medicaid-specific code pricing. These Michigan Medicaid-specific codes are called “wrap around codes.”

This data only product distributes the Michigan ASC Fee Schedule Files. Prior to July 01, 2015, the Michigan ASC Fee Schedule Data Files were distributed as part of the MIASRF.

10.1.13 Michigan Outpatient Fee Schedule Data Files
The Michigan Outpatient Fee Schedule Data Files product is a custom fee schedule which consists of selected components of the CMS OPPS fee schedule applicable to the state of Michigan coupled with Michigan Medicaid-specific code pricing. These Michigan Medicaid specific codes are called “wrap around codes.” Both paying and non-paying Michigan Medicaid “wrap around codes” are included in the custom fee schedule.

This data only product distributes the Michigan Outpatient Fee Schedule Files. Prior to July 01, 2015, the Michigan APC Fee Schedule Data Files were distributed as part of the MIOSRF.

10.1.14 Nebraska Outpatient Fee Schedule Data Files
The Nebraska Outpatient Fee Schedule Data Files include the following data for each unique procedure code, carrier/locality, start date, and end date combination:
- Fee Schedule Type (type):
  - M = Nebraska Medicaid Fee Schedule
  - X = Other Fee Schedule (user-defined)
- Fee Schedule Rate (rate1)
- Fee Flag (fee_flag)

10.1.15 New Mexico Outpatient Fee Schedule Data Files
The New Mexico Outpatient Fee Schedule Data Files include the following data for each unique procedure code, carrier/locality, start date, end date, and modifier combination:
- Fee Schedule Rate
- Fee Schedule Type:
  - M = New Mexico Medicaid Fee Schedule
  - X = Other Fee Schedule (user-defined)
- Gap Fill
10.1.16 New York Outpatient Fee Schedule Data Files
The New York Outpatient Fee Schedule Data Files distribution for use with the New York Medicaid APG Pricer (prior to October 01, 2019) and the Enhanced New York Medicaid APG Pricer (effective October 01, 2019) encompasses all published Medicaid fee schedule rates applicable to the state of New York.

10.1.17 Ohio Outpatient Fee Schedule Data Files
The Ohio Outpatient Fee Schedule Data Files distribution, for use with the Medicaid APG Pro Pricer, encompasses Medicaid fee schedule rates applicable to facility outpatient claims otherwise paid under the APGs in the state of Ohio.

10.1.18 Virginia ASC Fee Schedule Data Files
The Virginia ASC Fee Schedule Data Files include the following data for each unique procedure code, carrier/locality, start date, end date, and modifier combination:
- Fee Schedule Rate
- Fee Schedule Type:
  - M = Virginia Medicaid Fee Schedule
  - X = Other (user-defined)
- Special Payment Flag
- Fee Flag

10.1.19 Virginia Outpatient Fee Schedule Data Files
The Virginia Outpatient Fee Schedule Data Files include the following data for each unique procedure code, carrier/locality, start date, end date, and modifier combination:
- Fee Schedule Rate
- Fee Schedule Type:
  - M = Virginia Medicaid Fee Schedule
  - X = Other (user-defined)
- Special Payment Flag
- Fee Flag

10.1.20 Washington Outpatient Fee Schedule Data Files
The Washington Outpatient Fee Schedule Data Files include the following data for each unique procedure code, carrier/locality, start date, end date, and modifier combination:
- Fee Schedule Rate
- Fee Schedule Type:
- M = Washington Medicaid Fee Schedule
- X = Other (user-defined)
- Special Payment Flag
- Fee Flag

10.1.21 Wisconsin Outpatient Fee Schedule Data Files
The Wisconsin Outpatient Fee Schedule Data Files distribution for use with the Wisconsin Medicaid APG Pricer encompasses all Medicaid fee schedule rates applicable to the state of Wisconsin.

10.2 Fee Schedule Change Reports
The Fee Schedule Change Reports are supplemental documentation to help clients manage and understand Medicare and Medicaid updates and retroactive changes. These change reports are available on the Optum Client Portal.

The Fee Schedule Change Reports communicate the exact changes being made in a specific fee schedule release, but in greater detail than the Optum PPS Product Suite Release Notes. Features of the change reports are listed below:

- Contains a listing of procedure codes that were New/Deleted/Updated/End Dated along with the corresponding Effective Date, Carrier/Locality, Fee Schedule Version, and associated rates.
- For updated codes, the Previous Value(s) and Updated Value(s) are shown (as shown in Figure 10-2).
- For new codes, the Updated Value(s) is shown (as shown in Figure 10-3).
- Beginning CY 2018 and forward, these change reports contain three years' worth of data.

These change reports are Microsoft® Excel® spreadsheets. Filters are enabled, so that specific types of changes are easy to find. The report is sorted by procedure code, then by Effective Date, and then by the fee schedule version number, so that all changes for a specific procedure code can be seen in one place. The Fee Schedule Change Reports also contains a Legend tab (shown below in Figure 10-1) which explains the different options in the Status column.
Figure 10-1. Fee Schedule Change Report Legend Tab

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>This Code, Carrier/Locality, and Modifier combination is new in this version of the fee schedule.</td>
</tr>
<tr>
<td>Deleted</td>
<td>This Code, Carrier/Locality, and Modifier combination is completely removed in this version of the fee schedule. This status is rare and is only used when a Code is retroactively deleted back to its earliest effective date.</td>
</tr>
<tr>
<td>Updated</td>
<td>This Code, Carrier/Locality, and Modifier combination is updated in this version of the fee schedule. The specific fields and values that are updated can be viewed in the various Previous Value and Updated Value columns of the Change Report.</td>
</tr>
<tr>
<td>End Dated</td>
<td>This Code, Carrier/Locality, and Modifier combination is no longer effective. This most commonly occurs when the Code is no longer valid or when a fee schedule rate for the Code is no longer published by the applicable government agency.</td>
</tr>
</tbody>
</table>

Figure 10-2. Example of an Updated Procedure Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Effective Date</th>
<th>Status</th>
<th>Fee Schedule Version</th>
<th>Rate 1</th>
<th>Previous Value</th>
<th>Updated Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0100T</td>
<td>20190101</td>
<td>Updated</td>
<td>V1901.00</td>
<td>5436.830</td>
<td>4061.480</td>
<td></td>
</tr>
<tr>
<td>0101T</td>
<td>20190101</td>
<td>Updated</td>
<td>V1901.00</td>
<td>1279.910</td>
<td>1256.790</td>
<td></td>
</tr>
<tr>
<td>0102T</td>
<td>20190101</td>
<td>Updated</td>
<td>V1901.00</td>
<td>1279.10</td>
<td>1256.790</td>
<td></td>
</tr>
<tr>
<td>0191T</td>
<td>20190101</td>
<td>Updated</td>
<td>V1901.00</td>
<td>2573.330</td>
<td>2679.620</td>
<td></td>
</tr>
<tr>
<td>0200T</td>
<td>20190101</td>
<td>Updated</td>
<td>V1901.00</td>
<td>2721.370</td>
<td>2744.320</td>
<td></td>
</tr>
<tr>
<td>0201T</td>
<td>20190101</td>
<td>Updated</td>
<td>V1901.00</td>
<td>2721.320</td>
<td>2744.320</td>
<td></td>
</tr>
</tbody>
</table>
Figure 10-3. Example of a New Procedure Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Effective Date</th>
<th>Status</th>
<th>Fee Schedule Version</th>
<th>Previous Value</th>
<th>Updated Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0510T</td>
<td>20190101</td>
<td>New</td>
<td>V1901.00</td>
<td></td>
<td>1256.790</td>
</tr>
<tr>
<td>0511T</td>
<td>20190101</td>
<td>New</td>
<td>V1901.00</td>
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</tr>
<tr>
<td>0512T</td>
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<td>161.800</td>
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</tr>
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<td>0513T</td>
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<td>0.000</td>
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</tr>
<tr>
<td>0514T</td>
<td>20190101</td>
<td>New</td>
<td>V1901.00</td>
<td>0.000</td>
<td></td>
</tr>
</tbody>
</table>
11 Rate Files

This chapter provides an introduction to the EASYGroup™ Rate Files. It contains the following sections:

- National Medicare Provider Rate Files (NMPRFs) Overview
  - Uses of the NMPRFs
  - Ambulatory Surgical Center (ANMPRF)
  - Critical Access Hospital (CNMPRF)
  - End Stage Renal Disease (ESRD NMPRF)
  - Federally Qualified Health Centers (FQHC NMPRF)
  - Home Health Agency (HHA NMPRF)
  - Inpatient (NMPRF)
  - Inpatient Psychiatric Facility (IPF NMPRF)
  - Inpatient Rehabilitation Facility (IRF NMPRF)
  - Long Term Care (LTC NMPRF)
  - Outpatient (ONMPRF)
  - Physician (PNMPRF)
  - Skilled Nursing Facility (SNF NMPRF)
- Using Rate Manager with the NMPRF
- State Rate Files Overview
  - Uses of the State Rate Files
- Inpatient State Rate Files
  - Arizona State Rate Files (AZSRF)
  - California State Rate Files (CASRF)
  - Colorado State Rate Files (COSRF)
  - Florida State Rate Files (FLSRF)
  - Georgia State Rate Files (GASRF)
  - Illinois State Rate Files (ILSRF)
  - Indiana State Rate Files (INSRF)
  - Iowa State Rate Files (IASRF)
  - Kansas State Rate Files (KSSRF)
  - Louisiana State Rate Files (LASRF)
  - Michigan State Rate Files (MISRF)
  - Minnesota State Rate Files (MNSRF)
- Nebraska State Rate Files (NESRF)
- New Mexico State Rate Files (NMSRF)
- New Jersey State Rate Files (NJSRF)
- New York State Rate Files (NYSRF)
- Ohio State Rate Files (OHSRF)
- Pennsylvania State Rate Files (PASRF)
- Rhode Island State Rate Files (RISRF)
- Texas State Rate Files (TXSRF)
- TRICARE Rate Files
- Virginia State Rate Files (VASRF)
- Washington State Rate Files (WASRF)
- Wisconsin State Rate Files (WISRF)

• Outpatient State Rate Files
  - Colorado Outpatient State Rate Files (COOSRF)
  - Florida Outpatient State Rate Files (FLOSRF)
  - Illinois Outpatient State Rate Files (ILOSRF)
  - Iowa Outpatient State Rate Files (IAOSRF)
  - Michigan Ambulatory Surgical State Rate Files (MIASRF)
  - Michigan Outpatient State Rate Files (MIOSRF)
  - Nebraska Outpatient State Rate Files (NEOSRF)
  - New Mexico Outpatient State Rate Files (NMOSRF)
  - New York Outpatient State Rate Files (NYOSRF)
  - Ohio Outpatient State Rate Files (OHOSRF)
  - TRICARE APC Rate Files
  - Virginia Ambulatory Surgical Center State Rate Files (VAASRF)
  - Virginia Outpatient State Rate Files (VAOSRF)
  - Washington Outpatient State Rate Files (WAOSRF)
  - Wisconsin Outpatient State Rate Files (WIOSRF)

• Sources of Data
• Rate File Limitations
• Rate File Change Report Layouts
• State Rate File Paysources/Payer IDs
11.1 National Medicare Provider Rate Files (NMPRFs) Overview

The National Medicare Provider Rate Files (NMPRFs) are a comprehensive source of provider-specific Medicare reimbursement information. These products contain all the rate variables needed to calculate reimbursement under the appropriate Medicare payment system. The information contained in these files is compatible with the EASYGroup™ Medicare Pricers (available in C or COBOL) and can also be used with Optum reimbursement management products: Web.Strat™, ECM Pro™ Web Services, and the EASYGroup™ Server (available for Windows®).

The NMPRF contains information related to a Medicare payment system reimbursement for a certain time period. These files contain information for Medicare-participating providers located in all 50 states and Puerto Rico. The NMPRF is divided into the following products:

- Ambulatory Surgical Center (ANMPRF)
- Critical Access Hospital (CNMPRF)
- End Stage Renal Disease (ESRD NMPRF)
- Federally Qualified Health Centers (FQHC NMPRF)
- Home Health Agency (HHA NMPRF)
- Inpatient (NMPRF)
- Inpatient Psychiatric Facility (IPF NMPRF)
- Inpatient Rehabilitation Facility (IRF NMPRF)
- Long Term Care Hospital (LTCH NMPRF)
- Outpatient (ONMPRF)
- Skilled Nursing Facility (SNF NMPRF)

Each record in the NMPRF contains information about a single provider for a specific time period. In most cases, providers have multiple records per federal fiscal year in the NMPRF, including:

- Records identified by the provider’s NPI and appropriate taxonomy code(s).
- Records identified by the provider’s legacy number (i.e., Medicare provider ID, OSCAR, TIN, etc.).
- Additional records for providers whose fiscal year is different than the payment system fiscal year.
- Additional records for other reimbursement changes unrelated to fiscal year considerations (e.g., mid-year wage index changes). In these instances, an additional record is added to the file with an effective date that corresponds to the effective date of the change.
Generally, NMPRF files are intended to contain three years of reimbursement data. When new fiscal or calendar year data is added, the oldest year is dropped from the file. Similarly, for those NMPRF files on a quarterly update schedule, when a new quarter of data is added, the older quarter is dropped from the file.

11.1.1 Uses of the NMPRFs

Each NMPRF is designed to be a tool for providers, payers, health care plans, and others that need to determine a provider’s patient-specific payments according to Medicare’s prospective pricing rules. It is a comprehensive resource that includes payment system national program parameters along with provider-specific information compiled by CMS. Combined with Optum components the NMPRF can be used to compute payment rates under Medicare rules, even for providers that are currently exempt from Medicare payment systems or for patients with other forms of insurance. As such, the NMPRF has many potentially valuable applications including those listed below.

• Each NMPRF can be used to calculate Medicare reimbursement for stays by Medicare beneficiaries, subject to the limitations of the data as detailed below.
• Each NMPRF can serve as a mutually acceptable basis for pricing provider bills under contracts that require emulation of Medicare payment system rules.
• Each NMPRF can be used by health care providers and purchasers as the basis for rate negotiations, especially when the negotiations involve prices as a percent of Medicare reimbursement.
• Each NMPRF can be used to evaluate the relative expense of services provided by providers competing in specific market areas, thus identifying opportunities for reducing costs by redirecting patients to more efficient providers.
• Purchasers and health plans can use each NMPRF to quantify and document potential savings from the more efficient use of health care providers.
• Analysts can use each NMPRF to convert provider-specific charges to estimated amounts that would be reimbursed by Medicare under well-defined circumstances.

11.1.2 Ambulatory Surgical Center (ANMPRF)

The ANMPRF contains reimbursement information for all Medicare-participating free-standing ambulatory surgical centers located in the all 50 states and Puerto Rico. These files include pricing data to calculate APC (Ambulatory Payment Category) reimbursement, effective for ASCs January 1, 2008. For ambulatory surgical services, the federal Fiscal Year (FY) is based on the Calendar Year (CY) cycle, January through December.
The ANMPRF is designed to be used with the EASYGroup™ Medicare ASC Pricer, EASYGroup™ Server, ECM Pro™ Outpatient Web Service™ and Web.Strat™.

11.1.3 Critical Access Hospital (CNMPRF)

The CNMPRF contains both inpatient and Method I outpatient pricing information for all critical access hospitals located in the United States for which cost report and provider-specific data is made publicly available.

**Note**
The CNMPRF does not support Method II claims.

Each record in the CNMPRF contains information about a single hospital for a specific time period. Hospital records in the file will be updated each Fiscal Year (FY) (the federal FY is October through September), based on the availability of updated information from cost reports and other CMS reference data files.

**For Inpatient:** Patient-specific reimbursement under the Critical Access Hospital Prospective Payment System (CAH Payment System) is calculated by applying per diem rates or a percent of charges billed to information about the patient’s stay (e.g., length of stay or billed charges). The CNMPRF contains both per diem rates and a percent of charges billed, plus an additional per diem amount for swing beds. All inpatient CAH will be reimbursed a per diem rate unless the user manually changes this setting in the rate files (please refer to the Medicare Inpatient Rate Variables Worksheet (RVW) for further information).

**Note**
Interim claims are not supported.

**For Outpatient:** Accurate calculation of patient-specific reimbursement under the CAH Payment System is based on a percent of billed charges, except for laboratory services for non-patients; which are fee schedule-based. The CNMPRF contains this hospital-specific percent of billed rates, as well as the appropriate fee schedule file names and indicators, lab carriers, lab payment factors, and lab co-payment factors.

The CNMPRF is designed to be used with the EASYGroup™ Medicare DRG and APC Pricers, EASYGroup™ APC-HOPD Fee Schedule Data Files, the EASYGroup™ Server, ECM Pro™ Inpatient and Outpatient Web Services, and Web.Strat™.

11.1.4 End Stage Renal Disease (ESRD NMPRF)

The ESRD NMPRF contains all rate variables needed to calculate Method I reimbursement under the Medicare composite payment rules for the ESRD facility settings, and all rate variables necessary to calculate dialysis
reimbursement under the ESRD bundled Payment System, effective January 1, 2011. This file contains information for all hospital-based and independent renal dialysis facilities in the United States for which cost reports and provider-specific data is made publicly available. The ESRD NMPRF contains all available information starting January 1, 2009 and forward. For renal dialysis services, the federal FY is based on the CY cycle, January through December.

The ESRD NMPRF is designed to be used with the EASYGroup™ Medicare ESRD Pricer, the EASYGroup™ Server, ECM Pro™ Outpatient Web Service and Web.Strat™.

11.1.5 Federally Qualified Health Centers (FQHC NMPRF)
The FQHC NMPRF contains all rate variables needed to calculate reimbursement under the Medicare FQHC Payment System. This file contains information for all FQHC facilities in the United States for which cost reports and provider-specific data is made publicly available. The FQHC NMPRF contains all available information beginning October 1, 2014 and forward.

The FQHC NMPRF is designed to be used with the EASYGroup™ Medicare FQHC Pricer, the EASYGroup™ Server, the ECM Pro™ Outpatient Web Service, and Web.Strat™.

11.1.6 Home Health Agency (HHA NMPRF)
The HHA NMPRF contains all rate variables needed to calculate reimbursement under the Medicare Home Health Payment System. This file contains information for all home health agencies in the United States, for which cost reports and provider-specific data is made publicly available. The HHA NMPRF contains all available information starting January 1, 2009 and forward. For home health services, the federal FY is based on the CY cycle, January through December.

The HHA NMPRF is designed to be used with the EASYGroup™ Medicare HHA Pricer, the EASYGroup™ Server, ECM Pro™ Outpatient Web Service, and Web.Strat™.

11.1.7 Inpatient (NMPRF)
The NMPRF contains all the rate data needed to calculate inpatient acute care hospital reimbursements under the Medicare Inpatient Prospective Payment System. Patient-specific reimbursement is generally calculated by applying hospital-specific rate information (e.g., hospital-specific Medicare base rates, outlier thresholds, wage index values, etc.) to information about the patient’s stay (e.g., DRG-specific weights). For inpatient services, the federal FY is based on the CY cycle, October through September.

The NMPRF is designed to be used with the EASYGroup™ Medicare DRG Pricer, the EASYGroup™ Server, ECM Pro™ Inpatient Web Service, and Web.Strat™.
11.1.8.1 Sole Community and Medicare Dependent Hospitals
Under the Medicare Payment System, reimbursement for hospital operating costs is wholly based on a wage-adjusted federal rate (blended for regional and national portions, as appropriate), with one exception. Sole Community Hospitals (SCHs), Medicare Dependent Hospitals (MDHs), and Essential Access Community Hospitals (EACHs) are allowed an add-on amount if their hospital-specific operating base rate is greater than the federal rate. For this comparison, the hospital-specific rate is set equal to the greater of the hospital’s FY 1982 or FY 1987 operating base rate updated to the current year. In general terms, this operating add-on amount is equal to the difference between the applicable hospital-specific base rate and the wage-adjusted federal rate. SCHs and EACHs are entitled to the entire add-on amount, while MDHs are eligible for 50 percent of the difference. The add-on amount has been stored in the SCH/MDH Add-On field. This add-on is combined with the hospital’s Federal Wage-Adjusted Rate to create the hospital’s final operating Base Payment System Reimbursement Rate. Outlier payments as well as any applicable adjustments for Indirect Medical Education (IME) or disproportionate share do not apply to the add-on amount.

Note
Within the Inpatient NMPRF, SCHs, MDHs and EACHs can be identified using the Provider Type field. SCHs will have one of the following values: 16 or 17. MDHs have a value of either 14 or 15, and EACHs have a value of either 21 or 22.

11.1.9.2 Hospitals in Operation Less Than Two Years
Most hospitals in the United States now receive Medicare reimbursement for both capital and operating costs according to prospective, per case pricing rules. One exception involves new hospitals which are exempt from prospective capital payment for the first two years of their operations. As an alternative, they are paid 85% of their reasonable costs during this period. Reasonable costs can only be determined retrospectively. Therefore, the NMPRF cannot be used to calculate capital reimbursement for a new hospital during the initial years of its operation. Until Medicare makes available the information needed to determine a prospective capital reimbursement rate for a new hospital, the NMPRF contains zeros in the fields that would be used for this purpose. As soon as Medicare makes the necessary information available, it is incorporated into the NMPRF.

11.1.10.3 Hospitals Located in Maryland
Acute care hospitals in Maryland are exempt from the Medicare Payment System. Under the terms of a statewide waiver, Maryland hospitals are instead paid according to the rules of a state-specific, prospective rate-setting system. All Maryland hospitals have been defined in the NMPRF to pay 94% of total claim charges.

However, the NMPRF can be used to estimate what these hospitals would be paid on a per case basis for operating costs if they were not exempt from the
Payment System. To do so, set the Waiver variable located in the hospital rate record to N.

However, users are cautioned about two issues when they apply NMPRF information to Maryland hospitals. First, the information tends to be somewhat out-of-date because CMS does not need to maintain current information for reimbursement purposes. Second, the NMPRF does not contain information needed to calculate per case reimbursement for capital costs in Maryland hospitals. Due to their exempt status, the NMPRF treats Maryland hospitals like new hospitals in setting the value of fields associated with capital reimbursement.

11.1.11.4 Hospitals Located in Alaska and Hawaii
Under the Medicare Payment System, hospitals in Alaska and Hawaii receive special Cost-of-Living Adjustments (COLAs) to standard federal rates. While the applicable operating COLA is stored in the NMPRF, the Medicare DRG Pricer will derive the appropriate capital COLA from the operating COLA field. The Medicare DRG Pricer will then apply COLAs to each field subject to a COLA adjustment according to payment system rules: the non-labor related operating standardized amounts (National Non-Labor and Regional Non-Labor-Related fields), the Standard Federal Rate field for capital, and cost outlier thresholds (Cost OL Thresh field) for each hospital in these two states.

Note
Please refer to the most recent Medicare Rate Variables Worksheet (RVW) for descriptions for the above-mentioned fields.

Note
COLAs are not applied to labor-related operating standardized amounts because differences in labor-related operating costs are recognized through the wage Index.

11.1.12.5 Hospitals Located in Puerto Rico
Under the Medicare Payment System, hospitals in Puerto Rico are paid based on blended national and Puerto Rico rates. National as well as local Puerto Rico factors are used to derive these blended rates. The NMPRF includes a number of fields that are specific to Puerto Rico hospitals, including Puerto Rico Operating and Capital base rates, Wage Index, Geographic Adjustment Factor, and labor portion (LP). The Regional Portion for these hospitals has been set to the appropriate local share of the Puerto Rico payment rate, and the national portion to the appropriate national share.

Note
Please refer to the most recent Medicare Rate Variables Worksheet (RVW) for descriptions for the above-mentioned fields.

11.1.13 Inpatient Psychiatric Facility (IPF NMPRF)
The Inpatient Psychiatric Facility National Medicare Provider Rate Files (IPF NMPRF) contain all rate variables needed to calculate inpatient psychiatric reimbursements under the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF Payment System). For inpatient psychiatric services, the fiscal year is based on the calendar year cycle, July through June, with a Grouper update in October.

The IPF NMPRF is designed to be used with the EASYGroup™ Inpatient Psychiatric Facility (IPF) Pricer, EASYGroup™ Server, ECM Pro™ Inpatient Web Service,™ and Web.Strat™.

11.1.14 Inpatient Rehabilitation Facility (IRF NMPRF)

The IRF NMPRF contains all the rate variables needed to calculate inpatient rehabilitation reimbursements under the Medicare Inpatient Rehabilitation Facility Payment System. Patient-specific reimbursement under the IRF Payment System is generally calculated by applying hospital-specific rate information (e.g., low income patient, rural, teaching adjustments, outlier thresholds, wage index values, etc.) to information about the patient’s stay (e.g., CMG-specific weights). For inpatient rehab services, the federal FY is based on the CY cycle, October through September.

The IRF NMPRF is designed to be used with the EASYGroup™ Medicare IRF Pricer, EASYGroup™ Server, ECM Pro™ IRF Web Service, and Web.Strat™.

11.1.15 Long Term Care (LTC NMPRF)

The LTC NMPRF contains all the rate variables needed to calculate inpatient long term care reimbursements under the Medicare Long Term Care Payment System. For long term care services starting FY 2010, the FY is based on the CY cycle, October through September. Prior to FY 2010, the FY was July through June, with a Grouper update in October.

The LTC NMPRF is designed to be used with the EASYGroup™ Medicare LTC Pricer, EASYGroup™ Server, ECM Pro™ Inpatient Web Service,™ and Web.Strat™.

Note

The 09LTCIP rate file included in the LTC NMPRF distribution contains inpatient rate data that the LTC Payment System needs for the calculation of short stays. However, the LTCIP files are not full Payment System rate records. Most of the Payment System rate data is not used for the long term care short stay amount.

11.1.16 Outpatient (ONMPRF)

The ONMPRF contains all the APC and hospital-specific rate variables needed to calculate outpatient hospital reimbursements under the Medicare hospital OPPS. In the ONMPRF, hospitals have multiple records per calendar quarter, effective on January 1, April 1, July 1, and October 1 up to a
maximum of three years, depending on the release schedule. For outpatient services, the federal FY is based on the CY cycle, January through December. The ONMPRF is designed to be used with the EASYGroup™ Medicare APC-HOPD Pricer, EASYGroup™ Server, ECM Pro™ Outpatient Web Service,™ and Web.Strat™.

11.1.17.1 Hospitals Located in Maryland
Acute care hospitals in Maryland are exempt from the Medicare Payment System. Under the terms of a statewide waiver, Maryland hospitals are paid according to the rules of a state-specific, prospective rate-setting system. All Maryland hospitals have been defined in the ONMPRF to pay 94% of total claim charges. However, the ONMPRF can be used to estimate what these hospitals would be paid under the OPPS if they were not operating under a waiver. To do so, set the Facility Type variable located in the hospital rate record to something other than 05 (OPPS Exempt).

11.1.18 Physician (PNMPRF)
The PNMPRF includes reimbursement data for all Medicare-participating physician and non-physician practitioners in the United States by NPI and Taxonomy, effective January 1, 2011. The PNMPRF includes multiple files for each supported platform. Physician rate data is stored in Physician-specific rate files (separate from all other EASYGroup™ rate files) and includes all national reimbursement variables and practitioner-specific reimbursement variables including the following:

11.1.19.1 National Reimbursement Variables
- Conditional and independent bilateral adjustment factors
- Co-surgery and assistant to surgery adjustment factors
- Multiple surgical procedure and multiple diagnostic imaging procedure discount factors
- Anesthesia minutes used for calculating anesthesia time units
- Monitored anesthesia reduction factor
- Mental health treatment limitation factor
- Primary care HPSA, mental health HPSA, HSIP, and PCIP payment factors
- Coverage and co-insurance factors for physician, ambulance, and laboratory services, as well as DMEPOS and Part B drugs

11.1.20.2 Practitioner-Specific Reimbursement Variables
- OIG Sanction Flag
- PCIP Eligibility Flag

Note
The PNMPRF does not include NPI records without Taxonomy (i.e., “NPI Only” records), since Taxonomy is required by the Physician Pricer to
determine the specialty of a practitioner and, therefore the percentage of the MPFS that the practitioner should be paid. The PNMPRF also does not include records with the legacy Unique Physician Identification Number (UPIN).

The PNMPRF is designed to be used with the EASYGroup™ Medicare Physician Pricer, EASYGroup™ Server, and the ECM Pro™ Physician Web Services.

Note
For further information on the PNMPRF please refer to the EASYGroup™ Technical Reference Guide.

11.1.21 Skilled Nursing Facility (SNF NMPRF)
The SNF NMPRF contains all the rate variables needed to calculate Part A and Part B (bill types 21x, 22x, 23x, and 18x) reimbursements under the Medicare Skilled Nursing Facility Payment System. For skilled nursing services, the federal FY is based on the CY cycle, October through September.

The SNF NMPRF is designed to be used with the EASYGroup™ Medicare SNF Pricer, EASYGroup™ Server, ECM Pro™ SNF Web Service, and Web.Strat™.

11.1.22 Using Rate Manager with the NMPRF
Rate Manager offers a wide range of capabilities for managing, modeling, and reporting on reimbursement contracts. Rate Manager provides NMPRF users with an easy-to-use Windows® interface for:

- Creating reports of hospital/facility-specific rate information.
- Reviewing and updating hospital/facility-specific rate information.
- Reviewing DRG-specific weights, mean lengths of stay, and other normative variables.
- Creating reports of DRG-specific rate information.
- Reviewing APC-specific rates, mean lengths of stay, and other normative variables.
- Creating reports of APC-specific rate information.
- Reviewing CMG-specific weights, mean lengths of stay, and other normative variables.
- Creating reports of CMG-specific rate information.
- Reviewing and updating RUG-specific rate information.
- Reviewing and updating HHRG-specific rate information.
11.2 State Rate Files Overview

The State Rate Files are developed by Optum and are a comprehensive source of hospital-specific Medicaid and TRICARE APC reimbursement information. They contain all the specific information or rate variables needed to calculate hospital reimbursements under the Medicaid and TRICARE APC payment systems. The information contained in these files can be loaded in Rate Manager for use with EASYGroup™ and Web.Strat™.

Note
Each state Medicaid program follows a unique rate update schedule. With each update, rates may be revised for many facilities, or for just a few facilities. When a state Medicaid program posts a new set of rates for all, or most, facilities, Optum releases an update to the associated State Rate File. If an update involves changes to selected facilities only, Optum follows a general 5% guideline, meaning that if 5% or more of the facilities in the file have rate changes, an update will be scheduled. If not, those changes are stored and tracked until additional changes are posted, and that 5% threshold is reached, at which time an update is scheduled.

11.2.1 Uses of the State Rate Files

The State Rate Files are designed to be a tool for providers, payers, health care plans, and others that need to determine a hospital’s patient-specific payments according to prospective pricing rules. The State Rate Files have many potentially valuable applications including those listed below:

- Can be used to calculate reimbursement for inpatient stays or outpatient visits, subject to the limitations of the data as detailed below.
- Can serve as a mutually acceptable basis for pricing hospital bills under contracts that require emulation of payment system rules.
- Can be used by health care providers and purchasers as the basis for rate negotiations, especially when the negotiations involve prices as a percent of reimbursement.
- Can be used to evaluate the relative expense of services provided by hospitals competing in specific market areas, thus identifying opportunities for reducing costs by redirecting patients to more efficient providers.
- Purchasers and health plans can use the State Rate Files to quantify and document potential savings from the more efficient use of health care providers.
• Analysts can use the State Rate Files to convert hospital-specific charges to estimated amounts that would be reimbursed by Medicaid or TRICARE APC under well-defined circumstances.

11.2.2 Inpatient State Rate Files

11.2.3.1 Arizona State Rate Files (AZSRF)
The AZSRF is a comprehensive source of hospital-specific Arizona state inpatient Medicaid reimbursement information. It contains all the specific variables needed to calculate inpatient hospital reimbursements (including inlier, outlier, and transfer payments) under the Arizona Medicaid APR Payment System. The AZSRF was constructed from information obtained directly from the Arizona Health Care Cost Containment System (AHCCCS). Facility-specific data includes wage-adjusted base rates, ratios of costs to charges, thresholds, and other adjustments and factors used in payment calculations for all Arizona hospitals, as well as selected high-volume out-of-state facilities. DRG-specific data includes average length of stay, relative weights, and other factors. The Facility IDs included are Arizona Medicaid Provider IDs as well as directly linked National Provider Identifiers (NPIs). The standard rates for all facilities are included in the Arizona Medicaid Rate Variables Worksheet (RVW).

11.2.4.2 California State Rate Files (CASRF)
The CASRF was constructed from information obtained directly from the California Department of Health Care Services (DHCS). It contains all the facility-specific information or rate variables needed to calculate inpatient hospital reimbursements under the California Medicaid Payment System. The standard rates for out of state facilities are included in the California Medicaid Rate Variables Worksheet (RVW). These rate files do not include information for California Medicaid Payment System-exempt hospitals (including California Medicaid Border Hospitals).

11.2.5.3 Colorado State Rate Files (COSRF)
The COSRF was constructed from information obtained directly from the Colorado Department of Health Care Policy & Financing. It contains all the facility-specific information or rate variables needed to calculate inpatient hospital reimbursements under the Colorado Medicaid Payment System. In addition, the file contains rates for out-of-state urban and rural facilities to support payment for all other out-of-state providers.

Hospital-specific data includes base rates, mark-up/discount, and other factors used in payment calculations for Colorado hospitals. DRG-specific data includes relative weights and other data. All rates are identified based on each hospital's National Provider Identifier (NPI). The standard rates for all hospitals are included in the Colorado Medicaid Rate Variables Worksheet (RVW).

11.2.6.4 Florida State Rate Files (FLSRF)
The FLSRF was constructed from information obtained directly from the Florida Agency for Health Care (AHCA). It contains all the facility-specific
information or rate variables needed to calculate inpatient hospital reimbursements under the Florida Medicaid Payment System.

Rates include Base Payments, Inter-Governmental Transfers (IGT) Add-On Payments (prior to October 01, 2020), and other factors used in payment calculations. The FLSRF is pre-loaded with DRG weights for multiple effective dates. The Facility IDs included are Florida Medicaid Provider IDs. The standard rates for all facilities are included in the Florida Medicaid Rate Variables Worksheet (RVW).

11.2.7.5 Georgia State Rate Files (GASRF)
The GASRF was constructed from information obtained directly from the Georgia Health and Human Services Commission. The rate file data fields were built from information contained in public use files released by the state Health and Human Services Commission.

The GASRFs are a comprehensive source of hospital-specific Georgia state inpatient Medicaid reimbursement information. It contains all the specific information or rate variables needed to calculate inpatient hospital reimbursements (including inlier, outlier, and transfer payments) under the Georgia Medicaid Payment System.

The Georgia rates are updated every two to three years. The GASRF contains information related to Georgia state Medicaid since July 01, 2005. The file contains information for Medicaid-participating hospitals for the state of Georgia. The standard rates for out of state facilities are included in the Georgia Medicaid Rate Variables Worksheet (RVW). These rate files do not include information for payment system-exempt hospitals.

Each record in the GASRF contains information about a single hospital for a specific time period. In most cases, the effective date is either January 1 or July 1 of a calendar year.

- Capital and Graduate Medical Education (GME) Add-Ons:
  The GASRF includes the capital add-on for each facility as defined by the Georgia State Department of Health. This distribution does not include the GME add-on. This field is set to $0. Users can manually add a GME add-on to a facility using Rate Manager.

- Cost Outlier Add-Ons:
  According to the Georgia State Department of Health, cost outliers are only paid after the claim is submitted for review. The GASRF distribution will calculate the outlier add-ons as if the claim was reviewed and declared eligible for the cost outlier payment.

- Transfer Payments:
  According to the Georgia State Department of Health, if a patient is transferred from one hospital for admission and then to a second hospital for medically appropriate cause, and the claims for both hospitals fall into the same DRG, each hospital’s payment will be the lesser of the DRG rate
or the rate calculated by the CCR methodology. If a patient is transferred from one hospital for admission and then to a second hospital for medically appropriate cause, and the claims for both hospitals fall into different DRGs, each hospital’s payment will be the amount that a non-transfer claim would be paid. The GASRF distribution is set up so that the CCR method will be paid to any claim in which the CCR payment is less than the DRG payment.

- **Newborn Screening Add-On:**

  Effective January 1, 2007, Georgia law (OCGA 31-12-6 & 31-12-7) and rules and regulations (Chapter 290-5-24) requires that every newborn receive a blood test screening for twenty-eight separate disorders. The Georgia Department of Community Health will make a standard Medicaid payment to a hospital when this newborn screening is performed.

11.2.8.6 **Illinois State Rate Files (ILSRF)**

The ILSRFs are a comprehensive source of hospital-specific Illinois State Medicaid inpatient reimbursement information. It contains all the specific information or rate variables needed to calculate inpatient hospital reimbursements (DRG inlier, cost or LOS outliers, and transfer payments) under the Illinois Medicaid Payment System.

The Illinois rates are updated when new data becomes available from the Illinois Department of Healthcare and Family Services. The file contains information for Medicaid hospitals located in and outside the state of Illinois. Each record in the ILSRF contains information about a single hospital for a specific time period.

Patient-specific reimbursement under the Illinois Medicaid Payment System is generally calculated by applying hospital-specific rate information to information about the patient’s stay. The ILSRF contains the hospital-specific information needed by the EASYGroup™ Illinois Medicaid Pricer, EASYGroup™ Server, or Web.Strat™ to calculate a patient’s anticipated Illinois Medicaid reimbursement.

11.2.9.7 **Indiana State Rate Files (INSRF)**

The INSRF is a comprehensive source of facility-specific Indiana Medicaid inpatient reimbursement information. It contains all the specific information or rate variables needed to calculate inpatient facility reimbursements (per diem, inlier, outlier, and transfer payments) under the Indiana Medicaid APR-DRG Payment System.

The Indiana rates are updated when new data becomes available from Indiana Health Coverage Program (IHCP). The file contains information for Medicaid facilities located in the state of Indiana. Each record in the INSRF contains information about a single facility for a specific time period.

Patient-specific reimbursement under the Indiana Medicaid APR-DRG Payment System is generally calculated by applying facility-specific rate information (e.g., facility-specific APR-DRG and/or per diem base rates, outlier threshold, ratio of cost-to-charges, etc.) to information about the patient’s stay.
(e.g., APR-DRG specific weights). The INSRF contains the facility-specific information needed by the Medicaid APR Pro Pricer to calculate a patient’s anticipated Indiana Medicaid reimbursement. The standard rates are included in the Indiana Medicaid APR Rate Variables Worksheet (RVW).

11.2.10.8 Iowa State Rate Files (IASRF)
The IASRF was constructed from information obtained directly from the Iowa Medicaid Enterprise (IME). It contains all the specific information and rate variables needed to calculate inpatient hospital reimbursement under the Iowa Medicaid Payment System. The standard rates are included in the Iowa Medicaid Rate Variables Worksheet (RVW).

11.2.11.9 Kansas State Rate Files (KSSRF)
The KSSRF was constructed from information obtained directly from the Kansas Medical Assistance Program (KMAP). It contains all the specific information and rate variables needed to calculate inpatient hospital reimbursements under the Kansas Medicaid Payment System. The standard rates are included in the Kansas Medicaid Rate Variables Worksheet (RVW).

11.2.12.10 Louisiana State Rate Files (LASRF)
The LASRF is a comprehensive source of hospital-specific Louisiana state inpatient Medicaid reimbursement information. It contains all the specific variables needed to calculate inpatient hospital reimbursements under the Louisiana Medicaid Payment System. The LASRF was constructed from information obtained directly from the state of Louisiana.

Hospital-specific data includes base rates, capital add-on amounts, medical education add-on amounts, Ratio of Costs-to-Charges (RCCs), a high cost outlier threshold, psychiatric per diem, rehabilitation per diem, and other factors used in payment calculations for Louisiana hospitals. DRG-specific data includes relative weights and other data. The Facility ID included is the Medicaid Identifier (ID). The standard rates for all hospitals are included in the Louisiana Medicaid Rate Variables Worksheet (RVW).

11.2.13.11 Michigan State Rate Files (MISRF)
The MISRF was constructed from information obtained directly from the Michigan Department of Health and Human Services (MDHHS). It contains all the specific information and rate variables needed to calculate inpatient hospital reimbursement under the Michigan Medicaid APR-DRG Payment System. The standard rates are included in the Michigan Medicaid and Michigan Medicaid APR Rate Variables Worksheets (RVWs).

11.2.14.12 Minnesota State Rate Files (MNSRF)
The MNSRF was constructed from information obtained directly from the Minnesota Department of Human Services. It contains all the facility-specific information or rate variables needed to calculate inpatient hospital reimbursements under the Minnesota Medicaid Payment System.

Facility-specific data includes base rates, mark-up/discount, and other factors used in payment calculations for Minnesota hospitals. DRG-specific data includes relative weights and other data. All rates are identified based on each
hospital's Medicaid Identifier (ID), along with Payer ID 32. The standard rates for all hospitals are included in the Minnesota Medicaid Rate Variables Worksheet (RVW).

11.2.15.13 Nebraska State Rate Files (NESRF)
The NESRF is a comprehensive source of hospital-specific Nebraska state inpatient Medicaid reimbursement information for Managed Care Organizations (MCOs). It contains all the specific variables needed to calculate inpatient hospital reimbursements (including inlier, outlier, and transfer payments) under the Nebraska Medicaid APR Payment System. The NESRF was constructed from information obtained directly from the Nebraska Department of Health and Human Services. Facility-specific data includes base rates, per diems, ratios of costs-to-charges, thresholds, and other adjustments and factors used in payment calculations for all Nebraska hospitals, as well as selected high-volume out-of-state facilities. DRG-specific data includes average length of stay, relative weights, and other factors. The Facility IDs included are Nebraska Medicaid Provider IDs. The standard rates for all facilities are documented in the Nebraska Medicaid Rate Variables Worksheet (RVW).

11.2.16.14 New Mexico State Rate Files (NMSRF)
The NMSRFs are a comprehensive source of hospital-specific New Mexico State Medicaid inpatient reimbursement information. It contains all the specific information or rate variables needed to calculate inpatient hospital reimbursements (DRG inlier, outlier, and transfer payments) under the New Mexico Medicaid Payment System. The New Mexico rates are updated when new data becomes available from the New Mexico Medical Assistance Division (MAD). The file contains information for Medicaid hospitals located in the state of New Mexico. Each record in the NMSRF contains information about a single hospital for a specific time period.

Patient-specific reimbursement under the New Mexico Medicaid Payment System is generally calculated by applying hospital-specific rate information to information about the patient's stay. The NMSRF contains the hospital-specific information needed by the EASYGroup™ New Mexico Medicaid Pricer, EASYGroup™ Server, or Web.Strat™ to calculate a patient’s anticipated reimbursement according to New Mexico Medicaid billing rules.

11.2.17.15 New Jersey State Rate Files (NJSRF)
The NJSRF is a comprehensive source of hospital-specific New Jersey state inpatient Medicaid reimbursement information. It contains all the specific variables needed to calculate inpatient hospital reimbursements under the New Jersey Medicaid APR Payment System. The NJSRF was constructed from information obtained directly from the state of New Jersey.

Hospital-specific data includes base rates, adjustment factors for hospitals that provide critical services, Ratio of Costs-to-Charges (RCCs) and other factors used in payment calculations for New Jersey hospitals. DRG-specific
data includes relative weights and other data. The Facility Identifier (ID) included is the Medicaid ID. The standard rates for all hospitals are included in the New Jersey Medicaid APR Rate Variables Worksheet (RVW).

**11.2.18.16 New York State Rate Files (NYSRF)**

The NYSRFs are a comprehensive source of hospital-specific New York State inpatient Medicaid, worker’s compensation, fee for service, and no fault reimbursement information for the All Patient-Diagnosis Related Group (AP-DRG) and All Patient Refined-Diagnosis Related Group (APR-DRG) Prospective Payment Systems. It contains all the specific information or rate variables needed to calculate inpatient hospital reimbursements (including inlier, outlier, and transfer payments) under the New York State Medicaid, worker’s compensation, fee for service (APR-DRG Payment Systems only), and no fault Prospective Payment Systems.

The New York rates are updated at least twice a year, generally effective each January and July. The file contains information for Medicaid, worker’s compensation, fee for service (APR Payment System only), and no fault-participating hospitals located in the State of New York. These rate files do not include information for payment system-exempt hospitals.

Each record in the NYSRF contains information about a single hospital for a specific time period. In most cases, the effective date is either January 1 or July 1 of a calendar year. The New York Medicaid APR-DRG C Platform Payment System was effective as of December 1, 2009. The New York Medicaid APR-DRG COBOL Platform Payment System (coming soon) was effective as of January 01, 2013.

New York State defines three different sets of DRG-specific payment information (e.g., weights, means, and trims). The first two sets are for the AP-DRG Payment System. The first set is specific to downstate hospitals and the second is specific to upstate hospitals. The third set is APR-DRG specific.

- **Weights:**

  This designation of upstate or downstate is published by the New York Department of Health (NYDOH). The NYSRF distribution contains DRG-specific information in the format required by Web.Strat™, EASYGroup™, and Rate Manager. In the NYSRF, the appropriate weights are associated with each facility.

**11.2.19.17 Ohio State Rate Files (OHSRF)**

The OHSRF was constructed from information obtained directly from the Ohio Department of Medicaid. It contains all the specific information and rate variables needed to calculate inpatient hospital reimbursement under the Ohio Medicaid APR-DRG Payment System. The standard rates are included in the Ohio Medicaid APR-DRG Rate Variables Worksheet (RVW).
11.2.20.18 Pennsylvania State Rate Files (PASRF)
The PASRF is a comprehensive source of hospital-specific Pennsylvania state inpatient Medicaid reimbursement information. It contains all the specific information and rate variables needed to calculate inpatient hospital reimbursement under the Pennsylvania Medicaid APR-DRG Payment System. The PASRF was constructed from information obtained directly from the state of Pennsylvania. The standard rates are included in the Pennsylvania Medicaid APR Rate Variables Worksheet (RVW).

11.2.21.19 Rhode Island State Rate Files (RISRF)
The RISRF was constructed from information obtained directly from the state of Rhode Island’s Executive Office of Health & Human Services. It contains all the facility-specific information or rate variables needed to calculate inpatient facility reimbursements under the Rhode Island Medicaid Payment System. Facility-specific data includes base rates, mark-up/discount, and other factors used in payment calculations for Rhode Island facilities. DRG-specific data includes relative weights and other data. All rates are identified based on each facility’s National Provider Identifier (NPI), along with Payer ID 41. The standard rates for all facilities are included in the Rhode Island Medicaid Rate Variables Worksheet (RVW).

11.2.22.20 Texas State Rate Files (TXSRF)
The TXSRFs are a comprehensive source of hospital-specific Texas Medicaid inpatient reimbursement information. It contains all the specific information or rate variables needed to calculate inpatient hospital reimbursements (including inlier, outlier and transfer payments) under the Texas Medicaid Payment System.

The TXSRF contains information related to Texas Medicaid since October 1, 2005. Releases of the TXSRF will occur as needed. The file contains information for Medicaid-participating hospitals located in the state of Texas. These rate files do not include information for payment system-exempt hospitals.

Each record in the TXSRF contains information about a single hospital for a specific time period. On an ongoing basis there is the potential for two time periods in one calendar year; rate changes that go into effect at the beginning of the state’s calendar year (September 1st) and a second time period for when the DRG weights go into effect (most likely October 1st).

- LOS and Cost Outlier Add-Ons:

According to the Texas Health and Human Services Commission (HHSC), the patient must be under 21 years of age to be eligible for the Marginal Cost Factor - LOS and Marginal Cost Factor - Cost add-ons.

11.2.23.21 TRICARE Rate Files
The TRICARE rate files are a comprehensive source of hospital-specific TRICARE inpatient reimbursement information. It contains all the specific information or rate variables needed to calculate inpatient reimbursements under the TRICARE/CHAMPUS Payment System.
Based on statutory requirements, TRICARE has adapted Medicare’s payment system for reimbursement of hospital inpatient services provided to military personnel, veterans, and their families. This payment system pays for hospital inpatient services based on DRGs.

11.2.24.22 Virginia State Rate Files (VASRF)
The VASRF is a comprehensive source of hospital-specific Virginia state inpatient Medicaid reimbursement information. It contains all the specific variables needed to calculate inpatient hospital reimbursements under the Virginia Medicaid APR-DRG Payment System. The VASRF was constructed from information obtained directly from that state of Virginia. Facility-specific data includes wage-adjusted base rates, ratios of costs-to-charges, thresholds, and other adjustments and factors used in payment calculations for all Virginia hospitals. DRG-specific data includes average length of stay, relative weights, and other factors. The Facility IDs included are National Provider Identifiers (NPIs). The standard rates for all facilities are included in the Virginia Medicaid APR Rate Variables Worksheet (RVW).

11.2.25.23 Washington State Rate Files (WASRF)
The WASRF is a comprehensive source of hospital-specific Washington state inpatient Medicaid reimbursement information. It contains all the specific variables needed to calculate inpatient hospital reimbursements (including inlier, outlier, and transfer payments) under the Washington Medicaid APR-DRG Payment System. The WASRF was constructed from information obtained directly from Washington State. Facility-specific data includes wage-adjusted base rates, ratios of costs-to-charges, thresholds, and other adjustments and factors used in payment calculations for all Washington hospitals, as well as selected high-volume out-of-state facilities. DRG-specific data includes average length of stay, relative weights, and other factors. The Facility IDs included are Washington Medicaid Provider IDs as well as directly linked National Provider Identifiers (NPIs). The standard rates for all facilities are included in the Washington Medicaid APR Rate Variables Worksheet (RVW).

11.2.26.24 Wisconsin State Rate Files (WISRF)
The WISRF is a comprehensive source of hospital-specific Wisconsin state inpatient Medicaid reimbursement information. It contains all the specific variables needed to calculate inpatient hospital reimbursements under the Wisconsin Medicaid APR-DRG Payment System. The WISRF was constructed from information obtained directly from the state of Wisconsin. Facility-specific data includes base rates, Ratios of Costs-to-Charges (RCCs), a high cost outlier threshold, provider adjustors, and other factors used in payment calculations for all Wisconsin hospitals, as well as out-of-state facilities. DRG-specific data includes relative weights and other data. The Facility IDs included are National Provider Identifiers (NPIs) and Medicaid Identifiers (ID). The standard rates for all facilities are included in the Wisconsin Medicaid APR-DRG Rate Variables Worksheet (RVW).
11.2.27 Outpatient State Rate Files

11.2.28.1 Colorado Outpatient State Rate Files (COOSRF)
The COOSRF is a comprehensive source of APG reimbursement information for participating outpatient hospitals. It contains all of the specific information or rate variables needed to calculate outpatient hospital reimbursement under the Colorado Medicaid APG Payment System.

The file contains Medicaid outpatient rates and weights for hospitals located in the state of Colorado and is updated when new data becomes available from the state of Colorado. In addition, the file contains rates for out-of-state urban and rural facilities to support payment for all other out-of-state providers, based on hospital variables provided by the state of Colorado.

11.2.29.2 Florida Outpatient State Rate Files (FLOSRF)
The FLOSRF is a comprehensive source of APG reimbursement information for participating outpatient hospitals. It contains all of the specific information or rate variables needed to calculate outpatient hospital reimbursement under the Florida Medicaid APG Payment System.

The file contains Medicaid outpatient rates and weights for hospitals located in the state of Florida and is updated when new data becomes available from the Florida Agency for Health Care Administration.

11.2.30.3 Illinois Outpatient State Rate Files (ILOSRF)
The ILOSRF is a comprehensive source of APC reimbursement information for participating hospital/outpatient departments/clinics and Ambulatory Surgical Centers (ASCs). It contains all the specific information or rate variables needed to calculate outpatient hospital reimbursements under the Illinois Medicaid APG Payment System.

The file contains Medicaid outpatient rates and weights for hospitals located in the state of Illinois, plus selected out-of-state facilities, and is updated when new data becomes available from the Illinois Department of Healthcare and Family Services (HFS).

- **Facility Rates:**

  Illinois Medicaid publishes, for each facility, a final adjusted base rate, which is based on a standardized base rate adjusted for the wage index, increased for high Medicaid volume, and reduced due to the SMART Act where applicable. This final adjusted rate is included in the ILOSRF for every facility. Also included are standardized factors for multiple procedure discounting and adjustments for terminated or bilateral services and repeat ancillary services.

- **Weights:**

  Illinois Medicaid publishes a set of APG-specific weights. The ILOSRF distribution contains APG-specific weights in the format required by Web.Strat™ and Rate Manager. The appropriate weights are associated with each facility.
11.2.31.4 Iowa Outpatient State Rate Files (IAOSRF)
The IAOSRF is a comprehensive source of hospital-specific Iowa-specific Medicaid outpatient reimbursement information. It contains all the specific information or rate variables needed to calculate outpatient hospital reimbursements (fee schedules, outlier payments, and discounting) under the Iowa Medicaid APC Payment System.

The file contains Iowa Medicaid outpatient rates and weights for hospitals located in the state of Iowa and is updated when new data becomes available from the Iowa Department of Human Services.

- **ACE Rule File:**
  The Iowa Medicaid APC Payment System utilizes the ACE Rule File (acerule.dat) to bypass Outpatient Code Edits (OCEs) for Critical Access Hospital (CAH) claims. The IAOSRF contains the associated ACE Override ID which allows the OCEs to be bypassed for CAH claims. The naming convention for the ACE Override ID in the ACE Rule File for Iowa Medicaid is EDITSOFF. Refer to the EASYGroup™ Technical Reference Guide for further information.

- **APC Rule File:**
  The Iowa Medicaid APC Payment System utilizes the APC Rule File (apcrule.dat) as an integral part of the payment calculation. The APC Rule File with its associated override IDs changes the Payment Status Indicators for a large volume of codes from their CMS-defined value to Payment Status Indicator A or E. In addition, this file is used to override APCs and maximum allowable units. The naming convention for the Override IDs in the APC Rule File for Iowa Medicaid is IAMCDOVERRIDE1. Refer to the Appendix B for further information.

- **Weights:**
  Iowa Medicaid publishes a set of APC-specific weights. The IAOSRF distribution contains APC-specific weights in the format required by Web.Strat™ and Rate Manager. The appropriate weights are associated with each facility.

11.2.32.5 Michigan Ambulatory Surgical State Rate Files (MIASRF)
The MIASRF was constructed from information obtained directly from the Michigan Department of Community Health.

The MIASRF consists of facility-specific reimbursement rates, state-specific fee schedules, APC-based grouping rules, and Correct Coding Initiative (CCI) editing rules. These files are used to calculate the expected Medicaid reimbursement for all patients in these free-standing Ambulatory Surgical Centers (ASCs). The MIASRF is designed to be used with EASYGroup™ and Web.Strat™ ASC Pro Payment Systems.

- **ASC Rule File:**
  The Michigan Medicaid ASC Payment System utilizes the ASC Rule File (ascrule.dat) as an integral part of
the payment calculation. The ASC Rule File with its associated override IDs, changes the Payment Status Indicators for a large volume of codes from their CMS-defined value to Payment Status Indicators AX, AZ, or EX. This directs the codes to the fee schedule described above to determine price. In some instances pricing may be zero. The naming convention for the override IDs in the ASC Rule File for Michigan Medicaid ASC is MIASCOVERRIDE1.

11.2.33.6 Michigan Outpatient State Rate Files (MIOSRF)
The MIOSRFs are a comprehensive source of hospital-specific Michigan State Medicaid outpatient reimbursement information. It contains all the specific information or rate variables needed to calculate outpatient hospital reimbursements (fee schedules, outlier payments, and discounting) under the Michigan Medicaid APC Payment System.

The Michigan rates are updated when new data becomes available from Michigan Department of Community Health (MDCH). The file contains information for Medicaid hospitals located in the state of Michigan. Each record in the MIOSRF contains information about a single hospital for a specific time period.

- APC Rule File:
The Michigan Medicaid APC Payment System utilizes the APC Rule File (apcrule.dat) (part of the Rate Manager APC Pro Module) as an integral part of the payment calculation. The APC Rule File with its associated override IDs changes the Payment Status Indicator for a large volume of codes from their CMS-defined value to a Payment Status Indicator of A. This directs the codes to the fee schedule described above to determine price where in some instances pricing may be zero. The naming convention for the override IDs in the APC Rule File for Michigan Medicaid outpatient is MIMCDOVERRIDE1.

11.2.34.7 Nebraska Outpatient State Rate Files (NEOSRF)
The NEOSRF is a comprehensive source of APG reimbursement information for participating outpatient hospitals. It contains all of the specific information or rate variables needed to calculate outpatient hospital reimbursement under the Nebraska Medicaid APG Payment System.

The file contains Medicaid outpatient rates and weights for hospitals located in the state of Nebraska and is updated when new data becomes available from the state of Nebraska. In addition, the file contains rates for out-of-state non-participating hospitals.

11.2.35.8 New Mexico Outpatient State Rate Files (NMOSRF)
The NMOSRF is a comprehensive source of APC reimbursement information for participating outpatient hospitals. It contains all of the specific information or rate variables needed to calculate outpatient hospital reimbursement under the New Mexico Medicaid APC Payment System.

The NMOSRF contains payment rules and rates (beginning on January 01, 2019) for all New Mexico acute care hospitals, Critical Access Hospitals (CAHs), and outpatient rehabilitation facilities that will be paid under the New Mexico Medicaid APC Payment System. All rates are identified using each
facility’s National Provider Identifier (NPI), and Taxonomy Code (if applicable), along with Payer ID 21.

11.2.36.9 New York Outpatient State Rate Files (NYOSRF)
The NYOSRF is a comprehensive source of Ambulatory Patient Group (APG) reimbursement for participating hospital/outpatient departments/clinics, emergency departments, free-standing diagnostic and treatment centers, Office for People With Developmental Disabilities (OPWDD) facilities, Office of Alcoholism and Substance Abuse (OASAS) facilities, Office of Mental Health (OMH) facilities, and free-standing ASCs. It contains all the specific information or rate variables needed to calculate outpatient hospital reimbursements under the New York Medicaid APG Payment System.

The New York Medicaid outpatient rates will be updated when new data becomes available from New York Department of Health (NYSDOH). The file contains information for Medicaid outpatient hospitals located in the state of New York.

Note
Beginning with the V0907 release, rate files include two sets of hospital rates for out-of-state providers. The 998NAPG and 998NAPGNPI records contain hospital variables for out-of-state providers in counties that are contiguous to New York City along with Dutchess, Putnam, Westchester, Rockland, and Orange counties. The 997NAPG and 997NAPGNPI records should be utilized to support payment for all other out-of-state providers.

• Weights:
New York publishes a set of APG-specific payment information, (e.g., weights). The NYOSRF distribution contains APG-specific information in the format required by Rate Manager. The appropriate weights are associated with each facility.

11.2.37.10 Ohio Outpatient State Rate Files (OHOSRF)
The OHOSRF is a comprehensive source of APG reimbursement information for participating hospital/outpatient departments/clinics. It contains all the specific information or rate variables needed to calculate outpatient hospital reimbursement under the Ohio Medicaid APG Payment System.

The file contains Medicaid outpatient rates and weights for hospitals located in the state of Ohio and is updated when new data becomes available from the Ohio Department of Medicaid.

• Weights:
Ohio Medicaid publishes a set of APG-specific weights. The OHOSRF distribution contains APG-specific weights in the format required by Web.Strat™ and Rate Manager. The appropriate weights are associated with each facility.
11.2.38.11 TRICARE APC Rate Files
The TRICARE APC rate files are a comprehensive source of hospital-specific TRICARE outpatient reimbursement information. It contains all the specific information or rate variables needed to calculate outpatient reimbursements under the TRICARE APC Payment System.

Based on statutory requirements, TRICARE has adapted Medicare’s payment system for reimbursement of hospital outpatient services provided to military personnel, veterans, and their families. This payment system was first implemented on May 1, 2009, and pays for hospital outpatient services based on Ambulatory Payment Classifications (APCs).

11.2.39.12 Virginia Ambulatory Surgical Center State Rate Files (VAASRF)
The VAASRF contains payment rules and rates for all ambulatory surgery centers that are paid under the Virginia Medicaid ASC Payment System. All rates are identified based on each facility’s ten digit National Provider Identifier (NPI) along with Payer ID 56.

The Virginia Medicaid ambulatory surgery center rates will be updated when new data becomes available from Virginia Medicaid.

- Weights:
  Virginia publishes a set of APG-specific weights. The VAASRF distribution contains APG-specific weights for ASCs in the format required by Web.Strat™ and Rate Manager. The appropriate weights are associated with each facility.

11.2.40.13 Virginia Outpatient State Rate Files (VAOSRF)
The VAOSRF is a comprehensive source of APG reimbursement information for participating hospital/outpatient departments/clinics. It contains all the specific information or rate variables needed to calculate outpatient hospital reimbursements under the Virginia Medicaid APG Payment System.

The Virginia Medicaid outpatient rates will be updated when new data becomes available from Virginia Medicaid. The file contains Medicaid outpatient information for hospitals located in the state of Virginia.

- Weights:
  Virginia publishes a set of APG-specific weights. The VAOSRF distribution contains APG-specific weights in the format required by Web.Strat™ and Rate Manager. The appropriate weights are associated with each facility.

11.2.41.14 Washington Outpatient State Rate Files (WAOSRF)
The WAOSRF is a comprehensive source of APG reimbursement information for participating hospital/outpatient departments/clinics. It contains all the specific information or rate variables needed to calculate outpatient hospital reimbursements under the Washington Medicaid APG Payment System.

The Washington Medicaid outpatient rates will be updated when new data becomes available from the Washington Health Care Authority (HCA). The file contains Medicaid outpatient information for hospitals located in the state of Washington.
• Weights:
Washington publishes a set of APG-specific weights. The WAOSRF distribution contains APG-specific weights in the format required by Web.Strat™ and Rate Manager. The appropriate weights are associated with each facility.

11.2.42.15 Wisconsin Outpatient State Rate Files (WIOSRF)
The WIOSRF is a comprehensive source of APG reimbursement information for participating hospital/outpatient departments/clinics. It contains all the specific information or rate variables needed to calculate outpatient hospital reimbursements under the Wisconsin Medicaid APG Payment System.
The Wisconsin Medicaid outpatient rates will be updated when new data becomes available from the Wisconsin Department of Health Services (DHS). The file contains Medicaid outpatient information for hospitals located in the state of Wisconsin.

• Weights:
Wisconsin publishes a set of APG-specific weights. The WIOSRF distribution contains APG-specific weights in the format required by Web.Strat™ and Rate Manager. The appropriate weights are associated with each facility.

11.3 Sources of Data

11.3.1 NMPRF Data
Each NMPRF was constructed from information obtained directly from CMS. Many NMPRF data fields were built from information contained in public use files released by CMS. Other NMPRF elements were based on information periodically published by the following:

• CMS in the Federal Register
• CMS Program Transmittals
• CMS Outpatient Cost-to-Charge Ratio (OCCR) Files
• CMS Provider-Specific Files (PSF)
• CMS Provider of Services (POS) Files
• CMS Impact File
• CMS PC Pricer Software
• Prospective Payment System Hospital Data Sets (Medicare Cost Report)
Optum has worked to verify the accuracy and timeliness of the source data used to create the NMPRFs. This verification process involved consultations with the CMS staff directly responsible for assembling the public data files and direct consultation with individual providers and health plans. Conclusions regarding the validity of source data and its impact on the potential uses of these files are discussed later in this chapter.
11.4 Rate File Limitations

11.4.1 NMPRFs

Data contained in each NMPRF is subject to two basic limitations. First, the information contained in the file comes from the CMS, whereas actual Medicare reimbursements are determined by regional Medicare Administrative Contractors (MACs) acting on behalf of CMS. CMS periodically collects payment information from MACs and assembles this information for the purpose of both analysis and for public release. The quality of the data published by CMS depends upon the accuracy of the reporting by the MACs. Second, delays by MACs in collecting and submitting this information to CMS and the frequency with which CMS updates publicly released files, will affect the extent to which information released by CMS is appropriate for pricing Medicare claims, at the time of and subsequent to the release of that information.

Data elements that are completely accurate at the time that Optum assembles a NMPRF or at the time Optum supplies this file to the client can become inaccurate over time. Provider-specific information used to reimburse for Medicare services can change to reflect revisions or settlements in Medicare cost reports, or administrative decisions by either CMS or its MACs. The most accurate and stable fields are those that pertain to the National Medicare Payment System program and are published annually in the Federal Register (such as the national and regional adjusted standardized amounts or labor portion). Yet, even these variables can change for individual providers if the provider is reclassified during the year. The least stable fields are provider-specific fields, such as the disproportionate share adjustment, whose values are determined based on cost report submissions.

In most cases, data contained in a NMPRF will match information Optum has obtained directly from providers. In addition, CMS states that the information contained in the source files was either used to reimburse providers under the specific Medicare payment system at some point in time, or would have been used for this purpose except for the special treatment accorded to certain providers (i.e., community hospitals in Maryland or cancer treatment centers). However, users must recognize the limitations of this data and are urged to verify specific data elements with individual providers to achieve the greatest possible accuracy in calculating Medicare reimbursement.

The NMPRF contains the best information currently available to Optum. It also contains retroactive information available and occurring within the current fiscal year. The NMPRF can be used to establish accurate Medicare reimbursement rates for many discharges occurring in the United States during the current and preceding federal fiscal years. Even when it is not entirely accurate (based on information provided by CMS) this file will provide approximate Medicare payment rates that are acceptable for most analytic purposes.
Optum updates NMPRFs on a periodic basis and will work with clients to understand anomalies and inaccuracies in this data. However, for the reasons described above, Optum extends no warranties or assurances that the information contained in a NMPRF can be used to determine exact Medicare reimbursement during any specific period. Users that require dollar accuracy in calculating actual reimbursement rates must confirm specific reimbursement rate variables with providers and MACs.

11.4.2 State Rate Files
Each state rate file contains the best information currently available to Optum. It can be used to establish accurate reimbursement rates for many discharges occurring during the current year. Even when it is not entirely accurate, based on information provided, these files will provide approximate Medicaid or TRICARE payment rates that are acceptable for most analytic purposes. Optum updates the state rate files on a periodic basis and will work with clients to understand anomalies and inaccuracies in this data. However, for the reasons described above, Optum extends no warranties or assurances that the information contained in the state rate files can be used to determine exact Medicaid or TRICARE reimbursement during any specific period. Users that require dollar accuracy in calculating actual reimbursement rates must confirm specific reimbursement rate variables with providers.

11.5 Rate File Change Report Layouts
The rate files include supplemental documentation to help clients manage and understand Medicare and Medicaid updates and retroactive changes. This documentation is available on the Optum Client Portal and through the Optum Update Wizard.

Optum has made substantial enhancements to the format and content of the rate file change report spreadsheets. The rate file change reports communicate the exact changes being made in a specific rate file release in a much more detailed manner than the Optum PPS Product Suite Release Notes. Features of the change reports are listed below:

- Filters are enabled so that specific types of changes are even easier to find. The report is also sorted by provider number (either Legacy ID or NPI/Taxonomy), then by Effective Date, and then by the rate file version number, so that all changes for a specific provider can be seen in one place.

- The “Changed-Legacy” and “Changed-NPI” tabs show both old and new values in separate columns.

- The “Changed-Legacy” and “Changed-NPI” tabs also include cumulative information, so that clients will be able to search for prior changes (going back to the beginning of 2017) without opening multiple spreadsheets.

- Clients can sort/filter in the “Changed-Legacy” and “Changed-NPI” tabs by the following options:
- **Updated**: Updated records show a Previous Value and an Updated Value:

Figure 11-1. Example Updated Record

![Updated Record Table]

- **New**: New facility rate records show an Updated Value:

Figure 11-2. Example New Record

![New Record Table]

- **Closed**: Closed records show an Updated Value of 0.00:

Figure 11-3. Example Closed Record

![Closed Record Table]

- **Reopened**: Reopened records show a Previous Value of 0.00 along with an Updated Value:
11.5.1.1 Closed Facilities Lists
Files prefixed with closed- will contain a list of provider numbers (legacy or NPI) and names (if available) of facilities for which there is no available rate information for the most current time period but the facility had active rates in the previous release of the rate file.

A facility may appear on the closed lists if any of the following conditions are true:

- The facility was absorbed by a larger entity.
- The facility has changed FIs.
- The facility has unreasonable numbers from the cost report file (CAH only).
- The facility has closed.
- The facility is no longer a Medicare participating hospital.
- The wage index information is unavailable for the facility.
- The facility is no longer a Medicaid or TRICARE APC participating hospital (if applicable).

11.6 State Rate File Paysources/Payer IDs
Please refer to the Input & Output Parameter Blocks User’s Guide for the list of state rate file Paysources/Payer IDs.
A Payment System Key

This appendix lists each EASYGroup™ component that is included within each payment system. The following payment systems are included in this section:

Note
Some components listed below may have separate licensing fees. Please contact your Optum Client Manager or the Optum Client Services department for further information.

• Medicare Inpatient Payment Systems
  - Medicare Inpatient
  - Medicare Critical Access Hospital (CAH)
  - Medicare Inpatient Psychiatric Facility (IPF)
  - Medicare Inpatient Rehabilitation Facility (IRF)
  - Medicare Long Term Care (LTC)
  - Medicare Skilled Nursing Facility (SNF)
• Medicare Outpatient Payment Systems
  - Medicare Outpatient
  - Medicare Ambulatory Surgery Center (ASC)
  - Medicare Critical Access Hospital (CAH)
  - Medicare End Stage Renal Disease (ESRD)
  - Medicare Federally Qualified Health Centers (FQHC)
  - Medicare Home Health Agency (HHA)
  - Medicare Physician
• Other Inpatient Payment Systems
  - DRG Pro
  - Medicaid APR Pro
  - TRICARE/CHAMPUS
• Other Outpatient Payment Systems
  - Alabama Blue Cross Blue Shield (BCBS) APG
  - APC Pro
  - ASC Pro
  - Medicaid APG Pro
  - TRICARE APC
• Medicaid Inpatient Payment Systems
  - Arizona Medicaid
  - California Medicaid
  - Colorado Medicaid (effective July 01, 2018)
  - Florida Medicaid (prior to April 01, 2018)
  - Florida Medicaid (effective April 01, 2018)
  - Georgia Medicaid
  - Illinois Medicaid APR-DRG (effective July 01, 2014)
  - Indiana Medicaid APR-DRG (effective October 01, 2015 - March 31, 2018)
  - Indiana Medicaid APR-DRG (effective April 01, 2018)
  - Iowa Medicaid
  - Kansas Medicaid
  - Kentucky Medicaid
  - Louisiana Medicaid
  - Massachusetts Medicaid
  - Michigan Medicaid APR-DRG (effective October 01, 2015)
  - Minnesota Medicaid (effective July 01, 2017)
  - Mississippi Medicaid
  - Nebraska Medicaid APR-DRG (effective July 01, 2014)
  - New Jersey Medicaid (C Platform) (prior to October 01, 2018)
  - New Jersey Medicaid (COBOL Platform) (prior to October 01, 2018)
  - New Jersey Medicaid APR-DRG (effective October 01, 2018)
  - New Mexico Medicaid
  - New York Medicaid APR-DRG
  - North Carolina Medicaid
  - North Carolina Worker's Compensation
  - Ohio Medicaid APR-DRG (effective July 01, 2013)
  - Pennsylvania Medicaid APR-DRG (effective July 01, 2010)
  - Rhode Island Medicaid
  - South Carolina Medicaid
  - Texas Medicaid
  - Virginia Medicaid APR-DRG (prior to October 01, 2017)
  - Virginia Medicaid APR-DRG (effective October 01, 2017)
- Washington HCA
- Washington Medicaid APR-DRG (effective July 01, 2014)
- Wisconsin Medicaid (prior to January 01, 2017)
- Wisconsin Medicaid APR-DRG (effective January 01, 2017)

**Medicaid Outpatient Payment Systems**
- Colorado Medicaid APG
- Florida Medicaid APG
- Illinois Medicaid APG (prior to January 01, 2019)
- Illinois Medicaid APG (effective January 01, 2019)
- Iowa Medicaid APC
- Massachusetts Medicaid APG
- Michigan Medicaid APC
- Michigan Medicaid ASC
- Nebraska Medicaid APG
- New Mexico Medicaid APC
- New York Medicaid APG (prior to October 01, 2019)
- New York Medicaid APG (effective October 01, 2019)
- Ohio Medicaid APG
- Virginia Medicaid APG (prior to October 01, 2017)
- Virginia Medicaid APG (effective October 01, 2017)
- Virginia Medicaid ASC (effective January 01, 2018)
- Washington Medicaid APG
- Wisconsin Medicaid APG
A.1 Medicare Inpatient Payment Systems

A.1.1 Medicare Inpatient
- Optimizer
- DSC Editor
- ICD-10 Medicare DRG Grouper
- Medicare DRG Pricer
- Inpatient Data Files
- NMPRF
- Medicare DRG Weights
- Rate Manager

A.1.2 Medicare Critical Access Hospital (CAH)
- Optimizer
- DSC Editor
- ICD-10 Medicare DRG Grouper
- Medicare DRG Pricer
- CNMPRF
- Medicare DRG Weights
- Rate Manager

A.1.3 Medicare Inpatient Psychiatric Facility (IPF)
- Optimizer
- DSC Editor
- ICD-10 Medicare DRG Grouper
- IPF Pricer
- IPF NMPRF
- Medicare IPF DRG Weights
- Rate Manager

A.1.4 Medicare Inpatient Rehabilitation Facility (IRF)
- Optimizer
- DSC Editor
- IRF Grouper
- IRF Pricer
- IRF NMPRF
A.1.5 Medicare Long Term Care (LTC)
- Optimizer
- DSC Editor
- ICD-10 Medicare DRG Grouper
- LTC Pricer
- LTC NMPRF
- Medicare LTC DRG Weights
- Rate Manager

A.1.6 Medicare Skilled Nursing Facility (SNF)
- Optimizer
- ACE Editor
- SNF RUG Reader (on or prior to October 01, 2019)
- SNF Reader (effective October 01, 2019)
- SNF Pricer
- SNF Fee Schedule Data Files
- SNF Data Files
- SNF NMPRF
- Medicare RUG Weights (on or prior to October 01, 2019)
- Medicare PDPM Rates (effective October 01, 2019)
- Rate Manager

A.2 Medicare Outpatient Payment Systems

A.2.1 Medicare Outpatient
- Optimizer
- ACE Editor
- APC Grouper
- APC-HOPD Pricer
- APC Fee Schedule Data Files
- Outpatient Data Files
- ONMPRF
- Medicare APC Weights/Rates
A.2.2 Medicare Ambulatory Surgery Center (ASC)
- Optimizer
- ACE Editor
- ASC Grouper
- ASC Pricer
- ASC Fee Schedule Data Files
- ANMPRF
- Rate Manager

A.2.3 Medicare Critical Access Hospital (CAH)
- Optimizer
- ACE Editor
- APC Grouper
- APC-HOPD Pricer
- APC Fee Schedule Data Files
- CNMPRF
- Medicare APC Rates
- Rate Manager

A.2.4 Medicare End Stage Renal Disease (ESRD)
- Optimizer
- ACE Editor
- ESRD Reader
- ESRD Pricer
- ESRD Fee Schedule Data Files
- ESRD Data Files
- ESRD NMPRF
- Rate Manager

A.2.5 Medicare Federally Qualified Health Centers (FQHC)
- Optimizer
- ACE Editor
- FQHC Pricer
- FQHC Fee Schedule Data Files
- FQHC NMPRF
• Rate Manager

A.2.6 Medicare Home Health Agency (HHA)
• Optimizer
• ACE Editor
• HHA HHRG Reader (prior to January 01, 2020)
• HHA PDGM Reader (effective January 01, 2020)
• HHA Pricer
• HHA Data Files
• HHA Fee Schedule Data Files
• HHA NMPRF
• Medicare HHRG Weights (prior to January 01, 2020)
• Medicare PDGM Weights (effective January 01, 2020)
• Rate Manager

A.2.7 Medicare Physician
• Optimizer
• Physician Editor
• Physician Pricer
• Physician Data Files
• Physician Fee Schedule Data Files
• PNMPRF
• Rate Manager

A.3 Other Inpatient Payment Systems

A.3.1 DRG Pro
• Optimizer
• DSC Editor
• Contract Multi-Pricer
• Rate Manager

A.3.2 Medicaid APR Pro
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Medicaid APR Pro Pricer
• Rate Manager

A.3.3 TRICARE/CHAMPUS
• Optimizer
• DSC Editor
• ICD-10 TRICARE Grouper
• TRICARE/CHAMPUS Pricer
• ICD-10 Mapper
• Inpatient Data Files
• TRICARE Rate Files
• TRICARE Weights
• Rate Manager

A.4 Other Outpatient Payment Systems

A.4.1 Alabama Blue Cross Blue Shield (BCBS) APG
• Optimizer
• ACE Editor
• 3M™ GPS/GPCS
• APG Grouper
• Medicaid APG Pro Pricer
• Alabama BCBS Outpatient Fee Schedule Data Files
• Alabama BCBS Outpatient Data Files
• APG Grouper Data Files
• Alabama BCBS APG Weights
• Rate Manager

A.4.2 APC Pro
• Optimizer
• ACE Editor
• APC Grouper
• Contract APC Pricer
• Outpatient Data Files
• Contract APC Weights
• Rate Manager
• Rate Manager APC Pro Module

A.4.3 ASC Pro
• Optimizer
• ACE Editor
• ASC Grouper
• Contract ASC Pricer
• Rate Manager
• Rate Manager ASC Pro Module

A.4.4 Medicaid APG Pro
• Optimizer
• ACE Editor
• 3M™ GPS/GPCS
• APG Grouper
• Medicaid APG Pro Pricer
• APG Grouper Data Files
• Rate Manager

A.4.5 TRICARE APC
• Optimizer
• 3M™ GPS/GPCS
• TRICARE APC Editor
• TRICARE APC Pricer
• TRICARE APC Rate Files
• Rate Manager

A.5 Medicaid Inpatient Payment Systems

A.5.1 Arizona Medicaid
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Arizona Medicaid Pricer
• AZSRF
  • Arizona Medicaid Weights
  • Rate Manager

A.5.2 California Medicaid
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• California Medicaid Pricer
• CASRF
• California Medicaid Weights
• Rate Manager

A.5.3 Colorado Medicaid (effective July 01, 2018)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Medicaid APR Pro Pricer
• Colorado Inpatient Data Files
• COSRF
• Colorado Medicaid Weights
• Rate Manager

A.5.4 Florida Medicaid (prior to April 01, 2018)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Florida Medicaid Pricer
• FLSRF
• Florida Medicaid Weights
• Rate Manager

A.5.5 Florida Medicaid (effective April 01, 2018)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Medicaid APR Pro Pricer
• Florida Inpatient Data Files
• FLSRF
• Florida Medicaid Weights
• Rate Manager

A.5.6 Georgia Medicaid
• Optimizer
• DSC Editor
• ICD-10 TRICARE Grouper
• Georgia Medicaid Pricer
• ICD-10 Mapper
• GASRF
• Georgia Medicaid Weights
• Rate Manager

A.5.7 Illinois Medicaid APR-DRG (effective July 01, 2014)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Illinois Medicaid APR Pricer
• ILSRF
• Illinois Medicaid APR DRG Weights
• Rate Manager

A.5.8 Indiana Medicaid APR-DRG (effective October 01, 2015 - March 31, 2018)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Indiana Medicaid APR Pricer
• INSRF
• Indiana Medicaid APR-DRG Weights
• Rate Manager

A.5.9 Indiana Medicaid APR-DRG (effective April 01, 2018)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Medicaid APR Pro Pricer
• Indiana Inpatient Data Files
• INSRF
• Indiana Medicaid APR-DRG Weights
• Rate Manager

A.5.10 Iowa Medicaid
• Optimizer
• DSC Editor
• ICD-10 Medicare DRG Grouper
• Iowa Medicaid Pricer
• ICD-10 Mapper
• IASRF
• Iowa Medicaid Weights
• Rate Manager
A.5.11 Kansas Medicaid
• Optimizer
• DSC Editor
• ICD-10 Medicare DRG Grouper
• Kansas Medicaid Pricer
• ICD-10 Mapper
• KSSRF
• Kansas Medicaid Weights
• Rate Manager

A.5.12 Kentucky Medicaid
• Optimizer
• DSC Editor
• ICD-10 Medicare DRG Grouper
• Kentucky Medicaid Pricer
• ICD-10 Mapper
• Kentucky Medicaid Weights
• Rate Manager

A.5.13 Louisiana Medicaid
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Medicaid APR Pro Pricer
• Louisiana Inpatient Data Files
• LASRF
• Louisiana Medicaid Weights
• Rate Manager

A.5.14 Massachusetts Medicaid
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Medicaid APR Pro Pricer
• Massachusetts Inpatient Data Files
• Massachusetts Medicaid Weights
• Rate Manager

A.5.15 Michigan Medicaid APR-DRG (effective October 01, 2015)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Michigan Medicaid APR Pricer
• MISRF
• Michigan Medicaid APR-DRG Weights
• Rate Manager

A.5.16 Minnesota Medicaid (effective July 01, 2017)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Medicaid APR Pro Pricer
• Minnesota Inpatient Data Files
• MNSRF
• Minnesota Medicaid Weights
• Rate Manager

A.5.17 Mississippi Medicaid
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Medicaid APR Pro Pricer
• Mississippi Inpatient Data Files
• MSSRF
• Mississippi Medicaid Weights
• Rate Manager
A.5.18 Nebraska Medicaid APR-DRG (effective July 01, 2014)
  • Optimizer
  • DSC Editor
  • 3M™ GPS/GPCS
  • APR-DRG Grouper
  • Nebraska Medicaid APR Pricer
  • NESRF
  • Nebraska Medicaid APR-DRG Weights
  • Rate Manager

A.5.19 New Jersey Medicaid (C Platform) (prior to October 01, 2018)
  • Optimizer
  • DSC Editor
  • AP-DRG Grouper
  • New Jersey Medicaid Pricer
  • Alternate ICD-10 Mapper
  • New Jersey Medicaid Weights
  • Rate Manager

A.5.20 New Jersey Medicaid (COBOL Platform) (prior to October 01, 2018)
  • Optimizer
  • DSC Editor
  • AP-DRG Grouper
  • New Jersey Medicaid Pricer
  • ICD-10 Mapper
  • New Jersey Medicaid Weights
  • Rate Manager

A.5.21 New Jersey Medicaid APR-DRG (effective October 01, 2018)
  • Optimizer
  • DSC Editor
  • 3M™ GPS/GPCS
  • APR-DRG Grouper
• Medicaid APR Pro Pricer
• New Jersey Inpatient Data Files
• NJSRF
• New Jersey Medicaid Weights
• Rate Manager

A.5.22 New Mexico Medicaid
• Optimizer
• DSC Editor
• ICD-10 Medicare DRG Grouper
• New Mexico Medicaid Pricer
• NMSRF
• New Mexico Medicaid Weights
• Rate Manager

A.5.23 New York Medicaid APR-DRG
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• New York Medicaid APR Pricer
• NYSRF
• New York Medicaid APR-DRG Weights
• Rate Manager

A.5.24 North Carolina Medicaid
• Optimizer
• DSC Editor
• ICD-10 Medicare DRG Grouper
• North Carolina Medicaid Pricer
• ICD-10 Mapper
• North Carolina Medicaid Weights
• Rate Manager

A.5.25 North Carolina Worker’s Compensation
• Optimizer
• AP-DRG Grouper
• North Carolina Worker’s Compensation Pricer
• ICD-9 Mapper
• North Carolina Medicaid Weights
• Rate Manager

A.5.26 Ohio Medicaid APR-DRG (effective July 01, 2013)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Ohio Medicaid APR Pricer
• OHSRF
• Ohio Medicaid APR-DRG Weights
• Rate Manager

A.5.27 Pennsylvania Medicaid APR-DRG (effective July 01, 2010)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Pennsylvania Medicaid APR Pricer
• PASRF
• Pennsylvania Medicaid APR-DRG Weights
• Rate Manager

A.5.28 Rhode Island Medicaid
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Medicaid APR Pro Pricer
• Rhode Island Inpatient Data Files
• RISRF
• Rhode Island Medicaid Weights
• Rate Manager
A.5.29 South Carolina Medicaid
- Optimizer
- DSC Editor
- 3M™ GPS/GPCS
- APR-DRG Grouper
- South Carolina Medicaid Pricer
- South Carolina Medicaid Weights
- Rate Manager

A.5.30 Texas Medicaid
- Optimizer
- DSC Editor
- 3M™ GPS/GPCS
- APR-DRG Grouper
- Texas Medicaid Pricer
- TXSRF
- Texas Medicaid Weights
- Rate Manager

A.5.31 Virginia Medicaid APR-DRG (prior to October 01, 2017)
- Optimizer
- DSC Editor
- 3M™ GPS/GPCS
- APR-DRG Grouper
- Virginia Medicaid APR Pricer
- VASRF
- Virginia Medicaid APR-DRG Weights
- Rate Manager

A.5.32 Virginia Medicaid APR-DRG (effective October 01, 2017)
- Optimizer
- DSC Editor
- 3M™ GPS/GPCS
- APR-DRG Grouper
• Medicaid APR Pro Pricer
• Virginia Inpatient Data Files
• VASRF
• Virginia Medicaid APR-DRG Weights
• Rate Manager

A.5.33 Washington HCA
• Optimizer
• DSC Editor
• AP-DRG Grouper
• Washington HCA Case-Based and Non Case-Based Pricers
• ICD-9 Mapper
• Washington HCA Weights
• Rate Manager

A.5.34 Washington Medicaid APR-DRG (effective July 01, 2014)
• Optimizer
• DSC Editor
• 3M™ GPS/GPCS
• APR-DRG Grouper
• Washington Medicaid APR Pricer
• WASRF
• Washington Medicaid APR-DRG Weights
• Rate Manager

A.5.35 Wisconsin Medicaid (prior to January 01, 2017)
• Optimizer
• DSC Editor
• ICD-10 Wisconsin DRG Grouper
• Wisconsin Medicaid Pricer
• ICD-10 Mapper
• WISRF
• Wisconsin Medicaid Weights
• Rate Manager
A.5.36 Wisconsin Medicaid APR-DRG (effective January 01, 2017)

- Optimizer
- DSC Editor
- 3M™ GPS/GPCS
- APR-DRG Grouper
- Medicaid APR Pro Pricer
- Wisconsin Inpatient Data Files
- WISRF
- Wisconsin Medicaid APR-DRG Weights
- Rate Manager

A.6 Medicaid Outpatient Payment Systems

A.6.1 Colorado Medicaid APG

- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- Medicaid APG Pro Pricer
- Colorado Outpatient Fee Schedule Data Files
- Colorado Outpatient Data Files
- APG Grouper Data Files
- COOSRF
- Colorado Medicaid APG Weights
- Rate Manager

A.6.2 Florida Medicaid APG

- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- Medicaid APG Pro Pricer
- APG Grouper Data Files
- Florida Outpatient Data Files
• FLOSRF
• Florida Medicaid APG Weights
• Rate Manager

A.6.3 Illinois Medicaid APG (prior to January 01, 2019)
• Optimizer
• ACE Editor
• 3M™ GPS/GPCS
• APG Grouper
• Illinois Medicaid APG Pricer
• Illinois Outpatient Data Files
• APG Grouper Data Files
• ILOSRF
• Illinois APG Weights
• Rate Manager

A.6.4 Illinois Medicaid APG (effective January 01, 2019)
• Optimizer
• ACE Editor
• 3M™ GPS/GPCS
• APG Grouper
• Medicaid APG Pro Pricer
• Illinois Outpatient Data Files
• APG Grouper Data Files
• ILOSRF
• Illinois APG Weights
• Rate Manager

A.6.5 Iowa Medicaid APC
• Optimizer
• ACE Editor
• APC Grouper
• Contract APC Pricer
• Iowa Outpatient Fee Schedule Data Files
• Outpatient Data Files
• IAOSRF
• Iowa Medicaid APC Weights
• Rate Manager
• Rate Manager APC Pro Module

A.6.6 Massachusetts Medicaid APG
• Optimizer
• ACE Editor
• 3M™ GPS/GPCS
• APG Grouper
• Medicaid APG Pro Pricer
• Massachusetts Outpatient Fee Schedule Data Files
• APG Grouper Data Files
• Massachusetts APG Weights
• Rate Manager

A.6.7 Michigan Medicaid APC
• Optimizer
• ACE Editor
• APC Grouper
• Contract APC Pricer
• Michigan Outpatient Fee Schedule Data Files
• MIOSRF
• Outpatient Data Files
• Contract APC Weights
• Rate Manager
• Rate Manager APC Pro Module

A.6.8 Michigan Medicaid ASC
• Optimizer
• ACE Editor
• ASC Grouper
• Contract ASC Pricer
• Michigan ASC Fee Schedule Data Files
• MIASRF
• Rate Manager
• Rate Manager ASC Pro Module
A.6.9 Nebraska Medicaid APG
- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- APG Pro Pricer
- Nebraska Outpatient Fee Schedule Data Files
- Nebraska Outpatient Data Files
- APG Grouper Data Files
- NEOSRF
- Nebraska Medicaid APG Weights
- Rate Manager

A.6.10 New Mexico Medicaid APC
- Optimizer
- MOE Editor
- New Mexico Medicaid APC Pricer
- New Mexico Outpatient Fee Schedule Data Files
- New Mexico Outpatient Data Files
- NMOSRF
- Rate Manager

A.6.11 New York Medicaid APG (prior to October 01, 2019)
- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- New York Medicaid APG Pricer
- New York Outpatient Fee Schedule Data Files
- New York Outpatient Data Files
- APG Grouper Data Files
- NYOSRF
- New York Medicaid APG Weights
- Rate Manager
A.6.12 New York Medicaid APG (effective October 01, 2019)
- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- Enhanced New York Medicaid APG Pricer
- New York Outpatient Fee Schedule Data Files
- New York Outpatient Data Files
- APG Grouper Data Files
- NYOSRF
- New York Medicaid APG Weights
- Rate Manager

A.6.13 Ohio Medicaid APG
- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- Medicaid APG Pro Pricer
- Ohio Outpatient Fee Schedule Data Files
- Ohio Outpatient Data Files
- APG Grouper Data Files
- OHOSRF
- Ohio Medicaid APG Weights
- Rate Manager

A.6.14 Virginia Medicaid APG (prior to October 01, 2017)
- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- Virginia Medicaid APG Pricer
- Virginia Outpatient Fee Schedule Data Files
- APG Grouper Data Files
- VAOSRF
- Virginia Medicaid APG Weights
- Rate Manager

A.6.15 Virginia Medicaid APG (effective October 01, 2017)
- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- Medicaid APG Pro Pricer
- Virginia Outpatient Fee Schedule Data Files
- Virginia Outpatient Data Files
- APG Grouper Data Files
- VAOSRF
- Virginia Medicaid APG Weights
- Rate Manager

A.6.16 Virginia Medicaid ASC (effective January 01, 2018)
- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- Medicaid APG Pro Pricer
- Virginia ASC Fee Schedule Data Files
- Virginia ASC Data Files
- APG Grouper Data Files
- VAASRF
- Virginia Medicaid APG Weights for ASCs
- Rate Manager

A.6.17 Washington Medicaid APG
- Optimizer
- ACE Editor
- 3M™ GPS/GPCS
- APG Grouper
- Washington Medicaid APG Pricer
- Washington Outpatient Fee Schedule Data Files
• APG Grouper Data Files
• WAOSRF
• Washington Medicaid APG Weights
• Rate Manager

A.6.18 Wisconsin Medicaid APG
• Optimizer
• ACE Editor
• 3M™ GPS/GPCS
• APG Grouper
• Wisconsin Medicaid APG Pricer
• Wisconsin Outpatient Fee Schedule Data Files
• APG Grouper Data Files
• WIOSRF
• Wisconsin Medicaid APG Weights
• Rate Manager
B  Supported Pricing Rules

Important
Please note that this is not a complete list of all Optum PPS pricing functionality and does not include information on all pricing methodologies that Optum currently supports. Please refer to the other applicable pricing rules sections in this user’s guide for further information.

This appendix provides information that will help the user decide which Pricer they need to utilize, if applicable. This appendix also describes special considerations for certain Pricers. This appendix includes the following sections:

- Never Events/Provider Preventable Conditions (PPC) Functionality
- How to Determine Which DRG Pricer to Utilize
- DRG Pricer Functionality
  - Inpatient Psychiatric Facility (IPF) Pricer
  - Contract Multi-Pricer
  - Arizona Medicaid Pricer (C Only)
  - California Medicaid Pricer (C Only)
  - Florida Medicaid Pricer (C Only) (prior to April 01, 2018)
  - Illinois Medicaid APR Pricer (C Only) (effective July 01, 2014)
  - Indiana Medicaid APR Pricer (C Only) (prior to April 01, 2018)
  - Iowa Medicaid Pricer (C Only)
  - Kansas Medicaid Pricer (C Only)
  - Kentucky Medicaid Pricer (C Only)
  - Medicaid APR Pro Pricer (C Only)
    - Colorado Medicaid (effective July 01, 2018)
    - Florida Medicaid (effective April 01, 2018)
    - Indiana Medicaid (effective April 01, 2018)
    - Louisiana Medicaid (effective January 01, 2019)
    - Massachusetts Medicaid (effective October 01, 2014)
    - Minnesota Medicaid (effective July 01, 2017)
    - Mississippi Medicaid (effective July 01, 2015)
    - New Jersey Medicaid APR (effective October 01, 2018)
    - Rhode Island Medicaid (effective July 01, 2018)
    - Virginia Medicaid APR (effective October 01, 2017)
- Wisconsin Medicaid APR (effective January 01, 2017)
- Michigan Medicaid Pricer (prior to October 01, 2015)
- Michigan Medicaid APR Pricer (C Only) (effective October 01, 2015)
- Nebraska Medicaid APR Pricer (C Only) (effective July 01, 2014)
- New York Medicaid APR Pricer (C Only)
- North Carolina Medicaid Pricer (C Only)
- Ohio Medicaid APR Pricer (C Only) (effective July 01, 2013)
- South Carolina Medicaid Pricer (C Only)
- Virginia Medicaid APR Pricer (C Only) (prior to October 01, 2017)
- Washington Medicaid APR Pricer (C Only) (effective July 01, 2014)

• How to Determine Which APG Pricer to Utilize
  • APG Pricer Functionality
    - Enhanced New York Medicaid APG Pricer (C Only) (effective October 01, 2019)
    - Illinois Medicaid APG Pricer (C Only) (effective July 01, 2014 - December 31, 2018)
    - Medicaid APG Pro Pricer (C Only)
      - Alabama Blue Cross Blue Shield (BCBS) APG (effective October 01, 2016)
      - Colorado Medicaid APG (effective July 01, 2018)
      - Florida Medicaid APG (effective July 01, 2017)
      - Illinois Medicaid APG (effective January 01, 2019)
      - Massachusetts Medicaid APG (effective December 30, 2016)
      - Nebraska Medicaid APG (effective January 01, 2020)
      - Ohio Medicaid APG (effective July 01, 2017)
      - Virginia Medicaid APG (effective October 01, 2017)
      - Virginia Medicaid ASC (effective January 01, 2018)
    - Virginia Medicaid APG Pricer (C Only) (prior to October 01, 2017)
    - Washington Medicaid APG Pricer (C Only) (effective July 01, 2014)
    - Wisconsin Medicaid APG Pricer (C Only) (effective January 01, 2015)

• How to Determine Which APC Pricer to Utilize
  • APC Pricer Functionality
    - Contract APC Pricer
      - Iowa Medicaid APC (C Only) (effective January 01, 2016)
      - New Mexico Medicaid APC Pricer
B.1 Never Events/Provider Preventable Conditions (PPC) Functionality

The following states have implemented a Never Events or Provider Preventable Conditions (PPC) policy, as described below.

- Arizona Medicaid (effective October 01, 2014)
- Colorado Medicaid (effective July 01, 2018)**
- Colorado Medicaid APG (effective July 01, 2018)**
- Georgia Medicaid (effective July 01, 2012)**
- Indiana Medicaid (effective July 01, 2012)**
- Indiana Medicaid APR (effective July 01, 2012)**
- Iowa Medicaid (effective October 01, 2015)
- Iowa Medicaid APC (effective January 01, 2016)**
- Illinois Medicaid APR (effective July 01, 2014)
- Massachusetts Medicaid (effective October 01, 2014)
- Minnesota Medicaid (effective July 01, 2017)
- Mississippi Medicaid (effective July 01, 2015)
- Nebraska Medicaid (effective January 01, 2013)
- Nebraska Medicaid APG (effective July 01, 2014)
- New York Medicaid (effective January 01, 2011)

**Note**

For New York Medicaid please refer to the New York Medicaid APR Pricer (C Only) section below.

- Ohio Medicaid APG (effective July 01, 2017)
- Ohio Medicaid APR (effective July 01, 2013)
- Rhode Island Medicaid (effective July 01, 2018)
- South Carolina Medicaid (effective October 01, 2011)
- Virginia Medicaid APG (effective January 01, 2014)**
- Virginia Medicaid ASC (effective January 01, 2018)**
- Washington Medicaid (effective January 01, 2010)
- Washington Medicaid APR (effective July 01, 2014)
- Wisconsin Medicaid (effective July 01, 2012)**
- Wisconsin Medicaid APG (effective January 01, 2015)**
- Wisconsin Medicaid APR (effective January 01, 2017)
Note
States marked with a double asterisk (**) above have implemented a PPC policy.

- Never Events

Medicaid does not pay for surgery when a practitioner erroneously performs the following Never Events:

1. Wrong Surgery on a Patient
2. Surgery on Wrong Body Part
3. Surgery on Wrong Patient

The Pricer will deny payment when the applicable DSC Editor finds one or more of the ICD-9-CM or ICD-10-CM diagnosis codes shown below in Table B-1 on a claim. When this occurs, the Pricer will issue claim-level Pricer Return Code 27 (Wrong Procedure Performed). Since the DSC Editor is responsible for identifying claims that contain Never Events, both editing and pricing must be requested. To request editing, you must set the DSC Editor Requests flag in the ECB [ezg_cntl_block] structure to 1 (Yes) by either passing the values directly in the ECB [ezg_cntl_block] structure or by setting the values in Rate Manager.

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
<th>ICD-9-CM/ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>E876.5</td>
<td>Performance of Wrong Operation (Procedure) on Correct Patient</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>E876.6</td>
<td>Performance of Operation (Procedure) on Patient Not Scheduled for Surgery</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>E876.7</td>
<td>Performance of Correct Operation (Procedure) on Wrong Side/Body Part</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>Y65.51</td>
<td>Performance of Wrong Procedure (Op) on Correct Patient</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>Y65.52</td>
<td>Performance of Procedure (Op) on Patient Not Scheduled for Surgery</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>Y65.53</td>
<td>Performance of Correct Procedure (Op) on Wrong Side or Body Part</td>
<td>ICD-10-CM</td>
</tr>
</tbody>
</table>

- Provider Preventable Conditions (PPCs)

Medicaid does not pay for surgery when a practitioner erroneously performs the following PPCs:

1. Wrong Surgery on a Patient
2. Surgery on Wrong Body Part
3. Surgery on Wrong Patient
Payment will be denied for claim lines with the modifiers shown below in Table B-2. As such, line-level Pricer Return Code 16 (Claim Contains a Never Event/Never Event) or claim-level Pricer Return Code 27 (Wrong Procedure Performed) (Wisconsin APG only) will be returned for claim lines billed with these modifiers.

Table B-2: PPC Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>Surgical or Other Invasive Procedure on Wrong Body Part</td>
</tr>
<tr>
<td>PB</td>
<td>Surgical or Other Invasive Procedure on Wrong Patient</td>
</tr>
<tr>
<td>PC</td>
<td>Wrong Surgery or Other Invasive Procedure on Patient</td>
</tr>
</tbody>
</table>

B.2 How to Determine Which DRG Pricer to Utilize

Prior to pricing a record, you must determine which DRG Pricer is appropriate to invoke. In addition, the reimbursement rate variables in effect at the time of the patient’s hospitalization and DRG-specific weights, means, and trims must be available. The Test Driver (available for the C Platform only) shows how information appropriate to a particular patient’s hospitalization can be retrieved from external files and reformatted for use by the DRG Pricer. Refer to the EASYGroup™ Installation Guide for further information on the Test Driver.

The Test Driver program included with your distribution assumes that all data needed to drive patient-specific pricing are stored in the files described below. These files contain the data needed to set-up the Hospital Rate Calculator File, DRG Rate File, and Configuration File, as required by the DRG Pricer. Please refer to the EASYGroup™ Technical Reference Guide for details on the layouts on these files.

- **Hospital Rate Calculator File**: File with hospital-specific payment information (e.g., base rates, conversion factors, Ratio of Cost-to-Charges (RCCs), etc.). The information in this file will be used to setup the Hospital Rate Calculator File.

- **DRG Rate File**: File with DRG-specific payment information (e.g., weights, means, and trims). The information in this file is used to set up the DRG Rate record.

- **Payers File**: File with the payer-specific information.

- **Configuration File**: File that contains hospital-specific processing requirements.

The Test Driver uses the Payers File to determine whether pricing and retrieval of the Hospital Rate Calculator File, DRG Rate File, and Configuration File records should be based on either admission date or discharge date. Test routines for retrieving information from these files can be found in the Test Driver program. The Test Driver program, *iptest.c* (CSource) has been provided, so that it can be modified for your environment.
When pricing a patient record, the DRG Pricer must access and retrieve the pricing information in effect at the time of the patient’s hospitalization. This includes an indication of the pricing rules or DRG Pricer program to be applied, as well as the hospital and payer-specific reimbursement rate variables to be used with the selected DRG Pricer. The Test Driver program contains a routine for determining which pricing information to retrieve.

The Test Driver program is passed the following key information for the test database: hospital number, paysource code, and a reimbursement date. Reimbursement date is set equal to admission or discharge date, as appropriate. For purposes of the Test Driver, the decision to use admission or discharge date is based on a flag stored on the Payers File. The Test Driver then uses hospital number, paysource code, and reimbursement date to query the Hospital Rate Calculator File for a record with the same hospital number and paysource code with the closest effective date, which is less than or equal to the reimbursement date. When the appropriate Hospital Rate Calculator Record is found, the information retrieved is transferred to the Hospital Rate Calculator File.

One of the variables transferred to the Hospital Rate Calculator File in the previous step is an indication of the pricing rules or DRG Pricer program to be applied to the patient record being processed. The Pricer type transferred to Hospital Rate Calculator File must be one of the types listed in the column labeled, Pricer/Payer Type, refer to DRG Pricer Types, Chapter 6 for a complete listing.

Some programs or payers reimburse for hospital services by marking up or discounting the amount that Medicare/Medicaid would have paid for the same services. This pricing scenario can be accommodated by setting the Markup/Discount Factor field, as appropriate. This Markup/Discount Factor is applied to all final payment fields: the applicable base rate, the applicable add-on payment(s), and the total reimbursement.

When implemented, this field defaults to a value of 1.00 if no value (i.e., a value of zeros) has been entered into this field. Thus, not setting the Markup/Discount Factor for payers will not negatively impact reimbursement calculations. Payers will continue to price in the usual manner without setting the Markup/Discount Factor.

B.3 DRG Pricer Functionality

B.3.1 Inpatient Psychiatric Facility (IPF) Pricer

Medicare requires special rules for the reporting of Electroconvulsive Therapy (ECT) services. IPFs are to report one of the following ICD-10-CM procedure codes: GZB0ZZZ, Electroconvulsive therapy, unilateral-single seizure, GZB2ZZZ, Electroconvulsive therapy, bilateral-single seizure, or GZB4ZZZ, Other electroconvulsive therapy, as well as report the number of ECT services on the line level detail. ECT reimbursement logic depends on the value coded
in the units field that is reported with Revenue Code 0901 (Psychiatric/Psychological Treatments Electroshock Treatment). For clients that do not support passing the line level structure, the number of provided ECT services will be determined by counting the number of instances of procedure code on the claim.

Medicare also requires special rules for the reporting of interrupted stay/Alternate Level of Care Days (alc_days, PCB2-ICD-ALC-DAYS) days. IPFs are directed to pass UB-04 Occurrence Span Code 74, with the discharge date in UB-04 Occurrence Span Date #1, and the day before readmission in UB-04 Occurrence Span Date #2, to indicate that there was an interrupted stay. The Medicare IPF Pricer will first look for the possible interrupted stay in the occurrence span fields. If occurrence span code 74 is found, the Medicare IPF Pricer will adjust the patient’s length of stay by subtracting the value supplied in the Alternate Level of Care Days field. A Pricer Return Code of 18 (Invalid Occurrence Span Date) indicates that there is an error with the occurrence span dates; supply the correct occurrence span dates, ensuring that span date 2 is a larger value than the span date, and call the Medicare IPF Pricer again.

**Note**
All of the above mentioned fields are located in the PCB2.ICD [ip_claim_data] structure or the PCB2-ICD-IP-CLAIM-DATA structure.

**B.3.1.1 Interrupted Stay (Effective January 01, 2011)**
Effective January 01, 2011, CMS has added additional special rules for the reporting of interrupted stays. When a patient is admitted to the same or another IPF before midnight on the third consecutive day following the discharge from the initial IPF stay, it is treated as one stay and one discharge for the purposes of payment. In other words, interrupted stays are considered constant for the objective of applying the variable per diem adjustment.

For example, if a patient is discharged from the initial IPF and within 3 days is admitted to the second IPF, this is considered an interrupted stay under the IPF payment system. When the payer receives the claim from the second IPF, they will append payer-only UB-04 Value Code (valcode, PCB1-VALCODE) 75 to the claim with the number of previously covered days from the initial IPF in the corresponding UB-04 Value Amount (valamt, PCB1-VALAMT) field. The Medicare IPF Pricer will then use this information to determine which variable per diems should be used in the reimbursement calculations.

**Note**
All of the above mentioned fields are located in the PCB2.ICD [ip_claim_data] structure or the PCB2-ICD-IP-CLAIM-DATA structure.
B.3.2 Contract Multi-Pricer

B.3.2.1 DRG Reimbursement Methodologies
The Contract Multi-Pricer has the ability to price each DRG using one of the following six methodologies:

• Base * DRG Weight
• Case Rate
• Cost Reduction Factor (CRF) or Percent of Charges
• Per Diem
• Tiered Per Diem
• Case Rate plus Per Diem (per diem applied once the length of stay exceeds a DRG-specific day threshold)

Note
Only one DRG reimbursement methodology can be chosen for each DRG.

B.3.2.2 Transfer Reimbursement Methodologies
The Contract Multi-Pricer has the ability to pay for transfer cases using one of the following three transfer reimbursement methodologies:

• Acute Care Transfers Only
• Acute, Post-Acute, and Special Post-Acute Care Transfers
• Daily Rate Transfer

The user has the ability to choose which transfer reimbursement methodology should be applied to a given contract and whether or not transfer pricing should take precedence over one day stay pricing for a given contract.

Note
Only one transfer reimbursement methodology can be chosen for each contract.

B.3.2.3 First Dollar and Second Dollar Outlier Methodologies:
The Contract Multi-Pricer has the ability to pay for cases with exceptionally high costs or above average length of stays using one of the following outlier reimbursement methodologies:

• Combination First Dollar and Second Dollar Stop Loss
• First Dollar - Dollar Threshold (per diem rate)
• First Dollar - Dollar Threshold (PPR to per diem rate cap)
• First Dollar - Dollar Threshold (PPR)
• First Dollar – Day Threshold (per diem rate)
• Second Dollar - Dollar Threshold (PPR)
• Second Dollar - Day Threshold (per diem rate)
• Second Dollar - Day Threshold (day threshold based on DRG average mlos – per diem rate)
• Second Dollar - Standard DRG cost outlier threshold

The user has the ability to choose which outlier methodology should be applied to a given contract and whether or not transfer cases should be eligible for outliers for a given contract.

**Note**

Only one outlier reimbursement methodology can be chosen for each contract.

B.3.2.4 Short Stay and One Day Stay Reimbursement Methodologies:
The Contract Multi-Pricer has the ability to pay for patients who are in the hospital for a lower than expected period of time (i.e., short stays) and for patients who are in the hospital for only one day (i.e., one day stays). The user has the ability to choose to apply either one or both of these reimbursement methodologies to a given contract, and whether or not one day stay pricing should take precedence over transfer pricing for a given contract.

B.3.2.5 Long Stay Reimbursement Methodologies:
The Contract Multi-Pricer has the ability to pay for patients who are in the hospital for a longer than expected period of time (i.e., long stays).

B.3.2.6 Reimbursement Methodology Hierarchy:
When a given contract has been set up to reimburse claims with the Contract Multi-Pricer using more than one of the reimbursement methodologies described above, the following will be the order of precedence:

• Short Stay Pricing
• Transfer Pricing (unless one day stay pricing has been requested to take precedence over transfers)
• First Dollar Outlier
• One Day Stay Pricing
• DRG Pricing

B.3.2.7 Percent of Charge Reimbursement Methodologies
The Contract Multi-Pricer has the ability to cap reimbursement at a maximum percent of charges and also to increase reimbursement to a minimum percent of charges. The user has the ability to choose to apply either one or both of these reimbursement methodologies to a given contract.
B.3.2.8 DRG Base Payment Adjustment
The Contract Multi-Pricer supports a second DRG base payment methodology that utilizes the DRG weight and two base rates (operating and capital). This new DRG base payment methodology utilizes the following payment calculation:

\[ DRG \text{ Base Payment} = (Operating \text{ Base Rate} + Capital \text{ Base Rate}) \times DRG \text{ Weight} \]

Note
Please refer to the Contract Multi-Pricer Rate Variables Worksheet (RVW) for detailed guidance on the reimbursement methodologies described above.

B.3.3 Arizona Medicaid Pricer (C Only)

B.3.3.1 APR-DRG Payment Calculations
For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Arizona Medicaid Pricer for claims on or after October 01, 2014:

- APR-DRG Base Payment

The APR-DRG base payment reimbursement calculation utilizes a policy adjustor and a high Medicaid hold harmless adjustor. The policy adjustor will be a value other than 1.00 for claims that group to normal newborn, neonatal, obstetrics, psychiatric, or rehabilitation APR-DRGs. When the patient’s age on a claim is under the pediatric cut-off age and the claim is not grouped to one of the previous mentioned categories, the policy adjustor is set to the established pediatric service adjustor. The high Medicaid hold harmless adjustor is used to adjust reimbursement for hospitals designated as High Medicaid Utilization Facilities. The APR-DRG base payment reimbursement is calculated using the following formula:

\[ \text{Unadjusted APR-DRG Base Payment} = \text{Hospital Base Rate} \times DRG \text{ Weight} \times \text{High Medicaid Hold Harmless Adjustor Factor} \times \text{Policy Adjustor} \]

- Transfer Per Diem Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the transfer per diem payment is less than the APR-DRG base payment. Claims with a Discharge Disposition of 02 (Discharged/Transferred to Short-Term General Hospital), 05 (Discharged/Transferred to a Designated Cancer Center or Children’s Hospital), or 66 (Discharged/Transferred to a Critical Access Hospital) are eligible for transfer per diem reimbursement. The transfer per diem reimbursement is calculated using the following formula:

\[ \text{Transfer Per Diem Payment} = (\text{Unadjusted APR-DRG Base Payment} / \text{APR-DRG Average Length of Stay}) \times (\text{LOS} + 1) \]
• Per Diem Hospital Payment

The per diem hospital payment calculation applies to facilities flagged as long term acute care, psychiatric, or rehabilitation facilities. The per diem hospital payment calculation is calculated using the following formulas (for each facility type):

- **Long Term Acute Care Hospitals Per Diem Payment Calculation** = Long Term Acute Care Per Diem Amount * LOS

- **Rehabilitation Facilities Per Diem Payment Calculation** = Rehabilitation Per Diem Amount * LOS

- **Psychiatric Hospitals Per Diem Payment Calculation** = Psychiatric Per Diem Amount * LOS

• Cost Outlier Payment

For long term acute care hospitals and rehabilitation facilities a per diem cost is calculated in order to determine eligibility for a cost outlier add-on. Psychiatric facilities are not eligible for the cost outlier add-on. If the per diem cost exceeds the established per diem cost outlier threshold, the cost outlier add-on is equal to the total charges multiplied by the hospital-specific outlier Ratio of Cost-to-Charges (RCCs).

\[ \text{Per Diem Cost} = \frac{(\text{Total Covered Charges} \times \text{RCCs})}{\text{LOS}} \]

\[ \text{Cost Outlier Add-On} = \text{Total Charges} \times \text{Hospital-Specific Outlier RCC} \]

The cost outlier add-on for all other facilities is determined by comparing the total cost to the cost outlier threshold, calculated as the sum of a hospital-specific threshold, and the APR-DRG base payment. If the cost exceeds the threshold, the add-on is calculated by subtracting the calculated threshold from the costs, and multiplying the difference by the APR-DRG-specific marginal cost factor.

\[ \text{Cost} = \text{Total Covered Charges} \times \text{Hospital RCC} \]

\[ \text{Cost Outlier Threshold} = \text{Hospital-Specific Cost Outlier Threshold} + \text{Unadjusted Base Rate} \]

\[ \text{Cost Outlier Add-On} = (\text{Cost} - \text{Cost Outlier Threshold}) \times \text{APR-DRG Specific Marginal Cost Factor} \]

• Adjusted Base Payment and Adjusted Cost Outlier Payment

Arizona Medicaid applies a hospital-specific provider adjustment factor to the inlier and outlier payments. This factor includes a transitional adjustor to mitigate the financial impact of transition to the new Prospective Payment System (PPS), as well as a documentation and coding factor to adjust for anticipated coding changes and resulting increases in case-mix severity as hospitals adapt to the new APR-DRG based reimbursement methodology.

\[ \text{Adjusted Base Payment} = \text{Unadjusted Base Payment} \times \text{Hospital Specific Provider Adjustment Factor} \]
Adjusted Cost Outlier Add-On = Unadjusted Add-On * Hospital Specific Provider Adjustment Factor

- Total Reimbursement

The total reimbursement is calculated by adding the individual pricing components described above, as follows:

Total Reimbursement = Adjusted APR-DRG Base Payment + Adjusted Cost Outlier Add-On

- Mark-Up/Discount Factor

The Arizona Medicaid Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- Not Currently Supported

The Arizona Medicaid Pricer does not support the following:

- Admin Days
- Non-Covered Days
- Rehabilitation Per Diem Claims
- Psychiatric Per Diem Claims

B.3.4 California Medicaid Pricer (C Only)

B.3.4.1 APR-DRG Payment Calculations

Effective July 01, 2013, the California Department of Health Care Services (DHCS) began reimbursing inpatient hospital claims using a prospective payment methodology. The APR-DRG payment will apply to all hospital inpatient facilities, but does not handle the following facility types:

- Designated Public Hospitals
- Non-Designated Public Hospitals
- Free-Standing Psychiatric Hospitals
- Hospice Providers
- Swing Bed Stays
- Indian Health Services Hospitals
- California Medicaid Border Hospitals

- APR-DRG Base Payment

The California DHCS has adopted the modified base * weight calculation. The APR-DRG Base Payment is calculated by the California Medicaid Pricer by using the following formula:

Base Payment = Hospital Base Rate * DRG Relative Weight * Hospital Case-Mix
• APR-DRG Weight Adjustors

California Medicaid uses weight adjustors for eligible newborn services, obstetric services, and for patients ages 1 - 21 years.

• Transfer Payment

Patients who are transferred from one acute care facility to another facility will be eligible for reimbursement using a policy to reduce payment for stays shorter than the average length of stay. The discharge dispositions shown below in Table B-3, are eligible for transfer reimbursement.

The California DHCS has chosen to follow a model similar to Medicare for reimbursing transfer situations. The receiving hospital is paid the full DRG reimbursement. Per the rules defined by the California DHCS, the California Medicaid Pricer will pay the lesser of the base payment or transfer base payment.

If a claim qualifies as a transfer, as outlined above, the transferring facility is reimbursed as follows:

\[
\text{Transfer Base Payment} = \left( \frac{\text{DRG Base Payment}}{\text{DRG Mean Length of Stay}} \right) \times (\text{Length of Stay} + 1)
\]

Table B-3: Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to an Acute Care Facility</td>
<td>July 01, 2013</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
<td>July 01, 2013</td>
</tr>
<tr>
<td>63</td>
<td>Discharged/Transferred to Long Term Care (LTC) Hospital</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit</td>
<td>July 01, 2013</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to Critical Access Hospital</td>
<td>July 01, 2013</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care With a Planned Acute Care Hospital Inpatient Readmission</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>91</td>
<td>Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) With a Planned Acute Care Hospital Inpatient Readmission</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>93</td>
<td>Discharged/Transferred to a Psychiatric Distinct Part Unit of a Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>94</td>
<td>Discharged/Transferred to a Critical Access Hospital (CAH) With a Planned Acute Care Hospital Inpatient Readmission</td>
<td>July 01, 2014</td>
</tr>
</tbody>
</table>
• High Cost Outlier Payment

The cost of a hospital stay is determined by multiplying total charges by the hospital’s cost-to-charge ratio. The base payment is then subtracted from this total. If the hospital’s cost is greater than the cost outlier threshold, an incremental payment is made by multiplying the hospital cost by a marginal cost factor. To determine if a claim qualifies for an outlier payment, the following logic is applied:

\[ \text{Hospital Loss} = (\text{Total Charges} \times \text{Cost to Charge Ratio}) - \text{Base Payment} \]

\[ \text{Outlier Payment} = (\text{Hospital Loss} - \text{Cost Outlier Threshold 1}) \times \text{Marginal Cost Factor 1} \]

• Low Cost Outlier Payment

In order to determine the gain of a hospital stay subtract the cost outlier threshold from the base payment. If the hospital’s gain is greater than the cost outlier threshold, the base reimbursement is reduced by multiplying the hospital gain by a marginal cost factor. To determine if a claim qualifies for an outlier payment, the following logic is applied:

\[ \text{Hospital Gain} = \text{Base Payment} - \text{Cost Outlier Threshold 1} \]

\[ \text{Outlier Payment} = \text{Base Payment} - (\text{Hospital Gain} - \text{Cost Outlier Threshold 1}) \times \text{Marginal Cost Factor 1} \]

• Rehabilitation Per Diem Payment

Note

The California DHCS calculated reimbursement for rehabilitation DRGs outside of the base * weight methodology.

In order to reimburse rehabilitation DRGs, the APR-DRG must have a DRG Category equal to 01 (Rehab DRG) and one of the following Revenue Codes must be present on the claim.

• 0118 (Room & Board Private Rehabilitation)
• 0128 (Room and Board Semiprivate 2-bed Rehabilitation)
• 0138 (Room & Board Semiprivate 3 & 4 Beds Rehabilitation)
• 0158 (Room & Board Ward Rehabilitation)

\[ \text{Rehab DRG Reimbursement} = \text{Hospital Specific Rehab Per Diem} \times \text{Length of Stay} \]

• Markup/Discount Factor

The California Medicaid Pricer has an option to increase or reduce the overall claim payment by a hospital defined factor (Markup/Discount Factor). If the Markup/Discount Factor is set to a number other than 1.0, the final DRG Base Payment and Outlier Payments are multiplied by the Markup/Discount Factor.

• Total Reimbursement
The total reimbursement is calculated as the sum of the final DRG base payment and the final outlier payment (after any Markup/Discount Factor is applied).

The California Medicaid Pricer handles the DRG portion of the hospital inpatient reimbursement only (as noted above). The California Medicaid Pricer will not calculate reimbursement for the following:

- Administrative Days (Level 1 and Level 2)
- Dual Eligibility Adjustments (Medicare and Medicaid Members)
- Adjusted Final DRG Payments Based on Previously Paid Interim Payment
- Separately Payable Services, Supplies and Devices:
  - Bone Marrow and Blood Factors on Professional Claims.

Also, the California Medicaid Pricer does not reduce the overall claim reimbursement to account for other health coverage or patient share of cost.

B.3.5 Florida Medicaid Pricer (C Only) (prior to April 01, 2018)

B.3.5.1 APR-DRG Payment Calculations
Effective July 01, 2013, the Florida Agency for Health Care (AHCA) began reimbursing inpatient hospital claims using the APR-DRG prospective payment methodology. The APR-DRG payment will apply to all inpatient facilities, except four state-owned psychiatric facilities.

The Florida Medicaid Pricer handles the APR-DRG portion of the hospital inpatient reimbursement only. No adjustments above and beyond the APR-DRG portion will be made for:

- Transplant Claims
- Newborn Hearing Screening
- Dual Eligibility (Medicare and Medicaid Members)

Also, the Florida Medicaid Pricer will not reduce the overall claim reimbursement to account for “other health coverage” or “patient share of cost.”

- APR-DRG Base Payment

The Florida AHCA has adopted a modified base * weight reimbursement calculation. Inpatient hospital claims will be reimbursed using the following calculation:

DRG Base Payment = Hospital Base Rate* DRG Relative Weight* Policy Adjusters * Case-Mix Adjustor

- APR-DRG Weight Adjustors

Florida Medicaid is utilizing a service adjuster for rehabilitation services. Also, Florida Medicaid is utilizing provider adjusters for the following facilities:

- Rural Hospitals
- Long-Term Acute Care Hospitals
- Rehabilitation Hospitals
- Hospitals with Both High Medicaid Utilization and High Outlier Payment Percentages

These adjustments are applied to all stays at the affected hospitals, not just certain types of services.

• Transfer Payment

Patients who are transferred from one acute care facility to another facility are eligible for reimbursement using a policy to reduce payment for stays shorter than average lengths of stay. The discharge dispositions shown below in Table B-4, are eligible for transfer reimbursement.

The Florida AHCA has chosen to follow a model similar to Medicare for reimbursing transfer situations. The receiving hospital is paid via full DRG reimbursement. Per rules proposed by the Florida AHCA, the Florida Medicaid Pricer pays the lesser of the DRG base payment or transfer base payment.

If a claim qualifies as a transfer, as outlined above, the transferring facility is reimbursed as follows:

\[ \text{Transfer Base Payment} = \frac{\text{DRG Base Payment}}{\text{DRG Average Length of Stay}} \times (\text{Length of Stay} + 1) \]

Table B-4: Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to an Acute Care Facility</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to Critical Access Hospital</td>
</tr>
</tbody>
</table>

• Intergovernmental Transfer (IGT) Payment

Automatic and self-funded IG Ts are paid on a per claim basis where applicable. Two supplemental payments can be made per claim, one for automatic IG Ts and one for self-funded IG Ts. Each IGT payment is multiplied by the DRG weight and divided by the hospital’s case-mix. The Florida Medicaid Pricer adds these two payments and returns them in the Alternate Level of Care Add-On Payments field.

Intergovernmental Fund Payments:

Self-Funded IGT = Self-Funded IGT \times (\text{DRG Weight} / \text{Hospital Case-Mix})

Automatic IGT = Automatic IGT \times (\text{DRG Weight} / \text{Hospital Case-Mix})
Total IGT Payment (Displayed as Alternate Level of Care Add-On Payment) = Self-Funded IGT + Automatic IGT

• Outlier Payment

The Florida AHCA has adopted the Medicare stop-loss outlier model. For each claim, the hospital’s loss is determined by multiplying total charges by the hospital’s cost-to-charge ratio and then subtracting the DRG base payment. If the hospital’s loss is greater than a fixed standardized cost outlier threshold, an incremental payment is made by multiplying the difference by a Marginal Cost Factor.

There are two marginal cost factors that can be applied in the calculation below. The Marginal Cost Factor 2 is used when one of the following instances occurs on a claim:

- When a claim groups to a neonate DRG with an SOI of 3 or 4
- When a claim groups to a pediatric DRG with an SOI of 3 or 4 and the patient’s age is less than the pediatric cutoff age

All other claims will use the Marginal Cost Factor. To determine if a claim qualifies for an outlier payment, the following logic is applied:

Hospital Loss = (Total Charges* Cost-to-Charge Ratio) – DRG Base Payment

If the Hospital Loss is Greater than the Cost Outlier Threshold:

Outlier Payment = (Hospital Loss – Cost Outlier Threshold) * Applicable Marginal Cost Factor

• Non-Covered Day Adjustments

The Florida Medicaid Pricer identifies non-covered days via two methods:

- Alternate Level of Care Days:

If a claim has Medicaid non-covered days, these days can be entered as alternate level of care days. This number will be subtracted from the claim length of stay to determine the Medicaid covered days for reimbursement.

- Value Code and Value Amount:

If a claim has Medicaid non-covered days, a UB-04 Value Code of 81 should be submitted on the claim and the number of non-covered days will be entered in the UB-04 Value Amount field. This number will be subtracted from the claim length of stay to determine the Medicaid covered days for reimbursement.

If non-covered days appear on a claim, the DRG Base Payment and Outlier Payments are reduced by the Medicaid covered days divided by the claim length of stay.

Medicaid Covered Days = Claim Length of Stay – Non-Covered Days

Reduced Base Payment = DRG Base Payment * (Medicaid Covered Days / Claim Length of Stay)
Reduced Outlier Payment = Outlier Payment * (Medicaid Covered Days / Claim Length of Stay)

- Charge Cap Adjustment

The Florida AHCA has adopted a charge cap, which limits claim payment to the lesser of the DRG payment or total charges. To accomplish this, the state will reduce any DRG payment that is greater than the total charges:

Reduction Factor = Total Charges / (DRG Payment + Outlier Payment)

Reduced DRG Base Payment = DRG Base Payment * Reduction Factor

Reduced Outlier Payment = Outlier Payment * Reduction Factor

- Trauma Facility Payment

Claims from Level I/Level II Trauma Hospitals and Pediatric Trauma Hospitals receive a supplemental payment. To determine this payment, the percentage (shown below in Table B-5) is multiplied by the final DRG base payment. This trauma payment percentage is calculated as follows:

Trauma Hospital Payment = (Trauma Payment Percentage * DRG Base Payment)

<table>
<thead>
<tr>
<th>Trauma Hospital Type</th>
<th>Trauma Payment Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>17%</td>
</tr>
<tr>
<td>Level II</td>
<td>11%</td>
</tr>
<tr>
<td>Pediatric</td>
<td>4%</td>
</tr>
</tbody>
</table>

- Mark-Up/Discount Factor

The Florida Medicaid Pricer has an option to increase or reduce the overall claim payment by a hospital defined factor (Markup/Discount Factor). If this factor is set to a number other than 1.0, the final DRG Base Payment, IGT Payments, and Outlier Payments are multiplied by this factor.

- Total Reimbursement

Total reimbursement is calculated as the sum of the final DRG Base Payment, final IGT Payment, final Outlier Payment, and the final Trauma Hospital Payment; after any Mark-Up/Discount Factor is applied.

- Not Currently Supported

Effective January 18, 2018, the Florida AHCA uses the discharge date to validate ICD codes and assign APR DRGs. However, Florida AHCA is using date of admission to determine the APR DRG base rate and policy adjustors for pricing the claims. We cannot support this functionality in our software. The Florida Medicaid APR-DRG software is configured to apply grouping and pricing based on discharge date. We have learned that Florida AHCA is planning to change their logic so all elements of the DRG payment are based...
on discharge date. However, they have not determined an implementation date at this time.

B.3.6 Illinois Medicaid APR Pricer (C Only) (effective July 01, 2014)

B.3.6.1 APR-DRG Payment Calculations
For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Illinois Medicaid APR Pricer for claims with discharge dates on or after July 01, 2014:

- APR-DRG Base Payment

The APR-DRG base payment is calculated using the following formula. In this formula, the hospital specific payment rate is the statewide acute care base rate, wage-adjusted, and including any applicable medical education percentage add-on.

\[
\text{APR-DRG Base Payment} = \text{Hospital Specific Payment Rate} \times \text{APR-DRG Weight}
\]

- Transfer Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the transfer per diem payment is less than the APR-DRG base payment. Claims with a Discharge Disposition of 02 (Discharged/Transferred to Short-Term General Hospital), 05 (Discharged/Transferred to a Designated Cancer Center or Children’s Hospital), 66 (Discharged/Transferred to a Critical Access Hospital), 82 (Discharged/Transferred to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission), 85 (Discharged/Transferred to a Designated Cancer Center or Children’s Hospital with a Planned Acute Care Hospital Inpatient Readmission), or 94 (Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission) are eligible for transfer per diem reimbursement. Claims that are assigned to APR-DRG 580 (Neonate, Transferred <5 Days Old, Not Born Here) or APR-DRG 581 (Neonate, Transferred <5 Days Old, Born Here) will not be reimbursed on a transfer per diem basis. The transfer per diem reimbursement is calculated using the following formula:

\[
\text{Transfer Per Diem Payment} = \left( \frac{\text{APR-DRG Base Payment}}{\text{APR-DRG Average Length of Stay}} \right) \times (\text{Patient Length of Stay} + 1 \text{ Day})
\]

- Cost Outlier Payment

The cost outlier add-on is determined by comparing the true costs to a threshold calculated as the sum of the fixed outlier threshold, and the APR-DRG base payment. For transfer cases, the threshold is calculated as the sum of the fixed outlier threshold and the transfer per-diem payment. If the true costs exceeds the calculated cost outlier threshold, the add-on is derived by
subtracting the cost outlier threshold from the true costs and multiplying the difference by the applicable Severity of Illness (SOI) adjustment factor.

True Costs = Total Covered Charges * Hospital RCC

Cost Outlier Threshold = Fixed Outlier Threshold + Base Payment (or Transfer Payment, if applicable)

Cost Outlier Add-On = (True Costs - Cost Outlier Threshold) * SOI Adjustment Factor

• Medicaid High Volume Add-on (MHVA) Per Diem Payment

The MHVA amount is used to adjust reimbursement for Disproportionate Share Hospitals (DSH). For facilities that qualify for the MHVA payment, the payment will be determined by taking the applicable per diem amount and multiplying that amount by the Length of Stay (LOS).

MHVA Payment = MHVA Per Diem * LOS

• Medicaid Percentage Adjustment (MPA) Per Diem Payment

The MPA amount is used to adjust reimbursement for facilities with a high percentage of Medicaid patients. For facilities that qualify for the MPA payment, the payment will be determined by taking the applicable per diem amount and multiplying that amount by the length of stay (LOS). Normal newborn claims are not eligible for the MPA payment.

MPA Payment = MPA Per Diem * LOS

• Safety Net Per Diem Payment

The safety net payment is used to adjust reimbursement for eligible safety net facilities. For facilities that qualify for the safety net payment, the payment will be determined by taking the applicable Safety Net Hospital (SNH) per diem amount and multiplying that amount by the length of stay (LOS).

Safety Net Payment = SNH Per Diem * LOS

• Total Reimbursement

The APR-DRG base payment calculation will utilize a policy adjustor when one of the following criteria is met. The policy adjustor will be a value other than 1.00 for a claim that groups to a trauma APR-DRG and the provider is designated as a Level 1 or Level 2 Trauma Center, groups to a perinatal APR-DRG and the provider is designated as a Level 3 Perinatal Center, or groups to a transplant APR-DRG. The total reimbursement is calculated by adding the individual pricing components described above, as follows:

Total Reimbursement = ((APR-DRG Base Payment + Cost Outlier Add-On) * Policy Adjuster) + (MHVA Payment) + (MPA Payment) + (Safety Net Payment)

If the total reimbursement is greater than the total charges, the DRG base payment will be capped at total charges, but the MHVA, MPA and safety net payments are not included in that cap.

• Legislative Reductions
Per the *Save Medicaid Access and Resources Together (SMART) Act*, the total payment is reduced for eligible facilities by the legislative reduction factor.

- **Mark-Up/Discount Factor**

The Illinois Medicaid APR Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- **Not Currently Supported**

The Illinois Medicaid APR Pricer does not support MPA and MHVA per diem payments that are based on dates of service.

### B.3.7 Indiana Medicaid APR Pricer (C Only) (prior to April 01, 2018)

#### B.3.7.1 APR-DRG Payment Calculations

For inpatient acute care, rehabilitation, and psychiatric facilities payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Indiana Medicaid APR Pricer for claims with discharge dates on or after October 01, 2015 through March 31, 2018:

- **APR-DRG Base Payment**

The APR-DRG base payment is calculated using the following formula:

$$Base \ Payment = Hospital \ Specific \ Payment \ Rate \ * \ APR-DRG \ Weight$$

- **Rehabilitation Per Diem Payment**

The payment for rehabilitation cases is calculated as follows:

$$Base \ Payment = Rehabilitation \ Per \ Diem \ Rate \ * \ Length \ of \ Stay$$

- **Burn Per Diem Payment**

The payment for burn cases is calculated as follows:

$$Base \ Payment = Burn \ Per \ Diem \ Rate \ * \ Length \ of \ Stay$$

- **Psychiatric Per Diem Payment**

The payment for psychiatric cases is calculated as follows:

$$Base \ Payment = Psychiatric \ Per \ Diem \ Rate \ * \ Length \ of \ Stay$$

- **Organic Mental Health Disturbance Payment**

Indiana Medicaid has special pricing rules for organic mental health disturbances. If APR-DRG 757 (Organic Mental Health Disturbances) is assigned to a claim along with one of the ICD-10-CM diagnosis codes listed below in Table B-6 then the claim will be paid using the APR-DRG payment methodology. If APR-DRG 757 is assigned to a claim without one of the ICD-10-CM diagnosis codes listed in Table B-6, then the claim will be paid as follows:
Base Payment = Psychiatric Per Diem Rate * Length of Stay

Table B-6: Applicable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F70</td>
<td>Mild Intellectual Disabilities</td>
</tr>
<tr>
<td>F71</td>
<td>Moderate Intellectual Disabilities</td>
</tr>
<tr>
<td>F72</td>
<td>Severe Intellectual Disabilities</td>
</tr>
<tr>
<td>F73</td>
<td>Profound Intellectual Disabilities</td>
</tr>
<tr>
<td>F78</td>
<td>Other Intellectual Disabilities</td>
</tr>
<tr>
<td>F79</td>
<td>Unspecified Intellectual Disabilities</td>
</tr>
</tbody>
</table>

* Transfer Payment

Claims for patients who are transferred from one facility to another facility may be paid using a per diem methodology if the transfer payment is less than the APR-DRG base payment. Claims containing one of the Discharge Dispositions shown below in Table B-7 are eligible for transfer per diem reimbursement. Claims that are assigned to APR-DRG 580 (Neonate, Transferred <5 Days Old, Not Born Here) or APR-DRG 581 (Neonate, Transferred <5 Days Old, Born Here) are exempt from transfer payment. Claims paid per diem are also exempt from transfer payment. The Transfer Payment is calculated as follows:

Transfer Payment = (Base Payment / APR-DRG Mean Length of Stay) * Length of Stay

Table B-7: Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>62</td>
<td>Discharged/Transferred to Inpatient Rehabilitation Facility or Unit</td>
</tr>
<tr>
<td>63</td>
<td>Discharged/Transferred to Long Term Care Hospital, Medicare-Certified</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to a Critical Access Hospital</td>
</tr>
<tr>
<td>70</td>
<td>Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>90</td>
<td>Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
</tbody>
</table>
• Cost Outlier Payment

The cost outlier add-on payment is determined by comparing the true costs to the maximum of two times the Base Payment or the Fixed Loss Threshold:

\[
\text{True Costs} = \text{Total Covered Charges} \times \text{Hospital RCC}
\]

\[
\text{Cost Outlier Threshold} = \text{Maximum of (2} \times \text{Base Payment)} \text{ or Fixed Loss Threshold}
\]

For transfer cases, the threshold is calculated as the maximum of two times the Transfer Payment or the Fixed Loss Threshold:

\[
\text{Cost Outlier Threshold} = \text{Maximum of (2} \times \text{Transfer Payment)} \text{ or Fixed Loss Threshold}
\]

For burn cases, the threshold is calculated using the following formula:

\[
\text{Cost Outlier Threshold} = \text{Base Payment} \times 2
\]

If the true costs are greater than the Cost Outlier Threshold, the add-on payment is derived by subtracting the Cost Outlier Threshold from the true costs, and multiplying the difference by the applicable Marginal Cost Factor:

\[
\text{Cost Outlier Add-On Payment} = (\text{True Costs} - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor}
\]

**Note**

Claims paid via the psychiatric or rehabilitation methodologies are not eligible for cost outlier payments.

• Capital Payment

If applicable, the total payment will also include a Capital Payment. For transfer cases where the length of stay is greater than the APR-DRG Mean Length of Stay and for non-transfer cases, the Capital Payment is calculated as follows:

\[
\text{Capital Payment} = \text{Capital Per Diem Rate} \times \text{APR-DRG Mean Length of Stay}
\]
For burn, psychiatric, rehabilitation, and transfer cases where the length of stay is less than the APR-DRG Mean Length of Stay, the Capital Payment is calculated as follows:

\[
\text{Capital Payment} = \text{Capital Per Diem Rate} \times \text{Length of Stay}
\]

• Medical Education Payment

If applicable, the total payment will also include a Medical Education Payment. For transfer cases where the length of stay is greater than the APR-DRG Mean Length of Stay and for non-transfer cases, the Medical Education Payment is calculated as follows:

\[
\text{Medical Education Payment} = \text{Medical Education Per Diem Rate} \times \text{APR-DRG Mean Length of Stay}
\]

For burn, psychiatric, rehabilitation, and transfer cases where the length of stay is less than the APR-DRG Mean Length of Stay, the Medical Education Payment is calculated as follows:

\[
\text{Medical Education Payment} = \text{Medical Education Per Diem Rate} \times \text{Length of Stay}
\]

• Total Payment

The total payment is calculated by adding the individual pricing components described above as follows. If the total payment is greater than the total charges, the total payment will be capped at charges.

\[
\text{Total Payment} = \text{Base Payment} + \text{Capital Payment} + \text{Medical Education Payment} + \text{Cost Outlier Add-On Payment}
\]

• Mark-Up/Discount Factor

The Indiana Medicaid APR Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

B.3.8 Iowa Medicaid Pricer (C Only)

The Iowa Medicaid Pricer supports the following calculations for the state of Iowa.

B.3.8.1 DRG Payment Calculations

For inpatient acute care, payment is determined using a DRG-based methodology.

• DRG Base Payment

The DRG Base Payment is calculated as follows:

\[
\text{DRG Base Payment} = \text{Hospital Base Rate} \times \text{DRG Weight}
\]

Note

Optum has included the operating base rate and the capital cost in the Hospital Base Rate.
• Transfer Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology, if the per diem payment is less than the standard DRG payment. The discharge dispositions shown below in Table B-8 are eligible for transfer per diem reimbursement.

Transfer Per Diem Payment = (DRG Base Payment / DRG Mean Length of Stay) * Length of Stay

Table B-8: Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
</tr>
</tbody>
</table>

• Cost Outlier Payment

To qualify for the cost outlier payment, the service cost must exceed a threshold. The threshold is the greater of the hospital threshold or the statewide threshold. The claim cost, thresholds, and the cost outlier payment are calculated as follows:

Statewide Threshold = Statewide Average DRG Rate * DRG Weight * Statewide Outlier Factor

Hospital Threshold = DRG Base Payment + Cost Outlier Threshold

Cost = Total Charges * Ratio of Cost-to-Charges

Cost Outlier Payment = (Cost - Maximum of Statewide Threshold or Hospital Threshold) * Marginal Cost Factor

• Long Stay Outlier Payment

To qualify for the long stay outlier payment, the length of stay must be greater than the DRG long stay threshold. The long stay outlier payment is calculated as follows:

Long Stay Per Diem = DRG Base Payment / DRG Mean Length of Stay

Covered Days = Length of Stay - DRG Long Stay Threshold + 1

Long Stay Outlier Payment = Long Stay Per Diem * Covered Days * Long Stay Marginal Cost Factor

Note

Claims that qualify for a cost outlier payment are not eligible for a long stay outlier payment.

• Short Stay Payment
To qualify for the short stay payment, the length of stay must be less than the DRG short stay threshold. The short stay payment is calculated as the lesser of the DRG Base Payment or is calculated as shown below:

\[
\text{Short Stay Per Diem} = \frac{\text{DRG Base Payment}}{\text{DRG Mean Length of Stay}}
\]

\[
\text{Short Stay Payment} = \text{Short Stay Per Diem} \times \text{Length of Stay} \times \text{Short Stay Marginal Cost Factor}
\]

**Note**

Claims that qualify for a cost outlier payment are not eligible for a short stay payment.

For claims that qualify for both a short stay payment and a transfer payment, the transfer payment takes precedence and no short stay payment will be made.

• **Swing Bed Payment**

To qualify for the swing bed payment, the claim must be from a designated CAH swing bed unit with UB-04 Bill Type 018X (Hospital, Swing Beds) or 028X (SNF, Swing Beds). The swing bed payment is calculated as follows:

\[
\text{Swing Bed Payment} = \text{Swing Bed Per Diem} \times \text{Length of Stay}
\]

• **Total Reimbursement**

For short stay and swing bed claims, the total reimbursement will equal the short stay payment or the swing bed payment. For all other claims, the total reimbursement is calculated as the sum of the final DRG Base Payment and the final outlier payment (after any Mark-Up/Discount is applied).

• **Mark-Up/Discount Factor**

The Iowa Medicaid Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the final DRG Base Payment and outlier payments are multiplied by the Mark-Up/Discount Factor.

• **Not Currently Supported**

The Iowa Medicaid Pricer does not support the following:

- Rehabilitation Per Diem
- Psychiatric Per Diem
- Substance Abuse

**B.3.8.2 Special Pricing Rules for Neonatal Claims**

Iowa Medicaid increases payment for eligible facilities for neonatal services in a certified Level 2 or Level 3 Neonatal Intensive-Care Unit (NICU) if billed with the primary hospital National Provider Identification (NPI) and appropriate revenue code. The Iowa Medicaid Payment System utilizes the Medicare
DRG grouping methodology with some DRG reassignments for neonatal services. Optum handles these reassignments in the Iowa Medicaid Pricer using the hospital NICU level as shown below in Table B-9.

Table B-9: Neonatal DRG Reassignments

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>NICU Level 2</th>
<th>NICU Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>789</td>
<td>7892</td>
<td>7897</td>
</tr>
<tr>
<td>790</td>
<td>7902</td>
<td>7907</td>
</tr>
<tr>
<td>791</td>
<td>7912</td>
<td>7917</td>
</tr>
<tr>
<td>792</td>
<td>7922</td>
<td>7927</td>
</tr>
<tr>
<td>793</td>
<td>7932</td>
<td>7937</td>
</tr>
<tr>
<td>794</td>
<td>7942</td>
<td>7947</td>
</tr>
<tr>
<td>795</td>
<td>7952</td>
<td>7957</td>
</tr>
</tbody>
</table>

B.3.9 Kansas Medicaid Pricer (C Only)

The Kansas Medicaid Pricer handles the DRG portion of the hospital inpatient reimbursement only. Adjustments will not be made for the following items:

- Nursery Level IV Reimbursement Based on Revenue Code 0174 (Nursery Newborn - Level IV)
- Psychiatric Care and Behavioral Health Services Based on Revenue Codes 0114 (Room & Board Private Psychiatric), 0124 (Room & Board Semiprivate 2-Bed Psychiatric), 0136 (Room & Board Semiprivate 3 & 4 Beds Detox), 0144 (Room & Board Private (Deluxe) Psychiatric), or 0154 (Room & Board Ward Psychiatric)
- Rehabilitation Services Based on Revenue Codes 0118 (Room & Board Private Rehabilitation), 0128 (Room & Board Semiprivate 2-Bed Rehabilitation), 0138 (Room & Board Semiprivate 3 & 4 Beds Rehabilitation), 0148 (Room & Board Private (Deluxe) Rehabilitation) or 0158 (Room & Board Ward Rehabilitation)
- Coronary Care Unit Services Based on Revenue Codes 0201 (Intensive Care Surgical), 0211 (Coronary Care Myocardial Infarction), 0212 (Coronary Care Pulmonary Care), 0213 (Coronary Care Heart Transplant), 0214 (Coronary Care Intermediate CCU), or 0219 (Coronary Care Other)
- Trauma Hospital Services Based on Revenue Codes 0200 (Intensive Care General Classification), 0201 (Intensive Care Surgical), 0202 (Intensive Care Medical), 0203 (Intensive Care Pediatric), 0204 (Intensive Care Psychiatric), 0206 (Intensive Care Intermediate ICU), 0207 (Intensive Care Burn Care), 0208 (Intensive Care Trauma) and 0209 (Intensive Care Other)
• Transplant Services (heart, liver, and bone marrow) are Excluded From DRG Payment and are Paid the Lesser of Reasonable Cost or Customary Charges

B.3.9.1 DRG Payment Calculations
For inpatient acute care, payment is determined using a DRG based methodology.

• DRG Base Payment

The DRG Base Payment is calculated as follows:

\[ DRG \text{ Base Payment} = \text{Hospital Base Rate} \times \text{DRG Weight} \times (\text{GME Adjustment Factor} + 1) \times (\text{CAH Adjustment Factor} + 1) \]

• Non-Covered Day Adjustment

If a claim has Medicaid non-covered days, these days can be entered as alternate level of care days, which are reported in the Alternate Level of Care Days (alc_days) field located in the PCB2.ICD [ip_claim_data] structure. This number will be subtracted from the claim length of stay to determine the Medicaid covered days for reimbursement. The non-covered days payment is the lesser of the standard DRG payment (shown above) or the per diem payment shown below.

\[ \text{Adjusted Days} = \text{Claim Length of Stay} - \text{ALC Days} \]

\[ DRG \text{ Base Payment} = \text{DRG Daily Rate} \times \text{Adjusted Days} \times (\text{GME Adjustment Factor} + 1) \times (\text{CAH Adjustment Factor} + 1) \]

• Transfer Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the per diem payment is less than the standard DRG payment. The discharge dispositions shown below in Table B-10 are eligible for transfer per diem reimbursement.

\[ \text{Transfer Per Diem Payment} = (\text{DRG Daily Rate} \times \text{Adjusted Days}) \times (\text{GME Factor} + 1) \times (\text{CAH Adjustment Factor} + 1) \]

Kansas Medicaid has chosen to follow a model similar to Medicare for reimbursing transfer situations. The receiving hospital is paid the full DRG payment and the transferring hospital is paid the per diem payment if it is less than the DRG payment.

Table B-10: Discharge Disposition

<table>
<thead>
<tr>
<th>Discharge Dispositions</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to an Acute Care Facility</td>
</tr>
</tbody>
</table>

• Cost Outlier Payment

To qualify for the cost outlier payment the cost must exceed the DRG cost outlier threshold. To calculate the cost and the cost outlier payment:
Cost = ((Total Charges * (Adjusted Days / LOS)) * Hospital Ratio Cost-to-Charges)

Cost Outlier Payment = (Cost - DRG Cost Outlier Threshold) * Cost Outlier Adjustment Factor * (CAH Adjustment Factor + 1)

- Day Outlier Payment

To qualify for the day outlier payment the adjusted days must be greater than the DRG Day Outlier Limit. To calculate the day outlier payment:

\[ \text{Day Outlier Payment} = ((\text{Adjusted Days} - \text{DRG Day Outlier Limit} \times (\text{DRG Daily Rate})) \times \text{Day Outlier Adjustment Factor}) \times (\text{CAH Adjustment Factor} + 1) \]

Kansas Medicaid pays the greater of the cost outlier payment or the day outlier payment.

- Mark-Up/Discount Factor

The Kansas Medicaid Pricer has an option to increase or reduce the overall claim payment by a hospital defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the final DRG base payment and outlier payments are multiplied by the Mark-Up/Discount Factor.

- Reductions for Inpatient Services

Multiple reductions apply to claims that contain inpatient services, effective July 01, 2016. They are outlined below:

- A payment reduction of 2.14% applies to inpatient hospitals that are subject to the HealthCare Access Improvement Program (HCAIP).
- A 4% reduction applies to inpatient hospitals that are subject to the state-mandated budget shortfall reduction.
- A 6.04% reduction applies to inpatient hospitals that are subject to the HCAIP reduction, as well as the state-mandated budget shortfall reduction.

- Total Reimbursement

The total reimbursement is calculated as the sum of the final DRG base payment and the final outlier payment (after any Mark-Up/Discount Factor is applied). Total reimbursement is limited to the total charges on a claim.

**B.3.9.2 DRG Reassignments**

The Kansas Medicaid Payment System also utilizes the Medicare DRG grouping methodology with some DRG reassignments for various situations. The details on the DRG reassignments are documented on the [Kansas Medical Assistance Program (KMAP) web site](#). Optum handles these reassignments in the Kansas Medicaid Pricer using the following key claim information:

- Adjusted Days (Claim Length of Stay - Alternate Level of Care Days)
- Claim Grouped to DRG
• ICD-9-CM/ICD-10-CM Diagnosis Codes

Neonate birth weight is not required and is not used by the Medicare DRG Grouper or the Kansas Medicaid Pricer. The ICD-9-CM/ICD-10-CM diagnosis codes are used by the Kansas Medicaid Pricer to determine the birth weight of a neonate patient and the Pricer reassigns the MS-DRG as appropriate.

B.3.10 Kentucky Medicaid Pricer (C Only)

B.3.10.1 Kentucky Medicaid Prior to October 01, 2015

• Special Pricing Rules for Neonatal Claims

For Kentucky Medicaid, neonatal claims that have grouped to DRGs 385 - 390 are reassigned to a corresponding Kentucky-specific DRG, if a hospital is an acute care hospital with a level II or III nursery.

Table B-11: Neonatal Level II or II Nursery DRGs

<table>
<thead>
<tr>
<th>Hospital without Level II or III Nursery</th>
<th>Hospital with a level II nursery</th>
<th>Hospital with Level III Nursery</th>
<th>DRG Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>385</td>
<td>675</td>
<td>685</td>
<td>Neonates, Died, or Transferred to another Acute Care Facility</td>
</tr>
<tr>
<td>386</td>
<td>676</td>
<td>686</td>
<td>Extreme Immaturity or Respiratory Distress Syndrome, Neonate</td>
</tr>
<tr>
<td>387</td>
<td>677</td>
<td>687</td>
<td>Prematurity w/ Major Problems</td>
</tr>
<tr>
<td>388</td>
<td>678</td>
<td>688</td>
<td>Prematurity w/o Major Problems</td>
</tr>
<tr>
<td>389</td>
<td>679</td>
<td>689</td>
<td>Full Term Neonate w / Major Problems</td>
</tr>
<tr>
<td>390</td>
<td>680</td>
<td>690</td>
<td>Neonate w/ Other Significant Problems</td>
</tr>
</tbody>
</table>

The DRG reassignment causes a different set of weights to be used in pricing.

• Special Pricing Rules for Transplant Claims

Kentucky Medicaid does not use standard reimbursement logic for the DRGs in Table B-12. These DRGs are paid the minimum of either the Transplant Payment Maximum or the Transplant Payment Percentage multiplied by Total Covered Charges. If payment is requested for one of these DRGs, and either the Transplant Payment Maximum or the Transplant Payment Percentage is set to zero, Pricer Return Code 24 (Non-Covered Claim) will be issued. Transplants for kidney, cornea, pancreas, and simultaneous kidney/pancreas are paid using the standard reimbursement logic.
Table B-12: DRGs Exempt from Standard Reimbursement Logic

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>103</td>
<td>Heart transplant or implant of heart assist system</td>
</tr>
<tr>
<td>480</td>
<td>Liver transplant and/or intestinal transplant</td>
</tr>
<tr>
<td>481</td>
<td>Bone marrow transplant</td>
</tr>
<tr>
<td>495</td>
<td>Lung transplant</td>
</tr>
</tbody>
</table>
B.3.11 Medicaid APR Pro Pricer (C Only)

☑ Colorado Medicaid (effective July 01, 2018)

**B.3.11.1 APR-DRG Payment Calculations**

Inpatient acute care payments are determined by using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APR Pro Pricer for Colorado Medicaid APR claims with discharge dates on or after July 01, 2018.

- **APR-DRG Base Payment**

  The APR-DRG base payment is calculated using the following formula:

  \[
  \text{APR-DRG Base Payment} = \text{Hospital Base Rate} \times \text{APR-DRG Relative Weight}
  \]

- **Covered Days**

  Covered days are calculated using the following formula:

  \[
  \text{Covered Days} = \text{Length of Stay} - \text{Non-Covered Days Reported With Value Code 81}
  \]

- **Outlier Day Payment**

  Outlier days are reimbursed at 80% of the DRG per diem rate. The DRG per diem rate is calculated using the DRG base payment divided by the DRG average length of stay. The outlier days payment is calculated using the following formula:

  \[
  \text{Outlier Days} = \text{Covered Days} - \text{DRG Trim Point}
  \]

  \[
  \text{Outlier Day Payment} = \left(\frac{\text{APR-DRG Base Payment}}{\text{APR-DRG Average Length of Stay}}\right) \times \text{Outlier Days}
  \]

  Hospitals are eligible to receive outlier payments only if the Covered Days exceed the DRG Trim Point.

- **Transfer Per Diem Payment**

  Claims containing an Admission Source of 04 (Transfer From a Hospital), or one of the discharge dispositions shown below in Table B-13, may be eligible for Transfer Per Diem Reimbursement. Claims that meet one of these criteria qualify for this reimbursement when the DRG per diem rate multiplied by Covered Days is of lesser value than the APR-DRG Base Payment. These payments are calculated by:

  \[
  \text{Transfer Per Diem Payment} = \left(\frac{\text{APR-DRG Base Payment}}{\text{APR-DRG Average Length of Stay}}\right) \times \text{Covered Days}
  \]

### Table B-13: Discharge Dispositions Eligible for Transfer Per Diem Reimbursement

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Skilled Nursing Facility, Medicare-Certified</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>62</td>
<td>Discharged/Transferred to Inpatient Rehabilitation Facility or Unit</td>
</tr>
</tbody>
</table>
Mark-Up/Discount Factor

The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a hospital specific factor (Markup/Discount Factor). If this factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

Total Reimbursement

The total reimbursement is calculated as shown below. Total reimbursement is subject to a charge cap:

\[
Total \ Reimbursement = APR-DRG \ Base \ Payment + Outlier \ Day \ Payment
\]

Note

If the claim is eligible for the transfer per diem payment, replace APR-DRG Base Payment in the above formula with Transfer Per Diem Payment.

Not Supported

The Colorado Medicaid Payment System does not support claims from psychiatric, rehabilitation, long term care, and state-owned facilities.

Florida Medicaid (effective April 01, 2018)

B.3.11.2 APR-DRG Payment Calculations

The Florida Agency for Health Care Administration (AHCA) reimburses inpatient hospital claims using APR-DRG methodology. The APR-DRG payment applies to all inpatient facilities, except four state-owned psychiatric facilities.

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>63</td>
<td>Discharged/Transferred to Long Term Care Hospital, Medicare-Certified</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to Critical Access Hospital</td>
</tr>
<tr>
<td>69</td>
<td>Discharged/Transferred to a Designated Disaster Alternative Care Site</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>90</td>
<td>Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>91</td>
<td>Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>94</td>
<td>Discharged/Transferred to a Critical Access hospital (CAH) With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
</tbody>
</table>
The Medicaid APR Pro Pricer handles the APR-DRG portion of the hospital inpatient reimbursement only. No adjustments above and beyond the APR-DRG portion will be made for:

- Transplant Claims
- Newborn Hearing Screening
- Dual Eligibility (Medicare and Medicaid Members)

Also, the Medicaid APR Pro Pricer will not reduce the overall claim reimbursement to account for “other health coverage” or “patient share of cost.”

• APR-DRG Base Payment

The Florida AHCA has adopted a modified base * weight reimbursement calculation. Inpatient hospital claims will be reimbursed using the following calculation:

\[
\text{DRG Base Payment} = \text{Hospital Base Rate} \times \text{DRG Weight} \times \text{Policy Adjustor} \times \text{Case-Mix Adjustor}
\]

• APR-DRG Policy Adjustors

Florida Medicaid utilizes two different policy adjustors. The first adjustor is a Provider Adjustor and applies to the following facility types:

- Rural Hospitals
- Long-Term Acute Care Hospitals
- Rehabilitation Hospitals
- Hospitals with Both High Medicaid Utilization and High Outlier Payment Percentages

The second adjustor is an Age Adjustor and applies only to APR-DRGs with an SOI of 2, 3, or 4 (except for normal newborn and obstetric APR-DRGs) when the patient is under the age of 21. If a claim qualifies for both types of policy adjustors, the maximum adjustor is applied to the DRG base payment.

• Transfer Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the transfer per diem payment is less than the APR-DRG base payment. Claims with one of the Discharge Dispositions shown below in Table B-14 are eligible for transfer per diem reimbursement. Claims that are assigned to APR-DRG 580 (Neonate, Transferred <5 Days Old, Not Born Here) or APR-DRG 581 (Neonate, Transferred <5 Days Old, Born Here) will not be reimbursed on a transfer per diem basis. The transfer per diem reimbursement is calculated using the following formula:
Transfer Base Payment = (DRG Base Payment / DRG Average Length of Stay) * (Length of Stay + 1)

Table B-14: Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to an Acute Care Facility</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to Critical Access Hospital</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>93</td>
<td>Discharged/Transferred to a Psychiatric Distinct Part Unit of a Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>94</td>
<td>Discharged/Transferred to a Critical Access Hospital (CAH) With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
</tbody>
</table>

- Intergovernmental Transfer (IGT) Payment (prior to October 01, 2020)
  Automatic IGT payments are made on a per claim basis where applicable. The Automatic IGT rate is multiplied by the DRG weight and divided by the hospital’s case-mix. The Medicaid APR Pro Pricer returns this payment in the Alternate Level of Care Days Payments (alcpay) field in the POB1.DRG [drg_prcr_block1] structure.

  **Automatic IGT Payment (Displayed as Alternate Level of Care Days Payments) = Automatic IGT Rate * (DRG Weight / Hospital Case-Mix)**

- Cost Outlier Payment
  The cost outlier add-on payment is determined by comparing the true costs to a threshold calculated as the sum of the fixed outlier threshold, and the DRG base payment. For transfer cases, the threshold is calculated as the sum of the fixed outlier threshold and the transfer per-diem payment. If the true costs exceed the calculated cost outlier threshold, the add-on is derived by subtracting the cost outlier threshold from the true costs and multiplying the difference by the applicable marginal cost factor.

  Florida Medicaid uses two marginal cost factors. Marginal Cost Factor 2 is used when a claim meets one of the following criterion:
  - When a claim groups to a neonate DRG with an SOI of 3 or 4
- When a claim groups to a pediatric DRG with an SOI of 3 or 4 and the patient’s age is less than 21

All other claims use Marginal Cost Factor 1.

**True Costs** = **Total Covered Charges** * Hospital RCC

**Cost Outlier Threshold** = **Fixed Outlier Threshold** + DRG Base Payment (or Transfer Base Payment, if applicable)

**Outlier Payment** = \((\text{True Costs} - \text{Cost Outlier Threshold}) \times \text{Applicable Marginal Cost Factor}\)

**Non-Covered Day Adjustments**

If a claim includes non-covered days, those days can be submitted to EASYGroup™ via one of two methods:

- **Alternate Level of Care Days:**
  Non-covered days can be entered in the Alternate Level of Care Days (\(\text{alc\_days}\)) field in the PCB2.ICD [ip_claim_data] structure.

- **Value Code and Value Amount:**
  Non-covered days can be entered in the UB-04 Value Amount (\(\text{valamt}\)) field with a UB-04 Value Code (\(\text{valcode}\)) of 81 (Non-covered Days). Both of these fields are located in the PCB1 [patient_claim_data] structure.

If non-covered days are billed on a claim, the DRG Base Payment (or the Transfer Base Payment for transfer cases) and the Outlier Payment are reduced by the Medicaid covered days divided by the claim length of stay.

**Medicaid Covered Days** = **Length of Stay** – **Non-Covered Days**

**Reduced DRG Base Payment** = \(\text{DRG Base Payment (or Transfer Base Payment, if applicable)} \times (\text{Medicaid Covered Days} / \text{Length of Stay})\)

**Reduced Outlier Payment** = \(\text{Outlier Payment} \times (\text{Medicaid Covered Days} / \text{Length of Stay})\)

**Vagus Nerve Stimulator (VNS) Device Payment**

Florida Medicaid has an add-on payment for VNS devices for patients with intractable Epilepsy, that do not have a surgical treatment option. This add-on payment is made in addition to the surgical DRG payment. When a complete VNS device is inserted/fully replaced or partially replaced, payments are made at the lessor of the device charges or the applicable VNS device maximum fee. Although highly unlikely, if a patient were to receive two or more VNS devices during a single inpatient stay on different dates of service, two or more add-on payments would be made. The VNS device payment is calculated using the following formula:

**VNS Device Payment** = Less than (device charges or the applicable VNS device maximum fee)
• Charge Cap Adjustment

The Florida AHCA has a charge cap, which limits claim payment to the lesser of the total DRG payment or total charges. If the total charges are less than the total DRG payment, then the total charges takes precedence, otherwise the total DRG payment takes precedence:

\[
\text{Total DRG Payment} = \text{Outlier Payment} + \text{DRG Base Payment (or Transfer Base Payment if applicable)} + \text{VNS Device Payment}
\]

\[
\text{Reduction Factor} = \frac{\text{Total Charges}}{\text{Total DRG Payment}}
\]

\[
\text{Reduced DRG Base Payment} = (\text{DRG Base Payment (or Transfer Base payment, if applicable)} + \text{VNS Device Payment}) \times \text{Reduction Factor}
\]

\[
\text{Reduced Outlier Payment} = \text{Outlier Payment} \times \text{Reduction Factor}
\]

• Trauma Facility Add-On Payment

Claims from Level I/Level II Trauma Facilities and Pediatric Trauma Facilities receive a supplemental payment. To determine this payment, the percentage (shown below in Table B-15) is multiplied by the final DRG base payment or the final Transfer Base Payment for transfer cases. This trauma facility add-on payment is calculated as follows:

\[
\text{Trauma Facility Add-On Payment} = (\text{Trauma Payment Percentage} \times \text{DRG Base Payment (or Transfer Base Payment, if applicable)})
\]

Table B-15: Trauma Facility Payment Percentages

<table>
<thead>
<tr>
<th>Trauma Facility Type</th>
<th>Trauma Payment Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>17%</td>
</tr>
<tr>
<td>Level II</td>
<td>11%</td>
</tr>
<tr>
<td>Pediatric</td>
<td>4%</td>
</tr>
</tbody>
</table>

• Mark-Up/Discount Factor

The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a hospital defined factor (Markup/Discount Factor). If this factor is set to a number other than 1.0, the final DRG Base Payment (or the final Transfer Base Payment for transfer cases), the Automatic IGT Payment (prior to October 01, 2020), the Outlier Payment, and the Trauma Facility Add-On Payment are multiplied by this factor.
• Total Reimbursement

Total reimbursement is calculated as the sum of the final DRG Base Payment (or the final Transfer Base Payment for transfer cases), the final Automatic IGT Payment (prior to October 01, 2020), the final Outlier Payment, the final Trauma Facility Add-On Payment and the VNS device payment; after any Mark-Up/Discount Factor is applied.

• Not Currently Supported

Effective January 18, 2018, the Florida AHCA uses the discharge date to validate ICD codes and assign APR DRGs. However, Florida AHCA is using date of admission to determine the APR DRG base rate and policy adjustors for pricing the claims. We cannot support this functionality in our software. The Florida Medicaid APR-DRG software is configured to apply grouping and pricing based on discharge date. We have learned that Florida AHCA is planning to change their logic so all elements of the DRG payment are based on discharge date. However, they have not determined an implementation date at this time.

🇮🇳 Indiana Medicaid (effective April 01, 2018)

B.3.11.3 APR-DRG Payment Calculations

For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APR Pro Pricer for Indiana Medicaid APR claims with discharge dates on or after April 01, 2018.

• APR-DRG Base Payment

The APR-DRG base payment is calculated using the following formula:

\[
\text{Base Payment} = \text{Hospital Specific Payment Rate} \times \text{APR-DRG Weight}
\]

• Rehabilitation Per Diem Payment

The payment for rehabilitation cases is calculated as follows:

\[
\text{Base Payment} = \text{Rehabilitation Per Diem Rate} \times \text{Length of Stay}
\]

• Burn Per Diem Payment

The payment for burn cases is calculated as follows:

\[
\text{Base Payment} = \text{Burn Per Diem Rate} \times \text{Length of Stay}
\]

• Psychiatric Per Diem Payment

The payment for psychiatric cases is calculated as follows:

\[
\text{Base Payment} = \text{Psychiatric Per Diem Rate} \times \text{Length of Stay}
\]

• Organic Mental Health Disturbance Payment

Indiana Medicaid has special pricing rules for organic mental health disturbances. If APR-DRG 757 (Organic Mental Health Disturbances) is assigned to a claim along with one of the ICD-10-CM diagnosis codes listed below in Table B-16 then the claim will be paid using the APR-DRG payment
methodology. If APR-DRG 757 is assigned to a claim without one of the ICD-10-CM diagnosis codes listed in Table B-16, then the claim will be paid as follows:

**Base Payment = Psychiatric Per Diem Rate * Length of Stay**

Table B-16: Applicable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F70</td>
<td>Mild Intellectual Disabilities</td>
</tr>
<tr>
<td>F71</td>
<td>Moderate Intellectual Disabilities</td>
</tr>
<tr>
<td>F72</td>
<td>Severe Intellectual Disabilities</td>
</tr>
<tr>
<td>F73</td>
<td>Profound Intellectual Disabilities</td>
</tr>
<tr>
<td>F78</td>
<td>Other Intellectual Disabilities</td>
</tr>
<tr>
<td>F79</td>
<td>Unspecified Intellectual Disabilities</td>
</tr>
</tbody>
</table>

- **Transfer Payment**

Claims for patients who are transferred from one facility to another facility may be paid using a per diem methodology if the transfer payment is less than the APR-DRG base payment. Claims containing an Admission Source of 04 (Transferred From a Hospital) or one of the discharge dispositions shown below in Table B-17 are eligible for transfer per diem reimbursement. Claims paid per diem are exempt from transfer payment. The transfer payment is calculated as follows:

**Transfer Payment = (Base Payment / APR-DRG Mean Length of Stay) * Length of Stay**

Table B-17: Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>62</td>
<td>Discharged/Transferred to Inpatient Rehabilitation Facility or Unit</td>
</tr>
<tr>
<td>63</td>
<td>Discharged/Transferred to Long Term Care Hospital, Medicare-Certified</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to a Critical Access Hospital</td>
</tr>
<tr>
<td>70</td>
<td>Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
</tbody>
</table>
• Cost Outlier Payment

The cost outlier add-on payment is determined by comparing the true costs to the maximum of two times the Base Payment or the Fixed Loss Threshold:

\[
\text{True Costs} = \text{Total Covered Charges} \times \text{Hospital RCC}
\]

\[
\text{Cost Outlier Threshold} = \text{Maximum of (2} \times \text{Base Payment)} \text{ or Fixed Loss Threshold}
\]

For transfer cases, the threshold is calculated as the maximum of two times the Transfer Payment or the Fixed Loss Threshold:

\[
\text{Cost Outlier Threshold} = \text{Maximum of (2} \times \text{Transfer Payment)} \text{ or Fixed Loss Threshold}
\]

For burn cases, the threshold is calculated using the following formula:

\[
\text{Cost Outlier Threshold} = \text{Base Payment} \times 2
\]

If the true costs are greater than the Cost Outlier Threshold, the add-on payment is derived by subtracting the Cost Outlier Threshold from the true costs, and multiplying the difference by the applicable Marginal Cost Factor:

\[
\text{Cost Outlier Add-On Payment} = (\text{True Costs} - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor}
\]

Note

Claims paid via the psychiatric or rehabilitation methodologies are not eligible for cost outlier payments.

• Capital Payment

If applicable, the total payment will also include a Capital Payment. For transfer cases where the length of stay is greater than the APR-DRG Mean...
Length of Stay and for non-transfer cases, the Capital Payment is calculated as follows:

\[ \text{Capital Payment} = \text{Capital Per Diem Rate} \times \text{APR-DRG Mean Length of Stay} \]

For burn, psychiatric, rehabilitation, and transfer cases where the length of stay is less than the APR-DRG Mean Length of Stay, the Capital Payment is calculated as follows:

\[ \text{Capital Payment} = \text{Capital Per Diem Rate} \times \text{Length of Stay} \]

- Medical Education Payment

If applicable, the total payment will also include a Medical Education Payment. For transfer cases where the length of stay is greater than the APR-DRG Mean Length of Stay and for non-transfer cases, the Medical Education Payment is calculated as follows:

\[ \text{Medical Education Payment} = \text{Medical Education Per Diem Rate} \times \text{APR-DRG Mean Length of Stay} \]

For burn, psychiatric, rehabilitation, and transfer cases where the length of stay is less than the APR-DRG Mean Length of Stay, the Medical Education Payment is calculated as follows:

\[ \text{Medical Education Payment} = \text{Medical Education Per Diem Rate} \times \text{Length of Stay} \]

- Total Reimbursement

The total reimbursement is calculated by adding the individual pricing components described above as follows. If the total payment is greater than the total charges, the total payment will be capped at charges.

\[ \text{Total Reimbursement} = \text{Base Payment} + \text{Capital Payment} + \text{Medical Education Payment} + \text{Cost Outlier Add-On Payment} \]

- Mark-Up/Discount Factor

The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

✔ Louisiana Medicaid (effective January 01, 2019)

B.3.11.4 APR-DRG Payment Calculations

For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement for Louisiana Medicaid claims with discharge dates on or after January 01, 2019.

- APR-DRG Base Payment (excludes psychiatric and rehabilitation claims)

The hospital-specific base payment is adjusted for hospital's with a High Medicaid Group designation (i.e., 120% for Group A and 110% for Group B). The APR-DRG base payment is calculated using the following formula:
- For Fee-for-Service (FFS) Payers:

APR-DRG Base Payment = (Hospital-Specific Base Rate * APR-DRG Relative Weight) + Capital Add-On Payment + Medical Education Add-On Payment

- For Managed Care Organizations (MCOs):

APR-DRG Base Payment = (Hospital-Specific Base Rate * APR-DRG Relative Weight) + Capital Add-On Payment

- Capital Add-On Payment

If applicable, an additional hospital-specific capital payment is made to certain hospitals for capital cost.

- High Cost Outlier Add-On Payment

The high cost outlier add-on payment is determined by comparing the true costs to a threshold calculated as the sum of the fixed outlier threshold and the APR-DRG base payment. The fixed outlier threshold varies depending on the APR-DRG assigned and the hospital type. If the true costs exceed the calculated cost outlier threshold, the add-on is derived by subtracting the cost outlier threshold from the true costs and multiplying the difference by the marginal cost factor. The marginal cost factor varies based on the APR-DRG assigned, the hospital type, and the hospital's High Medicaid Group status.

- For FFS Payers:

True Costs = Total Covered Charges * Hospital-Specific Ratio of Cost-to-Charge (RCC)

Cost Outlier Threshold = Fixed Outlier Threshold + APR-DRG Base Payment

High Cost Outlier Payment = (True Costs - Cost Outlier Threshold) * Applicable Marginal Cost Factor

- For MCOs:

True Costs = Total Covered Charges * Hospital-Specific Ratio of Cost-to-Charge (RCC)

Cost Outlier Threshold = Fixed Outlier Threshold + APR-DRG Base Payment + Medical Education Add-On Payment

High Cost Outlier Payment = (True Costs - Cost Outlier Threshold) * Applicable Marginal Cost Factor

- Transfer Payment

Transfer claims with a discharge disposition of 02 (Discharged/Transferred to Short-Term General Hospital) are capped at true costs if the true costs exceed the APR-DRG base payment plus the high cost outlier payment. Claims that are assigned to psychiatric APR-DRGs (740-776), rehabilitation APR-DRGs (860 and 862), and neonate transfer APR-DRGs (580 and 581) are not eligible to receive a transfer payment. The transfer payment is calculated using the following formula:
**True Costs** = Total Covered Charges * Hospital-Specific Ratio of Cost-to-Charge (RCC)

**Transfer Threshold** = APR-DRG Base Payment + High Cost Outlier Payment

**Transfer Payment** = Minimum (True Costs or Transfer Threshold)

- **Mark-Up/Discount Factor**

  The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a hospital defined factor (Markup/Discount Factor). If this factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- **Total Reimbursement**

  Total reimbursement is calculated as the sum of the final APR-DRG base payment and the final high cost outlier payment (or the final transfer base payment for transfer claims); after any mark-up/discount is applied.

- **Psychiatric Per Diem Payment**

  The psychiatric per diem payment is applied to claims assigned to a psychiatric APR-DRG (e.g., APR-DRGs 0740-0776). This payment is equal to the psychiatric per diem rate multiplied by the assigned APR-DRG relative weight and the cumulative length of stay factor (where the day factor has a higher intensity in the initial days of a stay and a lower intensity later in the stay). The cumulative length of stay factor is calculated by adding a day factor to the cumulative day factor from the previous day. The day factor decreases as the length of stay increases up until day 22, then remains constant. The psychiatric per diem rate is adjusted for hospital’s with a High Medicaid Group designation (i.e., 120% for Group A and 110% for Group B). The psychiatric per diem payment is calculated using the following formula:

  \[ \text{Psychiatric Per Diem Payment} = \text{Psychiatric Per Diem Rate} \times \text{APR-DRG Relative Weight} \times \text{Cumulative Length of Stay Factor} \]

  **Table B-18: Example of Day and Cumulative Factors**

<table>
<thead>
<tr>
<th>Day</th>
<th>Day Factor</th>
<th>Cumulative Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>1.31</td>
</tr>
<tr>
<td>2</td>
<td>1.12</td>
<td>2.43</td>
</tr>
<tr>
<td>3</td>
<td>1.08</td>
<td>3.51</td>
</tr>
<tr>
<td>4</td>
<td>1.05</td>
<td>4.56</td>
</tr>
<tr>
<td>5</td>
<td>1.04</td>
<td>5.60</td>
</tr>
</tbody>
</table>

**Note**

Capital add-on payments, medical education add-on payments, high cost outlier payments, and transfer payments do not apply to psychiatric claims.
• Rehabilitation Per Diem Payment

The rehabilitation per diem payment is applied to claims assigned to a rehabilitation APR-DRG (e.g., APR-DRG 860 and 862). This payment is equal to the rehabilitation per diem rate multiplied by the assigned APR-DRG relative weight and the length of stay. The rehabilitation per diem rate is adjusted for hospital's with a High Medicaid Group designation (i.e., 120% for Group A and 110% for Group B). The rehabilitation per diem payment is calculated using the following formula:

\[
\text{Rehabilitation Per Diem Payment} = \text{Rehabilitation Per Diem Rate} \times \text{APR-DRG Relative Weight} \times \text{Length of Stay}
\]

Note
Capital add-on payments, medical education add-on payments, high cost outlier payments, and transfer payments do not apply rehabilitation claims.

• Post-Acute Care Per Diem Payment

The post-acute care per diem payment is applied to claims with patients that require post-acute care. The post-acute care per diem payment is equal to the statewide per diem rate multiplied by the length of stay. In order to receive this payment, post-acute care days must be submitted on a separate claim along with Revenue Code 0190 (Subacute Care General Classification). In addition, the claim must be assigned to an acute care DRG. The post acute care per diem payment is calculated as follows:

\[
\text{Post-Acute Per Diem Payment} = \text{Statewide Per Diem Rate} \times \text{Length of Stay (LOS)}
\]

Note
Capital add-on payments, medical education add-on payments, high cost outlier payments, and transfer payments do not apply to post-acute per diem claims.

• Not Currently Supported

The Louisiana Medicaid Payment System does not support transplant payments (including ICU per diem payment, ancillary charges, and the cost of organ acquisition).

✔ Massachusetts Medicaid (effective October 01, 2014)

B.3.11.5 APR-DRG Payment Calculations

For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APR Pro Pricer for claims with discharge dates on or after October 01, 2014.

• Hospital Pass Thru Per Discharge Add-On Payment
The hospital pass thru per discharge add-on is calculated using the following formula:

$$\text{Hospital Pass Thru Per Discharge Add-On} = \text{Organ Acquisition Add-On Payment} + \text{Malpractice Add-On Payment}$$

- APR-DRG Base Payment

The APR-DRG base payment is calculated using the following formula. In this formula, the hospital-specific payment rate is the statewide acute care wage-adjusted base rate.

$$\text{APR-DRG Base Payment} = (\text{Hospital-Specific Payment Rate} + \text{Capital Add-On Payment}) \times \text{APR-DRG Weight} + \text{Hospital Pass Thru Per Discharge Add-On}$$

- Cost Outlier Payment

The cost outlier add-on is determined by comparing the true costs to a threshold calculated as the sum of the fixed outlier threshold, and the APR-DRG base payment. For transfer cases, the threshold is calculated as the sum of the fixed outlier threshold and the transfer per diem payment. If the true costs exceed the calculated cost outlier threshold, the add-on is derived by subtracting the cost outlier threshold from the true costs and multiplying the difference by the marginal cost factor.

$$\text{True Costs} = \text{Total Covered Charges} \times \text{Hospital RCC}$$

$$\text{Cost Outlier Threshold} = \text{Fixed Outlier Threshold} + \text{APR-DRG Base Payment}$$

$$\text{Cost Outlier Add-On Payment} = (\text{True Costs} - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor}$$

- Transfer Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the transfer per diem payment is less than the APR-DRG base payment, plus the cost outlier add-on. Claims with a Discharge Disposition of 02 (Discharged/Transferred to Short-Term General Hospital), 04 (Discharged/Transferred to a Facility That Provides Custodial or Supportive Care), 05 (Discharged/Transferred to a Designated Cancer Center or Children’s Hospital), or 66 (Discharged/Transferred to a Critical Access Hospital) are eligible for transfer per diem reimbursement. The transfer per diem reimbursement is calculated using the following formula:

$$\text{Transfer Per Diem Payment} = \left(\frac{\text{APR-DRG Base Payment} + \text{Cost Outlier Add-On Payment}}{\text{APR-DRG Mean Length of Stay}}\right) \times \text{Patient Length of Stay}$$

- Potentially Preventable Readmission (PPR) Adjustment

The PPR adjustment is calculated using the following formulas:

$$\text{Adjusted APR-DRG Base Payment} = \text{APR-DRG Base Payment} \times (1 - \text{PPR Factor})$$
Adjusted Cost Outlier Add-On Payment = Cost Outlier Add-On Payment * (1 - PPR Factor)

• Total Reimbursement
The total reimbursement is calculated by adding the individual pricing components described above, as follows:

Total Reimbursement = APR-DRG Base Payment + Adjusted Cost Outlier Add-On Payment

• Mark-Up/Discount Factor
The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

• Not Currently Supported
The Medicaid APR Pro Pricer does not support pricing for facilities based on per diem pricing (e.g., administrative days, psychiatric or rehabilitation Distinct Part Units (DPUs)) or pricing of inpatient admissions that occur following an outpatient surgery or procedure (i.e., patient admitted from an ambulatory surgical unit).

✔ Minnesota Medicaid (effective July 01, 2017)
Minnesota Medicaid’s inpatient acute care and rehabilitation payments are determined by using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APR Pro Pricer for Minnesota Medicaid APR claims with discharge dates on or after July 01, 2017.

• APR-DRG Base Payment
The APR-DRG base payment is calculated using the following formula. In this formula, the policy adjustor is applied only for specific mental health, newborn, obstetric, pediatric, and rehabilitation DRGs.

APR-DRG Base Payment = Hospital-Specific Base Rate * APR-DRG Weight * Applicable Policy Adjustor

• Transfer Base Payment
Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology, if the transfer per diem payment is less than the APR-DRG base payment. Claims with a discharge disposition shown below in Table B-19 are eligible for transfer per diem reimbursement. The transfer per diem reimbursement is calculated using the following formula:
Transfer Base Payment = \((\text{APR-DRG Base Payment} / \text{APR-DRG Average Length of Stay}) \times (\text{Length of Stay} + 1)\)

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit</td>
</tr>
</tbody>
</table>

- **High Cost Outlier Add-On Payment**

  The high cost outlier add-on payment is determined by comparing the true costs to a threshold calculated as the sum of the fixed outlier threshold, and the DRG base payment. For transfer claims, the threshold is calculated as the sum of the fixed outlier threshold and the transfer per-diem payment. If the true costs exceed the calculated cost outlier threshold, the add-on is derived by subtracting the cost outlier threshold from the true costs and multiplying the difference by the applicable Marginal Cost Factor.

  Minnesota Medicaid uses two marginal cost factors. Marginal Cost Factor 1 is used when a claim groups to a Severity of Illness (SOI) of 1 or 2. Marginal Cost Factor 2 is used when a claim groups to a SOI of 3 or 4. The high cost outlier payment is calculated using the following formulas:

  \[
  \text{True Costs} = \text{Total Covered Charges} \times \text{Hospital Ratio of Cost-to-Charges (RCC)}
  \]

  \[
  \text{Cost Outlier Threshold} = \text{Fixed Outlier Threshold} + \text{APR-DRG Base Payment (or Transfer Base Payment, if applicable)}
  \]

  \[
  \text{High Cost Outlier Add-On Payment} = (\text{True Costs} - \text{Cost Outlier Threshold}) \times \text{Applicable Marginal Cost Factor}
  \]

- **Disproportionate Share Hospital (DSH) Payment**

  This payment applies to children’s providers, psychiatric contract beds, major transplant providers, and high volume Medicaid providers.

- **Newborn Screening Add-On Payment**

  Minnesota Medicaid will make a standard payment to a hospital when a newborn receives a blood test screening for twenty-eight separate disorders.

- **Mark-Up/Discount Factor**

  The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-specific factor (Mark-up/Discount Factor). If this factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- **Total Reimbursement**
The total reimbursement is calculated as follows:

\[ \text{Total Reimbursement} = \left( (\text{APR-DRG Base Payment} + \text{High Cost Outlier Add-On Payment}) \times (1 + \text{DSH Factor}) \right) + \text{Newborn Screening Add-On Payment} \]

**Note**

If the claim is eligible for the transfer payment, replace APR-DRG Base Payment in the above formula with Transfer Base Payment.

- Not Currently Supported:

The Minnesota Medicaid Payment System currently does not support the following:

- Critical Access Hospital (CAH) per diem payments
- Non-covered days
- Provider tax payments

✔ Mississippi Medicaid (effective July 01, 2015)

**B.3.11.6 APR-DRG Payment Calculations**

For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APR Pro Pricer for claims with discharge dates on or after July 01, 2015.

- **APR-DRG Base Payment**

The APR-DRG base payment is calculated using the following formula. In this formula, the policy adjustor is applied only for specific DRGs and increases payment for those DRGs.

\[ \text{APR-DRG Base Payment} = \text{Standard Base Rate} \times \text{APR-DRG Weight} \times \text{Policy Adjustor} \]

- **Transfer Payment**

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the transfer per diem payment is less than the APR-DRG base payment. Claims with a Discharge Disposition shown in Table B-20 are eligible for transfer per diem reimbursement. The transfer per diem reimbursement is calculated using the following formula:

\[ \text{Transfer Per Diem Payment} = \left( \frac{\text{APR-DRG Base Payment}}{\text{APR-DRG Mean Length of Stay}} \right) \times (\text{Patient Length of Stay} + 1) \]

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
</tbody>
</table>
• High Cost Outlier Payment

The high cost outlier add-on is determined by comparing the true costs to a threshold calculated as the sum of the fixed outlier threshold, and the APR-DRG base payment. For transfer cases, the threshold is calculated as the sum of the fixed outlier threshold and the transfer per diem payment. If the true costs exceed the calculated cost outlier threshold, the add-on is derived by subtracting the cost outlier threshold from the true costs and multiplying the difference by the marginal cost factor. The high cost outlier add-on does not apply to mental health claims.

\[ \text{True Costs} = \text{Total Covered Charges} \times \text{Hospital RCC} \]
\[ \text{Cost Outlier Threshold} = \text{Fixed Outlier Threshold} + \text{APR-DRG Base Payment} \]
\[ \text{Cost Outlier Add-On Payment} = (\text{True Costs} - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor} \]

• Day Outlier Add-On Payment

The day outlier add-on only applies to mental health claims where the length of stay exceeds a fixed threshold. The day outlier add-on payment is calculated using the following formula:

\[ \text{Day Outlier Add-On Payment} = (\text{Patient Length of Stay} - \text{Mental Health Threshold}) \times \text{Mental Health Per Diem} \]

• Charge Cap Adjustment

There is a charge cap which limits the APR-DRG allowed amount to the lesser of the APR-DRG payment or the total covered charges on the claim. If the total

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Table B-20: Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>07</td>
<td>Left Against Medical Advice or Discontinued Care</td>
</tr>
<tr>
<td>63</td>
<td>Discharged/Transferred to Long Term Care Hospital, Medicare-Certified</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to Critical Access Hospital</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>91</td>
<td>Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>93</td>
<td>Discharged/Transferred to a Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>94</td>
<td>Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
</tbody>
</table>
covered charges are less than the APR-DRG payment, then the total covered charges take precedence, otherwise the APR-DRG payment takes precedence. The calculations are as follows:

\[ \text{APR-DRG Reimbursement} = \text{APR-DRG Base Payment} + \text{Cost Outlier Add-On Payment} \]

\[ \text{Total Reimbursement} = \text{Minimum (Total Covered Charges or APR-DRG Reimbursement)} + \text{Medical Education Add-On Payment} \]

- Medical Education Add-On Payment

Additional flat per-discharge payment amounts are made to certain hospital for medical education.

**Note**

Graduate Medical Education (GME) payments are no longer reimbursed as part of the APR-DRG methodology. These payments are now reimbursed directly to eligible facilities by the Mississippi Division of Medicaid, effective October 01, 2019. As such, GME payments are no longer added to the Total Reimbursement.

- Total Reimbursement

The total reimbursement is calculated by calculating the individual pricing components described above.

- Interim Claim Payment

If a patient stay exceeds 30 days, hospitals can choose to submit an interim claim. Interim claims are billed with a Discharge Disposition of 30 (Still a Patient). Payment for interim claims is calculated using the following formula:

\[ \text{Interim Claim Payment} = \text{Patient Length of Stay} \times \text{Interim Claim per diem} \]

- Mark-Up/Discount Factor

The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- Not Currently Supported

The Mississippi Medicaid Payment System does not support pricing adjustments for claims with non-covered days. Optum is currently awaiting clarification on these requirements from the state of Mississippi. If clarification from the state is received, this functionality may be included in a future release. The Mississippi Medicaid Payment System also does not support case-rate pricing for bariatric surgery, since the case rate covers services provided outside of the inpatient acute care stay.
New Jersey Medicaid APR (effective October 01, 2018)

**B.3.11.7 APR-DRG Payment Calculations**

For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APR Pro Pricer for New Jersey APR claims on or after October 01, 2018:

- **APR-DRG Base Payment**

  The APR-DRG base payment is calculated using the following formula:
  
  \[ APR-DRG \text{ Base Payment} = \text{Base Rate} \times \text{DRG Relative Weight} \]

- **Transfer Payment**

  Transfer payment is the lesser of the APR-DRG base payment or the APR-DRG daily rate for each covered day of stay, plus an outlier if applicable. Transfer claims are identified with a discharge disposition of 02 (Discharged/Transferred to Short-Term General Hospital).

  \[ \text{Transfer Payment} = \left( \frac{\text{APR-DRG Base Payment}}{\text{DRG Mean Length of Stay}} \right) \times \text{Length of Stay} \]

- **Outlier Payments**

  There are two types of outlier add-on payments:

  - **Cost Outliers** - claims that exceed certain cost limits that qualify for an additional payment above the APR-DRG base payment
  - **Day Outliers** - claims in which there are Alternate Level-of-Care (ALC) days

  ALC days are the days that both exceed the day outlier limit and are classified as days awaiting placement in an alternative level of care. The number of ALC days is determined by looking at the number of days billed with Occurrence Span Codes M3, M4, and 75. Hospitals may qualify for both day and cost outlier payments simultaneously.

  - **Cost Outlier Add-On Payment**

    The cost outlier add-on payment is calculated using the following formula:

    \[ \text{ALC Charges} = \text{Total of Line Charges Submitted with Revenue Codes 0190 - 0194, and 0199} \]
    \[ \text{True Costs} = \text{RCC} \times \left( \text{Total Charges} - \text{ALC Charges} \right) \]
    \[ \text{Threshold} = \text{DRG-Specific Cost Outlier Threshold} \]
    \[ \text{Cost Outlier Add-On Payment} = \left( \text{True Costs} - \text{Threshold} \right) \times \text{Marginal Cost Factor} \]

  - **Day Outlier Add-On Payment**

    Day outlier payments are applied when the total length of stay of the claim is higher than the day outlier limit for the assigned APR-DRG. If the number of ALC days is less than the difference between the claim length of stay and the
APR-DRG day outlier limit, then the day outlier add-on payment is calculated as follows:

\[
\text{Day Outlier Add-On Payment} = \text{Per Diem Rate} \times \text{ALC Days}
\]

Otherwise, the day outlier add-on payment is calculated as follows:

\[
\text{Day Outlier Add-On Payment} = \text{Per Diem Rate} \times (\text{Length of Stay} - \text{DRG Day Outlier Limit})
\]

- **Same Day Discharge Payment**

New Jersey has a policy that reduces reimbursement when the patient is admitted to and discharged from the hospital on the same date of service. Reimbursement is paid at the APR-DRG daily rate and is calculated as shown below. These claims are not eligible for outlier add-on payments.

\[
\text{Same Day Discharge Payment} = \left(\frac{\text{APR-DRG Base Payment}}{\text{DRG Mean Length of Stay}}\right) \times \text{Length of Stay}
\]

- **Provider Adjustment**

New Jersey applies a supplemental payment to hospitals that provide critical services to high volumes of Medicaid and other low income patients. Critical services are comprised of two categories:

- Maternity and neonates (all APR-DRGs in Major Diagnostic Categories (MDCs) 14 and 15)
- Mental health and substance abuse (all APR-DRGs in MDCs 19 and 20).

The add-on payments increase the statewide base rate for qualifying hospitals as a percentage add-on to the statewide base rate. The volume of critical services that hospitals provide is ranked. If a hospital is in the top 25% for either category of critical services it receives a 10% add-on. If a hospital is in the top 25% for both categories it receives a 15% add-on. This add-on payment applies to all reimbursement types except ALC day payments.

- **Mark-Up/Discount Factor**

The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a hospital defined factor (Markup/Discount Factor). If this factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- **Total Reimbursement**

The total reimbursement is calculated by adding the individual pricing components described above.

✔ Rhode Island Medicaid (effective July 01, 2018)

**B.3.11.8 APR-DRG Payment Calculations**

For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APR Pro Pricer for Rhode Island Medicaid claims on or after July 01, 2018:
• APR-DRG Base Payment

The APR-DRG base payment is calculated using the following formula. In this formula, the APR-DRG weight is applied only for specific mental health, newborn, obstetric, pediatric, and rehabilitation DRGs. These DRGs are included in the APR-DRG weights. The policy adjustor is for mental health services for patients less than 18 years of age.

\[
APR-DRG\ Base\ Payment = Hospital-Specific\ Base\ Rate \times APR-DRG\ Weight \times Applicable\ Policy\ Adjustor
\]

• Transfer Base Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology, if the transfer per diem payment is less than the APR-DRG base payment. Transfer reimbursement is the lesser of the DRG Base Payment or the DRG daily rate for each covered day of the stay, plus outlier (if applicable). Claims with a discharge disposition shown below in Table B-21 are eligible for transfer per diem reimbursement. The transfer per diem reimbursement is calculated using the following formula:

\[
Transfer\ Base\ Payment = \frac{APR-DRG\ Base\ Payment}{Average\ Length\ of\ Stay} \times (Length\ of\ Stay + 1\ Day)
\]

Table B-21: Discharge Dispositions Eligible for Transfer Per Diem Reimbursement

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>07</td>
<td>Left Against Medical Advice or Discontinued Care</td>
</tr>
</tbody>
</table>

• APR-DRG Policy Adjustors

Rhode Island Medicaid utilizes two different types of policy adjustors. The first type is DRG-specific for mental health, neonatal, obstetric, rehabilitation and normal newborn claims and is included in the adjusted weights. The second type is an age adjustor for mental health services for patients less than 18 years of age and is also DRG-based.

• High Cost Outlier Payment

High cost outliers are claims that exceed certain cost limits that qualify for an additional payment in addition to the DRG payment. Rhode Island only applies high cost outliers for physical health claims as identified by the DRG. The high cost outlier payment does not apply to mental health claims. The high cost outlier payment is calculated using the following formula(s):

\[
Cost = Total\ Covered\ Charges \times Hospital\ RCC
\]
Estimated Loss = Cost - DRG Base Payment

High Cost Outlier Payment = Estimated Loss * Marginal Cost Factor

Note
If the estimated loss is greater than the threshold, the high cost outlier payment is the difference between the cost and the DRG Base Payment.

• Day Outlier Payment

Day outlier payments are applied when the total length of stay of the claim is higher than the day outlier threshold. Rhode Island only applies day outliers for mental health claims as identified by the DRG. The day outlier add-on payment is calculated using the following formula:

\[
\text{Day Outlier Payment} = (\text{Length of Stay} - \text{Day Outlier Threshold}) \times \text{Day Outlier Per Diem Rate}
\]

• Total Reimbursement

The total reimbursement is calculated by adding the individual pricing components described above, as follows:

Total Reimbursement = APR-DRG Base Payment + High Cost Outlier Payment + Day Outlier Payment

Note
If the claim is eligible for the transfer payment, replace APR-DRG Base Payment in the above formula with Transfer Base Payment.

• Interim Claim Payment

If a patient stay exceeds 29 days, facilities can choose to submit an interim claim. Interim claims are identified with UB-04 Bill Types 0112 and 0113. Payment for interim claims is calculated using the following formula:

\[
\text{Interim Claim Payment} = \text{Length of Stay} \times \text{Interim Per Diem Rate}
\]

• Charge Cap Adjustment

There is a charge cap which limits the APR-DRG allowed amount to the lesser of the APR-DRG payment or the total covered charges on the claim. If the total covered charges are less than the total reimbursement, the APR-DRG payment equals the total charges.

• Partial Eligibility Adjustment

Rhode Island Medicaid adjusts reimbursement for claims that indicate incomplete Medicaid eligibility during a stay. In order for the adjustment to apply, UB-04 Occurrence Code A2 or A3 must be present on the claim. Facilities are reimbursed either by DRG or by the prorated amount calculated as follows, depending on if the Medicaid eligible days (length of stay) are greater than or less than the average length of stay for the DRG:
Partial Eligibility Adjustment = (DRG Payment / DRG Average Length of Stay) * Length of Stay

- Mark-Up/Discount Factor

The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a facility-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- Not Supported

The Rhode Island Medicaid Payment System does not support reimbursement outside of the APR-DRG methodology, including:
  - Per diem payments for sub-acute mental health stays
  - Claims for pediatric patients with dual diagnoses of mental illness intellectual or developmental disability

✔ Virginia Medicaid APR (effective October 01, 2017)

B.3.11.9 APR-DRG Payment Calculations

For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APR Pro Pricer for Virginia APR claims on or after October 01, 2017:

- APR-DRG Base Payment

The APR-DRG base payment reimbursement is calculated using the following formula:

\[
\text{APR-DRG Base Payment} = \text{APR-DRG Relative Weight} \times \text{Hospital-Specific Operating Base Rate} \times (1 + \text{Capital Adjustment Factor})
\]

- Psychiatric Per Diem Payment

Psychiatric services are reimbursed on a per diem basis. The calculation is as follows:

\[
\text{Psychiatric Per Diem Payment} = \text{Psychiatric Per Diem Rate} \times \text{Length of Stay} \times (1 + \text{Capital Adjustment Factor})
\]

- Rehabilitation Per Diem Payment

Rehabilitation services are reimbursed on a per diem basis. The calculation is as follows:

\[
\text{Rehabilitation Per Diem Payment} = \text{Rehabilitation Per Diem Rate} \times \text{Length of Stay} \times (1 + \text{Capital Adjustment Factor})
\]

- Cost Outlier Payment

In order to receive the cost outlier payment, the adjusted true costs for the claim must exceed the total of the wage-adjusted cost outlier threshold, plus the APR-DRG base payment. The following formulas are used to determine the true costs and the cost outlier payment:
True Costs = Total Covered Charges * Ratio of Cost-to-Charges (RCC) * APR-DRG Adjustment Factor

Cost Outlier Threshold = (((Hospital-Specific Cost Outlier Threshold * Labor Portion Factor * Wage Index) + (Hospital-Specific Cost Outlier Threshold * (1 - Labor Portion Factor))) * APR-DRG Adjustment Factor) + APR-DRG Base Payment

Cost Outlier Payment = (True Costs – Cost Outlier Threshold) * Marginal Cost Factor * (1 + Capital Adjustment Factor)

• Transfer Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology. Claims with a Discharge Disposition of 02 (Discharged/Transferred to Short-Term General Hospital), 05 (Discharged/Transferred to a Designated Cancer Center or Children’s Hospital), or 66 (Discharged/Transferred to a Critical Access Hospital) are eligible for transfer per diem reimbursement. The transfer per diem reimbursement is calculated using the following formula:

Transfer Per Diem Payment = APR-DRG Base Payment * (Length of Stay / APR-DRG Mean Length of Stay)

Cases assigned to neonate transfer APR-DRGs are exempt from this special transfer per diem pricing methodology.

• Total Reimbursement

The total reimbursement is calculated by adding the individual pricing components described above, as follows:

Total Payment = APR-DRG Base Payment + Cost Outlier Payment

• Mark-Up/Discount Factor

The Virginia Medicaid APR Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

• Not Currently Supported

- Certain Transplant Services

Cases assigned to liver, heart, lung, bone marrow, and pancreas transplant APR-DRGs are not covered by Virginia Medicaid. If these services are billed, the Virginia Medicaid APR Pricer will issue claim-level Pricer Return Code 24 (Non-Covered Claim).

✔ Wisconsin Medicaid APR (effective January 01, 2017)

B.3.11.10 APR-DRG Payment Calculations
For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement for Wisconsin Medicaid APR claims with discharge dates on or after January 01, 2017.
• APR-DRG Base Payment Calculation

The APR-DRG base payment reimbursement calculation utilizes a policy adjustor. The policy adjustor will be a value other than 1.00 for claims that group to normal newborn, neonatal, or transplant APR-DRGs. When the patient’s age on a claim is under the pediatric cut-off age and the claim is not grouped to one of the previous mentioned categories, the policy adjustor is set to the established pediatric policy adjustor. When the services on a claim are provided at a level 1 trauma center, the policy adjustor is set to the established provider policy adjustor. If the claim qualifies for multiple policy adjustors, the highest policy adjustor will be used. The APR-DRG base payment is calculated using the following formula:

*APR-DRG Base Payment = Hospital-Specific Base Rate * APR-DRG Weight * Applicable Policy Adjustor*

• Transfer Payment Calculation

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology, if the transfer per diem payment is less than the APR-DRG base payment. Claims with a discharge disposition shown in Table B-22 are eligible for transfer per diem reimbursement. Claims that are assigned to APR-DRG 580 (Neonate, Transferred <5 Days Old, Not Born Here) or APR-DRG 581 (Neonate, Transferred <5 Days Old, Born Here) will not be reimbursed on a transfer per diem basis. The transfer per diem reimbursement is calculated using the following formula:

*Transfer Per Diem Payment = (APR-DRG Base Payment / APR-DRG Mean Length of Stay (MLOS)) * (Patient Length of Stay (LOS) + 1)*

Table B-22: Discharge Dispositions for Transfer Payments

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to Critical Access Hospital</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>93</td>
<td>Discharged/Transferred to a Psychiatric Distinct Part Unit of a Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>94</td>
<td>Discharged/Transferred to a Critical Access Hospital (CAH) With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
</tbody>
</table>
• High Cost Outlier Payment Calculations

The high cost outlier add-on is determined by comparing the true costs to a threshold calculated as the sum of the fixed outlier threshold, and the APR-DRG base payment. For transfer cases, the threshold is calculated as the sum of the fixed outlier threshold and the transfer per diem payment. If the true costs exceed the calculated cost outlier threshold, the add-on is derived by subtracting the cost outlier threshold from the true costs and multiplying the difference by the marginal cost factor. There are two marginal cost factors that can be applied in the calculation below based on the severity level of the DRG.

\[
\text{True Costs} = \text{Total Covered Charges} \times \text{Hospital Ratio of Cost-to-Charge (RCC)} \\
\text{Cost Outlier Threshold} = \text{Fixed Outlier Threshold} + \text{APR-DRG Base Payment} \\
\text{Cost Outlier Add-On Payment} = (\text{True Costs} - \text{Cost Outlier Threshold}) \times \text{Applicable Marginal Cost Factor}
\]

• Total Payment Calculation

The total payment is calculated by adding the individual pricing components described above, as follows:

\[
\text{Total Payment} = \text{APR-DRG Base Payment} + \text{High Cost Outlier Add-On Payment}
\]

**Note**

The total payment does not include the pay for performance add-on or the access payment.

• Charge Cap Adjustment

The state of Wisconsin has adopted a charge cap, which limits claim payment to the lesser of the APR-DRG payment or total charges. If the total charges are less than the APR-DRG reimbursement, then the total charges takes precedence, otherwise the APR-DRG reimbursement takes precedence:

\[
\text{APR-DRG Reimbursement} = \text{DRG Base Payment} + \text{Add-On} \\
\text{Total Payment} = \text{Minimum (Total Charges or APR-DRG Reimbursement)}
\]

• Long Acting Reversible Contraceptive (LARC) Add-On Payment

Claims that contain LARC services that group to the APR-DRGs shown in Table B-23 will receive an add-on payment (after any applicable charge cap) if they meet one of following criteria:

- Diagnosis code Z30.430 (Encounter for Insertion of Intrauterine Contraceptive Device) is billed with procedure code 0UH97HZ, *Insertion of contraceptive device into uterus, via natural or artificial opening.*
- Any combination of the diagnosis codes and procedure codes shown in Table B-24.
Table B-23: LARC APR-DRGs

<table>
<thead>
<tr>
<th>APR-DRG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0540</td>
<td>Cesarean Delivery</td>
</tr>
<tr>
<td>0542</td>
<td>Vaginal Delivery With Complicating Procedures Excluding Sterilization &amp;/or D&amp;C</td>
</tr>
<tr>
<td>0545</td>
<td>Ectopic Pregnancy Procedure</td>
</tr>
<tr>
<td>0560</td>
<td>Vaginal Delivery</td>
</tr>
<tr>
<td>0564</td>
<td>Abortion Without D&amp;C, Aspiration Curettage or Hysterotomy</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td>Z30.017</td>
<td>Encounter for Initial Prescription of Implantable Subdermal Contraceptive</td>
</tr>
<tr>
<td>Z30.018</td>
<td>Encounter for Initial Prescription of Other Contraceptives</td>
</tr>
<tr>
<td>Z30.019</td>
<td>Encounter for Initial Prescription of Contraceptives, Unspecified</td>
</tr>
<tr>
<td>Z30.40</td>
<td>Encounter for Surveillance of Contraceptives, Unspecified</td>
</tr>
<tr>
<td>Z30.46</td>
<td>Encounter for Surveillance of Implantable Subdermal Contraceptive</td>
</tr>
<tr>
<td>Z30.49</td>
<td>Encounter for Surveillance of Other Contraceptives</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The LARC add-on payment is calculated as follows:

\[
\text{LARC Add-On Payment} = \text{Inlier Payment} + \text{Policy Add-On 1}
\]

- Mark-Up/Discount Factor

The Medicaid APR Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-up/Discount Factor). If the Mark-up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-up/Discount Factor.

- Not Currently Supported

The state of Wisconsin pays the following types of claims outside of the standard APR-DRG methodology:

- Psychiatric and rehabilitation per diem
- Acute care provided by the Department of Corrections
- Enhanced per diem rates for ventilator, coma, and neurological services

Currently, the Wisconsin Medicaid APR-DRG Payment System does not support the above-mentioned claim types.

B.3.12 Michigan Medicaid Pricer (prior to October 01, 2015)

Michigan Medicaid has special pricing rules for neonates treated in an accredited Neonatal Intensive Care Unit (NICU). DRGs 385 through 390 are assigned a fourth digit based on the patient being treated in an accredited NICU. Prior to January 01, 2008, if the Medicare DRG is 385, 386, 387, 388, 389, or 390, and the Nursery Level field of the PCB2.ICD [ip_claim_data] or the PCB2-ICD-IP-CLAIM-DATA input structure is set to 4, and the NICU Accreditation Indicator in the Hospital Rate Calculator File is set to 1 (indicating the patient has been treated in an accredited NICU unit), different rates and weights are required for pricing.

Prior to January 01, 2008, if the Michigan Medicaid Pricer retrieved the DRG rate record, it will look-up the DRG rate record for DRGs 3851, 3861, 3871, 3881, 3891, or 3901, and continue using the updated rates. After January 01, 2008, the Neonatal DRGs are 789, 790, 791, 792, 793, or 794.

**Note**

Neonatal DRGs changed to 789, 790, 791, 792, 793, or 794 due to the adoption of MS-DRG on January 01, 2008.

Michigan Medicaid also has special pricing rules for DRGs that were previously age categorized prior to January 01, 2008. An alternate weight will be assigned for patients age 0-17 in the following DRGs (refer to **Table B-25**).
All two-digit DRGs will display a 01 at the end, and three-digit DRGs will display a 1.

Table B-25: DRGs Associated With Alternate Weights for Ages 0-17

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>85 - 87</td>
<td>Traumatic stupor and coma, coma &lt; 1 hour</td>
</tr>
<tr>
<td>88 - 90</td>
<td>Concussion</td>
</tr>
<tr>
<td>100 - 101</td>
<td>Seizures</td>
</tr>
<tr>
<td>102 - 103</td>
<td>Headaches</td>
</tr>
<tr>
<td>152 - 153</td>
<td>Otitis media and URI</td>
</tr>
<tr>
<td>190 - 192</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>193 - 195</td>
<td>Simple pneumonia and pleurisy</td>
</tr>
<tr>
<td>202 - 203</td>
<td>Bronchitis and asthma</td>
</tr>
<tr>
<td>204</td>
<td>Respiratory signs and symptoms</td>
</tr>
<tr>
<td>326 - 328</td>
<td>Stomach, esophageal and duodenal procedure</td>
</tr>
<tr>
<td>480 - 482</td>
<td>Hip and femur procedures except major joint</td>
</tr>
<tr>
<td>492 - 494</td>
<td>Lower extremity and humor procedure except hip, foot, femur</td>
</tr>
<tr>
<td>640 - 641</td>
<td>Nutritional and miscellaneous metabolic disorders</td>
</tr>
<tr>
<td>642</td>
<td>Inborn errors of metabolism</td>
</tr>
<tr>
<td>727 - 728</td>
<td>Inflammation of the male reproductive system</td>
</tr>
<tr>
<td>811 - 812</td>
<td>Red blood cell disorders</td>
</tr>
<tr>
<td>837 - 839</td>
<td>Chemo with acute leukemia as SDX or with high dose chemo agent</td>
</tr>
<tr>
<td>864</td>
<td>Fever of unknown origin</td>
</tr>
<tr>
<td>865 - 866</td>
<td>Viral illness</td>
</tr>
<tr>
<td>915 - 916</td>
<td>Allergic reactions</td>
</tr>
<tr>
<td>917 - 918</td>
<td>Poisoning and toxic effects of drugs</td>
</tr>
<tr>
<td>919 - 921</td>
<td>Complications of treatment</td>
</tr>
</tbody>
</table>

B.3.13 Michigan Medicaid APR Pricer (C Only) (effective October 01, 2015)

B.3.13.1 APR-DRG Payment Calculations
For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Michigan Medicaid APR Pricer for claims with discharge dates on or after October 01, 2015:

- APR-DRG Base Payment

The APR-DRG base payment is calculated using the following formula. In this formula, the hospital specific payment rate is the statewide acute care base rate including wage adjustments.
**APR-DRG Base Payment** = Hospital Specific Payment Rate * APR-DRG Weight

- **Transfer Payment**

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the transfer per diem payment is less than the APR-DRG base payment. Claims containing one of the discharge dispositions shown below in Table B-26 are eligible for transfer per diem reimbursement. Claims that are assigned to APR-DRG 580 (Neonate, Transferred <5 Days Old, Not Born Here) or APR-DRG 581 (Neonate, Transferred <5 Days Old, Born Here) are exempt from transfer payment. The transfer per diem reimbursement is calculated as follows:

Transfer Per Diem Payment = ((APR-DRG Base Payment / APR-DRG Mean Length of Stay) * Length of Stay)

**Table B-26: Transfer Discharge Dispositions**

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>09</td>
<td>Admitted as an Inpatient</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to a Critical Access Hospital</td>
</tr>
<tr>
<td>70</td>
<td>Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>94</td>
<td>Discharged/Transferred to a Critical Access Hospital (CAH) With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>95</td>
<td>Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List With a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
</tbody>
</table>

- **Short Stay Outlier Payment**

A short stay outlier payment applies when the length of stay is less than the low day value assigned to the applicable APR-DRG and the claim is not classified as a transfer. The payment will be set to the minimum of either the claim costs or the APR-DRG base payment. The short stay outlier payment is calculated as follows:

Short Stay Outlier Payment = Minimum of: Total Covered Charges * RCC OR APR-DRG Base Payment
• Cost Outlier Payment
The cost outlier add-on is determined by comparing the true costs to the maximum of two times the APR-DRG Base Payment or the Maximum Cost Threshold. For transfer cases, the threshold is calculated as the maximum of two times the Transfer Per Diem Payment or the Maximum Cost Threshold. If the true costs exceed the calculated Cost Outlier Threshold, the add-on is derived by subtracting the Cost Outlier Threshold from the true costs and multiplying the difference by the applicable Cost Outlier Factor.

True Costs = Total Covered Charges * Hospital RCC
Cost Outlier Threshold = Maximum of (2 * APR-DRG Base Payment) or Maximum Cost Threshold
Cost Outlier Add-On = (True Costs - Cost Outlier Threshold) * Cost Outlier Factor

• Special Pricing Rules for Neonates
Michigan Medicaid has special pricing rules for neonates treated in an accredited NICU. These special pricing rules apply if the following criteria is met:
- APR-DRGs 580 - 640 have been assigned.
- The NICU Accreditation Indicator (nicu_ind) located in the Hospital Rate Calculator File (medcalc.dat) is set to 1 (indicating the patient has been treated in an accredited NICU unit).
- UB-04 Revenue Code 0173 (Nursery Newborn - Level III) or 0174 (Nursery Newborn - Level IV) has been billed on the claim.
  OR
- The Nursery Level (nurslev) field located in the PCB2.ICD [ip_claim_data] structure is set to 3 (Patient Treated in Accredited NICU (Claim Contains UB-04 Revenue Code 0173)) or 4 (Patient Treated in Accredited NICU (Claim Contains UB-04 Revenue Code 0174))

If the above criteria is met alternate DRG weights, means, and trims will be used for pricing.

• Hospital Short Stay Payment
If the claim meets all of the following criteria it will be paid a flat rate:
  1. The discharge date must be equal to or be one day greater than the date of admission.
  2. The claim must include one of the following Discharge Status Codes: listed below:

Table B-27: Short Stay Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Discharged to Home or Self Care</td>
</tr>
</tbody>
</table>
3. The claim must not include Revenue Code 036X (Operating Room Services) or Revenue Code 0481 (Cardiology Cardiac Cath Lab).

4. The claim must include a principal diagnosis code listed on the [Michigan Department of Health and Human Services (MDHHS) website](https://www.michigan.gov).

**Transplant Payment**

Certain transplant services are paid outside of the APR-DRG methodology (refer to Table B-28 below). These services are paid using a percent of charge methodology after removing the cost associated with organ acquisition. The costs associated with organ acquisitions are reported with Revenue Code 0811 (Acquisition of Body Components Living Donor) or 0812 (Acquisition of Body Components Cadaver Donor) and should be paid at 100% of the submitted charges. These transplant payments are calculated as follows:

\[
\text{Transplant Payment} = ((\text{Total Charges} - \text{Organ Acquisition Costs}) \times \text{RCC}) + \text{Organ Acquisition Costs}
\]

**Table B-27: Short Stay Discharge Dispositions**

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06</td>
<td>Discharged/Transferred to Home Health Service Organization</td>
</tr>
<tr>
<td>09</td>
<td>Admitted as an Inpatient</td>
</tr>
<tr>
<td>21</td>
<td>Discharged/Transferred to Court/Law Enforcement</td>
</tr>
<tr>
<td>30</td>
<td>Still a Patient</td>
</tr>
<tr>
<td>50</td>
<td>Hospice, Home</td>
</tr>
<tr>
<td>51</td>
<td>Hospice, Certified Medical Facility</td>
</tr>
</tbody>
</table>

**Table B-28: Transplant Services Paid Outside of APR-DRG Methodology**

<table>
<thead>
<tr>
<th>APR-DRG w/ Severity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 1</td>
<td>Liver Transplant and/or Intestinal Trans S1</td>
</tr>
<tr>
<td>1 - 2</td>
<td>Liver Transplant and/or Intestinal Trans S2</td>
</tr>
<tr>
<td>1 - 3</td>
<td>Liver Transplant and/or Intestinal Trans S3</td>
</tr>
<tr>
<td>1 - 4</td>
<td>Liver Transplant and/or Intestinal Trans S4</td>
</tr>
<tr>
<td>2 - 1</td>
<td>Heart and/or Lung Transplant S1</td>
</tr>
<tr>
<td>2 - 2</td>
<td>Heart and/or Lung Transplant S2</td>
</tr>
<tr>
<td>2 - 3</td>
<td>Heart and/or Lung Transplant S3</td>
</tr>
<tr>
<td>2 - 4</td>
<td>Heart and/or Lung Transplant S4</td>
</tr>
<tr>
<td>6 - 1</td>
<td>Pancreas Transplant S1</td>
</tr>
<tr>
<td>6 - 2</td>
<td>Pancreas Transplant S2</td>
</tr>
<tr>
<td>6 - 3</td>
<td>Pancreas Transplant S3</td>
</tr>
<tr>
<td>6 - 4</td>
<td>Pancreas Transplant S4</td>
</tr>
</tbody>
</table>
• Total Reimbursement
Total reimbursement for the claim is calculated differently depending on the claim type as follows:

Total Reimbursement for Short Stay Outlier Claims = Short Stay Outlier Payment + Hospital Capital Rate Per Discharge

Total Reimbursement for Transfer Claims = Transfer Per Diem Payment + Cost Outlier Add-On

Total Reimbursement for All Other Claims = APR-DRG Base Payment + Cost Outlier Add-On + Hospital Capital Rate Per Discharge

• Mark-Up/Discount Factor
The Michigan Medicaid APR Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

B.3.14 Nebraska Medicaid APR Pricer (C Only) (effective July 01, 2014)

B.3.14.1 APR-DRG Payment Calculations
For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Nebraska Medicaid APR Pricer for claims with discharge dates on or after July 01, 2014:

• APR-DRG Base Payment

The APR-DRG base payment calculation consists of an operating payment and a capital payment. The Fee-for-Service (FFS) method of reimbursement also consists of a per-discharge DME add-on.

• APR-DRG Base Payment for Managed Care Organizations (MCOs):

Operating Payment = Hospital-Specific Base Rate * APR-DRG Relative Weight

Capital Payment = Hospital-Specific Capital Per-Diem Rate * APR-DRG Average Length of Stay

APR-DRG Base Payment = Operating Payment + Capital Payment

• APR-DRG Base Payment for FFS Payers:

<table>
<thead>
<tr>
<th>APR-DRG w/ Severity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44 - 01</td>
<td>Kidney Transplant S1</td>
</tr>
<tr>
<td>44 - 02</td>
<td>Kidney Transplant S2</td>
</tr>
<tr>
<td>44 - 03</td>
<td>Kidney Transplant S3</td>
</tr>
<tr>
<td>44 - 04</td>
<td>Kidney Transplant S4</td>
</tr>
</tbody>
</table>
Operating Payment = Hospital-Specific Base Rate * APR-DRG Relative Weight * (1 + Hospital Indirect Medical Education (IME) Factor)

Capital Payment = Hospital-Specific Capital Per-Diem Rate * APR-DRG Average Length of Stay

APR-DRG Base Payment = Operating Payment + Capital Payment + Hospital-Specific Direct Medical Education (DME) Per-Discharge Add-On

• Transfer Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the transfer per diem payment is less than the APR-DRG base payment. Claims with a Discharge Disposition of 02 (Discharged/Transferred to Short-Term General Hospital), 05 (Discharged/Transferred to a Designated Cancer Center or Children's Hospital), 82 (Discharged/Transferred to a Short Term General Hospital for Inpatient Care with Planned Acute Care Hospital Inpatient Readmission), or 85 (Discharged/Transferred to a Designated Cancer Center or Children’s Hospital with a Planned Acute Care Hospital Inpatient Readmission) are eligible for transfer per diem reimbursement. The transfer per diem payment is used if the patient’s length of stay is less than the average length of stay for the APR-DRG, and is calculated using the following formula:

Transfer Payment = (APR-DRG Base Payment / APR-DRG Average Length of Stay (LOS)) * Patient LOS

• Cost Outlier Payment

Claims that are paid based on the APR-DRG formulas are considered for outlier payments. To qualify for the cost outlier add-on payment, the estimated cost of the claim must exceed the cost outlier threshold. To determine the cost outlier add-on payment, claim cost is calculated by multiplying the total covered charges by the hospital’s Ratio of Cost-to-Charges (RCCs). Next, the cost outlier threshold is calculated using the sum of the fixed outlier threshold set by the state of Nebraska and the base payment (including Indirect Medical Education (IME), but not including Direct Medical Education (DME)). If the costs exceed the threshold, then the cost outlier add-on payment is calculated by subtracting the threshold from the cost, and multiplying by the marginal cost factor. Claims that are assigned to neonatal and nervous system APR-DRGs with a Severity of Illness (SOI) indicator of 3 (Major) or 4 (Extreme) have a lower fixed cost threshold than a claim assigned to other APR-DRGs. The marginal cost factor for claims assigned to burn APR-DRGs is higher than the marginal cost factor for all other claims. Transfer claims are not eligible for outlier payments. The outlier payment for eligible claims is calculated using the following formula:

Cost Outlier Payment for FFS Payers:

Cost Outlier Payment = ((Total Charges * RCC) - (Operating Payment + Capital Payment + DRG Specific Outlier Threshold) * Marginal Cost Factor

Cost Outlier Payment for MCOs:
Cost Outlier Payment = ((Total Charges * RCC) - ((Operating Payment * (1 + IME)) + Capital Payment + DRG Specific Outlier Threshold)) * Marginal Cost Factor

• Critical Access Hospital (CAH) Payment

For Critical Access Hospitals, claim payment is calculated by multiplying the cost-based per diem by the length of stay.

CAH Payment = Critical Access Cost Based Per Diem * Length of Stay

• Psychiatric Payment

Claims assigned to psychiatric APR-DRGs are paid based on a tiered per diem reimbursement calculation. Nebraska Medicaid has published tiered per diem rates which are used by all acute care facilities providing psychiatric services. Payment for each psychiatric discharge is calculated based on the applicable per diem rate times the number of patient days for each tier. These claims are not subject to transfer pricing rules and are not eligible for outlier payments. Please refer to Table B-29 below for the length of stay and tier assignments.

Table B-29: Tier Levels

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1 and 2</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Days 3 and 4</td>
<td>Tier 2</td>
</tr>
<tr>
<td>Days 5 and 6</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Day 7 or longer</td>
<td>Tier 4</td>
</tr>
</tbody>
</table>

Payment is calculated as the number of tier 1 days times the standardized tier 1 rate, plus the number of tier 2 days (if any) times the standardized tier 2 rate, plus the number of tier 3 days (if any) times the standardized tier 3 rate, plus the number of tier 4 days (if any) times the standardized tier 4 rate.

• Rehabilitation Payment

Claims assigned to rehabilitation APR DRGs are paid using facility-specific per-diem rates, if the rehabilitation services are provided at an approved rehabilitation facility or distinct part unit. Payment is calculated using the following formula:

Rehabilitation Per Diem Payment = Rehab Per Diem Rate * Length of Stay

• Transplant Payment

Claims assigned to designated transplant APR-DRGs are paid based on a percent of charges, plus a per-discharge transplant DME add-on where applicable. Payment is calculated using the following formula:

Transplant Payment for FFS Payers:

Transplant Payment = (Transplant RCC * Total Charges) + Transplant DME
• Total Reimbursement

For transfer, critical access, psychiatric, rehabilitation, and transplant claims, the payment described above is the total reimbursement. These claims are not eligible for outlier consideration. For claims paid based on the standard APR DRG formulas, total reimbursement is calculated by adding the inlier and outlier payments, as follows:

\[ \text{Total Reimbursement} = \text{APR-DRG Base Payment} + \text{Outlier Payment} \]

• Mark-Up/Discount Factor

The Nebraska Medicaid APR Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.
B.3.15 New York Medicaid APR Pricer (C Only)

The New York State Department of Health (NYSDOH) has identified 13 events that should never occur during an inpatient hospitalization. New York Medicaid claims containing a diagnosis code representing a Never Event, plus a POA indicator of N (Not Present at Time of Admission) or U (Documentation is Insufficient to Determine if Condition is Present at Time of Inpatient Admission), will receive Pricing Method Indicator 01 (Flagged for Never Event) in the POB1.DRG [drg_prcr_block1] structure.

Note
For more information on POA Indicators please refer to Appendix F.

Effective January 01, 2011, the following Never Event diagnosis codes are paid on New York Medicaid claims:

Table B-30: New York Medicaid Never Events Diagnosis Codes and Descriptions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>998.4</td>
<td>Foreign body accidentally left during procedure NEC</td>
</tr>
<tr>
<td>998.7</td>
<td>Acute reaction to foreign substance accidentally left during a procedure NEC</td>
</tr>
<tr>
<td>999.1</td>
<td>Air embolism as a complication of medical care NEC</td>
</tr>
<tr>
<td>999.6</td>
<td>ABO incompatibility reaction NEC</td>
</tr>
</tbody>
</table>

Effective November 01, 2009, the NYSDOH adopted a Never Event policy for which payment would be reduced and which cannot be reliably identified by specific diagnosis and procedure codes. The state has issued instructions to hospitals on how to submit these non-covered claims. For these Never Events, claims are to be submitted normally, but a separate claim must also be submitted in parallel, which contains Rate Code 2590 (Non-Reimbursable With Serious Adverse Events) or 2591 (DRG With Serious Adverse Events). Rate Codes are to be reported in the UB-04 Value Amount field located in the PCB1 [patient_claim_data] structure along with a UB-04 Value Code of 24.

B.3.15.1 APR-DRG Payment Calculations

For inpatient acute care, payment is determined using an APR-DRG-based methodology, except in circumstances of transfers, as further discussed below. Please note, when Medicaid is referenced in the APR-DRG payment calculations below, it is referring to Payment Type 1 (Medicaid Managed Care Including Rebasing) and Payment Type 4 (Medicaid Managed Care Excluding Rebasing). Please refer to Table B-31 for a complete list of Payment Types.

Table B-31: Payment Types

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicaid Managed Care Including Rebasing</td>
</tr>
</tbody>
</table>
• Graduate Medicaid Education (GME) Payment

To receive GME reimbursement on or after January 01, 2010 for Medicaid Managed Care payment types (including and excluding rebasing), Rate Code 3130 (GME for Medicaid Managed Care) must be submitted to the New York Medicaid APR Pricer through the UB-04 Value Amount field with a UB-04 Value Code of 24. The New York Medicaid APR Pricer will use the following formula to calculate total reimbursement:

\[ \text{Total Payment} = (\text{DRG Weight} \times \text{Hospital Base Rate} \times \text{Wage Equalization Factor} \times \text{Indirect Medical Education Factor}) + \text{Direct Medical Education Per Discharge} \]

**Note**

The New York Medicaid APR Pricer will return a Pricing Method Indicator of 02 (GME Payment) for these claims.

• Inlier Payment

To receive inlier reimbursement for Medicaid Managed Care payment types on or after January 01, 2010, the inlier rate is calculated using the following formula, which excludes Indirect Medical Education (IME) from the calculation:

\[ \text{Inlier Payment} = \text{DRG Weight} \times \text{Hospital Base Rate} \times \text{Wage Equalization Factor} \]

For all other claims the inlier rate is calculated using the following formula:

\[ \text{Inlier Payment} = \text{DRG Weight} \times \text{Hospital Base Rate} \times \text{Wage Equalization Factor} \times (1 + \text{Indirect Medical Education Factor}) \]

• Per-Discharge Add-Ons Payment

To receive the per discharge add-on reimbursement for New York Medicaid claims additional payments may be made for capital expenses, for non-comparable add-on expenses, for direct medical education expenses, and to supplement specific facilities during the transition to the APR-DRG payment system.

For Medicaid Managed Care payment types on or after January 01, 2010, this additional payment is calculated using the following formula:

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Worker’s Comp</td>
</tr>
<tr>
<td>3</td>
<td>No Fault</td>
</tr>
<tr>
<td>4</td>
<td>Medicaid Managed Care Excluding Rebasing</td>
</tr>
<tr>
<td>5</td>
<td>Medicaid Fee-for-Service (FFS)</td>
</tr>
<tr>
<td>6</td>
<td>Medicaid Managed Care Including GME Payments</td>
</tr>
</tbody>
</table>
Per Discharge Add-On Payment = Hospital Capital and Non-Comparable Per-Discharge Add-On + Non-Comparable Per-Discharge Add-On + Transition Per-Discharge Add-On

For all other claims this additional payment is calculated using the following formula:

Per Discharge Add-On Payment = Hospital Capital and Non-Comparable Per-Discharge Add-On + Direct Medical Education Per-Discharge + Non-Comparable Per-Discharge Add-On + Transition Payment Discharge Add-On

• Alternate Level of Care (ALC) Payment

The ALC payment calculation is used to provide reimbursement related to any days that were spent in an ALC bed (sub-acute). The number of ALC days is calculated by the New York Medicaid APR Pricer using the Occurrence From Date and Occurrence Thru Date associated with Occurrence Span Code 75 and the following formula:

\[ \text{ALC Days} = \text{Occurrence Thru Date} - \text{Occurrence From Date} \]

The ALC payment will be calculated as follows:

\[ \text{Alternate Level of Care Payment} = \text{ALC Days} \times \text{Hospital ALC Per-Diem Rate} \]

For all claims that are billed with both APR-DRG and ALC days, the total reimbursement will include both APR-DRG and ALC payments.

• Transfer Per Diem Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the per diem payment is less than the inlier payment. Claims with a Length of Stay (excluding any ALC days) less than the Mean Length of Stay, and a Discharge Disposition of 02 (Discharged/Transferred to Short-Term General Hospital) are eligible for transfer per diem reimbursement. The transfer per diem reimbursement for Medicaid Managed Care payment types on or after January 01, 2010 is calculated using the following formula:

\[ \text{Transfer Per Diem Payment} = \left( \frac{\text{Inlier Payment}}{\text{DRG Mean Length of Stay}} \right) \times \left( 1 + \text{Transfer Payment Factor} \right) + \text{Hospital Capital and Non-Comparable Per-diem} \times (\text{Length of Stay} - \text{ALC Days}) \]

For all other claims the transfer per diem reimbursement is calculated using the following formula:

\[ \text{Transfer Per Diem Payment} = \left( \frac{\text{Inlier Payment}}{\text{DRG Mean Length of Stay}} \right) \times \left( 1 + \text{Transfer Payment Factor} \right) + \text{Hospital Capital and Non-Comparable Per-diem} \times (\text{Length of Stay} - \text{ALC Days}) + \text{Hospital DME Per-Discharge} \]

**Note**

Claims that are assigned to APR-DRGs 580 or 581 are not eligible for transfer per diem reimbursement.

• Outlier Payment
In order to receive the outlier reimbursement the claim cost must exceed the cost outlier threshold and one of the following conditions must be met:

- Medicaid Fee-for-Service payment type

or

- All other payment types with a Cost Outlier Payment Flag (costflag) of 0 (Cost Outlier Payment Allowed) in the Hospital Rate Calculator File (medcalc.dat)

The following formulas are used to determine the outlier cost amount, threshold amount, and the outlier payment.

\[
\text{Outlier Cost Amount} = (\text{Total Covered Charges} - \text{ALC Charges}) \times \text{Ratio of Cost-to-Charges}
\]

\[
\text{Threshold Amount} = (\text{DRG-Specific Cost Outlier Threshold} \times \text{Hospital Wage Equalization Factor}) \times \text{Marginal Cost Factor}
\]

\[
\text{Outlier Payment} = (\text{Outlier Cost Amount} - \text{Threshold Amount})
\]

**Note**

Patients that are discharged or transferred to a short-term general hospital, or claims that are assigned to APR-DRGs 580 or 581 are not eligible for outlier payments.

ALC charges are determined by calculating the sum of the line-level charges billed with Revenue Code 019X.

- **Total Reimbursement**

  The total reimbursement is calculated by adding the individual pricing components completed above, which is calculated using the following formula:

  \[
  \text{Total Payment} = \text{Inlier Payment} + \text{Per Discharge Add-On Payment} + \text{Outlier Payment} + \text{ALC Payment}
  \]

- **Elective Delivery Adjustment**

  The NYSDOH reduces the APR-DRG payment for early elective deliveries that are not medically necessary. As part of this policy, the NYSDOH requires one of the following condition codes on each inpatient delivery claim that contains a designated “elective delivery” procedure:

  - Condition Code 81 (C-Sections/Inductions < 39 Weeks - Medical Necessity)
  - Condition Code 82 (C-Sections/Inductions < 39 Weeks - Elective)
  - Condition Code 83 (C-Sections/Inductions 39 Weeks or Greater)

However, some of the procedure codes on the NYSDOH list can also be performed on patients that are not having a baby (for example, a D&C procedure on a post-menopausal female patient). The condition code billing requirements should not be applied to these claims. The NYSDOH has not
published specific rules for how to identify these non-delivery claims. Therefore, the New York Medicaid APR Pricer allows the option to bypass claim-level Pricer Return Code 24 by utilizing the Return Code 24 Override (override_rc24) flag located in the Hospital Rate Calculator File (medcalc.dat), effective July 01, 2013 for Medicaid Fee-for-Service (FFS) and October 01, 2013 for Medicaid Managed Care (MMC). If a condition code is supplied, appropriate payment reductions will be taken. If no condition code is supplied, payment will be calculated in full.

- **Mark-Up/Discount Factor**

  The New York Medicaid APR Pricer has an option to increase or reduce the overall claim payment by a hospital defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

**B.3.16 North Carolina Medicaid Pricer (C Only)**

**Note**

Payments for facilities with a disproportionate share of Medicaid or uninsured patients and for facilities with teaching programs are made directly by the state and not by Managed Care Organizations (MCO). As such, whenever these payments are referred to below set them to zero when calculating reimbursements for MCOs.

- **MS-DRG Base Payment**

  The MS-DRG base payment is calculated using the following formula. In this formula the capital payments are included in the base rates. If applicable, payment is increased for facilities with a disproportionate share of Medicaid or uninsured patients and for facilities with teaching programs.

  \[
  \text{Adjusted Base Rate} = \text{Base Rate} \times (1 + \text{Direct Medical Education Factor} + \text{Indirect Medical Education Factor})
  \]

  \[
  \text{MS-DRG Base Payment} = \text{Adjusted Base Rate} \times \text{MS-DRG Weight} \times (1 + \text{Disproportionate Share Adjustment Factor})
  \]

- **Rehabilitation Per Diem Payment**

  Claims assigned to rehabilitation MS-DRGs are paid using facility-specific per-diem rates, if the rehabilitation services are provided at an approved rehabilitation facility or distinct part unit. These payments apply to MS-DRG 945 (Rehabilitation With CC/MCC) and MS-DRG 946 (Rehabilitation Without CC/MCC). Payment is calculated using the below formula. If applicable, payment is increased for facilities with a disproportionate share of Medicaid or uninsured patients.

  \[
  \text{Rehabilitation Per Diem Payment} = \text{Rehab Per Diem Rate} \times \text{Length of Stay} \times (1 + \text{Disproportionate Share Adjustment Factor})
  \]
• Psychiatric Per Diem Payment

Claims assigned to psychiatric MS-DRGs are paid using facility-specific per-diem rates, if the psychiatric services are provided at an approved psychiatric facility or distinct part unit. These payments apply to psychiatric MS-DRG 876 (Procedure With Principal Diagnoses of Mental Illness), MS-DRGs 880 – 887, and MS-DRGs 894 - 897. Payment is calculated using the below formula. If applicable, payment is increased for facilities with a disproportionate share of Medicaid or uninsured patients.

\[
\text{Psychiatric Per Diem Payment} = \text{Psychiatric Per Diem Rate} \times \text{Length of Stay} \times (1 + \text{Disproportionate Share Adjustment Factor})
\]

• Transfer Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the transfer per diem payment is less than the MS-DRG payment. Claims with a Discharge Disposition of 02 (Discharged/Transferred to Short-Term General Hospital) are eligible for transfer per diem reimbursement. Claims assigned to MS-DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility, Length of Stay Less Than 3 Days) are exempt from transfer per diem methodology. The transfer per diem reimbursement is calculated using the following formula:

\[
\text{Transfer Per Diem Payment} = \text{MS-DRG Base Payment} \times \left(\frac{\text{Length of Stay}}{\text{MS-DRG Mean Length of Stay}}\right)
\]

• Cost Outlier Payment

In order to receive the cost outlier payment, the true costs for the claim must exceed the greater of the hospital-specific cost outlier threshold or the MS-DRG specific cost outlier threshold. Rehabilitation and Psychiatric claims are not eligible for cost outlier payments. If applicable, payment is increased for facilities with a disproportionate share of Medicaid or uninsured patients and for facilities. The following formulas are used to determine the true costs and the cost outlier payment:

\[
\text{True Costs} = \text{Total Covered Charges} \times \text{Ratio of Cost-to-Charges (RCC)}
\]

\[
\text{Cost Outlier Threshold} = \text{Greater of Hospital-Specific Cost Outlier Threshold or MS-DRG Specific Cost Outlier Threshold}
\]

\[
\text{Cost Outlier Payment} = (\text{True Costs} - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor} \times (1 + \text{Disproportionate Share Adjustment Factor})
\]

Note

If a claim qualifies for both a Day Outlier and a Cost Outlier payment the greater of the two will be applied.

• Day Outlier Payment

In order to receive the day outlier payment, there must be an exceptionally long length of stay and the claim must be for a child under the age of six at a
disproportionate share hospital or for a child under age one. An exceptionally long length of stay is defined as a length of stay that exceeds the MS-DRG Specific Day Outlier Threshold. Transfer claims are not eligible for Day Outlier payments. If applicable, payment is increased for facilities with a disproportionate share of Medicaid or uninsured patients and for facilities. The following formula is used to determine the day outlier payment:

\[
\text{Day Outlier Payment} = \frac{(\text{Adjusted Base Rate} \times \text{MS-DRG Weight}) \times \text{Marginal Cost Factor} \times (\text{Length of Stay} - \text{MS-DRG Specific Day Outlier Threshold})}{\text{MS-DRG Mean Length of Stay}} \times (1 + \text{Disproportionate Share Adjustment Factor})
\]

**Note**

If a claim qualifies for both a Day Outlier and a Cost Outlier payment the greater of the two will be applied.

- **DMA Inpatient Reduction**
  
  Effective January 01, 2014, reimbursement for inpatient hospital services is subject to a three percent reduction based on the North Carolina Shared Savings Plan.

- **Mark-up/Discount Factor**
  
  The North Carolina Medicaid Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- **Total Reimbursement**
  
  The total reimbursement is calculated by adding the individual pricing components described above, as follows:

  \[
  \text{Total MS-DRG Reimbursement} = (\text{MS-DRG Base Payment OR Transfer Per Diem Payment} + \text{Outlier Payment}) \times \text{Mark-up/Discount Factor} \times \text{DMA Inpatient Reduction Factor}
  \]

  \[
  \text{Total Per Diem Reimbursement} = \text{Psychiatric Per Diem Payment OR Rehabilitation Per Diem Payment} \times \text{Mark-up/Discount Factor} \times \text{DMA Inpatient Reduction Factor}
  \]

**B.3.17 Ohio Medicaid Pricer (C Only) (prior to July 01, 2013)**

For Ohio Medicaid, DRGs 388 through 390 are assigned a fourth digit based on level or type of nursery (1, 2, or 3), and DRGs 425 through 435 are assigned a fourth digit of 1 if the patient was treated in a distinct part psychiatric unit. These fourth digits cause a different set of weights to be used in pricing. The applicable DRG Grouper returns a four-digit DRG in the five-digit DRG field, when appropriate. DRGs 386 and 387 are assigned to alternate Ohio-specific DRGs based on level or type of nursery and birth weight. If the facility does not have a valid nursery level assigned and it is
required for DRG assignment, the Ohio Medicaid Pricer issues a Pricer Return Code of 09 (Invalid Nursery Level). If a birth weight is not provided and it is required for DRG assignment, the Ohio Medicaid Pricer issues a Pricer Return Code of 46 (Invalid Birthweight). Refer to Chapter 5 for information on how the Ohio Medicaid Grouper handles this issue.

B.3.18 Ohio Medicaid APR Pricer (C Only) (effective July 01, 2013)

B.3.18.1 APR-DRG Payment Calculations
For inpatient acute care, payment is determined using an APR-DRG based methodology, except in circumstances of transfers, and when the patient is still a patient, as further discussed below.

• APR-DRG Base Payment
If a claim is not eligible for a High-Cost Outlier Payment, a Transfer Per Diem Payment, or the Still a Patient Payment (all are discussed below), the APR-DRG Base Payment is calculated by the Ohio Medicaid APR-DRG Pricer by using the following formula:

\((\text{Base Rate} \times \text{DRG Weight})\)

• High-Cost Outlier Payment
To qualify for the High Cost Outlier Payment:
The Claim Cost ((Total Charges - Organ Acquisition Charges) \times \text{Hospital Ratio of Costs-to-Charges (RCC)}) must be greater than the (APR-DRG Base Payment + applicable Fixed Outlier Threshold)
The High Cost Outlier Payment is calculated by:

\(((\text{Claim Cost} - (\text{APR-DRG Base Payment} + \text{applicable Fixed Outlier Threshold} \times \text{Hospital Marginal Cost Factor})))\)

Note
Claims that receive high cost outlier payments are subject to a charge cap.

Organ Acquisition Charges (as discussed below in the DRG-Specific Organ Acquisition Payment section), are not included in the total claim charges when determining High-Cost Outlier Payment reimbursement eligibility.

• Capital Payment
For inpatient acute care claims, the total claim payment will include any applicable hospital-specific Capital Payments.

• Medical Education Payment
For inpatient acute care, total payment will include any applicable hospital-specific Medical Education Payments. These payments are calculated by:

\((\text{Medical Education Rate} \times \text{DRG Weight})\)
• Transfer Per Diem Payment

Claims containing an Admission Source of 04 (Transferred From a Hospital), or G (Transferred From a Designated Disaster Alternative Care Site (ACS)), or one of the discharge dispositions shown below in Table B-32, may be eligible for Transfer Per Diem Reimbursement. Claims that meet one of these criteria qualify for this reimbursement when the average daily charges multiplied by the Length of Stay (LOS) is of lesser value than the APR-DRG Base Payment.

**Note**
Free-standing psychiatric hospitals are not subject to transfer per-diem payments.

Table B-32: Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital (Valid Beginning October 01, 2007)</td>
</tr>
<tr>
<td>62</td>
<td>Discharged/Transferred to Inpatient Rehabilitation Facility or Unit (Valid Beginning January 01, 2002)</td>
</tr>
<tr>
<td>63</td>
<td>Discharged/Transferred to Long Term Care Hospital, Medicare-Certified (Valid Beginning January 01, 2002)</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit (Valid Beginning April 01, 2004)</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to Critical Access Hospital (Valid Beginning January 01, 2006)</td>
</tr>
<tr>
<td>69</td>
<td>Discharged/Transferred to a Designated Disaster Alternative Care (Valid Beginning October 20, 2013)</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care With a Planned Acute Care Hospital Inpatient Readmission (Valid Beginning October 2013)</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital With a Planned Acute Care Hospital Inpatient Readmission (Valid Beginning October 2013)</td>
</tr>
<tr>
<td>90</td>
<td>Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital With a Planned Acute Care Hospital Inpatient Readmission (Valid Beginning October 2013)</td>
</tr>
<tr>
<td>91</td>
<td>Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) With a Planned Acute Care Hospital Inpatient Readmission (Valid Beginning October 2013)</td>
</tr>
<tr>
<td>93</td>
<td>Discharged/Transferred to a Psychiatric Hospital/distinct Part Unit of a Hospital With a Planned Acute Care Hospital Inpatient Readmission (Valid Beginning October 2013)</td>
</tr>
<tr>
<td>94</td>
<td>Discharged/Transferred to a Critical Access Hospital (CAH) With a Planned Acute Care Hospital Inpatient Readmission (Valid Beginning October 2013)</td>
</tr>
</tbody>
</table>
• DRG-Specific Organ Acquisition Payment

Ohio Medicaid has a DRG-specific organ acquisition policy which reimburses separately for organ acquisition costs. Organ acquisition costs for the APR-DRGs shown below in Table B-33, billed with the following criteria, is reimbursed at 100% of the organ acquisition charges:

- All Severity of Illness (SOI) levels billed with associated organ acquisition charges, and;
- Revenue Code 0810 (Organ Acquisition Costs/Charges).

Table B-33: APR-DRGs Paid 100% of the Organ Acquisition Charges

<table>
<thead>
<tr>
<th>APR-DRG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Liver Transplant &amp;/or Intestinal Transplant</td>
</tr>
<tr>
<td>002</td>
<td>Heart &amp;/or Lung Transplant</td>
</tr>
<tr>
<td>006</td>
<td>Pancreas Transplant</td>
</tr>
</tbody>
</table>

The organ acquisition payment for the APR-DRGs shown below in Table B-34, billed with any SOI level and Revenue Code 0810, is reimbursed at 100% of the organ acquisition costs, which is calculated by:

\[
(Organ\ Cost = Organ\ Charges \times Hospital-Specific\ RCC)
\]

Table B-34: APR-DRGs Paid 100% of the Organ Acquisition Costs

<table>
<thead>
<tr>
<th>APR-DRG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>003</td>
<td>Bone Marrow Transplant</td>
</tr>
<tr>
<td>007</td>
<td>Allogeneic Bone Marrow Transplant</td>
</tr>
</tbody>
</table>

• Still a Patient Payment

A claim is eligible for this reimbursement if a patient is still admitted after 30 days, as indicated by Discharge Disposition 30 (Still a Patient). This reimbursement amount is calculated by:

\[
(Total\ Charges \times Hospital\ RCC)
\]
For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the South Carolina Medicaid Pricer for claims on or after October 01, 2011:

• APR-DRG Base Payment

The APR-DRG base payment reimbursement is calculated using the following formula:

\[
\text{APR-DRG Base Payment} = \text{APR-DRG Relative Weight} \times \text{Hospital-Specific Discharge Rate}
\]

• Transfer Per Diem Payment

Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the transfer per diem payment is less than the APR-DRG base payment. Claims with a Discharge Disposition of 02 (Discharged/Transferred to Short-Term General Hospital), 05 (Discharged/Transferred to a Designated Cancer Center or Children’s Hospital), or 66 (Discharged/Transferred to a Critical Access Hospital) are eligible for transfer per diem reimbursement. The transfer per diem reimbursement is calculated using the following formula:

\[
\text{Transfer Per Diem Payment} = \left( \frac{\text{APR-DRG Base Payment}}{\text{APR-DRG Average Length of Stay}} \right) \times \text{Length of Stay}
\]

• Same Day Stay Payment

Claims that have the same Admit Date and Discharge Date may be paid using a special methodology if the same day stay payment is less than the APR-DRG base payment. This special reimbursement methodology only applies to claims that are not:

1. Billed with a Discharge Status 02 (as described above), 05 (as described above), 20 (Expired/Died), or 66 (as described above), AND  
2. Assigned to APR-DRG 541 (Vaginal Delivery W Sterilization &/or D&C), 560 (Vaginal Delivery), 565 (False Labor), or 640 (Neonate Birthwt >2499g, Normal Newborn, or Neonate W Other Problem).

The same day stay reimbursement is calculated using the following formula:

\[
\text{Same Day Stay Payment} = \left( \frac{\text{APR-DRG Base Payment}}{\text{APR-DRG Average Length of Stay}} \right) \times \text{Same Day Stay Factor}
\]

• One Day Stay Payment

Claims for patients with a one day stay may be paid using a special methodology if the one day stay payment is less than the APR-DRG base payment. This special reimbursement methodology only applies to claims that are not:
1. Billed with a Discharge Status 02 (as described above), 05 (as described above), 20 (as described above), or 66 (as described above),
   AND
2. Assigned to APR-DRG 541 (as described above), 560 (as described above), 565 (as described above), or 640 (as described above).

The one day stay reimbursement is calculated using the following formula:

\[
\text{One Day Stay Payment} = \frac{\text{APR-DRG Base Payment}}{\text{APR-DRG Average Length of Stay}}
\]

- Cost Outlier Payment

In order to receive the cost outlier payment, the true costs for the claim must exceed the total of the APR-DRG specific cost outlier threshold, plus the APR-DRG base payment. The following formulas are used to determine the true costs and the cost outlier payment:

\[
\text{True Costs} = \text{Total Covered Charges} \times \text{Ratio of Cost-to-Charges (RCC)}
\]

\[
\text{Cost Outlier Payment} = (\text{True Costs} - (\text{APR-DRG Specific Cost Outlier Threshold} + \text{APR-DRG Base Payment})) \times \text{Marginal Cost Factor}
\]

- Total Reimbursement

The total reimbursement is calculated by adding the individual pricing components described above, as follows:

\[
\text{Total Payment} = \text{APR-DRG Base Payment} + \text{Cost Outlier Payment}
\]

- Mark-Up/Discount Factor

The South Carolina Medicaid Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- Not Currently Supported

The South Carolina Medicaid Pricer does not support claims from psychiatric hospitals or institutions for mental disease. Also, the South Carolina Medicaid Pricer does not support partial eligibility payment for non-covered days. Optum is currently awaiting clarification on this subject from the state of South Carolina. If clarification from the state is received, this functionality may be included in a future release.

B.3.20 Virginia Medicaid APR Pricer (C Only) (prior to October 01, 2017)

B.3.20.1 APR-DRG Payment Calculations

For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Virginia Medicaid APR Pricer for claims on or after October 01, 2014 through September 01, 2017.
• APR-DRG Base Payment
The APR-DRG base payment reimbursement is calculated using the following formula:

\[ \text{APR-DRG Base Payment} = \text{APR-DRG Relative Weight} \times \text{Hospital-Specific Operating Base Rate} \times (1 + \text{Capital Adjustment Factor}) \]

• Psychiatric Per Diem Payment
Psychiatric services are reimbursed on a per diem basis. The calculation is as follows:

\[ \text{Psychiatric Per Diem Payment} = \text{Psychiatric Per Diem Rate} \times \text{Length of Stay} \times (1 + \text{Capital Adjustment Factor}) \]

• Rehabilitation Per Diem Payment
Rehabilitation services are reimbursed on a per diem basis. The calculation is as follows:

\[ \text{Rehabilitation Per Diem Payment} = \text{Rehabilitation Per Diem Rate} \times \text{Length of Stay} \times (1 + \text{Capital Adjustment Factor}) \]

• Cost Outlier Payment
In order to receive the cost outlier payment, the adjusted true costs for the claim must exceed the total of the wage-adjusted cost outlier threshold, plus the APR-DRG base payment. The following formulas are used to determine the true costs and the cost outlier payment:

\[ \text{True Costs} = \text{Total Covered Charges} \times \text{Ratio of Cost-to-Charges (RCC)} \times \text{APR-DRG Adjustment Factor} \]

\[ \text{Cost Outlier Threshold} = (((\text{Hospital-Specific Cost Outlier Threshold} \times \text{Labor Portion Factor} \times \text{Wage Index}) + (\text{Hospital-Specific Cost Outlier Threshold} \times (1 - \text{Labor Portion Factor}))) \times \text{APR-DRG Adjustment Factor}) + \text{APR-DRG Base Payment} \]

\[ \text{Cost Outlier Payment} = (\text{True Costs} - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor} \times (1 + \text{Capital Adjustment Factor}) \]

• Transfer Payment
Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology. Claims with a Discharge Disposition of 02 (Discharged/Transferred to Short-Term General Hospital), 05 (Discharged/Transferred to a Designated Cancer Center or Children’s Hospital), or 66 (Discharged/Transferred to a Critical Access Hospital) are eligible for transfer per diem reimbursement. The transfer per diem reimbursement is calculated using the following formula:

\[ \text{Transfer Per Diem Payment} = \text{APR-DRG Base Payment} \times (\text{Length of Stay} / \text{APR-DRG Mean Length of Stay}) \]

Cases assigned to neonate transfer APR-DRGs are exempt from this special transfer per diem pricing methodology.
• Total Reimbursement
The total reimbursement is calculated by adding the individual pricing components described above, as follows:

Total Payment = APR-DRG Base Payment + Cost Outlier Payment

• Mark-Up/Discount Factor
The Virginia Medicaid APR Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

• Not Currently Supported
  - Certain Transplant Services
Cases assigned to liver, heart, lung, bone marrow, and pancreas transplant APR-DRGs are not covered by Virginia Medicaid. If these services are billed, the Virginia Medicaid APR Pricer will issue claim-level Pricer Return Code 24 (Non-Covered Claim).

B.3.21 Washington Medicaid APR Pricer (C Only) (effective July 01, 2014)

B.3.21.1 APR-DRG Payment Calculations
For inpatient acute care, payment is determined using an APR-DRG based payment methodology. The following calculations are used to determine reimbursement in the Washington Medicaid APR Pricer for claims with discharge dates on or after July 01, 2014:

• APR-DRG Base Payment
The APR-DRG base payment is calculated using a hospital-specific base rate, which is derived by wage-adjusting the standardized statewide base rate using the hospital-specific Medicare wage index and labor portion, and adding GME/IME where appropriate. Base payment is then calculated using the following formula:

APR-DRG Base Payment = Hospital Base Rate * DRG Weight

• Transfer Payment
Claims for patients who are transferred from one acute care facility to another facility may be paid using a per diem methodology if the patient’s length of stay plus one day is less than the average length of stay for the assigned APR-DRG. Claims with any of the Discharge Dispositions shown in Table B-35 are considered for transfer per diem reimbursement. The transfer per diem reimbursement is calculated using the following formula:
Transfer Payment = \( \frac{\text{APR-DRG Base Payment}}{\text{APR-DRG Average Length of Stay}} \times (\text{Patient Length of Stay} + 1\ \text{Day}) \)

Table B-35: Discharge Dispositions

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Discharged/Transferred to Short-Term General Hospital</td>
</tr>
<tr>
<td>03</td>
<td>Discharged/Transferred to Skilled Nursing Facility, Medicare-Certified</td>
</tr>
<tr>
<td>04</td>
<td>Discharged/Transferred to a Facility That Provides Custodial or Supportive Care</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>06</td>
<td>Discharged/Transferred to Home Health Service Organization</td>
</tr>
<tr>
<td>43</td>
<td>Discharged/Transferred to Federal Health Care Facility</td>
</tr>
<tr>
<td>50</td>
<td>Hospice, Home</td>
</tr>
<tr>
<td>51</td>
<td>Hospice, Certified Medical Facility</td>
</tr>
<tr>
<td>61</td>
<td>Discharged/Transferred to Swing Bed, Hospital-Based and Medicare-Approved</td>
</tr>
<tr>
<td>62</td>
<td>Discharged/Transferred to Inpatient Rehabilitation Facility or Unit</td>
</tr>
<tr>
<td>63</td>
<td>Discharged/Transferred to Long Term Care Hospital, Medicare-Certified</td>
</tr>
<tr>
<td>64</td>
<td>Discharged/Transferred to Nursing Facility, Certified Under Medicaid But Not Medicare</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/Transferred to Psychiatric Hospital or Distinct Part Unit</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/Transferred to Critical Access Hospital</td>
</tr>
<tr>
<td>70</td>
<td>Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List</td>
</tr>
<tr>
<td>81</td>
<td>Discharged to Home or Self-Care with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>82</td>
<td>Discharged/Transferred to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>83</td>
<td>Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>84</td>
<td>Discharged/Transferred to a Facility That Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>85</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>86</td>
<td>Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>87</td>
<td>Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>88</td>
<td>Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>89</td>
<td>Discharged/Transferred to a Hospital-Based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
</tbody>
</table>
• Cost Outlier Payment

Claims that are paid based on the APR-DRG formulas above are considered for outlier payments. To qualify for the cost outlier add-on payment, the estimated cost of the claim must exceed the cost outlier threshold. In order to determine the cost outlier add-on payment, claim cost is calculated by multiplying the total covered charges by the hospital Ratio of Cost-to-Charges (RCC). Next, the cost outlier threshold is calculated using the sum of the fixed outlier threshold set by the Washington HCA and the base payment, or transfer payment, calculated above. If the costs exceed the threshold, then the cost outlier add-on payment is calculated by subtracting the threshold from the cost, and multiplying by the marginal cost factor. The marginal cost factor value is determined by the Severity of Illness (SOI) indicator. If a claim is assigned to an APR-DRG with a SOI indicator of 1 (Minor) or 2 (Moderate) the marginal cost factor is 80% and if a claim is assigned to an APR-DRG with a SOI indicator of 3 (Major) or 4 (Extreme) the Marginal Cost Factor is 95%.

\[
\text{Cost} = (\text{Total Covered Charges} \times \text{Hospital RCC})
\]

\[
\text{Cost Outlier Threshold} = \text{Fixed Cost Outlier Threshold} + \text{Base Payment (or Transfer Payment, if applicable)}
\]

\[
\text{Cost Outlier Add-On} = (\text{Cost} - \text{Cost Outlier Threshold}) \times \text{DRG Outlier Marginal Cost Factor}
\]

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>91</td>
<td>Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>92</td>
<td>Discharged/Transferred to a Nursing Facility Certified Under Medicaid But Not Certified Under Medicare with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>93</td>
<td>Discharged/Transferred to a Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>94</td>
<td>Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
<tr>
<td>95</td>
<td>Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List with a Planned Acute Care Hospital Inpatient Readmission</td>
</tr>
</tbody>
</table>
*Total Reimbursement*

The total reimbursement is calculated as follows, capped at charges:

\[
Total \ Reimbursement = (Base \ Reimbursement \ Rate + Outlier \ Payments) + \ Newborn \ Screening \ Add-On * COVID-19 \ Add-On
\]

- **Newborn Screening Add-On Payment**

The Washington State Health Care Authority (HCA) requires that every newborn receive a blood test screening for twenty-eight separate disorders. The Washington State HCA will make a standard payment, in addition to the DRG payment, to a hospital when this newborn screening is performed. The APR-DRGs listed below in Table B-36 will receive this additional payment.

Certified Public Expenditure (CPE) hospitals paid via the fee-for-service methodology, Critical Access Hospitals (CAHs), and Long Term Care (LTC) hospitals are not eligible for this newborn screening add-on payment. Also, if the claim is an administrative day claim it will not be eligible for this add-on payment.

Table B-36: Neonatal APR-DRGs

<table>
<thead>
<tr>
<th>APR-DRG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0580</td>
<td>Neonate, Transferred &lt; 5 Days Old, Not Born Here</td>
</tr>
<tr>
<td>0581</td>
<td>Neonate, Transferred &lt; 5 Days Old, Born Here</td>
</tr>
<tr>
<td>0583</td>
<td>Neonate With ECMO</td>
</tr>
<tr>
<td>0588</td>
<td>Neonate Birth Weight &lt; 1500G With Major Procedure</td>
</tr>
<tr>
<td>0589</td>
<td>Neonate Birth Weight &lt; 500G or Gestation Age &lt; 24 Weeks</td>
</tr>
<tr>
<td>0591</td>
<td>Neonate Birthwt 500-749G w/o Major Procedure</td>
</tr>
<tr>
<td>0593</td>
<td>Neonate Birthwt 750-999G w/o Major Procedure</td>
</tr>
<tr>
<td>0602</td>
<td>Neonate Bwt 1000-1249G w/ Resp Dist Synd/Oth Maj Resp or Maj Anom</td>
</tr>
<tr>
<td>0603</td>
<td>Neonate Birthwt 1000-1249G w/ or w/o Other Significant Condition</td>
</tr>
<tr>
<td>0607</td>
<td>Neonate Bwt 1250-1499G w/ Resp Dist Synd/Oth Maj Resp or Maj Anom</td>
</tr>
<tr>
<td>0608</td>
<td>Neonate Bwt 1250-1499G w/ or w/o Other Significant Condition</td>
</tr>
<tr>
<td>0609</td>
<td>Neonate Bwt 1500-2499G w/ Major Procedure</td>
</tr>
<tr>
<td>0611</td>
<td>Neonate Birthwt 1500-1999G w/ Major Anomaly</td>
</tr>
<tr>
<td>0612</td>
<td>Neonate Bwt 1500-1999G w/ Resp Dist Synd/Oth Maj Resp Cond</td>
</tr>
<tr>
<td>0613</td>
<td>Neonate Birthwt 1500-1999G w/ Congenital/Perinatal Infection</td>
</tr>
<tr>
<td>0614</td>
<td>Neonate Bwt 1500-1999G w/ or w/o Other Significant Condition</td>
</tr>
<tr>
<td>0621</td>
<td>Neonate Bwt 2000-2499G w/ Major Anomaly</td>
</tr>
<tr>
<td>0622</td>
<td>Neonate Bwt 2000-2499G w/ Resp Dist Synd/Oth Maj Resp Cond</td>
</tr>
<tr>
<td>0623</td>
<td>Neonate Bwt 2000-2499G w/ Congenital/perinatal Infection</td>
</tr>
<tr>
<td>0625</td>
<td>Neonate Bwt 2000-2499G w/ Other Significant Condition</td>
</tr>
<tr>
<td>0626</td>
<td>Neonate Bwt 2000-2499G, Normal Newborn or Neonate w/ Other Problem</td>
</tr>
<tr>
<td>0630</td>
<td>Neonate Birthwt &gt;2499G w/ Major Cardiovascular Procedure</td>
</tr>
<tr>
<td>0631</td>
<td>Neonate Birthwt &gt;2499G w/ Other Major Procedure</td>
</tr>
</tbody>
</table>
- COVID-19 Add-On Payment

Washington Medicaid implemented a 20% reimbursement increase for COVID-19 admissions. This increase only applies to claims reimbursed under the APR-DRG methodology. The Washington Medicaid APR Pricer multiplies this factor by the lesser of the total reimbursement or the total charges plus the newborn screening add-on payment, when the claim includes a COVID-19 diagnosis code. The adjustment is applied if the COVID-19 diagnosis code is found anywhere on the claim, including as the admitting diagnosis code.

- Per Diem Diagnostic Related Group (DRG) Payment

The per diem DRG payment calculation applies to claims that are assigned to an APR-DRG in the following categories: psychiatric, detox, or rehabilitation. These claims are not eligible for cost outlier payments. The per diem DRG payment is calculated using the following formulas (for each DRG type):

\[
\text{Detox DRG Per Diem Payment Calculation} = \text{Detox Per Diem Amount} \times \text{LOS}
\]

\[
\text{Rehabilitation DRG Per Diem Payment Calculation} = \text{Rehabilitation Per Diem Amount} \times \text{LOS}
\]

\[
\text{Psychiatric DRG Per Diem Payment Calculation} = \text{Psychiatric Per Diem Amount} \times \text{LOS}
\]

- Administrative Days Payment

Administrative days occur when a patient no longer requires an acute level of care, but has not been discharged from the hospital because they are awaiting appropriate placement. Administrative days must be submitted on a separate claim with UB-04 Revenue Codes 0169 (Other Room and Board) or 0191 (Sub-Acute Care - Level I) and are reimbursed at a daily rate. Administrative days are paid based on the units reported with the above-mentioned revenue codes. The calculation is as follows:

\[
\text{Administrative Days Payment} = \text{Units} \times \text{Administrative Day Per Diem Rate}
\]

Previously, the Washington Medicaid APR Pricer paid administrative days billed with UB-04 Revenue Code 0169 (Other Room & Board - Other) or 0191 (Subacute Care - Level I), but did not separately reimburse pharmacy services and drugs. With the V2003.01 release, the Washington Medicaid APR Pricer separately reimburses pharmacy services and drugs on an administrative day claim. Pharmacy services and drugs are the only services that will be reimbursed.
separately reimbursed with UB-04 Revenue Code 0250 (Pharmacy General Classification) and will be calculated as follows:

- Critical Access Hospitals (CAHs)

**Pharmacy Services and Drugs Payment = Charges * Critical Access Rate**

- All Other Hospitals

**Pharmacy Services and Drugs Payment = Charges * Hospital RCC**

- Transplant Payment

The transplant percentage of charge payment calculation applies to claims that are assigned to a designated transplant APR-DRG. The transplant percentage of charge payment is calculated using the following formula:

**Transplant Payment Calculation = Total Charges * Hospital RCC**

- Certified Public Expenditure (CPE) Hospital Payment

CPE hospitals may be eligible for special reimbursement for all claims that are not administrative day claims. If the total charges multiplied by the hospital RCC and the federal matching assistance percentage is greater than the sum of the base payment and any outlier payment, then the reimbursement is calculated as follows. Note that Managed Care payers are not required to make this CPE adjustment, and can pay CPE claims based on the standard APR-DRG rules.

**CPE Hospital Payment Calculation = (Total Charges * Hospital RCC * Federal Matching Assistance Percentage)**

- Critical Access Hospitals (CAH) Payment

For Critical Access Hospitals, the payment is calculated by multiplying the total charges by the CAH inpatient payment factor.

**CAH Payment Rate Calculation = Total Charges * CAH Inpatient Payment Factor**

- Certified Chemical-Using Pregnant (CUP) Facility Payment

In order to qualify for the CUP facility payment, room and board must be billed with Revenue Code 0129 (Room & Board Semiprivate 2-Bed Other) and the claim must originate from a certified CUP facility. The CUP facility payment is calculated as follows:

**CUP Facility Payment Calculation = Units * CUP Rate**

- Long Term Acute Care Facility Payment

Long term acute care facility claims are subject to a per diem reimbursement calculation. The long term acute care facility payment is calculated as follows:

**Long Term Acute Care Facility Payment Calculation = Long Term Acute Care Per Diem Rate * LOS**
• **Bariatric Procedures Payment**

Prior to July 01, 2019, bariatric procedures are paid on a per case basis. In order to qualify for the bariatric reimbursement a claim must be billed with an eligible supporting diagnosis code and a bariatric procedure code. The bariatric payment is calculated as follows:

\[
\text{Bariatric Procedure Payment Calculation} = \text{Bariatric Case Rate} \times \text{Mark-Up/Discount Factor}
\]

- **Mark-Up/Discount Factor**

The Washington Medicaid APR Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

**B.4 How to Determine Which APG Pricer to Utilize**

Prior to pricing a record, you must determine which APG Pricer is appropriate to invoke. In addition, the reimbursement rate variables in effect at the time of the patient’s procedure or service, and APG-specific weights, means, and trims, must be available. The Test Driver (available for the C Platform only) shows how information appropriate to a particular patient’s procedure or service can be retrieved from external files and reformatted for use by the APG Pricer. Refer to the EASYGroup™ Installation Guide for further information on the Test Driver.

The Test Driver program included with your distribution assumes that all data needed to drive patient-specific pricing is stored in the files described below. These files contain the data needed to set-up the Hospital Rate Calculator File, APG Rate File, and Configuration File, as required by the APG Pricer. Please refer to the EASYGroup™ Technical Reference Guide for details on the layouts on these files.

- **Hospital Rate Calculator File**: File with hospital-specific payment information (e.g., base rates, conversion factors, RCCs, etc.). The information in this file will be used to set up the Hospital Rate Calculator File.

- **APG Rate File**: File with APG-specific payment information (e.g., weights, means, and trims). The information in this file is used to set up the APG rate record.

- **Payers File**: File with payer-specific information.

- **Configuration File**: File that contains hospital-specific processing requirements.

The Test Driver uses the Payers File to determine whether pricing and retrieval of the Hospital Rate Calculator File, APG Rate File, and Configuration File records should be based on either admission date or discharge date. Test routines for retrieving information from these files can be found in the Test
Driver program. The Test Driver program, optest.c (CSource) has been provided, so that it can be modified for your environment.

When pricing a patient record, the APG Pricer must access and retrieve the pricing information in effect at the time of the patient’s procedure or service. This includes an indication of the pricing rules or APG Pricer program to be applied, as well as the hospital and payer-specific reimbursement rate variables to be used with the selected APG Pricer. The Test Driver program contains a routine for determining which pricing information to retrieve.

The Test Driver program is passed the following key information for the test database: hospital number, paysource code, and a reimbursement date. Reimbursement date is set equal to the admission/discharge date. For purposes of the Test Driver, the decision to use the admission/discharge date is based on a flag stored on the Payers File. The Test Driver then uses hospital number, paysource code, and reimbursement date to query the Hospital Rate Calculator File for a record with the same hospital number and paysource code with the closest effective date, which is less than or equal to the reimbursement date. When the appropriate Hospital Rate Calculator record is found, the information retrieved is transferred to the Hospital Rate Calculator File.

One of the variables transferred to the Hospital Rate Calculator File in the previous step is an indication of the pricing rules or APG Pricer program to be applied to the patient record being processed. The Pricer type transferred to the Hospital Rate Calculator File must be one of the types listed in the column labeled, Pricer/Payer Type.

Some programs or payers reimburse for hospital services by marking up or discounting the amount that Medicare/Medicaid would have paid for the same services. This pricing scenario can be accommodated by setting the Markup/Discount Factor field, as appropriate. This Markup/Discount Factor is applied to all final payment fields: the applicable base rate, the applicable add-on payment(s), and the total reimbursement.

When implemented, this field defaults to a value of 1.00 if no value (i.e., a value of zeros) has been entered into this field. Thus, not setting the Markup/Discount Factor for payers will not negatively impact reimbursement calculations. Payers will continue to price in the usual manner without setting the Markup/Discount Factor.

**B.5 APG Pricer Functionality**

There are multiple types of Medicaid APG Pricers:

<table>
<thead>
<tr>
<th>“tt” Value</th>
<th>Pricer</th>
<th>Pricer/Payer Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>APGPro</td>
<td>Medicaid APG Pro</td>
<td>44</td>
</tr>
<tr>
<td>ILAPG</td>
<td>Illinois Medicaid APG</td>
<td>38</td>
</tr>
</tbody>
</table>
B.5.1 Enhanced New York Medicaid APG Pricer (C Only) (effective October 01, 2019)

B.5.1.1 APG Payment Calculations
For outpatient hospitals, payment is determined using an APG-based payment methodology. The following calculations are used to determine reimbursement in the Enhanced New York Medicaid APG Pricer for New York Outpatient claims with discharge dates on or after October 01, 2019.

- APG Base Payment

For each claim line, the APG base payment is calculated as follows:

\[
\text{APG Base Payment} = \text{Hospital Specific Payment Rate} \times \text{APG Weight}
\]

- APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

- Bilateral Procedures Adjustment

This adjustment applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).

\[
\text{Bilateral Procedures Discount} = \text{APG Base Payment} \times \text{Bilateral Procedures Discount Factor}
\]

- Terminated Procedures Adjustment

This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

\[
\text{Terminated Discount} = \text{APG Base Payment} \times \text{Terminated Procedures Discount Factor}
\]

- Repeat Ancillary Adjustment

This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. APG definitions determine which ancillaries are subject to this discounting.

\[
\text{Repeat Ancillary Discount} = \text{APG Base Payment} \times \text{Repeat Ancillary Discount Factor}
\]
- Multiple Significant Procedure Adjustment

When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted as follows. APG definitions determine which procedures are subject to this discounting.

\[ \text{Multiple Significant Procedure Discount} = \text{APG Base Payment} \times \text{Multiple Significant Procedure Discount Factor} \]

**Note**

For some services, bilateral or terminated discounting may be applied along with multiple procedure or repeat ancillary discounting.

- Packaged Services Adjustment

The APG methodology involves paying for the principal services on each claim, and packaging other services. Payment for these packaged services is included in the payment for the principal service, so no additional payment is made for services identified as packaged by the APG Grouper.

- Consolidated Services Adjustment

The APG methodology involves consolidating payment for related services. The first service is paid, and then other related services are consolidated and do not receive separate payment. Payment for these consolidated services is included in the payment for the principal service, so no additional payment is made for services identified as consolidated by the APG Grouper.

- 340B Program Adjustment

This adjustment applies when a drug is acquired through the 340B Program. Modifier UD (340B Drug), TB (Drug or Biological Acquired With 340b Drug Pricing Program Discount, Reported For Informational Purposes) or JG (Drug Or Biological Acquired With 340B Drug Pricing Program Discount) must be billed with the applicable drug code in order for the claim line to receive a 25% reduction.

**Note**

This adjustment applies to all drug APGs (APG Category 24).

- Masters and Bachelors Degree Level Policy Adjustment

This adjustment applies when services are provided by a Master’s level practitioner or Bachelor’s level practitioner. Modifier HO (Masters Degree Level) or Modifier HN (Bachelors Degree Level) must be billed with the applicable service in order for the claim-line to receive a 25% reduction.

- Adjustment for Services Provided in a Foreign Language

This adjustment applies when services are provided in a foreign language. Services that group to APGs 310 (Developmental & Neuropsychological Testing), 312 (Full Day Partial Hospitalization For Behavioral Health), 315

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(Counseling or Individual Brief Psychotherapy) - 318 (Group Psychotherapy), 321 (Crisis Intervention), 323 (Behavioral Health Assessment), 426 (Psychotropic Medication Management) and 490 (Incidental To Medical Visit or Significant Procedure) receive an additional 10% in reimbursement when billed with modifier U4 (Language Other Than English).

- School Based Group Psychotherapy Service Adjustment

This adjustment applies to school based group psychotherapy services. If Modifier U5 (Reduced Services) is billed with a service that groups to APGs 315-318 or 323, reimbursement for that service is reduced by 30%.

- Nurse Practitioner Adjustment

This adjustment applies to services provided by a nurse practitioner, services provided by a primary physician, and services provided by a specialty physician. If Modifier SA (Nurse Practitioner), AG (Primary Physician), or AF (Specialty Physician) is billed with a service that groups to APG 318 (Group Psychotherapy), that service receives an extra 20% in reimbursement. If modifier SA, AG or AF is billed with a service that groups to APG 315, 316 (Individual Comprehensive Psychotherapy) or 317 (Family Psychotherapy), that service receives an extra 45% in reimbursement.

**Note**

This policy does not apply to Rate Codes 1507 (OMH- Free Standing Article 31 Clinic - Off-Site) or 1519 (OMH - Hospital Article 31 Clinic - Off-Site).

- Off-Site Licensed Behavioral Health Practitioner (LBHP) Adjustment

This adjustment applies to off-site LBHP services. These services receive an additional 50% in reimbursement when billed with Rate Codes 1507 or 1519.

- Group Setting Adjustment

This adjustment applies to services provided in a group setting. Services that group to APG 451 (Smoking Cessation Treatment) and are billed with Modifier HQ (Group Setting) receive a 50% reduction.

- Office of Alcoholism and Substance Abuse Services (OASAS) Adjustment

For OASAS rate codes, procedure codes H0020, Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program), and H0033, Oral medication administration, direct observation, are reimbursed at 200% when billed with Modifier KP (First Drug of a Multiple Drug Unit Dose Formulation).

- Ancillary Policy Adjustment

New York Medicaid has an ancillary policy that applies to free-standing diagnostic and treatment centers (D&TCs). Under this policy, in order to receive payment for ancillary services that group to certain APGs, Modifier U6 (Reimbursable Ancillaries For D&TCs) must be billed on the claim line. If
Modifier U6 is not present on the line, then procedure codes that group to packaged ancillary APGs are not paid and procedures that group to non-packaged ancillary APGs will receive a payment reduction.

- **Pediatric Psychotherapy Policy Adjustment**

New York Medicaid applies a 5% increase to reimbursement for patients under the age of 21 for procedure codes 90832, *Psychotherapy, 30 minutes with patient*, and 90834, *Psychotherapy, 45 minutes with patient*, for OMH claims.

- **Vaccines for Children (VFC) Policy Adjustment**

New York Medicaid’s VFC policy adjusts payment based on patient age, APG, APG type and modifiers. For patients under 19 years of age, vaccine codes billed with Modifier SL (State Supplied Vaccine) that group to APGs 414 (Level I Immunization), 415 (Level II Immunization), and 416 (Level III Immunization) are paid at a flat rate. For patients 19 years of age and older, vaccine codes billed with Modifier FB (Item Provided Without Cost To Provider, Supplier or Practitioner, or Full Credit Received For Replaced Device) that group to APGs 414, 415, or 416, or APG Category 24 (Chemotherapy and Other Drugs) are paid at a different flat rate than the rate for patients under 19 years of age.

- **Flat Capital Add-On Adjustment**

A flat capital rate is added to the paid line with the highest weight for a given visit or episode.

- **Observation Policy Adjustment**

New York Medicaid’s observation policy reimburses the first 24 hours of observation at 100%. Units reflecting more than 24 hours but less than 48 hours are discounted by 20%. Any units in excess of 48 hours are not paid. If Modifier UC (Observation Services Provided In a Distinct Unit) is not present reimbursement is discounted an additional 20%.

\[ \text{Observation Policy Adjustment} = \text{Weights} \times \text{Units} \times \text{UC Adjustment} \]

- **Episode vs. Visit Discounting**

New York Medicaid supports claims with more than one date of service. If the claim contains a visit-level Rate Code, each date of service is treated as a separate visit. If the claim contains an episode-level Rate Code, all services on the claim are processed as if they had all been provided on a single date. Discounting for visits applies per day but in the case of an episode, it applies per claim. Please refer to Appendix M to identify visit vs. episode rate codes.

  - Fee Schedule Payment

New York Medicaid pays fee schedule items in two different ways:

\[ \text{Fee Schedule Payment Type 1} = \text{Fee Schedule Rate} \times \text{Units} \]

\[ \text{Fee Schedule Payment Type 2} = \text{Procedure Based Weight} \times \text{Base Rate} \times \text{Units} \]

  - Mark-up/Discount Factor:
The New York Medicaid APG Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor. The Mark-Up/Discount Factor is applied to the payment at the line level.

- Total Reimbursement:
  \[ Total \text{ Reimbursement} = \text{Rate} \times \text{Weight} \times \text{Policy Adjustments} \]

**B.5.2 Illinois Medicaid APG Pricer (C Only) (effective July 01, 2014 - December 31, 2018)**

**B.5.2.1 APG Payment Calculations**

For outpatient claims from acute care facilities and ASCs, payment is determined using an APG based payment methodology. The following calculations are used to determine reimbursement in the Illinois Medicaid APG Pricer effective for services on or after July 01, 2014:

- APG Base Payment

For each claim line, the APG base payment is calculated using the following formula. In this formula, the hospital-specific payment rate is the wage-adjusted base rate, including any applicable increases due to high Medicaid volume.

\[ \text{APG Base Payment} = \text{Hospital Specific Payment Rate} \times \text{APG Weight} \]

- APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

  - Bilateral Procedures Adjustment

This adjustment applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).

\[ \text{Bilateral Procedures Discount} = \text{APG Base Payment} \times \text{Bilateral Procedures Discount Factor} \]

  - Terminated Procedures Adjustment

This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

\[ \text{Terminated Discount} = \text{APG Base Payment} \times \text{Terminated Procedures Discount Factor} \]

  - Repeat Ancillary Adjustment

This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. APG definitions determine which ancillaries are subject to this discounting.
**Repeat Ancillary Discount** = APG Base Payment * Repeat Ancillary Discount Factor

- Multiple Significant Procedure Adjustment

When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted as follows. APG definitions determine which procedures are subject to this discounting.

**Multiple Significant Procedure Discount** = APG Base Payment * Multiple Significant Procedure Discount Factor

**Note**

For some services, bilateral or terminated discounting may be applied along with multiple procedure or repeat ancillary discounting.

- Packaged Services Adjustment

The APG methodology involves paying for the principal services on each claim, and packaging other services. Payment for these packaged services is included in the payment for the principal service, so no additional payment is made for services identified as packaged by the APG Grouper.

- Consolidated Services Adjustment

The APG methodology involves consolidating payment for related services. The first service is paid, and then other related services are consolidated and do not receive separate payment. Payment for these consolidated services is included in the payment for the principal service, so no additional payment is made for services identified as consolidated by the APG Grouper.

- Cost Outlier Add-On Payment

Effective July 01, 2018, Illinois Medicaid implemented a cost outlier add-on payment for expensive drugs and devices for eligible hospitals. All Illinois hospitals and several out-of-state hospitals are eligible to receive the additional reimbursement. Critical Access Hospitals (CAHs) and most out-of-state hospitals are not eligible for this additional payment. Eligible devices are those assigned to EAPGs 490 or 1001 - 1020 and billed with Revenue Codes 0274 - 0276 or 0278. Eligible drugs are those assigned to EAPGs 430 - 441, 443, 444, 460 - 465, 495, 496, or 1090 and billed with a covered revenue code.

The cost outlier add-on payment is calculated by first establishing the threshold and the true costs for the claim line as follows:

\[
\text{Threshold} = \text{Fixed Loss Amount ($1,000)} + \text{Line Payment before Smart Act Adjustment}
\]

\[
\text{True Costs} = (\text{Operating RCC} + \text{Capital RCC}) \times \text{Line Charges}
\]

They are then compared and if the threshold is greater than the true costs, the add-on payment is calculated as:

\[
\text{Add-On Payment} = (\text{Threshold} – \text{True Costs}) \times \text{Marginal Cost Factor (80%)}
\]
Total claim line reimbursement = (Line Payment before Smart Act Adjustment + Add-On Payment) * Smart Act Adjustment

- Legislative Reductions
Per the Save Medicaid Access and Resources Together (SMART) Act, the total payment is reduced for eligible facilities by the legislative reduction factor.

- Mark-Up/Discount Factor
The Illinois Medicaid APG Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- Total Reimbursement
The total reimbursement is calculated as the sum of all line-level reimbursement amounts.

B.5.3 Medicaid APG Pro Pricer (C Only)

- Alabama Blue Cross Blue Shield (BCBS) APG (effective October 01, 2016)

B.5.3.1 APG Payment Calculations
For outpatient hospitals, payment is determined using an APG-based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APG Pro Pricer for Alabama BCBS APG claims with discharge dates on or after October 01, 2016.

- APG Base Payment
The APG base payment is calculated using the following formula. The policy adjustor is determined by the APG Type and will be set to 0.45 for APG Type 22 (Mental Health) and 0.15 for APG Type 21 (Therapy Services):

\[ \text{APG Base Payment} = \text{Base Rate} \times \text{APG Weight} \times \text{Policy Adjustor} \]

- APG Base Payment With Adjustments
Each APG base payment may receive an adjustment for the following reasons:
  - Bilateral Procedures Adjustment
This adjustment applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).

\[ \text{Bilateral Procedures Adjustment} = \text{APG Base Payment} \times \text{Bilateral Procedures Discount Factor} \]
  - Terminated Procedures Adjustment
This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).
Terminated Discount = APG Base Payment * Terminated Procedures Discount Factor

- Repeat Ancillary Adjustment

This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. In other words, the first instance of the ancillary service is paid at 100% and any subsequent repeated instances are adjusted by 50%. APG definitions determine which ancillaries are subject to discounting.

Repeat Ancillary Discount = APG Base Payment * Repeat Ancillary Discount Factor

- Multiple Significant Procedure Adjustment

When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted by 50%. APG definitions determine which procedures are subject to this discounting.

Multiple Significant Procedure Discount = APG Base Payment * Multiple Significant Procedure Discount Factor

• Fee Schedule Payment

Alabama BCBS has identified a list of services that are not paid under APGs, but are paid based on the fee schedule. If an APG claim contains services that are on the fee schedule, they are not paid based on the formulas above, but instead are paid based on the fee schedule. Payment for fee schedule services is not capped at the line-level.

Fee Schedule Payment = Fee Schedule Rate * Units

• Mark-Up/Discount Factor

The Medicaid APG Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor. The Mark-Up/Discount Factor is applied to the payment at line level.

• Total Reimbursement

The total reimbursement is calculated as the sum of all line-level reimbursement amounts.

• Not Currently Supported

Alabama BCBS returns an informational edit when a claim line is billed without a HCPCS code for all revenue codes, except those shown below in Table B-38. The Optum software will not return this informational edit. Although an informational edit will not be returned in these situations, the Optum software will appropriately return APG 0999 (Unassigned), a line-level Pricer Return
Code of 01 (No Available APG/Fee Schedule Rate Record), and no pricing for these claim lines.

Table B-38: Exception Revenue Codes

<table>
<thead>
<tr>
<th>Revenue Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250 - 0258</td>
</tr>
<tr>
<td>0270 - 0273</td>
</tr>
<tr>
<td>0370</td>
</tr>
<tr>
<td>0710</td>
</tr>
<tr>
<td>0990 - 0999</td>
</tr>
</tbody>
</table>

In addition, Alabama BCBS does not support any fee schedule pricing.

✔️ Colorado Medicaid APG (effective July 01, 2018)

**B.5.3.2 APG Payment Calculations**

Payment is determined using an APG-based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APG Pro Pricer for Colorado Medicaid APG claims with dates of service on or after July 01, 2018.

- **APG Base Payment**

The APG base payment is calculated using the following formula.

\[
\text{APG Base Payment} = \text{Base Rate} \times \text{APG Weight}
\]

- **APG Base Payment With Adjustments**

Each APG base payment may receive an adjustment for the following reasons:

  - **Bilateral Procedure Adjustment**

This adjustment applies when a procedure eligible for a bilateral pricing adjustment is submitted with Modifier 50 (Bilateral Procedure).

\[
\text{Bilateral Procedures Adjustment} = \text{APG Base Payment} \times \text{Bilateral Procedures Discount Factor}
\]

  - **Terminated Procedure Adjustment**

This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

\[
\text{Terminated Discount} = \text{APG Base Payment} \times \text{Terminated Procedures Discount Factor}
\]

  - **Repeat Ancillary Adjustment**

This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. In other words, the first instance of the ancillary service is paid at 100% and any subsequent repeated instances
are adjusted by 50%. APG definitions determine which ancillaries are subject to discounting.

Repeat Ancillary Discount = APG Base Payment * Repeat Ancillary Discount Factor

- Multiple Significant Procedure Adjustment

When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted by 50%. APG definitions determine which procedures are subject to discounting.

Multiple Significant Procedure Discount = APG Base Payment * Multiple Significant Procedure Discount Factor

- Packaged Services Adjustment

The APG methodology involves payment for the principal services on each claim and packaging other services. Payment for these packaged services is included in the payment for the principal service, therefore no additional payment is made for services identified as packaged by the APG Grouper.

- Consolidated Services Adjustment

The APG methodology involves consolidating payment for related services. The first service is paid, and then other related services are consolidated and do not receive separate payment. Payment for these consolidated services is included in the payment for the principal service, therefore no additional payment is made for services identified as consolidated by the APG Grouper.

- 340B Program Adjustment

This adjustment applies when a drug is acquired through the 340B Program. Modifier UD (340B Drug) must be billed with the applicable drug code in order for the claim line to receive this adjustment.

340B Drug Program Adjustment = APG Base Payment * Policy Adjustor 1

- Charge Cap

The line-level payment is capped at charges using a charge redistribution methodology. Charges from packaged and consolidated lines that are for covered services are redistributed to the payable services before the charge cap is applied. Charges that are associated with non-covered services are excluded from this redistribution. The following services are non-covered:

- Drugs billed with Modifier JW (Drug Amount Discarded/Not Administered to Any Patient)
- Never Events
- Services assigned to APGs 0168 (Hemodialysis), 0169 (Peritoneal Dialysis), or 0993 (Inpatient Only Procedures)

Charge Cap = Total Covered Charges * (Adjusted APG Weight / Total Adjusted APG Weight)
• Immediate Postpartum Long Acting Reversible Contraceptive (IPP-LARC) Payment

The state of Colorado allows an adjustment to their inpatient reimbursement methodology to allow separate payments for IPP-LARC devices inserted in an inpatient care setting. These devices must be billed as the only service on an outpatient claim when they are inserted in an inpatient care setting. The IPP-LARC device will be reimbursed at the lesser of the fee schedule rate or the billed charges.

\[ \text{LARC Payment} = \text{Fee Schedule Rate} \times \text{Units} \]

• Mark-Up/Discount Factor

The Medicaid APG Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-specific factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total line payment is multiplied by the Mark-Up/Discount Factor.

• Total Reimbursement

The total reimbursement is calculated as the sum of all line-level payments.

✓ Florida Medicaid APG (effective July 01, 2017)

B.5.3.3 Florida Medicaid APG Episodes Versus Visits

The Florida Medicaid APG Payment System supports claims with more than one date of service; treating them as separate visits as long as the dates of service are not designated as a range of dates. However, if a claim is billed with any of the Revenue Codes shown below in Table B-39 on any paid line, the claim will be handled as a single episode and the multiple dates of service will no longer be taken into account.

Table B-39: Florida Medicaid Episode Revenue Codes

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0450</td>
<td>Emergency Room General Classification</td>
</tr>
<tr>
<td>0451</td>
<td>Emergency Room EMTALA Emergency Medical Screening Services</td>
</tr>
<tr>
<td>0761</td>
<td>Treatment/Observation Room Treatment Room</td>
</tr>
<tr>
<td>0762</td>
<td>Treatment/Observation Room Observation Room</td>
</tr>
</tbody>
</table>

B.5.3.4 APG Payment Calculations

Payment is determined using an APG-based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APG Pro Pricer for Florida Medicaid APG claims with dates of service on or after July 01, 2017.

• APG Base Payment

The APG base payment is calculated using the following formula. The policy adjustor is used to adjust reimbursement for hospitals designated as high Medicaid utilization facilities:
APG Base Payment = Base Rate * APG Weight * Policy Adjustor

- APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

- Bilateral Procedure Adjustment

This adjustment applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).

\[ \text{Bilateral Procedures Adjustment} = \text{APG Base Payment} \times \text{Bilateral Procedures Discount Factor} \]

- Terminated Procedure Adjustment

This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

\[ \text{Terminated Discount} = \text{APG Base Payment} \times \text{Terminated Procedures Discount Factor} \]

- Repeat Ancillary Adjustment

This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. In other words, the first instance of the ancillary service is paid at 100% and any subsequent repeated instances are adjusted by 50%. APG definitions determine which ancillaries are subject to discounting.

\[ \text{Repeat Ancillary Discount} = \text{APG Base Payment} \times \text{Repeat Ancillary Discount Factor} \]

- Multiple Significant Procedure Adjustment

When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted by 50%. APG definitions determine which procedures are subject to discounting.

\[ \text{Multiple Significant Procedure Discount} = \text{APG Base Payment} \times \text{Multiple Significant Procedure Discount Factor} \]

- Packaged Services Adjustment

The APG methodology involves payment for the principal services on each claim and packaging other services. Payment for these packaged services is included in the payment for the principal service, therefore no additional payment is made for services identified as packaged by the APG Grouper.

- Consolidated Services Adjustment

The APG methodology involves consolidating payment for related services. The first service is paid, and then other related services are consolidated and do not receive separate payment. Payment for these consolidated services is
included in the payment for the principal service, therefore no additional payment is made for services identified as consolidated by the APG Grouper.

• Mark-Up/Discount Factor

The Medicaid APG Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor. The Mark-Up/Discount Factor is applied to the payment at the line level.

• Automatic Rate Enhancement Supplemental Per Service Add-On Payment (Prior to October 01, 2020)

Florida Medicaid applies a per service automatic rate enhancement supplemental add-on payment for eligible facilities. This add-on payment is applied to covered claim lines, even if the claim line is not paid because of packaging, consolidation, and paid a zero APG weight. The add-on payment is not applied to non-covered claim lines.

• Vagus Nerve Stimulator (VNS) Device Payment

Florida Medicaid applies an add-on payment for VNS devices for patients with intractable Epilepsy, that do not have a surgical treatment option, effective November 02, 2017. This add-on payment is made in addition to the surgical APG payment. When a complete VNS device is inserted/fully replaced or partially replaced, payments are made at the lessor of charges or the applicable VNS device maximum fee. Applicable procedure codes must be present on the same date of service on the claim. The VNS device payment is calculated using the following formula:

\[
VNS\ Device\ Payment = \text{Lesser of (charges or the applicable VNS device maximum fee)}
\]

• Total Reimbursement

The total reimbursement is calculated as the sum of all line level payments, any Automatic Rate Enhancement Supplemental Per Service Add-On Payment, and VNS device payment.

\[
\text{Total Reimbursement} = APG\ Base\ Payment + \text{Automatic Rate Enhancement Supplemental Per Service Add-On Payment} + VNS\ Device\ Payment
\]

• Not Currently Supported

The Florida Medicaid APG Payment System currently does not support the following:

- Global transplant fee
- Benefit limit of $1,500.00

✔ Illinois Medicaid APG (effective January 01, 2019)

B.5.3.5 APG Payment Calculations

For outpatient claims from acute care facilities and ASCs, payment is determined using an APG based payment methodology. The following
calculations are used to determine reimbursement in the Illinois Medicaid APG Pricer effective for services on or after January 01, 2019:

- APG Base Payment

For each claim line, the APG base payment is calculated using the following formula. In this formula, the hospital-specific payment rate is the wage-adjusted base rate, including any applicable increases due to high Medicaid volume.

\[
\text{APG Base Payment} = \text{Hospital Specific Payment Rate} \times \text{APG Weight}
\]

- APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

- Bilateral Procedures Adjustment

This adjustment applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).

\[
\text{Bilateral Procedures Discount} = \text{APG Base Payment} \times \text{Bilateral Procedures Discount Factor}
\]

- Terminated Procedures Adjustment

This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

\[
\text{Terminated Discount} = \text{APG Base Payment} \times \text{Terminated Procedures Discount Factor}
\]

- Repeat Ancillary Adjustment

This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. APG definitions determine which ancillaries are subject to this discounting.

\[
\text{Repeat Ancillary Discount} = \text{APG Base Payment} \times \text{Repeat Ancillary Discount Factor}
\]

- Multiple Significant Procedure Adjustment

When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted as follows. APG definitions determine which procedures are subject to this discounting.

\[
\text{Multiple Significant Procedure Discount} = \text{APG Base Payment} \times \text{Multiple Significant Procedure Discount Factor}
\]

**Note**

For some services, bilateral or terminated discounting may be applied along with multiple procedure or repeat ancillary discounting.
- Packaged Services Adjustment
The APG methodology involves paying for the principal services on each claim, and packaging other services. Payment for these packaged services is included in the payment for the principal service, so no additional payment is made for services identified as packaged by the APG Grouper.

- Consolidated Services Adjustment
The APG methodology involves consolidating payment for related services. The first service is paid, and then other related services are consolidated and do not receive separate payment. Payment for these consolidated services is included in the payment for the principal service, so no additional payment is made for services identified as consolidated by the APG Grouper.

• Cost Outlier Add-On Payment
Effective July 01, 2018, Illinois Medicaid implemented a cost outlier add-on payment for expensive drugs and devices for eligible hospitals. All Illinois hospitals and several out-of-state hospitals are eligible to receive the additional reimbursement. Critical Access Hospitals (CAHs) and most out-of-state hospitals are not eligible for this additional payment. Eligible devices are those assigned to EAPGs 0490 or 1001 - 1020 and billed with Revenue Codes 0274 - 0276 or 0278. Eligible drugs are those assigned to EAPGs 0430 - 0441, 0443, 0444, 0460 - 0465, 0495, 0496, or 1090 and billed with a covered revenue code.

The cost outlier add-on payment is calculated by first establishing the threshold and the true costs for the claim line as follows:

\[
\text{Threshold} = \text{Fixed Loss Amount ($1,000)} + \text{Line Payment before Smart Act Adjustment}
\]

\[
\text{True Costs} = (\text{Operating RCC} + \text{Capital RCC}) \times \text{Line Charges}
\]

They are then compared and if the threshold is greater than the true costs, the Add-On Payment = (Threshold – True Costs) \times Marginal Cost Factor (80%)

Total claim line reimbursement = (Line Payment before Smart Act Adjustment + Add-On Payment) \times Smart Act Adjustment

• Legislative Reductions
Per the Save Medicaid Access and Resources Together (SMART) Act, the total payment is reduced for eligible facilities by the legislative reduction factor.

• Mark-Up/Discount Factor
The Illinois Medicaid APG Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

• Total Reimbursement
The total reimbursement is calculated as the sum of all line-level reimbursement amounts.
Massachusetts Medicaid APG (effective December 30, 2016)

B.5.3.6 Massachusetts Medicaid APG Episodes Versus Visits
The Massachusetts Medicaid APG Payment System supports claims with more than one date of service; treating them as separate visits as long as the dates of service are not designated as a range of dates. However, if a claim is billed with any Revenue Code shown below in Table B-40 on any paid line, the claim will be handled as a single episode and the multiple dates of service will no longer be taken into account.

Table B-40: Massachusetts Medicaid Episode Revenue Codes

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0450</td>
<td>Emergency Room General Classification</td>
</tr>
<tr>
<td>0451</td>
<td>Emergency Room EMTALA Emergency Medical Screening Services</td>
</tr>
<tr>
<td>0452</td>
<td>Emergency Room ER Beyond EMTALA Screening</td>
</tr>
<tr>
<td>0456</td>
<td>Emergency Room Urgent Care</td>
</tr>
<tr>
<td>0459</td>
<td>Emergency Room Other</td>
</tr>
<tr>
<td>0760</td>
<td>Treatment/Observation Room General Classification</td>
</tr>
<tr>
<td>0761</td>
<td>Treatment/Observation Room Treatment Room</td>
</tr>
<tr>
<td>0762</td>
<td>Treatment/Observation Room Observation Room</td>
</tr>
<tr>
<td>0769</td>
<td>Treatment/Observation Room Other</td>
</tr>
</tbody>
</table>

B.5.3.7 APG Payment Calculations
Payment is determined using an APG-based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APG Pro Pricer for Massachusetts Medicaid APG claims with dates of service on or after December 30, 2016.

• APG Base Payment

The APG base payment is calculated using the following formula:

\[
\text{APG Base Payment} = \text{Base Rate} \times \text{APG Weight}
\]

• APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

- Bilateral Procedures Adjustment

This adjustment applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).

\[
\text{Bilateral Procedures Adjustment} = \text{APG Base Payment} \times \text{Bilateral Procedures Discount Factor}
\]
- Terminated Procedures Adjustment
This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

\[ \text{Terminated Discount} = \text{APG Base Payment} \times \text{Terminated Procedures Discount Factor} \]

- Repeat Ancillary Adjustment
This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. In other words, the first instance of the ancillary service is paid at 100% and any subsequent repeated instances are adjusted by 50%. APG definitions determine which ancillaries are subject to discounting.

\[ \text{Repeat Ancillary Discount} = \text{APG Base Payment} \times \text{Repeat Ancillary Discount Factor} \]

- Multiple Significant Procedure Adjustment
When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted by 50%. APG definitions determine which procedures are subject to discounting.

\[ \text{Multiple Significant Procedure Discount} = \text{APG Base Payment} \times \text{Multiple Significant Procedure Discount Factor} \]

- Fee Schedule Payment Calculation
Massachusetts Medicaid has published a list of clinical laboratory services that are not paid under APGs, but are paid based on a fee schedule. If an APG claim contains services that are on this fee schedule, they are not paid based on the formulas above, but instead are paid the fee schedule payment or are paid using the AMCC payment methodology described below. Payment for fee schedule services is capped at line item charges.

\[ \text{Fee Schedule Payment} = \text{Fee Schedule Rate} \times \text{Units} \]

- Automated Multi-Channel Chemistry (AMCC) and Panel Test Payment
The Massachusetts Outpatient Fee Schedule file includes special rates for pricing AMCC and panel tests which are subject to special pricing rules. These rates are pre-fixed with “ATP.” Panel tests are a grouping of AMCC tests that are typically performed automatically on a single piece of testing equipment. Each panel test is made up of multiple AMCC tests. AMCC tests and panel tests that are billed separately on the same date of service must be grouped together and that group must be paid the lesser of the ATP rate or the total of the payments for each individual AMCC test. As such, the following calculations are performed for each date of service if more than one AMCC or panel test is billed on that date.
- The number of AMCC tests that have been billed separately are counted. If a panel test is also billed, the number of AMCC tests contained in that panel is added to the count. AMCC and panel tests are flagged in the AMCC Indicator field in the Fee Schedule Data File.

- The count is then used to lookup the appropriate ATP rate in the Fee Schedule Data File. For example, if the count is two, the rate for ATP02 is used.

- The individual payments for each AMCC and panel test are then summed together.

- If this sum is greater than the ATP rate, then the payment for all AMCC and panel tests is limited to the ATP rate. The ATP rate is assigned as the payment for the first AMCC or panel test billed on that date of service. All other AMCC and panel tests are bundled into that line and are assigned line-level Pricer Return Code 38 (Payment Bundled with Other AMCC Test).

- If this sum is not greater than the ATP rate, payment for the AMCC and panel tests is not adjusted.

For further information on AMCC and panel test pricing please refer to the Appendix E: Additional Medicare Physician Pricing Rules of this guide.

• Claim-Level Cost Outlier Payment

The cost outlier add-on is determined by comparing the total cost of all items on the claim that are paid under APG to the cost outlier threshold, calculated as the sum of a threshold, and the total EAPG base payment. If the total cost exceeds the cost outlier threshold, the add-on is calculated by subtracting the cost outlier threshold from the total cost, and multiplying the difference by the marginal cost factor. Each episode on a claim is evaluated individually for outlier payments and a separate outlier payment will be made for each episode, if applicable. If an outlier payment is made, it will be applied to the first APG paid line in the episode that does not have an error.

Total Cost = Total Covered Charges * Hospital-Specific RCC

Cost Outlier Threshold = Total APG Base Payment + Threshold

Cost Outlier Add-On = (Total Cost - Cost Outlier Threshold) * Marginal Cost Factor

• Mark-Up/Discount Factor

The Medicaid APG Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor. The Mark-Up/Discount Factor is applied to the payment at the line level.
• Total Reimbursement
The total reimbursement is calculated as the sum of all line-level payments and any outlier payment amounts.

• Not Currently Supported
The Massachusetts Medicaid APG Payment System currently does not have a rate file.
Massachusetts pays the following outside of the standard EAPG methodology, therefore the following is not supported:
- Psychiatric facilities
- Rehabilitation facilities
- Long Term Care (LTC) facilities
- Graduate Medical Education (GME) adjustments
- Disproportionate Share Hospital (DSH) payments
- Final payments to Critical Access Hospitals (CAHs) (interim payments made via the EAPG payment methodology are supported)

✔ Nebraska Medicaid APG (effective January 01, 2020)
The Medicaid APG Pro Pricer supports the following calculations for outpatient claims from the state of Nebraska.

B.5.3.8 APG Payment Calculations
For outpatient hospitals, payment is determined using an APG-based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APG Pro Pricer for Nebraska Medicaid APG claims with From Dates on or after January 01, 2020.

• APG Base Payment
The APG base payment is calculated using the following formula:

\[ \text{APG Base Payment} = \text{APG Weight} \times \text{Base Rate} \times \text{Policy Adjustor} \]

• APG Policy Adjustors
Nebraska Medicaid utilizes the policy adjustors (outlined below) that may be applied to reimbursement. If a claim line qualifies for multiple policy adjustors all applicable adjustments will be applied.

1. Provider Policy Adjustor
The provider policy adjustment is a provider-specific adjustor for facilities that provide a high volume of service to Medicaid recipients.

2. Physical Therapy & Rehabilitation (APG Type 21) Adjustor
The physical therapy and rehabilitation policy adjustor (APG Type 21) is applied to physical therapy and rehabilitation services.

OR

3. Mental Health & Counseling (APG Type 22) Adjustor
The mental health counseling policy adjustor (APG Type 22) is applied to mental health and counseling services.

**Policy Adjustor = Provider Policy Adjustor * APG Type Policy Adjustor**

- APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

- **Bilateral Procedures Adjustment**

  This adjustment applies when a bilateral procedure is billed with Modifier 50 (Bilateral Procedure).

  **Bilateral Procedures Adjustment = APG Base Payment * Bilateral Procedures Adjustment Factor**

- **Terminated Procedures Adjustment**

  This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

  **Terminated Procedures Adjustment = APG Base Payment * Terminated Procedures Discount Factor**

- **Repeat Ancillary Adjustment**

  This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. The first instance of the ancillary service is paid at 100% and any subsequent repeated instances are adjusted by 50%. APG definitions determine which ancillaries are subject to discounting.

  **Repeat Ancillary Adjustment = APG Base Payment * Repeat Ancillary Discount Factor**

- **Multiple Significant Procedure Adjustment**

  When more than one significant procedure is coded for the same service date, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted by 50%. APG definitions determine which procedures are subject to this discounting.

  **Multiple Significant Procedure Adjustment = APG Base Payment * Multiple Significant Procedure Discount Factor**

  - **Add-On Payment for Mental Health and Substance Abuse Services**

    Nebraska Medicaid implemented a 1.0200 line-level policy adjustor for mental health and substance abuse services when billed by specific...
hospitals. Eligible lines are identified by APG Category 16 (Behavioral Health Illness and Substance Abuse Therapies). This policy adjustor does not apply to claim lines reimbursed at $0.00 and applies prior to the charge cap. The add-on payment is calculated as follows:

\[ \text{Add-On Payment} = \text{APG Base Payment} \times \text{Add-On Payment Percentage} \]

- Fee Schedule Payment

Nebraska Medicaid has identified a list of services that are not paid under APGs, but are paid based on the fee schedule. If an APG claim contains services that are on the fee schedule, they are not paid based on the formulas above, but instead are paid based on the fee schedule. Payment for fee schedule services are capped at the claim-level (if applicable) and line-level.

\[ \text{Fee Schedule Payment} = \text{Fee Schedule Rate} \times \text{Units} \]

- Mark-Up/Discount Factor

The Medicaid APG Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- Charge Cap Adjustment

The line-level payment is capped at charges. This adjustment applies when the total of all line payments exceeds the total charges. This adjustment is determined by taking the total charges divided by the Total Line Payment. The payment for each line is then determined by multiplying its payment by this adjustment to cap the payment for the entire claim at total charges.

\[ \text{Total Line Payment} = \text{Total of All Line Payments} \]
\[ \text{Charge Cap Adjustment} = \frac{\text{Total Covered Charges}}{\text{Total Line Payment}} \]
\[ \text{Final Line Payment} = \text{Line Payment} \times \text{Charge Cap} \]

- Not Currently Supported

The Nebraska Medicaid APG Payment System does not support reimbursement for Critical Access Hospitals (CAHs) and payment adjustments for non-emergency Emergency Room (ER) services.

- Ohio Medicaid APG (effective July 01, 2017)

**B.5.3.9 APG Payment Calculations**

Payment is determined using an APG-based payment methodology. The following calculations are used to determine reimbursement in the Medicaid APG Pro Pricer for Ohio Medicaid APG claims with dates of service on or after July 01, 2017.

- APG Base Payment

The APG base payment is calculated using the following formula:

\[ \text{APG Base Payment} = \text{Base Rate} \times \text{APG Weight} \]
• APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

  - Bilateral Procedures Adjustment

This adjustment applies when a procedure eligible for a bilateral pricing adjustment is submitted with Modifier 50 (Bilateral Procedure).

\[ \text{Bilateral Procedures Adjustment} = \text{APG Base Payment} \times \text{Bilateral Procedures Discount Factor} \]

  - Terminated Procedures Adjustment

This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

\[ \text{Terminated Discount} = \text{APG Base Payment} \times \text{Terminated Procedures Discount Factor} \]

  - Repeat Ancillary Adjustment

This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. The first instance of the ancillary service is paid at 100% and any subsequent repeated instances are paid at a reduced percentage. APG definitions determine which ancillaries are subject to repeat ancillary discounting.

\[ \text{Repeat Ancillary Discount} = \text{APG Base Payment} \times \text{Repeat Ancillary Discount Factor} \]

  - Multiple Significant Procedure Adjustment

When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are paid at a reduced percentage. APG definitions determine which procedures are subject to discounting.

\[ \text{Multiple Significant Procedure Discount} = \text{APG Base Payment} \times \text{Multiple Significant Procedure Discount Factor} \]

• Fee Schedule Payment

Ohio Medicaid has published a list of services that are not paid under APGs, but are paid based on a fee schedule. These services and their calculations are outlined below. In most cases, payment for fee schedule items is capped at submitted line item charges.

• LARC Add-On Payment

The state of Ohio has two different billing scenarios for LARC payments.

  - The first scenario is for LARC services rendered in an outpatient setting and billed on an outpatient claim. This scenario follows Ohio’s regular APG reimbursement rules for pharmaceuticals.
- The second scenario is for LARC services rendered in an **inpatient** setting and billed on an outpatient claim. In 2017, the Ohio legislature determined that a separate payment could be made for a LARC device when implanted after a delivery during an inpatient hospitalization. In order to accommodate this additional separate payment, guidance was given in **Section 2.16.1 (Inpatient Hospital Setting)** of the **Hospital Billing Guidelines**, and indicates:
  
  - The outpatient claim for the LARC must include one detail line for the LARC device or implant only. No other procedure codes should be listed on the claim.
  
  - The LARC device or implant must be reported using Revenue Code 0278 (Medical/Surgical Supplies Other Implants).

In this scenario, the device will be paid the fee schedule rate, provided it is listed on the Provider-Administered Pharmaceuticals Fee Schedule and is a covered code.

The guidelines outline several requirements that must be met in order for the LARC to be reimbursable. Some of these requirements are not supported in the EASYGroup™ software due to system limitations (i.e., not having access to claims history) and are outlined below:

- A paid inpatient obstetrical delivery claim must exist for the recipient.
- The paid inpatient claim must include a secondary ICD-10-CM diagnosis code from the Z37 (Outcome of Delivery) range of codes.
- The date of service on the outpatient claim for the LARC device or implant must fall within the date span on the corresponding paid inpatient claim for the obstetrical delivery excluding the date of discharge.

LARC services rendered in an inpatient setting and billed on an outpatient claim are calculated as follows:

**LARC Add-On Payment = Fee Schedule Rate**

- **Vaccines for Children (VFC) Payment**

Vaccines received through the VFC program administered to patients younger than 19 years of age are paid using the following methodology:

**Fee Schedule Payment = Fee Schedule Rate**

- **Durable Medical Equipment (DME) Payment**

The payment for covered DME services is the lesser of charges or the fee schedule rate multiplied by units and any applicable discounts or adjustments.

**Fee Schedule Payment = Lesser of Charges or (Fee Schedule Rate * Units * Discounts)**

- **Pharmaceutical Payment**

Covered pharmacy drugs reported as procedure codes beginning with J or Q, and billed with Revenue Code 025X (Pharmacy General Classification) or
0636 (Pharmacy Drugs Requiring Detailed Coding), are paid lesser charges or the fee schedule rate multiplied by units and any applicable discounts or adjustments.

If no fee schedule rate is available, all valid J-codes and all covered Q-codes will be paid a percentage (currently 60%) of charges multiplied by the hospital RCC, as outlined below.

Fee Schedule Rate is Available:

\[
\text{Fee Schedule Payment} = \text{Lesser of Charges or } (\text{Fee Schedule Rate} \times \text{Units} \times \text{Discounts})
\]

No Fee Schedule Rate is Available:

\[
\text{Fee Schedule Payment} = \text{Factor} \times \text{Charges} \times \text{RCC}
\]

- Independently Billed High Cost Drugs or Medical Supplies and Devices Payment

Ohio Medicaid supports independently billed high-cost drugs, medical supplies, and devices. For these claims, Modifier UB (Medicaid Level of Care 11, as Defined by Each State) is required to be billed with the primary surgical service. Payment for drugs, supplies, and devices will be applied as described below in Table B-41. All other services that have the same service date as the procedure reported with Modifier UB and are not outlined in Table B-41 are not eligible for payment.

Table B-41: Independently Billed Services

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Procedure Code Billed?</th>
<th>Rate on Provider-Administered Fee Schedule?</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>025X0636</td>
<td>Yes, Valid J-Code</td>
<td>Yes</td>
<td>Lesser of Charges or (Fee Schedule Rate * Units)</td>
</tr>
<tr>
<td>025X0636</td>
<td>Yes, Covered Q-Code</td>
<td>Yes</td>
<td>Lesser of Charges or (Fee Schedule Rate * Units)</td>
</tr>
<tr>
<td>025X0636</td>
<td>Yes, Valid J-Code</td>
<td>No*</td>
<td>Charges * RCC * Factor</td>
</tr>
<tr>
<td>025X027X</td>
<td>No</td>
<td>No*</td>
<td>Charges * RCC * Factor</td>
</tr>
<tr>
<td>027X</td>
<td>Yes</td>
<td>No*</td>
<td>Charges * RCC * Factor</td>
</tr>
</tbody>
</table>

*Includes procedure codes that are listed on the Provider-Administered Fee Schedule with a Fee Schedule Rate of “by report.”

- Dental Payment

Covered dental services are paid based on a flat rate. There is one flat rate for Ambulatory Surgical Centers (ASCs), one flat rate for children’s hospitals, and a different flat rate for all other hospitals. The payment for significant dental procedures that group to APGs 350 (Level I Adjunctive General Dental
Services) - 372 (Level II Adjunctive General Dental Services) is determined by multiplying the Dental Payment Rate by any applicable discounts or adjustments. Units are not considered.

\[ \text{Dental Payment} = \text{Dental Payment Rate} \times \text{Discounts} \]

• Observation Services Payment

Covered observation services are paid based on a flat rate. The payment for observation services (identified with procedure code G0378, *Hospital observation service, per hour*) is determined by multiplying the Observation Payment Rate by any applicable discounts or adjustments. Payment is limited to one flat rate payment per day, up to a maximum of two days (even when billed over a 3 day period). Units are not considered for payment, but are subject to a cap per day and per claim.

\[ \text{Observation Payment} = \text{Observation Payment Rate} \times \text{Discounts} \]

• Laboratory and Radiology Services Payment

Laboratory and radiology services are paid based on the EAPG methodology, but are subject to a charge cap. Payment is the lesser of the billed charges or the base rate multiplied by the APG weight and any applicable discounts or adjustments.

\[ \text{Laboratory and Radiology Payment} = \text{Lesser of Charges or } (\text{Base Rate} \times \text{APG Weight} \times \text{Discounts}) \]

• Mark-Up/Discount Factor

The Medicaid APG Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor. The Mark-Up/Discount Factor is applied to the final payment at the line level.

• Total Reimbursement

The total reimbursement is calculated as the sum of all line-level payments.

✔ Virginia Medicaid APG (effective October 01, 2017)

B.5.3.10 APG Payment Calculations

The outpatient claim payments for acute care facilities are determined using an APG based payment methodology and include all APG and non-APG fee schedule pricing (including all discounting, packaging and consolidating rules used by Virginia Medicaid). The following calculations are used to determine reimbursement in the Medicaid APG Pro Pricer for Virginia APG claims with dates of services on or after October 01, 2017.

• APG Base Payment

For each claim line, the APG base payment is calculated using the following formula:

\[ \text{APG Base Payment} = \text{Hospital Base Rate} \times \text{APG Weight} \]
Virginia Medicaid implemented a reimbursement policy that reduces payments for preventable ER visits, effective July 01, 2020. The last digit of the applicable procedure codes represent the intensity level of the ER visit with 1 being the least resource intensive and 5 being the most resource intensive. Under this policy, if procedure codes 99282 - 99284 are billed with a principal diagnosis code that is on Virginia Medicaid’s Preventable Emergency Room List, then reimbursement for the ER procedure code will be based on an all-inclusive APG weight of 0.3850. All other claim lines will be packaged. There will be no change to reimbursement when a claim contains procedure code 99285.

\[
\text{APG Base Payment} = \text{Hospital Base Rate} \times \text{All-Inclusive APG Weight}
\]

- APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

- **Bilateral Procedure Adjustment**

This adjustment applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).

\[
\text{Bilateral Procedure Discount} = \text{APG Base Payment} \times \text{Bilateral Procedure Discount Factor}
\]

- **Terminated Procedure Adjustment**

This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

\[
\text{Terminated Procedure Discount} = \text{APG Base Payment} \times \text{Terminated Procedure Discount Factor}
\]

- **Repeat Ancillary Adjustment**

This adjustment applies when certain ancillary services are provided more than once during the same visit. All other ancillary procedures are adjusted with the applicable discount factor. APG definitions determine which ancillaries are subject to this discounting.

\[
\text{Repeat Ancillary Discount} = \text{APG Base Payment} \times \text{Repeat Ancillary Discount Factor}
\]

- **Multiple Significant Procedure Adjustment**

When more than one significant procedure is coded for the same service date, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted with the applicable discount factor. APG definitions determine which procedures are subject to this discounting.

\[
\text{Multiple Significant Procedure Discount} = \text{APG Base Payment} \times \text{Multiple Significant Procedure Discount Factor}
\]
Note
For some services, bilateral or terminated discounting may be applied along with multiple procedure or repeat ancillary discounting.

- 340B Program Adjustment
This adjustment applies when a drug is eligible for the 340B Program. Modifier UD (340B Drug) must be billed with the applicable drug code in order for the claim line to receive this adjustment.

\[
\text{340B Drug Program Adjustment} = \text{APG Base Payment} \times \text{Policy Adjustor 1}
\]

- Packaged Service Adjustment
The APG methodology involves paying for the principal services on each claim, and packaging other services. Payment for these packaged services is included in the payment for the principal service, so no additional payment is made for services identified as packaged by the APG Grouper.

- Consolidated Service Adjustment
The APG methodology involves consolidating payment for related services. The first service is paid, and then other related services are consolidated. Payment for these consolidated services is included in the payment for the principal service, so no additional payment is made for services identified as consolidated by the APG Grouper.

- Fee Schedule Payment Calculation
This calculation includes only the Vaccine for Children (VFC) vaccine codes which are payable via fee schedule for patients younger than 19 years. All others are paid via APG.

If an APG claim contains services that are on the fee schedule, they are not paid based on the calculations above, but instead are paid as described below. Payment for fee schedule services is capped at line item charges.

\[
\text{Fee Schedule Payment} = \text{Fee Schedule Rate} \times \text{Units}
\]

Note
Any claim line paid via fee schedule will not be subject to packaging.

- LARC Payment
The state of Virginia has two different billing scenarios for LARC payments.

- The first scenario is for LARC devices rendered in an outpatient setting and billed on an outpatient claim. This scenario follows Virginia's regular APG reimbursement rules.

- The second scenario is for LARC devices rendered in an inpatient setting and billed on an outpatient claim. These devices receive separate payment when the following criteria is met:
- The outpatient claim for the LARC must include one detail line for the LARC device. No other procedure codes should be listed on the claim.
- The single line item must contain an applicable LARC procedure code.

In this scenario, the LARC device is paid via fee schedule rate instead of via APG. LARC devices rendered in an inpatient setting and billed on an outpatient claim are calculated as described below. Payment for fee schedule services is capped at line item charges.

\[
\text{LARC Payment} = \text{Fee Schedule Rate} \times \text{Units}
\]

**Note**

Revenue code, diagnosis code, and National Drug Code (NDC) requirements also apply to LARC claims. These requirements are not supported in the EASYGroup™ software due to system limitations.

- **Mark-Up/Discount Factor**

The Virginia Medicaid APG Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- **Total Reimbursement**

The total reimbursement is calculated as the sum of all line-level reimbursement amounts.

✔ **Virginia Medicaid ASC (effective January 01, 2018)**

**B.5.3.11 APG Payment Calculations**

The outpatient claim payments for ASC facilities are determined using an APG-based payment methodology and include all APG and non-APG fee schedule pricing (including all discounting, packaging, and consolidating rules used by Virginia Medicaid). The following calculations are used to determine reimbursement in the Medicaid APG Pro Pricer for Virginia Medicaid ASC claims with dates of service on or after January 01, 2018.

- **APG Base Payment**

For each claim line, the APG base payment is calculated using the following formula:

\[
\text{APG Base Payment} = \text{Base Rate} \times \text{APG Weight}
\]

- **APG Base Payment With Adjustments**

Each APG base payment may receive an adjustment for the following reasons:

- Bilateral Procedures Adjustment

This adjustment applies when a procedure eligible for a bilateral pricing adjustment is submitted with Modifier 50 (Bilateral Procedure).
Bilateral Procedures Adjustment = APG Base Payment * Bilateral Procedures Discount Factor

- Terminated Procedures Adjustment

This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

Terminated Procedure Adjustment = APG Base Payment * Terminated Procedures Discount Factor

- Repeat Ancillary Adjustment

This adjustment applies when certain ancillary services are provided more than once during the same visit. All other ancillary procedures are adjusted with the applicable discount factor. APG definitions determine which ancillaries are subject to this discounting.

Repeat Ancillary Adjustment = APG Base Payment * Repeat Ancillary Discount Factor

- Multiple Significant Procedure Adjustment

When more than one significant procedure is coded for the same service date, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted with the applicable discount factor. APG definitions determine which procedures are subject to discounting.

Multiple Significant Procedure Adjustment = APG Base Payment * Multiple Significant Procedure Discount Factor

Note

For some services, bilateral or terminated discounting may be applied along with multiple procedure or repeat ancillary discounting.

- 340B Program Adjustment

This adjustment applies when a drug is eligible for the 340B Program. Modifier UD (340B Drug) must be billed with the applicable drug code in order for the claim line to receive this adjustment.

340B Drug Program Adjustment = APG Base Payment * Policy Adjustor 1

- Packaged Service Adjustment

The APG methodology involves paying for the principal services on each claim, and packaging other services. Payment for these packaged services is included in the payment for the principal service, so no additional payment is made for services identified as packaged by the APG Grouper.

- Consolidated Service Adjustment

The APG methodology involves consolidating payment for related services. The first service is paid, and then other related services are consolidated. Payment for these consolidated services is included in the payment for the
principal service, so no additional payment is made for services identified as consolidated by the APG Grouper.

- Fee Schedule Payment

This calculation includes only the Vaccine for Children (VFC) vaccine codes which are payable via fee schedule for patients younger than 19 years. All others are paid via APG.

If an APG claim contains services that are on the fee schedule, they are not paid based on the calculations above, but instead are paid as described below. Payment for fee schedule services is capped at line item charges.

\[ \text{Fee Schedule Payment} = \text{Fee Schedule Rate} \times \text{Units} \]

**Note**

Any claim-line paid via the fee schedule will not be subject to packaging.

- Mark-Up/Discount Factor

The Medicaid APG Pro Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- Total Reimbursement

The total reimbursement is calculated as the sum of all line-level reimbursement amounts.

**B.5.4 Virginia Medicaid APG Pricer (C Only) (prior to October 01, 2017)**

**B.5.4.1 APG Payment Calculations**

The outpatient claim payments for acute care facilities are determined using an APG based payment methodology and include all APG and non-APG fee schedule pricing (including all discounting, packaging and consolidating rules used by Virginia Medicaid). The following calculations are used to determine reimbursement in the Virginia Medicaid APG Pricer effective for services on or after January 01, 2014 through September 30, 2017.

- APG Base Payment

For each claim line, the APG base payment is calculated using the following formula:

\[ \text{APG Base Payment} = \text{Hospital Base Rate} \times \text{APG Weight} \]

- APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

- Bilateral Procedure Adjustment
This adjustment applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).

Bilateral Procedure Discount = APG Base Payment * Bilateral Procedure Discount Factor

- Terminated Procedure Adjustment
This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

Terminated Procedure Discount = APG Base Payment * Terminated Procedure Discount Factor

- Repeat Ancillary Adjustment
This adjustment applies when certain ancillary services are provided more than once during the same visit. All other ancillary procedures are adjusted with the applicable discount factor. APG definitions determine which ancillaries are subject to this discounting.

Repeat Ancillary Discount = APG Base Payment * Repeat Ancillary Discount Factor

- Multiple Significant Procedure Adjustment
When more than one significant procedure is coded for the same service date, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted with the applicable discount factor. APG definitions determine which procedures are subject to this discounting.

Multiple Significant Procedure Discount = APG Base Payment * Multiple Significant Procedure Discount Factor

**Note**
For some services, bilateral or terminated discounting may be applied along with multiple procedure or repeat ancillary discounting.

- Packaged Service Adjustment
The APG methodology involves paying for the principal services on each claim, and packaging other services. Payment for these packaged services is included in the payment for the principal service, so no additional payment is made for services identified as packaged by the APG Grouper.

- Consolidated Service Adjustment
The APG methodology involves consolidating payment for related services. The first service is paid, and then other related services are consolidated. Payment for these consolidated services is included in the payment for the principal service, so no additional payment is made for services identified as consolidated by the APG Grouper.
• Fee Schedule Payment
This calculation includes only the Vaccine for Children (VFC) vaccine codes which are payable via fee schedule for patients younger than 19 years. All others are paid via APG.

If an APG claim contains services that are on the fee schedule, they are not paid based on the calculations above, but instead are paid as described below. Payment for fee schedule services is capped at line item charges.

\[
\text{Fee Schedule Payment} = \text{Fee Schedule Rate} \times \text{Units}
\]

Note
Any claim line paid via fee schedule will not be subject to packaging.

• Mark-Up/Discount Factor
The Virginia Medicaid APG Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

• Total Reimbursement
The total reimbursement is calculated as the sum of all line-level reimbursement amounts.

B.5.5 Washington Medicaid APG Pricer (C Only) (effective July 01, 2014)

B.5.5.1 APG Payment Calculations
For outpatient claims from acute care facilities, payment is determined using an APG based payment methodology. The following calculations are used to determine reimbursement in the Washington Medicaid APG Pricer for claims with admission dates on or after July 01, 2014.

• APG Base Payment
For each claim line, the APG base payment is calculated using the following formula. In this formula, the hospital-specific payment rate is the wage-adjusted base rate, and includes Graduate Medical Education (GME) add-on payments where applicable.

\[
\text{APG Base Payment} = \text{Hospital-Specific Payment Rate} \times \text{APG Weight}
\]

• APG Base Payment With Adjustments
Each APG base payment may receive an adjustment for the following reasons:
- Bilateral Procedures Adjustment

This adjustment applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).
**Bilateral Procedures Discount** = APG Base Payment * Bilateral Procedures Discount Factor

- Terminated Procedures Adjustment

This adjustment applies when a procedure is terminated prior to completion, and is submitted with Modifier 73 (Discontinued Out-Patient) or 52 (Reduced Services).

**Terminated Discount** = APG Base Payment * Terminated Procedures Discount Factor

- Repeat Ancillary Adjustment

This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. APG definitions determine which ancillaries are subject to this discounting.

**Repeat Ancillary Discount** = APG Base Payment * Repeat Ancillary Discount Factor

- Multiple Significant Procedure Adjustment

When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted as follows. APG definitions determine which procedures are subject to this discounting.

**Multiple Significant Procedure Discount** = APG Base Payment * Multiple Significant Procedure Discount Factor

**Note**

For some services, bilateral or terminated discounting may be applied along with multiple procedure or repeat ancillary discounting.

- Packaged Services Adjustment

The APG methodology involves paying for the principal services on each claim, and packaging other services. Payment for these packaged services is included in the payment for the principal service, so no additional payment is made for services identified as packaged by the APG Grouper.

- Consolidated Services Adjustment

The APG methodology involves consolidating payment for related services. The first service is paid, and then other related services are consolidated. Payment for these consolidated services is included in the payment for the principal service, so no additional payment is made for services identified as consolidated by the APG Grouper.

- Pediatric Adjustment

The Pediatric Adjustment Factor is applied when the patient is under the age of 18. Critical Access Hospitals (CAHs) and fee schedule payments will not receive the Pediatric Adjustment Factor. The calculation is as follows:
**Pediatric Adjustment** = APG Base Payment * Pediatric Adjustment Factor

- Sole Community Hospital (SCH) Adjustment

The SCH Adjustment Factor may be applied to claim lines originating from a SCH, as follows:

**SCH Adjustment** = APG Base Payment * SCH Adjustment Factor

**Note**

The Washington HCA has not published a list of SCHs. The SCH Adjustment Factor will be in effect on January 01, 2015, and these facilities will be identified in a future release.

• Fee Schedule Payment

Washington Medicaid has published a list of services that are not paid under APGs, but are paid instead based on a fee schedule. If an APG claim contains services that are on this fee schedule, they are not paid based on the formulas above, but instead are paid as described below.

**Note**

There are maximum billable units defined for certain fee schedule services.

**Fee Schedule Payment** = Fee Schedule Rate * Units

• CAH Payment

CAHs are not paid under the APG methodology. Instead, payment for each service is calculated by multiplying the line-level charges by the CAH Outpatient Payment Factor.

**CAH Payment Rate** = Line-Level Charges * CAH Outpatient Payment Factor

• Percent of Charge Payment

Washington Medicaid has published a list of covered services that group to APG 993 that are not paid under APGs, but are paid on a percent of charge basis. If an APG claim contains any of these services, they are paid as described below:

**Percent of Charge Payment** = Line Charges * RCC

**Note**

Any claim line paid via fee schedule or percent of charges will not be subject to consolidation.

• Mark-Up/Discount Factor

The Washington Medicaid APG Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.
• Total Reimbursement

The total reimbursement is calculated as the sum of all line-level reimbursement amounts.

B.5.6 Wisconsin Medicaid APG Pricer (C Only) (effective January 01, 2015)

B.5.6.1 Wisconsin Medicaid APG Episodes Verses Visits

The Wisconsin Medicaid APG Payment System supports claims with more than one date of service; treating them as separate visits as long as the dates of service are not designated as a range of dates. However, if a claim is billed with any Revenue Code shown below in Table B-42 on any paid line, the claim will be handled as a single episode and the multiple dates of service will no longer be taken into account.

Table B-42: Wisconsin Medicaid Episode Revenue Codes

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0450</td>
<td>Emergency Room General Classification</td>
</tr>
<tr>
<td>0451</td>
<td>Emergency Room Emtala Emergency Medical Screening Services</td>
</tr>
<tr>
<td>0452</td>
<td>Emergency Room ER Beyond Emtala Screening</td>
</tr>
<tr>
<td>0456</td>
<td>Emergency Room Urgent Care</td>
</tr>
<tr>
<td>0459</td>
<td>Emergency Room Other</td>
</tr>
<tr>
<td>0762</td>
<td>Treatment/Observation Room Observation Room</td>
</tr>
</tbody>
</table>

B.5.6.2 APG Payment Calculations

For outpatient hospital claims, payment is determined using an APG based payment methodology. The following calculations are used to determine reimbursement in the Wisconsin Medicaid APG Pricer effective for services on or after January 01, 2015:

• APG Base Payment

For each claim line, the APG base payment is calculated using the following formula.

\[
APG \text{ Base Payment} = \text{Hospital-Specific Payment Rate} \times \text{APG Weight}
\]

• APG Base Payment With Adjustments

Each APG base payment may receive an adjustment for the following reasons:

- Bilateral Procedure Discount

This discount applies when a procedure eligible for a bilateral pricing discount is submitted with Modifier 50 (Bilateral Procedure).

\[
\text{Bilateral Procedures Discount} = \text{APG Base Payment} \times \text{Bilateral Procedures Discount Factor}
\]
- Repeat Ancillary Adjustment
This adjustment applies when certain ancillary services are provided more than once during the same visit or episode. All other ancillary procedures are adjusted with the applicable discount factor. APG definitions determine which ancillaries are subject to this discounting.

\[
Repeat\ Ancillary\ Discount = APG\ Base\ Payment \times Repeat\ Ancillary\ Discount\ Factor
\]

- Multiple Significant Procedure Adjustment
When more than one significant procedure is coded for the same service date or same episode, the highest-weighted of these is paid at 100%. All other significant procedures are adjusted with the applicable discount factor. APG definitions determine which procedures are subject to this discounting.

\[
Multiple\ Significant\ Procedure\ Discount = APG\ Base\ Payment \times Multiple\ Significant\ Procedure\ Discount\ Factor
\]

**Note**
For some services, bilateral discounting may be applied along with multiple procedure or repeat ancillary discounting.

- Packaged Services Adjustment
The APG methodology involves paying for the principal services on each claim, and packaging other services. Payment for these packaged services is included in the payment for the principal service, so no additional payment is made for services identified as packaged by the APG Grouper.

  • Fee Schedule Payment
Wisconsin Medicaid has published a list of services that are not paid under APGs, but are paid based on a fee schedule. If an APG claim contains services that are on this fee schedule, they are not paid based on the formulas above, but instead are paid as described below. Payment for fee schedule services is capped at line item charges.

\[
Fee\ Schedule\ Payment = Fee\ Schedule\ Rate \times Units
\]

**Note**
Any claim line paid via fee schedule or percent of charges will not be subject to consolidation.

  • Percent of Charge Payment
Wisconsin Medicaid has published a list of services that are not paid under APGs, but are paid on a percent of charge basis. If an APG claim contains any of these services, they are paid as described below:

\[
Percent\ of\ Charge\ Payment = Charge \times Percent\ of\ Charge\ Factor
\]
• **Mark-Up/Discount Factor**

The Wisconsin Medicaid APG Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

• **Cutback Percentage**

If the total charges billed on a claim are less than the total payments allowed, then claim lines paid via APG will be subject to a cutback percentage. This cutback percentage is calculated as follows:

\[
\text{Cutback Percentage} = \frac{(\text{Total Payment} - \text{Total Charges})}{\text{Sum of Payment for APG Lines}}
\]

\[
\text{APG Reduced Payment} = \text{Cutback Percentage} \times \text{APG Line Payment}
\]

• **Total Reimbursement**

The total reimbursement is calculated as the sum of all line-level reimbursement amounts. APG lines are capped at line-level submitted charges.

**B.6 How to Determine Which APC Pricer to Utilize**

Prior to pricing a record, you must determine which APC Pricer is appropriate to invoke. In addition, the reimbursement rate variables in effect at the time of the patient’s procedure or service, and APC-specific weights, means, and trims, must be available. The Test Driver (available for the C Platform only) shows how information appropriate to a particular patient’s procedure or service can be retrieved from external files and reformatted for use by the APC Pricer. Refer to the EASYGroup™ Installation Guide for further information on the Test Driver.

The Test Driver program included with your distribution assumes that all data needed to drive patient-specific pricing is stored in the files described below. These files contain the data needed to set-up the Hospital Rate Calculator File, APC Rate File, and Configuration File, as required by the APC Pricer. Please refer to the EASYGroup™ Technical Reference Guide for details on the layouts on these files.

• **Hospital Rate Calculator File**: File with hospital-specific payment information (e.g., base rates, conversion factors, RCCs, etc.). The information in this file will be used to set up the Hospital Rate Calculator File.
- **APC Rate File**: File with APC-specific payment information (e.g., weights, means, and trims). The information in this file is used to set up the APC rate record.

- **Payers File**: File with payer-specific information.

- **Configuration File**: File that contains hospital-specific processing requirements.

The Test Driver uses the Payers File to determine whether pricing and retrieval of the Hospital Rate Calculator File, APC Rate File, and Configuration File records should be based on either admission date or discharge date. Test routines for retrieving information from these files can be found in the Test Driver program. The Test Driver program, `optest.c` (CSource) has been provided, so that it can be modified for your environment.

When pricing a patient record, the APC Pricer must access and retrieve the pricing information in effect at the time of the patient’s procedure or service. This includes an indication of the pricing rules or APC Pricer program to be applied, as well as the hospital and payer-specific reimbursement rate variables to be used with the selected APC Pricer. The Test Driver program contains a routine for determining which pricing information to retrieve.

The Test Driver program is passed the following key information for the test database: hospital number, paysource code, and a reimbursement date. Reimbursement date is set equal to the admission/discharge date. For purposes of the Test Driver, the decision to use the admission/discharge date is based on a flag stored on the Payers File. The Test Driver then uses hospital number, paysource code, and reimbursement date to query the Hospital Rate Calculator File for a record with the same hospital number and paysource code with the closest effective date, which is less than or equal to the reimbursement date. When the appropriate Hospital Rate Calculator record is found, the information retrieved is transferred to the Hospital Rate Calculator File.

One of the variables transferred to the Hospital Rate Calculator File in the previous step is an indication of the pricing rules or APC Pricer program to be applied to the patient record being processed. The Pricer type transferred to the Hospital Rate Calculator File must be one of the types listed in the column labeled, Pricer/Payer Type.

Some programs or payers reimburse for hospital services by marking up or discounting the amount that Medicare/Medicaid would have paid for the same services. This pricing scenario can be accommodated by setting the Markup/Discount Factor field, as appropriate. This Markup/Discount Factor is applied to all final payment fields: the applicable base rate, the applicable add-on payment(s), and the total reimbursement.

When implemented, this field defaults to a value of 1.00 if no value (i.e., a value of zeros) has been entered into this field. Thus, not setting the Markup/Discount Factor for payers will not negatively impact reimbursement.
calculations. Payers will continue to price in the usual manner without setting the Markup/Discount Factor.

**B.7 APC Pricer Functionality**

**B.7.1 Contract APC Pricer**

- Iowa Medicaid APC (C Only) (effective January 01, 2016)

**B.7.1.1 Iowa-Specific Payment Rules**

The Iowa Medicaid APC Payment System utilizes Medicare APC pricing rules, which are used by the Contract APC Pricer, along with the additional Iowa-specific pricing methodologies outlined below.

- Anesthesia Payment

The anesthesia payment applies to claims that contain anesthesia procedure codes. These codes are indicated with a Gap Fill Indicator (`gapfill`) of A (Anesthesia) in the Fee Schedule Data File (`feeiayy.dat`). The anesthesia payment is calculated using the following formula:

\[
\text{Anesthesia Payment} = (\text{Anesthesia Base Units} + \text{Billed Units}) \times \text{Anesthesia Conversion Factor}
\]

- Maximum Fee Payment

When a procedure code has a corresponding Payment Type of MF (Maximum Fee) in the Medicaid Addendum B (which is posted to the Iowa Department of Human Services web site), the Alternate Pricing Flag (`alt_flag`) will be set to 2 (Maximum Fee) in the Fee Schedule Data File (`feeiayy.dat`). The reimbursement for the procedure code will equal the lesser of the billed charges or the fee schedule rate.

The Payment Types from Addendum B (shown below in Table B-43) explain how corresponding procedure codes will be paid. ACE analyzes those Payment Types and determines what Payment Status Indicator to assign to the procedure code by utilizing the APC Rule File (`apcrule.dat`) which is included in the IAOSRF distribution.

**Table B-43: Addendum B Payment Types and Corresponding Payment Status Indicators**

<table>
<thead>
<tr>
<th>Payment Type From Addendum B</th>
<th>Description</th>
<th>Assigned Payment Status Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>APC</td>
<td>Reimbursed Using the APC Methodology</td>
<td>Various</td>
<td>Various</td>
</tr>
<tr>
<td>FS</td>
<td>Fee Schedule</td>
<td>A</td>
<td>Services Paid Under Fee Schedule or Other Prospectively Determined Rate</td>
</tr>
<tr>
<td>BC</td>
<td>Billed Charges</td>
<td>A</td>
<td>Same as above</td>
</tr>
</tbody>
</table>
• Billed Charges Payment
When a procedure code has a corresponding Payment Type of BC (Billed Charges) in the Medicaid Addendum B, the Alternate Pricing Flag (alt_flag) will be set to 3 (Billed Charges) in the Fee Schedule Data File (fesiayy.dat). The reimbursement for the procedure code will equal the billed charges.

• Manually Priced/Paid by Report Payment
When a procedure code has a corresponding Payment Type of MP (Manually Priced) or a procedure code is listed as “Paid by Report” in the Medicaid Addendum B, the Alternate Pricing Flag (alt_flag) will be set to 1 (Manually Priced) in the Fee Schedule Data File (fesiayy.dat) and line-level Pricer Return Code 29 (Paid by Report/Manually Priced) will be returned.

• Emergency Services for Non-Participating Providers Payment
Iowa Medicaid requires that emergency services billed by non-participating providers should be paid 100% of the statewide base rate. Previously, all services (emergency and otherwise) that were billed by a non-participating provider were paid at 80% of the statewide base rate. All non-emergency services will continue to be paid at 80% of the statewide base rate. Emergency services are identified with the diagnosis codes listed on the Iowa Department of Human Services web site.
Non-participating providers are flagged with 08 (Non-Participating Hospital) in the Facility Type (fac_type) field located in the Hospital Rate Calculator File (medout.dat).
Furthermore, the Non-Participating Provider Factor (altprov_factor) field located in the Extended Hospital Rate Calculator File (medext.dat) is set to 80% for non-participating providers and set to 100% for all other providers.

<table>
<thead>
<tr>
<th>Payment Type From Addendum B</th>
<th>Description</th>
<th>Assigned Payment Status Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1</td>
<td>Reimbursed Based on the Lab Fee Schedule</td>
<td>A</td>
<td>Same as above</td>
</tr>
<tr>
<td>MF</td>
<td>Max Fee</td>
<td>A</td>
<td>Same as above</td>
</tr>
<tr>
<td>MP</td>
<td>Manually priced</td>
<td>A</td>
<td>Same as above</td>
</tr>
<tr>
<td>NIP</td>
<td>Non-Inpatient Program Service Reimbursed on the IA Fee Schedule</td>
<td>A</td>
<td>Same as above</td>
</tr>
<tr>
<td>NO</td>
<td>Not Covered by IA Medicaid (Payment Denied)</td>
<td>E</td>
<td>Non-Covered Service, Not Paid Under OPPS</td>
</tr>
<tr>
<td>RR</td>
<td>Review Required</td>
<td>E</td>
<td>Same as above</td>
</tr>
</tbody>
</table>
Critical Access Hospital (CAH) Claim Payment

Iowa Medicaid allows submission of claims with a UB-04 Bill Type of 085X (Special Facility, Critical Access). CAHs should be designated with a Facility Type of 05 (OPPS Exempt (CAH)). Payment for each claim line will be based on the line charges multiplied by the Ratio of Costs-to-Charges (RCCs) if no Return Code is issued, as shown below:

\[ \text{CAH Reimbursement} = \text{Line Charges} \times \text{Outpatient Ratio of Costs-to-Charges (RCCs)} \]

Non-Emergent” Emergency Room (ER) Services Payment

Iowa Medicaid supports a policy that reduces payment for non-urgent ER services (i.e., services referred to by the state of Iowa as “non-emergent” ER services) for participating providers. If a patient has been referred to the ER by a qualified medical professional, a payment reduction of 25% will be applied to the “non-emergent” ER service(s). If a patient has not been referred to the ER by a qualified medical professional, a payment reduction of 50% will be applied to the “non-emergent” ER service(s).

These payment reductions are taken off the APC amount for non-CAH claims. For CAH claims, reductions are taken off of the cost. These reductions do not apply to procedure code 99211, Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes. Iowa Medicaid APC claims receive the “non-emergent” ER reduction when one of the ICD-10 diagnosis codes considered “emergent” listed on the Iowa Department of Health web site is not reported as a principal diagnosis code or a secondary diagnosis code and when Revenue Code 045X (Emergency Room) is billed.

Not Currently Supported

The Iowa Medicaid APC Payment System currently does not support the following:

- Partial Hospitalization claims billed with UB-04 Bill Type 013X (Hospital, Outpatient) and Condition Code 41, or with UB-04 Bill Type 076X (Clinic, Community Mental Health) as these are paid outside of the APC methodology
- Out-of-State Hospitals
- State-Specific Correct Coding Initiative (CCIs) Edits
- Patient Coinsurance
- Support for Portions of the 340B Drug Pricing Program:
- For example, vaccines and diabetic supplies billed with Modifier UD (340B Drug)

- Additional Payment for Birth Control
- Medically Unlikely Edits (MUE) for Procedure Code T1013
- Discounting for multiple therapy services

In addition, claim lines with Modifiers GX (Notice of Liability Issued, Voluntary Under Payer Policy) or GZ (Item or Service Expected to be Denied as Not Reasonable and Necessary) will be denied, which is inconsistent with state policy.

B.7.2 New Mexico Medicaid APC Pricer

B.7.2.1 Grouping
The New Mexico Medicaid APC Payment System does not utilize a Grouper and reimbursement is not based on APC assignment. As such, APCs are not assigned. Payment Status Indicators, however, are assigned and reimbursement is, to some extent, based on the assigned Payment Status Indicators. Payment Status Indicators are assigned based off of the New Mexico Medicaid Outpatient Fee Schedule and may vary from the Payment Status Indicators assigned by Medicare. Certain procedure codes are designated on the New Mexico Medicaid Outpatient Fee Schedule without a Payment Status Indicator. For these codes the EASYGroup™ software will utilize the following Payment Status Indicators:

Table B-44: Payment Status Indicators Assigned Based on the New Mexico Medicaid Outpatient Fee Schedule

<table>
<thead>
<tr>
<th>Procedure Code Identifier From the New Mexico Medicaid Outpatient Fee Schedule</th>
<th>Assigned Payment Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPPS NM Medicaid Covered</td>
<td>A (Services Paid Under Fee Schedule or Other Prospectively Determined Rate)</td>
</tr>
<tr>
<td>OPPS NM Medicaid Not Covered</td>
<td>E (Non-Covered Service, Not Paid Under OPPS)</td>
</tr>
<tr>
<td>OPPS NM Medicaid Pay Price Review</td>
<td>A</td>
</tr>
<tr>
<td>OPPS NM Medicaid Price Review</td>
<td>A</td>
</tr>
<tr>
<td>OPPS NM Medicaid Special Review</td>
<td>A</td>
</tr>
</tbody>
</table>

B.7.2.2 Pricing Calculations
The New Mexico Medicaid APC Pricer reimburses outpatient claims primarily using a fee schedule rate. The following calculations are used to determine reimbursement for outpatient claims on or after January 01, 2019.

- Line Payment

Line payment is calculated as the fee schedule rate multiplied by the number of units.
*Line Payment* = *Fee Schedule Rate* * Units

- Line Payment With Adjustments

Each line payment may then be adjusted for one or more of the following reasons:

- Bilateral Procedure Adjustment

This adjustment applies when a bilateral procedure is billed with Modifier 50 (Bilateral Procedure). Conditionally bilateral procedures are paid 150% of the fee schedule rate when billed with Modifier 50. Independently bilateral procedures are paid 200% of the fee schedule rate when billed with Modifier 50.

- Multiple Significant Procedure Discount

Services assigned to Payment Status Indicator T (Procedure or Service, Multiple Reduction Applies) and dental codes (i.e., all covered procedure codes starting with the letter D) may receive a multiple significant procedure adjustment. The procedure with the highest billed charges will be reimbursed at 100% and subsequent procedures on the same date of service will be reimbursed at 50%.

*Adjusted Line Payment* = *Line Payment* * Bilateral Adjustment * Multiple Significant Procedure Discount

- 340B Drug Program Payment

This payment applies when a drug is acquired through the 340B Drug Program. Modifier UD (340B Drug) must be billed with the applicable drug code in order for the claim line to receive this payment. Drugs acquired under the 340B Drug Program are not reimbursed via the fee schedule, instead they are reimbursed at billed charges (which is equivalent to acquisition costs). These drugs are identified by the UB-04 Revenue Codes listed below (in Table B-45).

*Line Payment (for 340B Drug)* = *Line Charges*

---

**Table B-45: 340B Drug Program UB-04 Revenue Codes**

<table>
<thead>
<tr>
<th>UB-04 Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>Pharmacy General Classification</td>
</tr>
<tr>
<td>0251</td>
<td>Pharmacy Generic Drugs</td>
</tr>
<tr>
<td>0252</td>
<td>Pharmacy Non-Generic Drugs</td>
</tr>
<tr>
<td>0254</td>
<td>Pharmacy Drugs Incident to Other Diagnostic Services</td>
</tr>
<tr>
<td>0631</td>
<td>Pharmacy Single Source Drug</td>
</tr>
<tr>
<td>0632</td>
<td>Pharmacy Multiple Source Drug</td>
</tr>
<tr>
<td>0633</td>
<td>Pharmacy Restrictive Prescription</td>
</tr>
<tr>
<td>0634</td>
<td>Pharmacy Erythropoetin (EPO) Less Than 10,000 Units</td>
</tr>
</tbody>
</table>
• Vaccines for Children (VFC) Payment

Under the VFC Program certain vaccines are provided to health care providers at no charge to be administered to children 18 years old or younger. Since these vaccines are provided for free, there is no reimbursement for them for patients 18 years or younger. If there is a published fee schedule rate and a payable Payment Status Indicator is assigned, these vaccines are paid via the fee schedule rate for patients over 18 years of age.

• Observation Services Payment

Observation services are reimbursed up to 24 hours/units per day. If more than 24 units are billed on one day of service, claim lines will either receive a reduced reimbursement equivalent to 24 units or receive line-level Pricer Return Code 50 (Invalid Observation Billing), depending on how many claim lines the observation services are billed on. The payment for observation services (identified with procedure code G0378, Hospital observation service, per hour) is determined by multiplying the fee schedule rate for this service by units and any applicable discounts or adjustments.

• Provider-Specific Institutional Percentage Payment Reduction (for claims prior to July 01, 2019)

A provider-specific institutional percentage of 97% applies to all claims excluding Critical Access Hospital (CAH) claims. Laboratory services identified with CLAB New Mexico Fee on the New Mexico Medicaid Outpatient Fee Schedule are also excluded from this payment reduction.

Final Line Payment = (Line Payment or Adjusted Line Payment) * Reduction Factor

• Provider-Specific Institutional Percentage Payment Adjustment (for claims after July 01, 2019)

A provider-specific institutional percentage of 97% applies to all claims. Laboratory services identified with CLAB New Mexico Fee on the New Mexico Medicaid Outpatient Fee Schedule are also excluded from this payment reduction. In addition, reimbursement rates are based on facility type (for Fee-for-Service (FFS) and Managed Care Organizations (MCOs)) as follows:

- 25% for Safety Net Hospitals and Critical Access Hospitals (CAHs)
- 10% for the University of New Mexico Hospital
- 18% for all other in-state hospitals

Table B-45: 340B Drug Program UB-04 Revenue Codes

<table>
<thead>
<tr>
<th>UB-04 Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0635</td>
<td>Pharmacy Erythropoetin (EPO) 10,000 Units or More Units</td>
</tr>
<tr>
<td>0636</td>
<td>Pharmacy Drugs Requiring Detailed Coding</td>
</tr>
</tbody>
</table>
A 2% payment increase applies to MCO reimbursement rates for governmental and investor-owned hospitals, a 13% payment increase applies to MCO reimbursement rates for hospitals with a high share of Native American members, and a 3.8% payment increase applies to MCOs reimbursement rates for not-for-profit community hospitals.

**Final Line Payment = (Line Payment or Adjusted Line Payment) * Adjustment Factor**

- **Mark-Up/Discount Factor**
  
  The New Mexico Medicaid APC Pricer has an option to increase or reduce the overall claim payment by a hospital-defined factor (Mark-Up/Discount Factor). If the Mark-Up/Discount Factor is set to a number other than 1.0, the total payment is multiplied by the Mark-Up/Discount Factor.

- **Non-Covered Claims**
  
  Claims that do not contain any covered UB-04 Revenue Codes will receive claim-level Pricer Return Code 99 (No Covered Revenue Code on Claim).

- **Never Events**
  
  The New Mexico Medicaid APC Pricer will apply Never Event edits as identified by Modifiers PA (Surgical or Other Invasive Procedure on Wrong Body Part), PB (Surgical or Other Invasive Procedure on Wrong Patient), and PC (Wrong Surgery or Other Invasive Procedure on Patient). Claim lines that contain one of these modifiers will receive $0.00 in reimbursement and will receive line-level Pricer Return Code 04 (Not Covered or Not Covered Under OPPS).

- **Manually Priced/Paid by Report**
  
  When a procedure code is listed on the New Mexico Medicaid Outpatient Fee Schedule with a Procedure Identifier of OPPS NM Medicaid Pay Price Review, OPPS NM Medicaid Price Review, or OPPS NM Medicaid Special Review it will be assigned line-level Pricer Return Code 29 (Paid by Report/Manually Priced).

- **Packaging**
  
  The New Mexico Medicaid APC Pricer makes payment for the principal services on each claim and packages all ancillary on services. Payment for these packaged services is included in the payment for the principal service, therefore no additional payment is made for services identified as packaged. The following services will be assigned Payment Status Indicator N and line-level Pricer Return Code 09 (Packaged Service):

  - Any claim line with a UB-04 Revenue Code of 0253, 0370, 0371, 0372, or 0710
  - Any claim line without a procedure code
  - Any claim line with a non-covered UB-04 Revenue Code when there is at least one covered UB-04 Revenue Code on the claim
• Non-Covered Services

Lines with billed charges that are less than $1.01 receive $0.00 in reimbursement. These lines will receive line-level Pricer Return Code 04 (Not Covered or Not Covered Under OPPS). Additionally lines that are assigned to Payment Status Indicator B, C, E, M, or Y will receive line-level Pricer Return Code 04.

• Not Currently Supported

New Mexico Medicaid has a requirement that certain UB-04 Revenue Codes are required to be billed with a procedure code. The state of New Mexico has not yet been able to provide which UB-04 Revenue Codes require a procedure code, therefore this functionality is not included.
C Additional Medicare APC-HOPD & Contract APC Pricing Rules

This section provides information on additional pricing rules governing outpatient reimbursement. This section includes the following:

- Mental Health Services
- Composite APCs
- APC Worksheet References
- APC Worksheet References

**Note**
This section describes complex functionality that is performed in the Ambulatory Code Editor™ (ACE). If an `EditGroupPrice` call is made to the Optimizer and a claim is processed by ACE, the resulting information is passed to either the Medicare APC-HOPD or Contract APC Pricers, to calculate the appropriate reimbursement. This section describes how the Medicare APC-HOPD and Contract APC Pricers address the returned information from ACE, from a reimbursement perspective.

The contents of this section do not apply if ACE is not invoked as part of an `EditGroupPrice` call. Additionally, this section is not applicable for the Medicare ASC or Contract ASC Pricers.

C.1 Mental Health Services
(APCs 05853, 05863, and 08010)

C.1.1 APCs 05853 and 05863:
Partial Hospitalization Per Diem Payment

Under the partial hospitalization benefit, patients requiring substantial psychiatric services in an outpatient setting may be eligible for the partial hospitalization per diem reimbursement. The two partial hospitalization APCs that these patients may be eligible for are 05853 (Partial Hospitalization (3 or More Services) for CMHCs) and 05863 (Partial Hospitalization (3 or More Services Per Day) for Hospital-Based PHPs). For either level, at least one of the services must be an extended, family, or group psychotherapy service, referred to as a List A service. All other types of psychotherapy services, neuropsychological testing services, activity therapy, occupational therapy, education, training services, and all services on List A are on another list, referred to as List B. Some List B services are considered add-on services, and are not counted toward the APC assignment. Hospital outpatient claims (UB-04 Bill Type 013X) with Condition Code 41 (Partial Hospitalization Claim), and community mental health center claims with UB-04 Bill Type 076X that
have a mental health principal diagnosis, are eligible for this per diem reimbursement.

If ACE has been called and there are no other claim level edits, the ACE Editor will first, assign a packaging flag to the eligible lines that are considered packaged under the PHP service, and second, assign an APC of 05853 or 05863 to the line which is to be paid. The Pricer will then utilize the return fields from ACE to appropriately reallocate the charges from the packaged lines to the line that receives the APC for outlier consideration.

If ACE is not called, partial hospitalization rules will not be applied. The Pricer will issue a claim-level Pricer Return Code of 25 for claims not meeting the partial hospitalization criteria (refer to the EASYGroup™ Technical Reference Guide for more information on Return Codes).

If the claim is a hospital outpatient claim (UB-04 Bill Type 013X) with Condition Code 41, non-partial hospitalization services (i.e., fee schedule services) are paid as they are for other outpatient claims. For community mental health center claims, only the partial hospitalization services are paid. All other services on the claim are ignored by the Pricer.

**Example:**

For a claim with UB-04 Bill Type 0131, Condition Code 41, a single service date, a mental health diagnosis and the following HCPCS codes and modifiers:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Modifier</th>
<th>APC</th>
<th>Payment Status Indicator</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 Minutes With Patient and/or Family Member</td>
<td>59</td>
<td>05863</td>
<td>P</td>
<td>Paid</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 Minutes With Patient and/or Family Member</td>
<td>59</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 Minutes With Patient and/or Family Member</td>
<td>00000</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
<td>00000</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is a valid level II partial hospitalization claim since there are four partial hospitalization services occurring on the same date and at least one of those services is from List A. The assignment of APC 05863 is placed on HCPCS code 90832 which is the only List A service on the day. Notice that APC 05863 receives a Payment Status Indicator of P and a Pricer Return Code of 00 while all other services receive a Payment Status Indicator of N and a Pricer Return
Code of 09 indicating that the payment for these services has been packaged into the per diem reimbursement.

C.1.2 APC 08010:

Mental Health Services Per Diem Limit

For regular hospital outpatient claims (that is, for claims without condition code 41 and with UB-04 Bill Type 012X, 013X, or 014X), Medicare has designed a per diem limit for mental health services to be equal to the hospital-base level II per diem benefit under the partial hospitalization program. With this rule, Medicare effectively limits the amount a facility can receive for partial hospitalization services provided to a single patient on a single service date to the hospital-base level II partial hospitalization per diem benefit.

If ACE is called, then it will calculate the expected payment for all psychiatric services on the claim for each unique service date. If this payment exceeds the per diem payment amount for that time period, ACE will then assign composite APC 08010 (Mental Health Services) to the first psychiatric service on the day. After assigning this composite APC, ACE assigns to that service, a units value of 1, so that the claim will receive only a single day’s per diem payment for this service date. All other services on the same service date are then marked by the ACE as packaged, so that the APC Pricer will not pay any additional money for those services.

All other items on the claim, such as fee schedule items and other non-psychiatric services, are paid as they would be normally.

If ACE is not called, the mental health per diem limit will not be applied. The APC Pricer will not receive the return information from the ACE Editor to assign composite APC 08010, and each of the component lines will be priced individually according to the individual Medicare reimbursement rules that apply to the respective lines.

C.2 Composite APCs

In addition to the mental health APCs discussed above, effective January 01, 2008, Medicare introduced composite APCs for other bundled services. Composite APCs are assigned to represent a bundled incidence of service that involves multiple procedure codes.

C.2.1 Observation Composite APCs

Observation composite APCs are assigned if, on a single date of service, a patient receives eight hours or more of observation services, along with one or more services from a primary list of services (List A). Also, no payment status T or J1 service was provided on the day of, or the day prior to, the observation service. If the requirements are met, the composite APC is assigned to the service with the highest published APC rate.

- APC 8002: Level 1 Observation Composite (prior to January 01, 2014)
- APC 8003: Level 2 Observation Composite (prior to January 01, 2014)
- APC 8009: Observation Composite (prior to January 01, 2016)

Note
Effective January 01, 2016, observation services are reimbursed under Comprehensive APC 8011 (Comprehensive Observation Services).

C.2.2 Imaging Family Composites
Medicare has determined that three imaging families will be eligible for composite APC payment beginning January 01, 2009 (Version 10.0 of the OCE): Ultrasound, CT/CTA, and MRI/MRA. For composite payment purposes, the CT/CTA and MRI/MRA imaging families have been further separated into procedures that are performed “with contrast” and procedures that are performed “without contrast.” The five imaging composite APCs are as follows:

- APC 8004: Ultrasound Composite
- APC 8005: CT and CTA without Contrast Composite
- APC 8006: CT and CTA with Contrast Composite
- APC 8007: MRI and MRA without Contrast Composite
- APC 8008: MRI and MRA with Contrast Composite

When more than one of these procedures in a single composite APC is provided on a single date of service, one composite APC, one payment, and a payment status of S will be assigned. If one of these procedures is also an independent or conditional bilateral procedure and is billed with modifier 50 (Bilateral Procedure), it will count as two units during composite APC assignment.

The first eligible code on the claim is assigned the composite APC with a service unit of 1. All other codes on the claim that are eligible for the composite are packaged (payment status of N).

If two procedures in the same imaging family are performed on the same date of service, but one is performed with contrast and the other is performed without contrast, then the “with contrast” composite APC and payment will be assigned. Terminated procedures (modifier 52 or 73) are not eligible for these composites. Standard APCs will be assigned to all procedures that are terminated.

If ACE has been called and there are no other claim level edits, ACE will first, assign a packaging flag to the eligible lines that are considered packaged components under the composite service and second, assign the appropriate composite APC to the line which is to be paid. The APC Pricer will then utilize the return fields from ACE to appropriately reallocate the charges from the packaged lines to the line that receives the APC for outlier consideration.
If ACE is not called, composite APCs will not be assigned. The APC Pricer will not receive the return information from ACE to assign the appropriate composite APC, and each of the component lines will be assigned individual APCs and priced individually according to the Medicare reimbursement rules that apply to the respective lines.

C.3 APC Worksheet References

The following references provide explanations of the pricing rules governing the outpatient reimbursement summarized in the APC Worksheet.

Note

Not applicable for Medicare ASC or Contract ASC pricing.

C.3.1 Wage Adjustment

APC payment for services with Payment Status Indicators of J1, J2, P, S, T, or V is wage-adjusted to account for geographic variation in the cost of labor. Wage adjustment is accomplished by multiplying the labor portion (Labor%) of the APC payment by the hospital’s assigned Wage Index (WI).

\[
\text{Wage Adj Pay Rate} = (\text{APC Pay Rate} \times \text{Labor\%} \times \text{WI}) + (\text{APC Pay Rate} \times (1 - \text{Labor\%}))
\]

Wage indices are used by the inpatient PPS and published in the Inpatient Final Rule. For inpatient reimbursement, the wage indices are effective on October 1. However, for outpatient reimbursement, they are not effective until the following January. For 2002, the implementation of the October 1, 2001 wage indices was delayed until April 1, 2002.

The labor portion is published in every APC Final Rule and is constant across all APCs.

C.3.2 Discounting

In the Outpatient Prospective Payment System (OPPS), discounting is applied when multiple type T procedures are performed on the same day and also when type T procedures are terminated prior to completion. For multiple T procedures, the T procedure with the highest payment rate is paid at 100% while other T procedures occurring on the same day, in the same claim are paid at 50%. Similarly, when type T procedures are terminated prior to anesthesia, they are reimbursed at 50% of their rate. In addition, S, T and X procedures are subject to bilateral discounting in the presence of modifier 50.
All services paid by the APC Pricer are assigned a discounting fraction. The following table provides a description for the assignment of the discounting fraction formula.

Table C-2: Assignment of the Discounting Fraction Formula

<table>
<thead>
<tr>
<th>Payment Amount</th>
<th>Modifier 52 or 73</th>
<th>Modifier 50</th>
<th>Type “T” Procedure</th>
<th>Non-Type “T” Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest</td>
<td>No</td>
<td>No</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Highest</td>
<td>Yes</td>
<td>No</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Highest</td>
<td>No</td>
<td>Yes</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Highest</td>
<td>Yes</td>
<td>Yes</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Not Highest</td>
<td>No</td>
<td>No</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Not Highest</td>
<td>Yes</td>
<td>No</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Not Highest</td>
<td>No</td>
<td>Yes</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Not Highest</td>
<td>Yes</td>
<td>Yes</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

C.3.2.1 Discounting Formula (Disc Form):

1. Disc Fact = 1.0
2. Disc Fact = (1.0 + D * (U – 1)) / U
3. Disc Fact = T / U
4. Disc Fact = (1 + D) / U
5. Disc Fact = D
6. Disc Fact = T * D / U'
7. Disc Fact = D * (1 + D) / U'
8. Disc Fact = 2.0
9. Disc Fact = 2.0 * D / U

Where:
D = 0.5 (discounting fraction)
U = number of units
T = 0.5 (terminated procedure discount)

C.3.2.2 Assignment of a Particular Discounting Formula is Dependent Upon Five Criteria:

1. Payment ranking: If the procedure has the highest APC payment rate among all the T procedures on a claim for that day, it is grouped into...
the Highest category. Otherwise, it is grouped as Not Highest.
Payment ranking is done after the application of the terminated
discount and before the application of any bilateral adjustments. A Y in
the High Pay Flag column indicates the highest ranking T procedure
for that date.

2. The presence of modifier 52 or 73 indicating a procedure terminated
prior to anesthesia. A Y in the Term Flag column indicates a
terminated procedure.

3. The presence of modifier 50 indicating that the procedure was
performed bilaterally.

4. Type of procedure (type T or non-type T).

5. Bilateral indicator (conditional, independent, inherent, or non-bilateral):
    - Conditional: This service can be performed bilaterally and there is a
      physical or practical relationship between each bilateral service.
    - Independent: This service can be performed bilaterally and there is no
      physical or practical relationship between each bilateral service.
    - Inherent: This service is inherently bilateral.
    - Non-Bilateral: This service cannot be performed bilaterally or the
      concept of a bilateral service does not apply.

C.3.3 Outlier Payment

Prior to April 1, 2002, outlier reimbursement is calculated from the following steps:

1. Adjust total APC-related charges (sum of total charges for APCs and
   packaged items) to cost using the hospital’s overall ratio of cost-to-
   charges.

   \[
   \text{Total Cost} = \text{Total Charge (Subtotal)} \times \text{RCC}
   \]

2. Eligibility for outlier payment is dependent on the difference between
   the total cost (Step 1) and the total APC payment multiplied by an
   outlier payment factor (Outlier Factor).

   \[
   \text{Step 2} = \text{Total Cost} - (\text{Outlier Factor} \times \text{Total Pay (APC Subtotal)})
   \]

3. If Step 2 is greater than zero, the outlier payment for the claim is
   calculated as Step 2 multiplied by the outlier payment percent (Outlier
   Percent).

   \[
   \text{Outlier} = \text{Step 2} \times \text{Outlier Percent}
   \]
Example:

For a facility with an RCC = 0.75, an outlier factor of 2.5 and the following claim:

Step 1 = \((600 + 110 + 120) \times 0.75\) = 622.50

Note
The $100 charge for code 80074 is not included in this calculation because services with payment status A are not paid under PPS.

Step 2 = 622.50 – \((2.5 \times (100.48 + 44.46))\) = 260.15

If the outlier payment percent = 75, then:

Step 3 = 260.15 \times 0.75 = 195.11

C.3.4 Line Item Outlier Payment – April 1, 2002 and After

Effective April 1, 2002, Medicare implemented line item outlier payments for APCs. The procedure for calculating a line item outlier is as follows:

1. When a line item charge for any surgical procedure (prior to January 1, 2003, payment status S or T; effective January 1, 2003, all payment status T items plus payment status S items with a HCPCS code between 09999 and 70000) on a claim is less than $1.01, the total charges for all surgical APCs are redistributed among surgical APCs depending on the proportion the line item surgical payment represents with respect to the sum of all line item surgical payments. Otherwise, when all surgical APCs occurring on a claim have charges greater than or equal to $1.01, these charges are not redistributed and retain their user-entered value. Charges for non-surgical APCs are not redistributed and retain their user-entered value.

   a) If at least one surgical APC has charges less than $1.01, redistribute surgical charges among surgical APCs as follows:

   \[
   \text{Adj Charge} = \frac{\text{Total Surgical APC Charges}}{\text{Total Line Item Pay for Surgical APCs}} \times (\text{Line Item Pay} - \text{Total Charges})
   \]

   b) If all surgical APCs have charges greater than or equal to $1.01 or for non-surgical APCs:
Adj Charge = Charge

2. Reallocate the charges associated with all services packaged into a composite APC to the service line receiving the composite APC assignment.

3. Allocate packaged charges to non-transitional pass-through line items with APCs (payment status P, S, T, or V). Packaged charges are those charges associated with services that have a payment status N or line items without HCPCS codes, but with packaged revenue codes. The total packaged charges (sum of the charges for line items with payment status N and line items without HCPCS, but with a packaged revenue code) are allocated using the following formula. For each line item with pay status P, S, T, or V:

\[ Pkg\ Charge = \frac{Total\ Packaged\ Charges}{Total\ Line\ Item\ Pay\ for\ P,\ S,\ T,\ and\ V\ APCs} \times \text{Line Item Pay} \]

4. Calculate Total Charges for each line item.

\[ Total\ Charge = Adj\ Charge + Pkg\ Charge \]

5. Adjust line item total charges to cost using the hospital’s overall ratio of cost-to-charges.

\[ Line\ Item\ Cost = Total\ Charge \times RCC \]

6. Determine the APC outlier threshold. Prior to January 1, 2005, this threshold was the APC payment for the line (Total Pay). Starting January 1, 2005, the APC outlier threshold is the sum of the APC payment for the line (Total Pay) and the outlier fixed cost threshold.

\[ APC\ Outlier\ Threshold = Total\ Pay + Outlier\ Fixed\ Cost\ Threshold \]

7. A line item is eligible for a cost outlier if the line item cost (Step 5) exceeds the APC outlier threshold for that line (Step 6).

\[ Line\ Item\ Cost > APC\ Outlier\ Threshold \]

8. If Step 7 is true, outlier payment for this line item is the difference between the line item cost (Step 5) and the Total Pay multiplied by the Outlier Factor, all multiplied by the outlier payment percent (Outlier Percent).

\[ Outlier = (Line\ Item\ Cost - (Line\ Item\ Pay \times Outlier\ Factor)) \times Outlier\ Percent \]
Example:

For a facility with an RCC = 0.80, an outlier factor of 1.75, an outlier fixed cost threshold of $1175:

1. *Total surgical APC charges* * (Line Item Pay / Total Line Item Pay for Surgical APCs).
   
   For the first line item:
   
   \[
   \text{Adj Charge} = (0 + 3000) \times \frac{18.18}{18.18 + 1184.73} = 45.34
   \]
   
   For the second line item:
   
   \[
   \text{Adj Charge} = (0 + 3000) \times \frac{1184.73}{18.18 + 1184.73} = 2954.66
   \]

2. *Pkg Charge* = *Total Packaged Charges* * (Line Item Pay / Total Line Item Pay for P, S, T, V, and X APCs)
   
   For the first line item:
   
   \[
   \text{Pkg Charge} = (110 + 120) \times \frac{18.18}{18.18 + 1184.73} = 3.48
   \]
   
   For the second line item:
   
   \[
   \text{Pkg Charge} = (110 + 120) \times \frac{1184.73}{18.18 + 1184.73} = 226.52
   \]

Note

The $100 charge for code 80074 is not included in this calculation because services with payment status A are not packaged.

3. *Total Charge* = *Adj Charge* + *Pkg Charge*
   
   For the first line item:
   
   \[
   \text{Total Charge} = 45.34 + 3.48 = 48.82
   \]
   
   For the second line item:
   
   \[
   \text{Total Charge} = 2954.66 + 226.52 = 3181.18
   \]

4. *Line Item Cost* = *Total Charge* * RCC
For the first line item:
Line Item Cost = 48.82 * 0.8 = 38.58
For the second line item:
Line Item Cost = 3181.18 * 0.8 = 2544.94

5. APC Outlier Threshold = Total Pay + Outlier Fixed Cost Threshold
   For the first line item:
   APC Outlier Threshold = 18.18 + 1175.00 = 1193.18
   For the second line item:
   APC Outlier Threshold = 1184.73 + 1175.00 = 2359.73

6. Outlier qualification: Line item cost must be greater than APC outlier threshold.
   For the first line item:
   422.06 is not greater than 1193.18
   For the second line item:
   3181.18 is greater than 2359.73

7. Outlier payment for this line item is the difference between the line item cost (Step 4) and the Total Pay multiplied by the Outlier Factor, all multiplied by the outlier payment percent (Outlier Percent).
   For the first line item:
   Not eligible for outlier
   For the second line item:
   Outlier = \((2544.94 \, - \, (1184.73 \, \times \, 1.75)) \, \times \, 0.5 = 235.83\)

C.3.5 Packaged Procedure/Claim Lines

Under the OPPS, packaged claim lines are items or services that are considered to be incidental to the procedures with which they are performed. Consequently, packaged lines do not receive APC payment as the costs associated with these items are included in the APC payment for other procedures occurring on the claim. However, the charges associated with packaged items (services with payment status N, Pricer Return Code 09 or line items without HCPCS codes, but with revenue codes that are considered to represent packaged services under the OPPS) are included in the pricing calculations for outlier and transitional corridor payments. For line item outlier calculations, packaged charges are allocated to line items with APCs based on the ratio of each APC payment rate to the sum of the APC payment rates for the claim and are consequently included in the Total Charge for these APCs. Packaged charges are also included in the Total OPPS Charges used in the calculation of the Transitional Corridor Estimate.
C.3.6 Fee Schedule Pricing

In general, fee schedule pricing is calculated by multiplying Medicare’s published fee schedule rate by the number of units with no discounting. Medicare’s published fee schedules include: Ambulance (AA), Clinical Laboratory (AL), Durable Medical Equipment (DMEPOS) (AD), the Physician fee schedule including Rehabilitation Services (AR) and National fee schedules.

C.3.6.1 Percent of Charge Reimbursement

When the charges (Charges) for a fee schedule line item are lower than the published fee schedule rate (Fee Sched Rate), the payment rate for this line item (Fee Sched Pay) becomes 100% of the reported line item charges. A Y in the Chrg Flag signifies this occurrence. Under percent of charge reimbursement, units are not included in the calculation.

C.3.7 Transitional Pass-Through Drug Payment

Beginning in April 2002, a pro-rata reduction is applied to payment for transitional pass-through drugs (APCs with pay status G). Unlike pass-through devices, this reduction does not apply to the full pass-through device payment, but rather to the portion of the pass-through payment that exceeds five times the CMS designated APC minimum co-payment. Calculation of pass-through drug payment is as follows:

1. Apply pro-rata reduction to the portion of the APC payment rate that exceeds five times the designated APC minimum co-payment.
   
   \[
   \text{Maximum} \{0, (\text{APC Rate} - (5 \times \text{APC Minimum Copay})) \times (1 - \text{ProRata Pass Through Drug Reduction}) + (5 \times \text{APC Minimum Copay})\}
   \]

2. Apply discount and units.

   \[
   \text{Total Pay} = \text{Step 1} \times \text{Discount} \times \text{Units}
   \]

3. Recalculate the Medicare program payment percentage. This will be used to apportion the total line item payment into a Medicare payment and patient co-payment; see Payment/Co-Payment/Deductible section below.

   \[
   \text{Mcare Pay%} = \frac{\text{Step 1} - \text{APC National Copay}}{\text{Step 1}}
   \]

Example:

For the following claim line with a pro-rata reduction of 63.6%:

Table C-5: Example

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>APC</th>
<th>Payment Status Indicator</th>
<th>APC Pay Rate</th>
<th>Discount</th>
<th>Units</th>
<th>APC Min Co-pay</th>
<th>APC Natl Co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9185</td>
<td>0842</td>
<td>G</td>
<td>271.82</td>
<td>1.00</td>
<td>1</td>
<td>38.91</td>
<td>38.91</td>
</tr>
</tbody>
</table>

1. Apply pro-rata reduction.
\[
(271.82 - (5 \times 38.91)) \times (1 - 0.636) + (5 \times 38.91) = 222.68
\]

2. Apply discount and units.
\[
(222.68 \times 1.00 \times 1) = 222.68
\]

3. Recalculate the Medicare program payment percentage.
\[
(222.68 - 38.91) / 222.68 = 0.825265
\]

C.3.8 Transitional Pass-Through Device Payment

Transitional pass-through devices (APCs with pay status H) are paid by adjusting the charges associated with the device to cost using an outpatient ratio of costs-to-charges. Beginning in April 2002, surgical APCs associated with the use of a pass-through device have been identified. For each of these APCs, an offset was calculated representing the portion of the APC payment related to the device. When a transitional pass-through device is billed on the same claim as one of these APCs, the device payment is reduced by this offset. This offset is pro-rated among device payments based on the ratio of the device charge to the sum of charges for all devices on the claim. In addition, the application of a pro-rata reduction to device payment was introduced for claims beginning in April 2002. The following steps outline the calculation of the device payment.

1. Wage-adjust the offsets.
\[
= (Offset \times Labor\% \times WI) + (Offset \times (1 - Labor\%))
\]

2. Apply the appropriate discount and units to the wage-adjusted offsets and sum the total offset.
Total Offset = (Step 1 \times Disc \times Units)

3. Calculate the total line item payment for the device, pro-rating the total offset to devices based on the ratio of the device charge to the sum of charges for all devices on the claim and appropriately applying the pro-rata transitional pass-through reduction. Total payment for a device should not be lower than $0.
Total Pay = ((Total Charge \times Ratio of Cost-to-Charges) – (Total Offset \times (Total Charge / Sum of Charges for Devices))) \times (1 – Pro Rata Pass Through Device Reduction)

C.3.8.1 Important Concepts to Remember:

1. While offsets are associated with surgical APCs, they are deducted from the payment of transitional pass-through devices.

2. Reduced payment for pass-through devices only occurs when devices are billed on the same claim as APCs with an associated offset.

3. Several offsets can be deducted from the device payment when multiple APCs with offsets are billed with pass-through devices.

4. The offset amount is wage-adjusted and discounted according to the same rules as its affiliated surgical APC.
5. An offset associated with an APC line item is only applied once on a claim regardless of the number of pass-through devices billed.

6. Reduction of pass-through device payment is limited to the unreduced device payment amount (i.e., payment for the device cannot be lower than $0). When the total offset exceeds the sum of the un-reduced payment amounts for the devices, the total line item payments for devices are set to $0.

Example:
The following four items occur on the same service date:

Table C-6: Example - Same Service Date Items

<table>
<thead>
<tr>
<th>APC</th>
<th>Description</th>
<th>Pay Status</th>
<th>Discount</th>
<th>Units</th>
<th>APC Pay Rate</th>
<th>Total Charge</th>
<th>Offset</th>
</tr>
</thead>
<tbody>
<tr>
<td>0080</td>
<td>Diagnostic Cardiac Cath</td>
<td>T</td>
<td>0.50</td>
<td>1</td>
<td>$1778.08</td>
<td>$298.66</td>
<td></td>
</tr>
<tr>
<td>0086</td>
<td>Ablate Heart Dysrhythm Focus</td>
<td>T</td>
<td>1.00</td>
<td>1</td>
<td>$3723.12</td>
<td>$1320.96</td>
<td></td>
</tr>
<tr>
<td>1732</td>
<td>Cath, EP, diag/abl 3D/ vect</td>
<td>H</td>
<td>1</td>
<td></td>
<td>$1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1724</td>
<td>Cath, trans atherec, rotation</td>
<td>H</td>
<td>1</td>
<td></td>
<td>$4000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For a hospital with a wage index of 1.2, a ratio of cost-to-charges of 0.90, a 60% labor percentage, and a total charge of $1000 for APC 1732 and $4000 for APC 1724, the device payment is calculated as follows:

1. Wage-adjust the offsets
   \[ \text{Offset adjusted} = (\text{Offset} \times \text{Labor\%} \times WI) + (\text{Offset} \times (1 – \text{Labor\%})) \]
   \[ APC\ 0080\ (\$298.66 \times 1.2 \times 0.60) + (\$298.66 \times 0.40) = \$334.50 \]
   \[ APC\ 0086\ (\$1320.96 \times 1.2 \times 0.60) + (\$1320.96 \times 0.40) = \$1479.47 \]

2. Apply the appropriate discount and units and sum the total offset.
   \[ \text{Total Offset} = (\text{Step 1} \times \text{Disc} \times \text{Units}) \]
   Assuming no other services were reported on the sample claim, APC 0080 receives a discount factor of 0.50 for multiple T procedure discounting while APC 0086 has a discount factor of 1.00 since it is the highest paying type T procedure.
   \[ APC\ 0080\ (\$334.50 \times 0.50 \times 1) = \$167.25 \]
   \[ APC\ 0086\ (\$1479.47 \times 1.00 \times 1) = \$1479.47 \]
   \[ \text{Total Offset} = (\$167.25 + \$1479.47) = \$1646.72 \]

3. Calculate the total line item payment for the device.
   \[ APC\ 1732\ (((\$1000 \times 0.90)) - ((\$1646.72 \times (\$1000 / \$5000))) \times (1 – 0.6360) = \$207.72 \]
C.3.9 Payment/Co-Payment/Deductible

The total line item payment (Total Pay) is partitioned into four segments:

1. Medicare payment (Mcare Pay)
2. Patient co-payment (PT Copay)
3. Line item deductible (Allocated Deductible)

C.3.9.1 Medicare Payment

For each APC, the Medicare payment is calculated by multiplying the wage-adjusted, discounted line item payment (Total Pay) less the line item deductible by the Medicare program payment percentage.

\[ Mcare \ Pay = (Total \ Pay - Allocated \ Deductible) \times Mcare \ Pay\% \]

An explanation of the Mcare Pay\% is provided below under Line Item Deductible.

C.3.9.2 Patient Co-Payment

The patient co-payment is calculated by multiplying the wage-adjusted, discounted line item payment less the line item deductible by the patient co-payment percentage.

\[ PT \ Copay = (Total \ Pay - Allocated \ Deductible) \times PT \ Copay\% \]

Hospital elected co-payment reductions are indicated on the worksheet by a Y in the Hosp Red Copay Flag column. These co-payment reductions are not wage-adjusted but are discounted.

A Y in the Max Copay Flag column indicates that a co-payment limitation has occurred on this claim as determined by the following criteria.

The total daily co-payment for services with Payment Status Indicators of G, J, or K along with an associated S, T or V procedure is limited to the inpatient deductible ($812 in CY 2002, $792 in CY 2001 and $776 in CY 2000). Medicare associates the S, T, or V procedure with the highest co-payment (determined by comparing one unit of the non-discounted co-payments for the S, T, and V items that occur on the same day as G, J, and K items) with the G, J, and K items that occur on the same day. For the purpose of the following explanation, the wage-adjusted (non-discounted) co-payment rate for the selected S, T, or V procedure will be referred to as the STV Hi Copay (not displayed on the worksheet).

If the STV Hi Copay is greater than the inpatient deductible, Medicare sets the co-payment for one unit of this procedure to the inpatient deductible and adds the difference \((STV \ Hi \ Copay - Inpatient \ Deductible)\) into the Medicare payment (Mcare Pay) for that item and sets the co-payment for all G, J, and K items to zero.
If the STV Hi Copay is not greater than the inpatient deductible, Medicare sums the co-payments for all G, J, and K items (Sum of GJK Copay; not displayed in the worksheet) on the same date, and adds the sum to the co-payment for the selected S, T, or V item (STV Hi Copay). If this total is greater than the inpatient deductible, Medicare distributes the difference across all the G, J, and K co-payments by calculating and applying a reduction ratio (RR; not displayed on the worksheet) to each of these lines.

$$RR = \frac{\text{Inpatient Deductible} - \text{STV Hi Copay}}{\text{Sum of GJK Copay}}$$

The adjusted co-payments and payments for each G, J, or K line item is then calculated as follows.

$$PT\ Copay = (\text{Total Pay} - \text{Allocated Deductible}) \times PT\ Copay\% \times RR$$

$$Mcare\ Pay = Mcare\ Pay + ((\text{Total Pay} - \text{Allocated Deductible}) \times PT\ Copay\%) - PT\ Copay$$

Therefore, the total co-payment for all G, J, and K items (all units) and the selected S, T, or V item (one unit) will not exceed the inpatient deductible.

If the claim contains just G, J, and K items, the co-payments for these procedures are summed and if the total is greater than the inpatient deductible the PT Copay and Mcare Pay are calculated using the reduction factor as shown above, setting the STV Hi Copay equal to zero.

**C.3.9.3 Line Item Deductible**

Allocation of the beneficiary deductible was designed by Medicare to minimize the financial burden of the beneficiary. This is done using Medicare’s Program Payment Percentage (Mcare Pay%) for each APC. The program payment percentage is calculated by dividing the Medicare payment by the total payment (Medicare payment + national unadjusted co-payment) for a particular line item, thus indicating the percentage of payment that Medicare will incur for that service. Since, Medicare absorbs a variable percent of the payment for different APCs, line items for a claim are ranked from the lowest to highest PPP and the beneficiary deductible is allocated to line items in that order. Therefore, for a given claim the deductible is allotted first to those services with the lowest percentage covered by Medicare.

If an outstanding deductible remains after allocation to APCs on a claim, all or a portion of the remainder is applied to any non-lab fee schedule services that also occur on the claim. Since, Medicare pays the same percent for each of these items (80%), the deductible is allocated to these services in the order in which they appear on the claim.

**Note**

Influenza and Pneumococcal Pneumonia Vaccines (APC 354), Cervical or Vaginal Cancer Screening; Pelvic and Clinical Breast Examination (HCPCS code G0101), and Screening Papanicolaou Smear; Obtaining, Preparing and Conveyance or Cervical or Vaginal Smear to Laboratory (HCPCS code Q0091) are excluded from deductible allocation.
C.3.10 Hold Harmless (Transitional Corridor) Estimates

Transitional corridor payments were established for the first three and a half years (FY 2000-2003) of the Outpatient Prospective Payment System (OPPS). These payments helped protect providers from a significant loss in payment while transitioning to OPPS. Transitional Outpatient Payments (TOPs) expired on January 1, 2004 for all hospitals except cancer, children’s and qualifying small rural hospitals. These hold harmless hospitals are still eligible for a hold harmless payment. The calculation of this payment is based on the comparison of a provider’s total OPPS payments for a given year to the payments they would have received before OPPS (pre-BBA payment). CMS will provide monthly interim transitional corridor payments with a retrospective annual adjustment. If configured, the APC Pricer can estimate this payment on a per claim basis. The following steps describe the calculation of the hold harmless payment.

1. Calculate the total OPPS payment (OPPS Pay). The total OPPS payment is the sum of the payments for lines with Payment Status Indicators of G, H, J, K, P, S, T, V, plus any outlier add-on payments.

2. Calculate the pre-BBA payment (Pre BBA Pay). This is an estimate of what the hospital would have been paid by Medicare for these services prior to the new OPPS. It is calculated by multiplying the hospital’s total charges for OPPS services (charges for lines with Payment Status Indicators of G, H, J, K, P, S, T, V, N, or lines with a Pricer Return Code of 09) adjusted to costs by the hospital’s 1996 payment to cost ratio.

   \[
   \text{Pre BBA Pay} = \text{Total OPPS Charges} \times \text{Outpatient RCC} \times \text{Outpatient RPC}
   \]

   **Note**

   Charges for services with Payment Status Indicator N and a packaged revenue code are included in the calculation of the transitional corridor payment.

3. Subtract the total OPPS payment (Step 1) from the pre-BBA payment (Step 2).

4. Multiply Step 3 by the hold harmless factor and hold harmless multiplier.
D  Supported SNF PDPM Pricing Rules

This appendix outlines the pricing functionality for the SNF Pricer (effective October 01, 2019). This appendix includes the following sections:

- SNF Pricer PDPM Functionality
  - Overview
    - HIPPS Coding
    - Basic Per-Diem Reimbursement
    - Variable Per-Diem Adjustment
    - HIV/AIDS Adjustment
    - Wage Adjustment
    - Reimbursement for Each HIPPS Claim Line
    - Final SNF PDPM Reimbursement
    - Value-Based Purchasing (VBP) Adjustment
D.1 SNF Pricer PDPM Functionality

D.1.1 Overview

Effective October 01, 2019, Medicare is implementing the new Patient Driven Payment Model (PDPM) for reimbursement of SNF Part A claims. Under this new model, the prior Resource Utilization Groups (RUGs) are being replaced, and the patient assessment instrument is being revised. SNF claims will continue to bill Health Insurance Perspective Payment System (HIPPS) codes with UB-04 Revenue Code 0022, where the units represent the number of days at that assessment level. However, the HIPPS codes reported on these lines will no longer contain the RUG codes, but instead will contain a four-character PDPM, with a fifth character identifying the assessment status. The PDPM HIPPS codes will be “grouped” by CMS Grouper software, using the patient assessment as input. Each assessment will produce a unique HIPPS code. SNFs must submit at least one assessment within five days of admission for each SNF Part A stay, with additional assessments when the patient’s condition changes significantly.

D.1.1.1 HIPPS Coding

Medicare SNF Part A claims must contain at least one valid HIPPS code billed with UB-04 Revenue Code 0022.

- Character 1 will contain the Physical Therapy (PT) assessment outcome, with values from A to P
- Character 1 will also reflect the Occupational Therapy (OT) assessment outcome, with values from A to P
- Character 2 will contain the Speech Language Pathology (SLP) assessment outcome, with values from A to L
- Character 3 will contain the nursing assessment outcome, with values from A to Y
- Character 4 will contain the Non-Therapy Ancillary (NTA) assessment outcome, with values from A to F

The fifth character of the HIPPS code will contain the assessment indicator, with values 0 (assessment pending) or 1 (assessment completed).

If the assessment has not yet been completed, SNFs are to bill with HIPPS code ZZZZZ, to indicate the pending assessment status. HIPPS code ZZZZZ will produce the lowest possible per-diem payment in each category.

D.1.1.2 Basic Per-Diem Reimbursement

Every value in each service category is tied to a service-specific payment amount, which is based on a standardized base rate and a unique case-mix index value, which was calculated to reflect resource consumption. There is a set of payment amounts for urban SNF locations, and a set of payment amounts for rural locations. In addition to the case-mix adjusted payments for the services listed above, a fixed non-case-mix payment is added to the payment for each day. There is a non-case-mix rate for urban settings, and

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another for rural settings. For each day \([i]\) of the SNF Part A stay, the adjusted HIPPS per-diem rate is calculated as follows:

\[
\text{Unadjusted Per-Diem } [i] = \text{PT Rate} + \text{OT Rate} + \text{SLP Rate} + \text{Nursing Rate} + \text{NTA Rate} + \text{Non-Case-Mix Rate}
\]

D.1.1.3 Variable Per-Diem Adjustment
Each day's per-diem rates for PT and OT will receive a variable per-diem adjustment, which begins at 100% on day 1 of the inpatient stay, and gradually reduces to 76% on day 100 (after day 100, Medicare coverage of the SNF Part A stay is exhausted). Each day's per-diem NTA rate is also adjusted by a variable per-diem factor, which begins at 3.00 for the first three days, and remains at 1.00 for the remaining 97 covered days. For each day \([i]\) of the SNF Part A stay, the adjusted HIPPS per-diem rate is calculated as follows:

\[
\text{Adjusted Per-Diem } [i] = (\text{VPD Factor } * \text{PT Rate}) + (\text{VPD Factor } * \text{OT Rate}) + \text{SLP Rate} + \text{Nursing Rate} + (\text{VPD Factor } * \text{NTA Rate}) + \text{Non-Case-Mix Rate}
\]

D.1.1.4 HIV/AIDS Adjustment
If the SNF claim contains a principal or secondary diagnosis of B20 (HIV/AIDS), the nursing component of payment is increased by 18%, and the non-therapy ancillary payment will be based on a higher level of resource requirement than what was billed in the fourth character of the HIPPS code:

- If NTA billed at A = leave at A
- If NTA billed at B,C,D = set to A
- If NTA billed at E = set to B
- If NTA billed at F = set to C

\[
\text{Adjusted Per-Diem } [i] = (\text{VPD Factor } * \text{PT Rate}) + (\text{VPD Factor } * \text{OT Rate}) + \text{SLP Rate} + (1.18 * \text{Nursing Rate}) + (\text{VPD Factor } * \text{HIV-Inflated NTA Rate}) + \text{Non-Case-Mix Rate}
\]

D.1.1.5 Wage Adjustment
The labor portion of these payments is wage-adjusted based on the facility-specific wage index.

\[
\text{Wage-Adjusted Per-Diem } [i] = (\text{Adjusted Per-Diem } [i] * \text{Labor Portion} * \text{Wage Index}) + (\text{Adjusted Per-Diem } [i] * (1 – \text{Labor Portion}))
\]

D.1.1.6 Reimbursement for Each HIPPS Claim Line
The payment for each HIPPS claim line must be the sum of the individually calculated adjusted per-diem rates, where each day's payment includes the appropriate VPD factors, and these individual per-diem rates are summed across the total units billed on that claim line. Units should reflect the number of days at that level of care, and should not include any leave of absence days or the day of discharge unless the discharge status = 30.

D.1.1.7 Final SNF PDPM Reimbursement
The final SNF payment is the sum of the payment on each HIPPS/Revenue Code 0022 claim line:
D.1.1.8 Value-Based Purchasing (VBP) Adjustment
The final SNF PDPM payment is subject to adjustment based on the SNF VBP program. Each facility receives a VBP adjustment factor based on quality and improvement in various performance categories:

\[ VBP-Adjusted \text{ Payment} = \text{Total Payment} \times \text{VBP Factor} \]
E Additional Medicare Physician Pricing Rules

This appendix provides information on additional pricing rules governing the reimbursement of physician and non-physician practitioner claims. This appendix includes the following sections:

- Physician Payment Modifiers
- Multiple Procedure Discounting
  - Endoscopic Discounting
  - Diagnostic Imaging Discounting
  - Therapy Services Discounting
  - Surgical Discounting
  - Cardiovascular Discounting
  - Ophthalmology Discounting
E.1 Physician Payment Modifiers

The below-listed modifiers, if billed with certain procedure codes, may affect the reimbursement calculated by the Physician Pricer as outlined below.

Table E-1: Physician Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>Preventive Service</td>
<td>Indicates that the co-payment will be waived for certain anesthesia services billed with a preventive colorectal cancer screening and that the co-payment will be waived for Advance Care Planning (ACP) services when billed with an Annual Wellness Visit (AWV).</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Procedure</td>
<td>If billed with more than one unit, indicates that the service will not be paid. If billed with one unit, indicates that the service will be paid 150% of the fee schedule rate if the service is conditionally bilateral or 200% of the fee schedule rate if the service is independently bilateral.</td>
</tr>
<tr>
<td>54</td>
<td>Surgical Care Only</td>
<td>Indicates that payment will be limited to the amount allotted for preoperative and intraoperative services only.</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative Care Only</td>
<td>Indicates that payment will be limited to the amount allotted for postoperative services only.</td>
</tr>
<tr>
<td>56</td>
<td>Preoperative Management Only</td>
<td>Indicates that payment will be limited to the amount allotted for preoperative services only.</td>
</tr>
<tr>
<td>59</td>
<td>Distinct Procedural Service</td>
<td>Indicates that the service is not subject to diagnostic imaging discounting.</td>
</tr>
</tbody>
</table>
Table E-1: Physician Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>62</td>
<td>Two Surgeons</td>
<td>Indicates that the service will be reimbursed 62.5% of the fee schedule rate if the Co-Surgery Indicator for this service is 1 (Co-Surgeons Could be Paid, Though Supporting Documentation is Required to Establish the Medical Necessity of Two Surgeons for the Procedure) or 2 (Co-Surgeons Permitted and no Documentation Required if the Two-Specialty requirement is Met).</td>
</tr>
<tr>
<td>66</td>
<td>Surgical Team</td>
<td>Indicates that, if documentation proves that the service is medically necessary, it will be paid by report.</td>
</tr>
<tr>
<td>78</td>
<td>Return to OR for Related Surgery During Postop Period</td>
<td>Indicates that payment will be limited to the amount allotted for intraoperative services only. Indicares that the service is not subject to endoscopic discounting, diagnostic imaging discounting, and surgical discounting.</td>
</tr>
<tr>
<td>80</td>
<td>Assistant Surgeon</td>
<td>Indicates that the service will be paid 16% of the fee schedule rate if the Assistant to Surgery Indicator for the service is 0 (Payment Restriction for Assistants at Surgery Applies to This Procedure Unless Supporting Documentation is Submitted to Establish Medical Necessity) or 2 (Payment Restriction for Assistants at Surgery Does Not Apply to This Procedure, Assistant at Surgery May be Paid.)</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>Reimbursement Impact</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>81</td>
<td>Minimum Assistant Surgeon</td>
<td>Indicates that the service will be paid 16% of the fee schedule rate if the Assistant to Surgery Indicator for the service is 0 (Payment Restriction for Assistants at Surgery Applies to This Procedure Unless Supporting Documentation is Submitted to Establish Medical Necessity) or 2 (Payment Restriction for Assistants at Surgery Does Not Apply to This Procedure. Assistant at Surgery May be Paid.)</td>
</tr>
<tr>
<td>82</td>
<td>Assistant Surgeon (When Qualified Resident Surgeon Not Available)</td>
<td>Indicates that the service will be paid 16% of the fee schedule rate if the Assistant to Surgery Indicator for the service is 0 (Payment Restriction for Assistants at Surgery Applies to This Procedure Unless Supporting Documentation is Submitted to Establish Medical Necessity) or 2 (Payment Restriction for Assistants at Surgery Does Not Apply to This Procedure. Assistant at Surgery May be Paid.)</td>
</tr>
<tr>
<td>AA</td>
<td>Anesthesia Services Personally Performed by Anesthesiologist</td>
<td>Indicates that the performed anesthesia service is eligible for the primary care Health Professional Shortage Area (HPSA) incentive payment.</td>
</tr>
<tr>
<td>AD</td>
<td>Medical Supervision by a Physician: More Than 4 Concurrent Anesthesia Procedures</td>
<td>Indicates that the performed anesthesia service is eligible for the primary care HPSA incentive payment.</td>
</tr>
<tr>
<td>AQ</td>
<td>Physician Providing a Service in an Unlisted Health Professional Shortage Area (HPSA)</td>
<td>Indicates that the service is eligible for the primary care/mental health HPSA incentive payment even though the billed zip code is not a designated HPSA bonus area.</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>Reimbursement Impact</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AS</td>
<td>Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) services for Assistant-at-Surgery, Non-Team Member</td>
<td>Indicates that the service will be paid 16% of the fee schedule rate if the Assistant to Surgery Indicator for the service is 0 (Payment Restriction for Assistants at Surgery Applies to This Procedure Unless Supporting Documentation is Submitted to Establish Medical Necessity) or 2 (Payment Restriction for Assistants at Surgery Does Not Apply to This Procedure. Assistant at Surgery May be Paid).</td>
</tr>
<tr>
<td>CH</td>
<td>0 Percent Impaired, Limited or Restricted</td>
<td>Reported with functional G-codes to meet therapy billing requirements. If therapy billing requirements are not met, payment for therapy services may be denied.</td>
</tr>
<tr>
<td>CI</td>
<td>At Least 1 Percent But Less Than 20 Percent Impaired, Limited or Restricted</td>
<td>Reported with functional G-codes to meet therapy billing requirements. If therapy billing requirements are not met, payment for therapy services may be denied.</td>
</tr>
<tr>
<td>CJ</td>
<td>At Least 20 Percent But Less Than 40 Percent Impaired, Limited or Restricted</td>
<td>Reported with functional G-codes to meet therapy billing requirements. If therapy billing requirements are not met, payment for therapy services may be denied.</td>
</tr>
<tr>
<td>CK</td>
<td>At Least 40 Percent But Less Than 60 Percent Impaired, Limited or Restricted</td>
<td>Reported with functional G-codes to meet therapy billing requirements. If therapy billing requirements are not met, payment for therapy services may be denied.</td>
</tr>
<tr>
<td>CL</td>
<td>At Least 60 Percent But Less Than 80 Percent Impaired, Limited or Restricted</td>
<td>Reported with functional G-codes to meet therapy billing requirements. If therapy billing requirements are not met, payment for therapy services may be denied.</td>
</tr>
<tr>
<td>CM</td>
<td>At Least 80 Percent But Less Than 100 Percent Impaired, Limited or Restricted</td>
<td>Reported with functional G-codes to meet therapy billing requirements. If therapy billing requirements are not met, payment for therapy services may be denied.</td>
</tr>
</tbody>
</table>
### Table E-1: Physician Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>CN</td>
<td>100 Percent Impaired, Limited or Restricted</td>
<td>Reported with functional G-codes to meet therapy billing requirements. If therapy billing requirements are not met, payment for therapy services may be denied.</td>
</tr>
<tr>
<td>CT</td>
<td>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</td>
<td>Indicates that the imaging service is eligible for a payment reduction that applies to the Technical Component (TC) of the fee schedule rate.</td>
</tr>
<tr>
<td>FX</td>
<td>X-Ray Taken Using Film</td>
<td>Indicates that the imaging service is eligible for a payment reduction that applies to the Technical Component (TC) of the fee schedule rate.</td>
</tr>
<tr>
<td>FY</td>
<td>Computed Radiography X-Ray</td>
<td>Indicates that the imaging service is eligible for a payment reduction that applies to the Technical Component (TC) of the fee schedule rate.</td>
</tr>
<tr>
<td>GC</td>
<td>This Service Has Been Performed in Part by a Resident Under the Direction of a Teaching Physician</td>
<td>Indicates that the performed anesthesia service is eligible for the primary care HPSA incentive payment.</td>
</tr>
<tr>
<td>GM</td>
<td>Multiple Patients on One Ambulance Trip</td>
<td>Indicates that an ambulance trip is eligible for payment reductions due to more than one patient being transported in a single ambulance trip.</td>
</tr>
<tr>
<td>GN</td>
<td>Services Delivered Under an Outpatient Speech Language Pathology Plan of Care</td>
<td>Reported with therapy services to identify the discipline. If discipline is not specified, payment for therapy services may be denied.</td>
</tr>
<tr>
<td>GO</td>
<td>Services Delivered Under an Outpatient Occupational Therapy Plan of Care</td>
<td>Reported with therapy services to identify the discipline. If discipline is not specified, payment for therapy services may be denied.</td>
</tr>
<tr>
<td>GP</td>
<td>Services Delivered Under an Outpatient Physical Therapy Plan of Care</td>
<td>Reported with therapy services to identify the discipline. If discipline is not specified, payment for therapy services may be denied.</td>
</tr>
<tr>
<td>GX</td>
<td>Services Not Covered by Medicare</td>
<td>Indicates that the service will be denied.</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>Reimbursement Impact</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>GY</td>
<td>Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit</td>
<td>Indicates that the service will be denied.</td>
</tr>
<tr>
<td>GZ</td>
<td>Item or Service Not Reasonable and Necessary</td>
<td>Indicates that the service will be denied.</td>
</tr>
<tr>
<td>PA</td>
<td>Surgical or Other Invasive Procedure on Wrong Body Part</td>
<td>Indicates that the service will be denied.</td>
</tr>
<tr>
<td>PB</td>
<td>Surgical or Other Invasive Procedure on Wrong Patient</td>
<td>Indicates that the service will be denied.</td>
</tr>
<tr>
<td>PC</td>
<td>Wrong Surgery or Other Invasive Procedure on Patient</td>
<td>Indicates that the service will be denied.</td>
</tr>
<tr>
<td>LT</td>
<td>Left Side</td>
<td>If billed on the same claim line as an RT modifier, indicates that the service will not be paid unless the service is payable via the CMS DMEPOS fee schedule. If billed on one line on the same day that the same procedure code is billed on a separate line with the RT modifier, indicates that payment for both lines will be limited to 150% of the fee schedule rate. The RT modifier line receives the full 150% payment, while the LT modifier line is not paid.</td>
</tr>
<tr>
<td>QK</td>
<td>Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals</td>
<td>Indicates that the service will be paid 50% of the amount that it would have been paid if personally performed by an anesthesiologist or non-supervised CRNA. Indicates that the performed anesthesia service is eligible for the primary care HPSA incentive payment.</td>
</tr>
<tr>
<td>QL</td>
<td>Patient Pronounced Dead After Ambulance Called</td>
<td>Indicates that air ambulance transport services will be paid using the urban fee schedule rate and that no adjustments will be made for rural points of pickup. Indicates that air and ground ambulance mileage services will not be paid.</td>
</tr>
</tbody>
</table>
Table E-1: Physician Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>QX</td>
<td>CRNA Service: With Medical Direction by a Physician</td>
<td>Indicates that the service will be paid 50% of the amount that it would have been paid if personally performed by an anesthesiologist or non-supervised CRNA.</td>
</tr>
<tr>
<td>QY</td>
<td>Medical Direction of One Certified Registered Nurse Anesthetist (CRNA) by an Anesthesiologist</td>
<td>Indicates that the service will be paid 50% of the amount that it would have been paid if personally performed by an anesthesiologist or non-supervised CRNA. Indicates that the performed anesthesia service is eligible for the primary care HPSA incentive payment</td>
</tr>
<tr>
<td>RT</td>
<td>Right Side</td>
<td>If billed on the same claim line as an LT modifier, indicates that the service will not be paid unless the service is payable via the CMS DMEPOS fee schedule. If billed on one line on the same day that the same procedure code is billed on a separate line with the LT modifier, indicates that payment for both lines will be limited to 150% of the fee schedule rate. The RT modifier line receives the full 150% payment, while the LT modifier line is not paid.</td>
</tr>
<tr>
<td>XE</td>
<td>Separate Encounter, a Service That Is Distinct Because It Occurred During a Separate Encounter</td>
<td>Indicates that the service is not subject to diagnostic imaging discounting.</td>
</tr>
<tr>
<td>XP</td>
<td>Separate Practitioner, a Service That Is Distinct Because It Was Performed By a Different Practitioner</td>
<td>Indicates that the service is not subject to diagnostic imaging discounting.</td>
</tr>
<tr>
<td>XS</td>
<td>Separate Structure, a Service That is Distinct Because It Was Performed on a Separate Organ/Structure</td>
<td>Indicates that the service is not subject to diagnostic imaging discounting.</td>
</tr>
</tbody>
</table>
Table E-1: Physician Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>XU</td>
<td>Unusual Non-Overlapping Service, The Use of a Service That Is Distinct Because It Does Not Overlap Usual Components of The Main Service</td>
<td>When billed with a diagnostic imaging service, PC/TC discounting does not apply. Also, may override NCCI code pair edits, where applicable.</td>
</tr>
</tbody>
</table>
E.2 Multiple Procedure Discounting

The Physician Pricer applies many different types of multiple procedure discounting to physician and non-physician practitioner claims, including:

1. Endoscopic discounting
2. Diagnostic imaging discounting
3. Therapy service discounting
4. Surgical discounting
5. Cardiovascular discounting
6. Ophthalmology discounting

E.2.1 Endoscopic Discounting

Endoscopic discounting is applied when multiple related endoscopic procedures (i.e., procedures with the same endoscopic base code) are performed on the same date of service. The endoscopic procedure with the highest fee schedule rate is paid 100% of that rate plus an additional reimbursement amount for each additional related endoscopic procedure on the same date of service. That additional reimbursement amount is calculated as the difference of the fee schedule rate for the service minus the fee schedule rate for the endoscopic base code.

All other related endoscopic procedures on the same date of service are bundled into the line with the highest fee schedule rate and are assigned line-level Pricer Return Code 33 (Bundled Service Not Separately Payable).

Note

Related endoscopic procedures that are billed with modifier 78 (Return to the OR for a Related Procedure During the Postoperative Period) are not subject to endoscopic discounting.

Example:

A claim for a single service date and 3 related endoscopic procedures:

Table E-2: Endoscopic Discounting Example

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Fee Schedule Rate</th>
<th>Base Code (Fee Schedule Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29806</td>
<td>1</td>
<td>$1,002.65</td>
<td>29805 ($440.45)</td>
</tr>
<tr>
<td>2</td>
<td>29819</td>
<td>1</td>
<td>$550.63</td>
<td>29805 ($440.45)</td>
</tr>
<tr>
<td>3</td>
<td>29828</td>
<td>1</td>
<td>$865.99</td>
<td>29805 ($440.45)</td>
</tr>
</tbody>
</table>

Since line 1 has the highest fee schedule rate, payment for this line will be calculated as follows:
Highest Paid Line Payment = $1,002.65 + ($550.63 - $440.45) + ($865.99 – $440.45) = $1,538.37

All other lines are bundled and assigned line-level Pricer Return Code 33:

Table E-3: Endoscopic Discounting Example, Continued

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Total Payment</th>
<th>Return Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29806</td>
<td>1</td>
<td>$1,538.37</td>
<td>00</td>
</tr>
<tr>
<td>2</td>
<td>29819</td>
<td>1</td>
<td>$0.00</td>
<td>33</td>
</tr>
<tr>
<td>3</td>
<td>29828</td>
<td>1</td>
<td>$0.00</td>
<td>33</td>
</tr>
<tr>
<td>Total Reimbursement</td>
<td></td>
<td>$1,538.37</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E.2.2 Diagnostic Imaging Discounting

Diagnostic imaging discounting is applied when multiple diagnostic imaging procedures are performed on the same date of service. The diagnostic imaging procedure with the highest Technical Component (TC) fee schedule rate is paid at 100%. All other diagnostic procedures on the same date of service are paid 50% of the TC fee schedule rate. The diagnostic imaging procedure with the highest Professional Component (PC) fee schedule rate is paid at 100% of the PC fee schedule rate. All other diagnostic procedures on the same date of service are paid 95% of the PC fee schedule rate.

Note

Diagnostic imaging procedures that are billed with Modifier 59 (Distinct Procedural Service), 78 (Return to the OR for a Related Procedure During the Postoperative Period), XE (Separate Encounter), XS (Separate Structure), XP (Separate Practitioner), and/or XU (Unusual Non-Overlapping Services) are not subject to diagnostic imaging discounting.

Example:
A claim for a single service date and 3 diagnostic imaging procedures:

Table E-4: Diagnostic Imaging Discounting Example

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Fee Schedule Rate</th>
<th>TC Rate</th>
<th>PC Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75574</td>
<td>1</td>
<td>$455.97</td>
<td>$342.89</td>
<td>$113.08</td>
</tr>
<tr>
<td>2</td>
<td>72149</td>
<td>1</td>
<td>$539.34</td>
<td>$452.58</td>
<td>$86.76</td>
</tr>
<tr>
<td>3</td>
<td>76604</td>
<td>1</td>
<td>$83.19</td>
<td>$56.77</td>
<td>$26.42</td>
</tr>
</tbody>
</table>

Line 1 has the highest PC fee schedule rate and is paid as follows:

\[
\text{Line 1 Payment} = (342.89 \times 0.5) + 113.08 = 284.53
\]

Line 2 has the highest TC fee schedule rate, line 2 is paid as follows:
Line 2 Payment = $452.58 + ($86.76 * 0.95) = $535.00

Line 3 is paid as follows:

Line 3 Payment = ($56.77 * 0.5) + ($26.42 * 0.95) = $53.48

Table E-5: Diagnostic Imaging Discounting Example, Continued

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75574</td>
<td>1</td>
<td>$284.53</td>
</tr>
<tr>
<td>2</td>
<td>72149</td>
<td>1</td>
<td>$535.00</td>
</tr>
<tr>
<td>3</td>
<td>76604</td>
<td>1</td>
<td>$53.48</td>
</tr>
</tbody>
</table>

Total Reimbursement $873.01

E.2.3 Therapy Services Discounting

Therapy service discounting is applied when multiple therapy services are performed on the same date of service. The therapy service with the highest Practice Expense Relative Value Unit (PE RVU) is paid 100% of the fee schedule rate. If two therapy services have the same PE RVU, the service with the highest fee schedule rate is paid 100% of that rate. All other therapy services are paid using the 50% reduced therapy rate.

Example:
A claim for a single service date and 2 therapy services:

Table E-6: Therapy Services Discounting Example

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Fee Schedule Rate</th>
<th>50% Reduced Therapy Rate</th>
<th>PE RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>92507</td>
<td>1</td>
<td>$92.57</td>
<td>$71.82</td>
<td>0.87</td>
</tr>
<tr>
<td>2</td>
<td>92526</td>
<td>1</td>
<td>$102.22</td>
<td>$77.42</td>
<td>1.04</td>
</tr>
</tbody>
</table>

Since line 1 has the highest PE RVU, it is paid using 100% of the fee schedule rate. Line 2 is then paid using the 50% reduced therapy rate as follows:

Line 1 Payment = $71.82 * 1 = $71.82

Line 2 Payment = $102.22 * 1 = $102.22

Table E-7: Therapy Services Discounting Example, Continued

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>92507</td>
<td>1</td>
<td>$71.82</td>
</tr>
<tr>
<td>2</td>
<td>92526</td>
<td>1</td>
<td>$102.22</td>
</tr>
</tbody>
</table>

Total Reimbursement $174.04
E.2.4 Surgical Discounting

Surgical discounting is applied when multiple surgical and/or endoscopic procedures are performed on the same date of service. The surgical or endoscopic procedure with the highest fee schedule rate is paid 100% of that rate. If the endoscopic procedure was already subject to endoscopic discounting, the previously discounted fee schedule rate is used for this determination. If two procedures have the same fee schedule rate, the procedure with the highest amount of billed charges is paid 100%.

All other surgical and endoscopic procedures are paid 50%.

Note

Surgical and endoscopic procedures that are billed with modifier 78 (Return to the OR for a Related Procedure During the Postoperative Period) are not subject to surgical discounting.

Example:

A claim for a single service date and 3 related endoscopic procedures plus 1 additional surgical procedure:

Table E-8: Surgical Discounting Example

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Fee Schedule Rate (already adjusted with endoscopic discounting logic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29806</td>
<td>1</td>
<td>$1,538.37</td>
</tr>
<tr>
<td>2</td>
<td>29819</td>
<td>1</td>
<td>$0.00</td>
</tr>
<tr>
<td>3</td>
<td>29828</td>
<td>1</td>
<td>$0.00</td>
</tr>
<tr>
<td>4</td>
<td>14301</td>
<td>1</td>
<td>$1,038.08</td>
</tr>
</tbody>
</table>

Table E-9: Surgical Discounting Example, Continued

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Total Payment</th>
<th>Return Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29806</td>
<td>1</td>
<td>$1,538.37</td>
<td>00</td>
</tr>
<tr>
<td>2</td>
<td>29819</td>
<td>1</td>
<td>$0.00</td>
<td>33</td>
</tr>
<tr>
<td>3</td>
<td>29828</td>
<td>1</td>
<td>$0.00</td>
<td>33</td>
</tr>
<tr>
<td>4</td>
<td>14301</td>
<td>1</td>
<td>$519.04</td>
<td>00</td>
</tr>
</tbody>
</table>

First, the rules for endoscopic discounting are applied to lines 1, 2, and 3 as outlined in the Endoscopic Discounting section above. After these rules are applied, line 1 has an adjusted fee schedule rate of $1,538.37. Since this rate is greater than the fee schedule rate for line 4, line 1 will be paid 100% of the adjusted fee schedule rate and line 4 will be paid 50% of the fee schedule rate:

\[
\text{Line 4 Payment} = \$1,038.08 \times 0.5 = \$519.04
\]
E.2.5 Cardiovascular Discounting

Cardiovascular discounting is applied to the Technical Component (TC) of global services for certain diagnostic cardiovascular procedures when performed on the same date of service. The diagnostic cardiovascular procedure with the highest TC fee schedule rate is paid at 100%. All other TC diagnostic cardiovascular procedures on the same date of service are paid 75% of the TC rate.

**Example:**

A claim for a single service date and 3 diagnostic cardiovascular procedures:

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Unit(s)</th>
<th>Fee Schedule Rate</th>
<th>TC Rate</th>
<th>PC Rate</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75840</td>
<td>1</td>
<td>$588.88</td>
<td>$544.44</td>
<td>$44.44</td>
<td>$588.88</td>
</tr>
<tr>
<td>2</td>
<td>93287</td>
<td>1</td>
<td>$148.30</td>
<td>$15.00</td>
<td>$133.30</td>
<td>$11.25</td>
</tr>
<tr>
<td>3</td>
<td>93922</td>
<td>1</td>
<td>$133.36</td>
<td>$122.23</td>
<td>$11.13</td>
<td>$102.80</td>
</tr>
</tbody>
</table>

Line 1 has the highest TC fee schedule rate and is paid at 100%.

Line 1 Payment = $544.44 + $44.44 = $588.88

Line 2 is paid at 75% of the TC fee schedule rate.

Line 2 Payment = ($15.00 * 0.75) + $133.30 = $144.55

Line 3 is paid at 75% of the TC fee schedule rate.

Line 3 Payment = ($122.23 * 0.75) + $11.13 = $102.80

E.2.6 Ophthalmology Discounting

Ophthalmology discounting is applied to the Technical Component (TC) of global services for certain diagnostic ophthalmology procedures when performed on the same date of service. The diagnostic ophthalmology procedure with the highest TC fee schedule rate is paid at 100%. All other diagnostic ophthalmology procedures on the same date of service are paid 80% of the TC fee schedule rate.

**Example:**

A claim for a single service date and 2 diagnostic ophthalmology procedures:

<table>
<thead>
<tr>
<th>Line #</th>
<th>Procedure Code</th>
<th>Unit(s)</th>
<th>Fee Schedule Rate</th>
<th>TC Rate</th>
<th>PC Rate</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table E-10: Cardiovascular Discounting Example

Table E-11: Ophthalmology Discounting Example
Table E-11: Ophthalmology Discounting Example

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>92082</td>
<td>1</td>
<td>$125.00</td>
<td>$75.00</td>
</tr>
<tr>
<td>2</td>
<td>92286</td>
<td>1</td>
<td>$175.00</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

Line 1 is paid at 80% of the TC fee schedule rate.

\[
\text{Line 1 Payment} = (\$75.00 \times 0.80) + \$50.00 = \$110.00
\]

Line 2 has the highest TC fee schedule rate and is paid at 100%.

\[
\text{Line 2 Payment} = \$100.00 + \$75.00 = \$175.00
\]
F Present on Admission (POA) Indicators

F.1 Overview

If requested, the applicable Pricers listed below perform Present on Admission (POA) indicator editing for claims with discharge dates on or after the corresponding effective dates.

Table F-1: POA Effective Dates

<table>
<thead>
<tr>
<th>Pricer</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Medicaid (C only)</td>
<td>October 01, 2014</td>
</tr>
<tr>
<td>Contract Multi-Pricer</td>
<td>October 01, 2008</td>
</tr>
<tr>
<td>Florida Medicaid (C only)</td>
<td>July 01, 2013</td>
</tr>
<tr>
<td>Georgia Medicaid (C only)</td>
<td>November 01, 2010</td>
</tr>
<tr>
<td>Indiana Medicaid (C only)</td>
<td>October 01, 2009</td>
</tr>
<tr>
<td>Illinois Medicaid APR (C Only)</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>Iowa Medicaid (C Only)</td>
<td>October 01, 2015</td>
</tr>
<tr>
<td>Kansas Medicaid (C only)</td>
<td>October 1, 2012</td>
</tr>
<tr>
<td>Kentucky Medicaid (C only)</td>
<td>July 01, 2010</td>
</tr>
<tr>
<td>Medicaid APR Pro (C only):</td>
<td></td>
</tr>
<tr>
<td>- Colorado Medicaid</td>
<td>July 01, 2018</td>
</tr>
<tr>
<td>- Florida Medicaid</td>
<td>April 01, 2018</td>
</tr>
<tr>
<td>- Indiana Medicaid APR</td>
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<tr>
<td>- Louisiana Medicaid</td>
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<tr>
<td>- Massachusetts Medicaid</td>
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<td>- Mississippi Medicaid</td>
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<tr>
<td>Nebraska Medicaid (C only)</td>
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<tr>
<td>Nebraska Medicaid APR (C only)</td>
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<tr>
<td>Ohio Medicaid APR (C only)</td>
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<td>South Carolina Medicaid (C only)</td>
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<tr>
<td>Texas Medicaid (C only)</td>
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</table>
Claims that contain POA coding errors will receive zero reimbursement. The two different types of POA coding errors include:

- Missing POA indicators
- Invalid POA indicators

The DSC Editor will need to be installed to evaluate POA coding and to return edits for invalid POA coding. The Pricer will then evaluate POA coding errors reported by the DSC Editor and, if any are found, will issue Pricer Return Code 21 (Invalid Present on Admission Indicator) and a reimbursement of $0.00.

This functionality in the Pricer is optional and can be turned on or off using Rate Manager, for any facility, paysource, or time period. Also, this functionality is only available when sending a combined EditGroupPrice request to the Optimizer or Server (C Only), or when calling the EditGroupPrice method in the ECM Pro™ Inpatient Web Service or the EASYGroup™ Web Service. For further information on the web services please refer to the applicable ECM Pro™ Web Service User’s Guide or the Interfacing With EASYGroup™ Guide.

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Table F-1: POA Effective Dates

<table>
<thead>
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<th>Pricer</th>
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<tr>
<td>TRICARE</td>
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<tr>
<td>Virginia Medicaid APR (C only)</td>
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<td>Washington Medicaid APR (C Only)</td>
<td>July 01, 2014</td>
</tr>
<tr>
<td>Wisconsin Medicaid (C only)</td>
<td>March 01, 2010</td>
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</table>
G Descriptions of Ambulatory Code Edits

Detailed descriptions and examples for all of the different types of edits that are applicable to prospective payment are provided in this appendix, for use with the Ambulatory Code Editor™ (ACE). This appendix includes the following sections:

- Outpatient Code Edits (OCEs)
- Correct Coding Initiative (CCI) Edits
- Medically Unlikely Edits (MUEs)
- National Medicaid CCI/MUE Edits

Note

Optum APC Assistant™ is a comprehensive, web-based resource containing all the latest APC regulatory information to successfully navigate through OPPS. If you do not license APC Assistant™ please contact Optum Client Services.

Note

Edits below presented in gray font are not active.
G.1 Outpatient Code Edits (OCEs)

G.1.1 OCE Edit 001

Invalid Diagnosis Code (Returned to Provider (RTP))

Each ICD-10-CM diagnosis code is edited for completeness and validity. ICD-10-CM diagnosis codes without a required fourth, fifth, sixth, or seventh digit, are considered invalid. Codes are also checked to ensure that they were valid at the time of the patient's visit. Date validity is tested using the From Date on the claim. If the claim does not contain at least one valid diagnosis code, OCE Edit 001 is generated.

G.1.1.1 Examples:

OCE Edit 001 will be returned when the following diagnosis codes are reported on a claim:

- Any invalid diagnosis code, for example:
  - A12.3 - invalid code
  - A01.0 - invalid code
  - 567.89 - invalid for service dates on or after October 01, 2005

G.1.1.2 APC Assistant™:

Check the ICD-10-CM lists on the Diagnoses page for all valid diagnosis codes for this time period. Any code not present on these lists will generate OCE Edit 001.

G.1.2 OCE Edit 002

Diagnosis and Age Conflict (Returned to Provider (RTP))

Indicates that the ICD-10-CM diagnosis code is inconsistent with the patient's age. Age categories are as follows:

- Newborn (age = 0)
- Pediatric (age = 0 - 17 years)
- Maternity
  - Age = 12 - 55 years (prior to October 01, 2019)
  - Age = 9 - 64 years (effective October 01, 2019)
- Adult (age > 14)

G.1.2.1 Examples:

OCE Edit 002 will be returned when the following diagnosis codes are reported on a claim:

- A33 - appropriate only for newborn patients
- G93.7 - appropriate only for pediatric patients
- O00.90 - appropriate only for maternity patients
- J61 - appropriate only for adult patients
G.1.2.2 APC Assistant™:
ICD-10-CM diagnosis codes that are specific to particular age groups are listed in the appropriate age category on the Diagnoses page. These diagnoses will generate OCE Edit 002 if they are listed for a patient that is outside of the age range.

G.1.3 OCE Edit 003
Diagnosis and Sex Conflict (Returned to Provider (RTP))
Indicates that the ICD-10-CM diagnosis code is inconsistent with the patient’s sex. Effective April 01, 2010 (Version 11.1 OCE), this OCE Edit will not be applied to claims that contain Condition Code 45 (Ambiguous Gender Category).

G.1.3.1 Examples:
OCE Edit 003 will be returned when the following diagnosis codes are reported on a claim:
- C53.8 - appropriate only for female patients
- Z98.52 - appropriate only for male patients

G.1.3.2 APC Assistant™:
All ICD-10-CM diagnosis codes that generate OCE Edit 003 for female patients are in the Male list on the Diagnoses page. All the diagnosis codes that generate OCE Edit 003 for male patients are in the Female list on the Diagnoses page.

G.1.4 OCE Edit 004
Medicare Secondary Payer Alert (Not Active as of 01/01/01)
Identifies a diagnosis code that may signal a condition (generally some type of trauma) for which Medicare is the secondary payer.

G.1.5 OCE Edit 005
External Causes of Morbidity Code Cannot be Used as Principal Diagnosis (Returned to Provider (RTP))
ICD-10-CM external causes of morbidity codes are equivalent to ICD-9-CM “E-codes.” These codes describe the circumstances that caused an injury, not the nature of the injury. The ICD-10-CM codes are prefixed with V, W, X, or Y. These codes are not acceptable billed by themselves or as the principal diagnosis, however, they can be billed as the secondary diagnosis. If one of these codes is billed as a principal diagnosis OCE Edit 005 will be issued, and the claim will be RTP.

G.1.5.1 Examples:
OCE Edit 005 will be returned when the following diagnosis codes are reported on a claim:
- Y83.9
• T40.7X5A

G.1.5.2 APC Assistant™:
All ICD-10-CM diagnoses codes that generate OCE Edit 005 are listed by searching for diagnoses that begin with V, W, X, or Y on the Diagnoses page.

G.1.6 OCE Edit 006
Invalid Procedure Code (Returned to Provider (RTP))
Each Level I or Level II procedure code is edited for completeness and validity. This OCE Edit indicates that the procedure code is invalid or was not valid for the patient’s dates of service. Date validity is verified using the From Date on the claim.

Effective October 01, 2011, this edit is suspended for UB-04 Bill Type 032X (Home Health Services Under a Plan of Treatment) claims containing Revenue Code 0023 (Home Health Prospective Payment System). Effective July 01, 2012, this edit will no longer be issued on UB-04 Bill Type 032X claims that span across two calendar years and are new effective the second calendar year.

G.1.6.1 Example:
OCE Edit 006 will be returned when procedure code 15342 is reported on a claim.

G.1.6.2 APC Assistant™:
Check the code lists from the Procedures page for all procedure codes valid for the time period. Any code not present will generate OCE Edit 006.

G.1.7 OCE Edit 007
Procedure and Age Conflict (Not Active as of 01/01/01)
This OCE Edit indicates that the procedure code is inconsistent with the patient’s age. Each procedure is assigned a valid minimum and valid maximum age. If the patient age falls outside of this range, the procedure is flagged as an error.

G.1.8 OCE Edit 008
Procedure and Sex Conflict (Returned to Provider (RTP))
This OCE Edit indicates that the procedure code is not valid for the patient’s sex. Effective April 01, 2010 (Version 11.1 OCE), this OCE Edit will not be applied to claims that contain Condition Code 45 (Ambiguous Gender Category).

G.1.8.1 Examples:
OCE Edit 008 will be returned when the following procedure codes are reported on a claim:

• 53430 - valid only for female patients
• 55250 - valid only for male patients
G.1.8.2 APC Assistant™:
Procedures that generate OCE Edit 008 for female patients are listed in the **008-Female Only** list on the Procedures page. Procedures that generate OCE Edit 008 for male patients are listed in the **008-Male Only** list on the Procedures page.

G.1.9 OCE Edit 009
Non-Covered Under Any Medicare Outpatient Benefit, for Reasons Other Than Statutory Exclusion (Line Item Denial (LID))
OCE Edit 009 identifies services that are never paid under any Medicare outpatient benefit. A subset of the procedure codes assigned to Payment Status Indicator E1 (Non-Allowed Item or Service) and all 099X Revenue Codes submitted without a procedure code, and assigned to Payment Status Indicator E1 are subject to this OCE Edit.

G.1.9.1 Examples:
OCE Edit 009 will be returned when the following procedure codes are reported on a claim:

- 69090
- V5011

G.1.9.2 APC Assistant™:
All procedure codes that will generate OCE Edit 009 are listed in the **009-Non-Covered** list on the Procedures page.

G.1.10 OCE Edit 010
Service Submitted for Denial (Condition Code 21) (Claim Denial)
Identifies services that are billed by a provider for a denial notice. OCE Edit 010 is triggered when a claim is submitted with Condition Code 21 (Request for Denial Notification).

G.1.11 OCE Edit 011
Service Submitted for MAC Review (Condition Code 20) (Claim Suspended)
Identifies non-covered services that are billed by the provider when a beneficiary requests a Medicare review for coverage. If a claim is submitted with Condition Code 20 (Request for MAC Review), the claim is placed in suspension pending Medicare review to determine coverage.

G.1.12 OCE Edit 012
Questionable Covered Service (Claim Suspended)
Identifies procedures that are only covered by the Medicare program under certain medical circumstances.

G.1.12.1 Examples:
OCE Edit 012 will be returned when the following procedure code is reported on a claim:
• 15833 - covered by Medicare only when medically necessary

G.1.12.2 APC Assistant™:
All procedure codes that generate OCE Edit 012 are listed in the 012-Questionable list located on the Procedures page.

G.1.13 OCE Edit 013
Separate Payment for Services is Not Provided by Medicare (Line Item Rejection)

Identifies separate payment for eligible services not provided by Medicare. OCE Edit 013 is returned when a claim line contains a procedure code assigned to Payment Status Indicator E2 (Items or Services for Which Pricing Information and Claims Data Are Not Available).

G.1.13.1 Example:
OCE Edit 013 will be returned when the following procedure code is reported on a UB-04 013X claim:

• 90393 - when assigned to Payment Status Indicator E2

G.1.13.2 APC Assistant™:
All procedure codes that generate OCE Edit 013 are listed in the 013-Not Sep Pay list located under Criteria on the Procedures page.

G.1.14 OCE Edit 014
Code Indicates a Site of Service Not Included in OPPS (Not Active as of 01/01/06)

Identifies codes that describe services not generally performed in the hospital outpatient setting. These services are not covered under OPPS and include codes for home health services, rest home visits, and hospice visits.

G.1.15 OCE Edit 015
Service Units Exceed Maximum/Medically Unlikely Edits (Returned to Provider (RTP)/Line Item Denial (LID))

G.1.15.1 Prior to January 01, 2009
Identifies numbers of units that are clinically impossible or unreasonable for the service billed. Units from all line items with the same procedure code on the same date of service will be added together before this OCE Edit is applied. The presence of certain modifiers will override this OCE Edit. Beginning with Version 2.2, only Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) will override this OCE Edit, and only for certain laboratory procedures.

G.1.15.2 Examples:
OCE Edit 015 will be returned when the following procedure codes are reported on a claim:

• 0042T - for a single date of service would generate OCE Edit 015
• G0249 - for a single date of service would generate OCE Edit 015

In Version 1.0 and Version 1.1, the following modifiers overrode this OCE Edit:
  • 59 (Distinct Procedural Service)
  • 76 (Repeat Procedure or Service by Same Physician)
  • 77 (Repeat Procedure by Another Physician)
  • 91 (Repeat Clinical Diagnostic Laboratory Test)

Note
If no single claim line has invalid units, but all claim lines for the same code and date have invalid units when added together, OCE Edit 015 will be returned for each of those claim lines.

G.1.15.3 January 01, 2009 - June 30, 2014
OCE Edit 015 was eliminated due to the new Medically Unlikely Edits (MUEs), which compare billed units against anatomic or clinically reasonable upper limits on units for specific procedure codes. Effective for claims on or after January 01, 2009 for facility claims and on or after July 01, 2010 for professional claims, ACE will check claims for MUEs and flag any claim line that contains units that exceed the MUE maximums using existing OCE Edit 015. If a claim line contains units that exceed the MUE for a given procedure code, ACE will assign OCE Edit 015. Note that the MUE Edits are applied separately to each individual claim line. Each line of a claim is adjudicated separately against the MUE value for the procedure code reported on that line. Units from all line items with the same procedure code on the same date of service are not added together before this OCE Edit is applied.

Note
This change to OCE Edit 015 was an implementation specific to the ACE to facilitate the reporting of MUE maximums. The Medicare Outpatient Code Editor (OCE) is no longer returning OCE Edit 015 for any 2009 claims; Medicare Administrative Contractors (MACs)/Fiscal Intermediaries (FIs) are applying the MUEs separately from the OCE Edits.

G.1.15.4 July 01, 2014 and After
Effective for claims on or after July 01, 2014, ACE will check claims for MUEs and flag any claim line that contains units that exceed the MUE maximums using OCE Edit 015. For further information, please refer to the Medically Unlikely Edits (MUEs) section below.

G.1.15.5 Example
OCE Edit 015 will be returned when a claim line contains three units of procedure code 85041, that claim line will violate the MUE for that code, and the claim line would be denied.
G.1.15.6 APC Assistant™:
Codes subject to OCE Edit 015 will have a Max Units value on the Procedures page. A dash (-) shown as the Max Units value means there is no associated MUE for the procedure code. Beginning January 01, 2012, CMS began assigning maximum unit values of zero to some E&M codes (inpatient-only services). These codes will show an associated Max Units value of 0 in APC Assistant™ and will generate OCE Edit 015 when billed with a unit of one or more.

G.1.16 OCE Edit 016
Multiple Bilateral Procedures Without Modifier 50 (Not Active as of 10/01/05)
OCE Edit 016 identifies situations where more than one exclusively conditional bilateral service is reported for the same date of service and a Modifier of 50 is not reported. An exclusively conditional bilateral code represents a service that can be, but is not always, performed bilaterally. When performed bilaterally Modifier 50 must be used, and the entire service is paid at 150% of the fee for a non-bilateral service. The first service is paid at 100% and the second at 50%. This OCE Edit does not apply to inherently bilateral, independently bilateral, or non-bilateral codes.

Note
CMS removed all codes from the Exclusively Bilateral list effective October 01, 2005. This change effectively eliminated OCE Edit 016 starting October 01, 2005, since this OCE Edit only applied to exclusively bilateral services.

G.1.17 OCE Edit 017
Inappropriate Specification of Bilateral Procedure (Returned to Provider (RTP))
OCE Edit 017 identifies situations where bilateral procedures are incorrectly billed. This OCE Edit identifies the situation where an exclusively conditional bilateral code is reported more than once for the same date of service and all or some of these codes are billed with Modifier 50 (Bilateral Procedure). This OCE Edit also identifies inherently bilateral procedures that are billed on more than one line. This OCE Edit does not apply to independently bilateral or non-bilateral services. Beginning with the April 2009 OCE, CMS began bypassing OCE Edit 017 if Modifier 76 (Repeat Procedure or Service) was submitted on the second or subsequent line or unit of an inherently bilateral code. Beginning with the October 2009 OCE, CMS also bypassed OCE Edit 017 if Modifier 77 (Repeat Procedure by Another Physician) was submitted on the second or subsequent line or unit of an inherently bilateral code.

Note
CMS removed all codes from the Exclusively Bilateral list effective October 01, 2005. Therefore, effective October 01, 2005 OCE Edit 017 only applies to inherently bilateral services.
G.1.17.1 Example:
OCE Edit 017 will be returned when the following procedure code is reported on a claim:

- 11010:
  - Appearing on two different claim lines for the same service date
  - Both claim lines will be flagged with OCE Edit 017

G.1.17.2 APC Assistant™:
Inherently bilateral procedures are listed in the Bil Ind>Inh-Inherent list on the Procedures page.

Note
The Exclusive List has been removed from the Procedures page and has been empty as of October 01, 2005.

G.1.18 OCE Edit 018
Inpatient Procedure (Line Item Denial (LID))

Identifies inpatient-only procedures. Medicare has established a list of procedures that it believes can only be safely performed in the inpatient setting. Medicare will not pay for these procedures when they are performed in the outpatient setting.

Edits for inpatient procedures can result in a line item denial (OCE Edit 018) or a line item rejection (OCE Edit 045). OCE Edit 018 is assigned to:

1. An inpatient-only procedure (identified by Payment Status Indicator C) that does not occur on the Separate Procedures List;
2. An inpatient-only procedure that is also included on the Separate Procedures List if a service assigned to Payment Status Indicator T does not occur on the same date.

Services provided on the same date as an inpatient procedure are assigned to an edit category, OCE Edit 049 (Same Day as Impatient Service) and denied for payment.

Inpatient-only services may be eligible for payment when Modifier CA (Procedure Payable Only in the Inpatient Setting When Performed Emergently on an Outpatient Who Expires Prior to Admission) is submitted, indicating that the patient received this service on an emergency basis, but then died or was transferred before the hospital could admit the patient. Effective January 01, 2015, this inpatient service is paid as Comprehensive APC 05881 (Ancillary Outpatient Services When Patient Dies). In this case, all other services provided on the same date are not assigned OCE Edit 049, but instead are packaged into the APC 05881 payment.

G.1.18.1 Example 1:
OCE Edit 018 will be returned when the following procedure codes are reported on a claim:
• 27025:
  - Inpatient-only procedure that is not on the Separate Procedures List.
  - This procedure, and all other services on the claim with the same service
date, would be flagged by the OCE for line item rejection.

• 27005:
  - Inpatient-only procedure that is found on the Separate Procedures List.
  - In the absence of a type T procedure on the same date, OCE Edit 018
will be assigned to 27005 and all services on the claim with the same
service date would be flagged for line item denial.

G.1.18.2 APC Assistant™:
All procedure codes that generate OCE Edit 018 are listed in the 018-
Inpatient Only list located on the Procedures page. Separate inpatient
procedures are listed in the 045-Inpt Sep Proc list located on the Procedures
page.

G.1.19 OCE Edit 019
Mutually Exclusive Procedure That is Not Allowed by NCCI Even if
Appropriate Modifier is Present (Line Item Rejection (LIR)) (Not Active)

Mutually exclusive procedures cannot be billed together on the same claim for
the same day. This OCE Edit is based upon Correct Coding Initiative (CCI)
logic and identifies the unpaid procedure of the mutually exclusive pair. The
unpaid procedure of the mutually exclusive procedure pair is often, but not
always, the more expensive procedure. The presence of a modifier will not
eliminate this OCE Edit under any circumstances. The effective dates of
certain mutually exclusive code pairs are different between the OCE and the
CCI.

Note
With the July 2012 I/OCE, CMS deactivated OCE Edit 019 and combined it
with OCE Edit 020, retroactive to the beginning of the I/OCE.

G.1.20 OCE Edit 020
Code 2 of a Code Pair That is Not Allowed by NCCI Even if Appropriate
Modifier is Present (Line Item Rejection (LIR))

Identifies the column 2 code of a column1/column2 Correct Coding Edit (CCI),
indicating that this code should not be reported along with the column 1 code
on the same service date. Often, the column 2 code is a component of a
procedure that is billed on the same date as the comprehensive procedure.
Services that are normally a component of a more comprehensive procedure
cannot be billed separately, but must be considered as included in the more
comprehensive procedure. This Edit is also based on CCI logic. The presence
of a modifier will not eliminate this Edit under any circumstances.
The effective dates of certain column 1/column 2 code pairs are different between the OCE and the CCI. Prior to the V5.0 OCE, this Edit was referred to as the Comprehensive/Component Edit. This definition was expanded in the Correct Coding Edits and subsequently in the OCE.

G.1.20.1 Example:
OCE Edit 020 will be returned when the following procedure codes are both reported on a claim:

- 93015
- 93016

The claim line containing procedure code 93016 will receive OCE Edit 020.

G.1.20.2 APC Assistant™:
All OCE/CCI column1/column2 code pairs are listed on the OCE/CCI Edit Pairs page.

G.1.21 OCE Edit 021
Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 (Returned to Provider (RTP))

Identifies an Evaluation and Management (E&M) service that is billed on the same day as a surgical procedure - either an S procedure (Procedure or Service, Not Discounted When Multiple) or a T procedure (Procedure or Service, Multiple Reduction Applies) and Modifier 25 is not added to the E&M code. E&M codes are not normally reimbursed on the same day as a surgery or an S or T procedure. Modifier 25 signals that the physician performs additional services at the visit beyond those associated with the procedure.

G.1.21.1 Example:
OCE Edit 021 will be returned when the following procedure codes are both reported on a claim:

- 10081
- G0402

A claim containing both of these procedure codes, without Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service) will generate OCE Edit 021.

G.1.21.2 APC Assistant™:
All procedure codes that can generate OCE Edit 021 in the presence of a surgical procedure and the absence of Modifier 25, are listed on the V - Clinic or emergency department visit list located under the Pay Stat drop-down on the Procedures page.

G.1.22 OCE Edit 022
Invalid Modifier (Returned to Provider (RTP))
Indicates that the two-character modifier associated with the procedure code is not valid for the service date or has never been valid according to OCE definitions.

Effective October 01, 2011, this edit is suspended for UB-04 Bill Type 032X (Home Health Services Under a Plan of Treatment) claims containing Revenue Code 0023 (Home Health Prospective Payment System).

**G.1.22.1 Example:**
OCE Edit 022 will be returned when Modifier 60 (CMS deleted Modifier 60 effective April 01, 2002) is present on a claim with a service date after April 01, 2002.

**G.1.22.2 APC Assistant™:**
All modifiers for this time period are listed on the Modifiers page. Any modifier not present on this page will generate OCE Edit 022.

**G.1.23 OCE Edit 023**
**Invalid Date (Returned to Provider (RTP))**
Identifies a From, Thru, or line item service date that is not within the normal calendar range. In addition, this OCE Edit flags claims with a From Date that is greater than the Thru Date, or with a missing line item service date with a procedure code, or with line item service dates that are not within the claim’s From/Thru Date range.

**G.1.24 OCE Edit 024**
**Date Out of OCE Range (Claim Suspended)**
ACE maintains twenty-eight consecutive quarters of I/OCE data. This edit identifies claims outside of this time period.

**G.1.25 OCE Edit 025**
**Invalid Age (Returned to Provider (RTP))**
The reported age is not between 0 and 124 years.

**G.1.26 OCE Edit 026**
**Invalid Sex (Returned to Provider (RTP))**
The OCE requires a patient sex of 1 (Male), 2 (Female), or 0 (Unknown).
G.1.27 OCE Edit 027

Only Incidental Services Reported (Claim Rejection)
 Identifies claims or records where the only services billed were incidental (Payment Status Indicator N). Incidental services are packaged under OPPS and are paid as part of another primary service or procedure performed.

This OCE Edit is assigned only if all of the following are true:

• The claim has at least one procedure code or at least one packaged revenue code; and
• The claim has no fee schedule items; and
• The claim has no procedure codes eligible for assignment to any APC; and
• None of the line items on the claim are denied or rejected (refer to OCE Edit 047)

OCE Edit 027 is performed immediately after OCE Edit 018. If OCE Edit 027 is assigned, no other OCE Edits will be assigned to these services.

G.1.27.1 Example:
OCE Edit 027 will be returned when only the following procedure code is reported on a claim:

• 00100

G.1.27.2 APC Assistant™:
All services classified by Medicare as incidental are included in the N - Packaged/incidental service list located under Pay Stat drop-down on the Procedures page. For claim lines without procedure codes, all revenue codes classified as packaged are included in the Packaged drop-down located on the Revenue Codes page.

G.1.28 OCE Edit 028

Code Not Recognized by Medicare for Outpatient Claims; Alternate Code for Same Service May Be Available (Line Item Rejection)

Identifies codes that are not reportable to Medicare for outpatient claims because Medicare requires an alternate code to be used. Most, but not all, of the codes in this category have been assigned to Payment Status Indicator E (Non-Covered). After January 01, 2017, the codes in this category are assigned to Payment Status Indicator E1 (Non-Allowed Item or Service).

G.1.28.1 Example:
OCE Edit 028 will be returned when the following procedure code is reported on a claim:

• 61640

If this code is billed it will receive OCE Edit 028.
Note
Not all codes are required to have an alternate code.

G.1.28.2 APC Assistant™:
All procedure codes that generate OCE Edit 028 are listed in the 028-
Unacceptable list located under the Criteria drop-down on the Procedures page.

G.1.29 OCE Edit 029
Partial Hospitalization Service for Non-Mental Health Diagnosis (Returned to Provider (RTP))

Identifies a partial hospitalization claim that does not have a mental health diagnosis as the principal diagnosis. Partial hospitalization claims must include a mental health diagnosis as the principal diagnosis since this program is for patients who have a profound and disabling mental health condition. Any claim with UB-04 Bill Type 0761 (Clinic - Community Health Center) or UB-04 Bill Type 013X (Hospital Outpatient) with Condition Code 41 (Partial Hospitalization) that does not have a principal diagnosis in the mental health range will receive this edit.

Note
OCE Edit 029 will not be returned when the principal diagnosis is a Code First diagnosis.

G.1.29.1 Example:
OCE Edit 029 will be returned when only the following diagnosis code is reported on a partial hospitalization claim (UB-04 Bill Type 076X):

- A00.0 with procedure code 90845

G.1.29.2 APC Assistant™:
Check the valid ICD-10-CM diagnosis codes in the MH - Mental Health list located under the Other Criteria drop-down on the Diagnoses page. Any code not listed will generate OCE Edit 029 on a partial hospitalization claim.

G.1.30 OCE Edit 030
Insufficient Services on Day of Partial Hospitalization (Line Item Denial)

Identifies a date of service on a partial hospitalization claim where mental health services were provided, but that day does not have the required level of service for the partial hospitalization per diem payment. This level of service is required since partial hospitalization programs are designed to provide individualized, coordinated, comprehensive, and multidisciplinary treatment. This edit applies to UB-04 Bill Type 013X (Hospital Outpatient) claims with Condition Code 41 (Partial Hospitalization) and UB-04 Bill Type 0761 (Clinic - Community Mental Health Center) claims only.
Partial hospitalization services are divided into two lists: List A and List B. List A contains extended, family, and group psychotherapy services. List B contains all services on List A and all other types of psychotherapy services, neuropsychological testing services, activity therapy, occupational therapy, and education and training services.

OCE Edit 030 is assigned to a partial hospitalization claim where one of the following is true:

1. At least one, but less than three, partial hospitalization services are provided on a day, or
2. At least three partial hospitalization services are provided on a day, but the services provided do not include at least one service from List A.

Each day of a partial hospitalization claim that does not receive OCE Edit 030 is potentially eligible to receive the partial hospitalization per diem payment for that day.

G.1.30.1 Example:
OCE Edit 030 will be returned when a partial hospitalization claim has a valid mental health principal diagnosis code but contains only procedure code 90845, *Psychoanalysis*.

The following section of OCE Edit 030 is **Not Active as of 01/01/09:**

OCE Edit 030 may not appear on a claim, even if the above criteria are met, if all of the following are true:

1. There are more than 3 days of service on the claim.
2. At least 57% (4/7) of the days that the claim spans included partial hospitalization services.
3. At least 75% of the days that the claim spans meet the partial hospitalization service criteria listed above (i.e., at least 3 partial hospitalization services one of which is on List A).

If one of the occupational training codes listed above appears multiple times, or with units greater than one, on a particular date, that service is counted only once in determining eligibility for OCE Edit 030. Prior to the Version 5.0 OCE, activity training and education and training services appearing multiple times were also counted only once in determining eligibility for OCE Edit 030.

G.1.31 OCE Edit 031

**Partial Hospitalization on Same Day as ECT (Electroconvulsive Therapy) or Type T Procedure (Not Active as of 01/01/06)**

Identifies a date of service where the patient received Electroconvulsive Therapy (ECT) or a surgical service (type T, Procedure or Service, Multiple Reduction Applies) on the same day as partial hospitalization services. The claim will be reviewed to determine if the partial hospitalization day is reasonable and necessary, taking into account the patient’s condition. This OCE Edit applies to UB-04 Bill Type 013X (Hospital Outpatient) claims with
Condition Code 41 (Partial Hospitalization) and UB-04 Bill Type 0761 (Clinic - Community Mental Health) claims only.

ECT is identified by APC 00320 (Electroconvulsive Therapy). The presence of an ECT service, or any service assigned to an APC with Payment Status Indicator T, on any date within a partial hospitalization claim, will generate OCE Edit 031 for the claim.

G.1.32 OCE Edit 032
Partial Hospitalization Claim Spans 3 or Less Days With Insufficient Services on At Least One of the Days (Not Active as of 01/01/09)
Combines OCE Edit 030 and OCE Edit 031 for partial hospitalization claims with From and Thru dates spanning two or three dates of service. For these claims, if one or more of the days qualifies for either OCE Edit 030 or 031, then the claim is also assigned OCE Edit 032. This edit applies to UB-04 Bill Type 013X (Hospital Outpatient) claims with Condition Code 41 (Partial Hospitalization) and UB-04 Bill Type 0761 (Clinic - Community Mental Health) claims only.

G.1.33 OCE Edit 033
Partial Hospitalization Claim Spans More Than 3 Days With Insufficient Number of Days Meeting PHP Services (Not Active as of 01/01/09)
Identifies a partial hospitalization claim with insufficient mental health services, where the claim spans more than three days. This edit applies to UB-04 Bill Type 013X (Hospital Outpatient) claims with Condition Code 41 (Partial Hospitalization) and UB-04 Bill Type 0761 (Clinic - Community Mental Health) claims only.

A claim with a claim span of more than three days, where less than four out of seven days (less than 57% of the days in the claim span) contain at least one partial hospitalization service, will be assigned OCE Edit 033.

In the context of this edit, claim span is defined as the earliest service date to the latest service date. For example, a claim with a From Date of October 1st, and a Thru Date of October 31st, but with services provided only on October 10th - 20th, would have a claim span of eleven days.

G.1.34 OCE Edit 034
Partial Hospitalization Claim Spans More Than 3 days With Insufficient Number of Days Meeting Partial Hospitalization Criteria (Not Active as of 01/01/09)
Combines OCE Edit 030 and OCE Edit 031 for partial hospitalization claims with From and Thru dates spanning more than three days. This edit applies to UB-04 Bill Type 013X (Hospital Outpatient) claims with Condition Code 41 (Partial Hospitalization) and UB-04 Bill Type 0761 (Clinic - Community Mental Health) claims only.
This edit applies to any claim that spans more than three days, which does not meet the criteria for OCE Edit 033. If a claim has been assigned OCE Edit 033, it is not eligible for OCE Edit 034. On the claim there must be an adequate number of days that do contain at least one partial hospitalization service, but in addition, at least 75% of those days must also contain the minimum level of partial hospitalization services required to qualify for the per diem payment. This is the minimum level of services that will not generate OCE Edit 030 for the day. If these conditions are not met, the claim will be assigned OCE Edit 034.

In the context of this edit, claim span is defined as the earliest service date to the latest service date. For example, a claim with a From Date of October 1st, and a Thru Date of October 31st, but with services provided only on October 10th - 20th, would have a claim span of eleven days.

G.1.35 OCE Edit 035

**Only Mental Health Education and Training Services Provided (Returned to Provider (RTP))**

Only mental health education and training services are provided. OCE Edit 035 is assigned to any claim where the only services on the claim or day are classified as mental health education and training services. OCE Edit 035 is not assigned to partial hospitalization claims, and does not require a mental health diagnosis.

**G.1.35.1 Example:**
OCE Edit 035 will be returned for a two-day claim containing procedure code G0177 and procedure code 92065. The second date with procedure code G0177 will receive OCE Edit 035.

**G.1.35.2 APC Assistant™:**
The procedure codes that generate OCE Edit 035 in the absence of other outpatient psychiatric services are listed in the **035-MH Ed/Train** list located in the Criteria drop-down on the Procedures page.

G.1.36 OCE Edit 036

**Extensive Mental Health Services Provided on Day of ECT (Electroconvulsive Therapy) or Type T Procedure (Not Active as of 01/01/06)**

Identifies dates of service where the patient received ECT or a surgical service (Type T, subject to multiple procedure discounting) and an extensive mental health services on the same day. This edit is similar to partial hospitalization OCE Edit 031, but applies only to mental health (non-partial hospitalization) claims. ECT is identified by APC 00320 (Electroconvulsive Therapy). Two procedure codes are assigned to this APC: procedure code 90870 and procedure code 90871.

Only procedures assigned to APCs 00323 (Extended Individual Psychotherapy), 00324 (Family Psychotherapy), or 00325 (Group
Psychotherapy) are considered extensive mental health services in the context of this edit.

The presence of a Payment Status Indicator T service alongside extensive mental health services does not trigger OCE Edit 036 unless the claim is eligible for the mental health per diem cap for that day. That is, where payment for mental health services for a particular service date exceeds the mental health per diem cap.

G.1.37 OCE Edit 037

**Terminated Bilateral Procedure or Terminated Procedure with Units Greater Than 1 (Returned to Provider (RTP))**

Identifies terminated procedures with a Modifier of 50 (Bilateral Procedure) or units greater than one (1). When a procedure is terminated, the first procedure that was planned should be reported with an appropriate modifier. Any other procedure should not be reported. Terminated procedures are identified with Modifier 52 (Reduced Services) or Modifier 73 (Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia).

**G.1.37.1 Example**

OCE Edit 037 will be returned if a claim line contains procedure code 70030 with Modifier 73 and two units of service.

G.1.38 OCE Edit 038

**Inconsistency Between Implanted Device or Administered Substance and Implantation or Associated Procedure (Returned to Provider (RTP))**

Identifies cases where a claim contains an implanted device, but does not contain an appropriate matching procedure. This edit is triggered whenever a Payment Status Indicator H or U item is present on a claim without a service assigned to Payment Status Indicator S, T, or J1 on the same date.

**G.1.38.1 Example**

OCE Edit 038 will be returned if a claim contains procedure code A9527 without any procedure codes that have a Payment Status Indicator of S, T, or J1.

**G.1.38.2 APC Assistant™:**

All procedure codes that are assigned to Payment Status Indicator of H, S, T, U, or J1 are listed under the appropriate Payment Status Indicator list located under Pay Stat on the Procedures page.

G.1.39 OCE Edit 039

**Mutually Exclusive Procedure That Would be Allowed by NCCI if Appropriate Modifier Were Present (Line Item Rejection) (Not Active)**

Identifies a procedure code that is one of a pair of mutually exclusive procedures. Such procedures would not ordinarily be paid, but would be allowed if the appropriate modifier were present.
Only certain modifiers will override this edit. They are: 58, 59, 78, 79, and 91 for Level I. For Level II, they are E1-E4, F1-F9, FA, LC, LD, LT, RC, RT, T1-T9, and TA.

**Note**
With the July 2012 IOCE, CMS has deactivated OCE Edit 039 and combined it with OCE Edit 040 retroactive to the beginning of the IOCE.

**G.1.40 OCE Edit 040**

**Code 2 of a Code Pair That Would be Allowed by NCCI if Appropriate Modifier Were Present (Line Item Rejection)**

Identifies the column 2 code of a column1/column2 Correct Coding Edit, indicating that this code should not be reported along with the column 1 code on the same service date. Often, the column 2 code is a component of a procedure that is billed on the same date as the comprehensive procedure. Services that are normally a component of a more comprehensive procedure cannot be billed separately, but must be considered as included in the more comprehensive procedure. This edit is also based on CCI logic.

Only certain modifiers will override this edit. They are: 24, 25, 27, 57, 58, 59, 78, 79, 91, E1-E4, F1-F9, FA, LC, LD, LM, LT, RC, RI, RT, T1-T9, TA,XE, XP, XS, and XU.

Prior to the V5.0 OCE, this edit was referred to as the Comprehensive/Component Edit. This definition was expanded in the Correct Coding Edits and subsequently in the OCE.

**G.1.40.1 Example:**
OCE Edit 040 will be returned if procedure code 77412 was reported with procedure code 77402 without the appropriate modifier. The claim line with procedure code 77402 will receive this edit.

**G.1.40.2 APC Assistant™:**
All OCE/CCI mutually exclusive code pairs are listed in the OCE/CCI Edit Pairs page. To view the modifiers that can override this edit, refer to the NCCI Mod drop-down on the Modifiers page.

**G.1.41 OCE Edit 041**

**Invalid Revenue Code ( Returned to Provider (RTP))**

The UB-04 revenue code reported was not valid for the patient’s dates of service or has never been valid, or the claim line was submitted without a revenue code.

Effective with the V5.0 OCE, any claim lines which have no procedure code and an invalid revenue code are also assigned to Payment Status Indicator W.

**Note**
In addition to identifying invalid revenue codes, the OCE groups revenue codes into four categories: non-covered, non-allowed, packaged, and other.
Any claim line that contains only revenue code and charges - that is, any claim line without a procedure code - is slotted by the OCE into one of those four groups. Only those charges associated with revenue codes in the packaged group will be included in the pricing and payment calculations. This information is passed on to the APC-HOPD Pricer, which determines which charges to include in its outlier payments and hold harmless adjustment calculations based on these categorizations.

G.1.41.1 Example:
OCE Edit 041 will be returned for claims with UB-04 Revenue Code 0184 (Leave of Absence) with or without a procedure code.

G.1.41.2 APC Assistant™:
Refer to the Revenue Codes page for a list of all valid revenue codes. Any code not on this list, or not valid as of the date of service, will generate OCE Edit 041.

G.1.42 OCE Edit 042
Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0 (Returned to Provider (RTP))

A medical visit involves evaluation and management services, provided either in a clinic or in the emergency room. Under the OPPS, multiple medical visits cannot be billed with the same revenue center on the same date of service. Under this circumstance, if separate and unrelated services are provided during the second visit, providers are instructed to include Condition Code G0 (Distinct Medical Visit) on the claim. If a claim does not have Condition Code G0, but has multiple medical visits on the same date and reported with the same revenue code, the OCE assigns OCE Edit 042 to each of these services.

G.1.42.1 Example
OCE Edit 042 will be returned if a claim contains procedure code 92002 and procedure code 95250 on the same day with Revenue Code 0510 (Clinic General Classification). Both claim lines will receive OCE Edit 042.

G.1.42.2 APC Assistant™:
All procedure codes that represent medical visits are listed in the V - Clinic or emergency department visit list located in Pay Stat drop-down on the Procedures page.

G.1.43 OCE Edit 043
Transfusion or Blood Product Exchange Without Specification of Blood Product (Returned to Provider (RTP))

There are only a few codes used in the OCE to identify blood administration services. These include procedure codes 36430, 36440, and 36460. There are approximately thirty-four codes used in the OCE to identify blood products. They are in the following range: P9010 - P9060. A blood product is needed
when reporting a blood transfusion or exchange. These lists may be updated with each version of the OCE.

G.1.43.1 Example
OCE Edit 043 will be returned on a claim with only procedure code 36430 since no blood administration procedure was reported.

G.1.43.2 APC Assistant™:
Blood administration services are listed in the 043 - Blood Transfusion list located in the Criteria drop-down on the Procedures page. Blood products are listed in the 043 - Blood Product list located in the Criteria drop-down on the Procedures page.

G.1.44 OCE Edit 044
Observation Revenue Code on Line Item With Non-Observation HCPCS Code (Returned to Provider (RTP))

This edit identifies claim lines containing inappropriately coded observation room services. This edit is triggered if a claim line is assigned to a designated observation room revenue code, but does not contain one of the codes Medicare has identified as appropriate for observation room charge lines.

G.1.44.1 Example:
OCE Edit 044 will be returned on a claim line with UB-01 Revenue Code 0762 (Treatment/Observation Room) and procedure code 73120.

G.1.44.2 APC Assistant™:
Observation room revenue codes can be identified under the Category drop-down on the Revenue Codes page. To obtain a list of observation room revenue code(s) refer to the Revenue Code page.

Observation room services can be identified under the 044-Observation option under the Criteria drop-down on the Procedures page.

G.1.45 OCE Edit 045
Inpatient Separate Procedures Not Paid (Line Item Rejection)

Medicare has established a list of procedures that it believes can only be safely performed in an inpatient setting. The purpose of OCE Edit 045 is to identify instances where inpatient only procedures will not trigger a day denial. When included on an outpatient claim, these services will generate OCE Edit 018, and all services on that date will be denied. With OCE Edit 018, the OCE will deny any service that occurred on the same day as an inpatient only procedure (indicated by Payment Status Indicator C). In contrast, assignment of OCE Edit 045 results in a line item rejection of only the inpatient procedure. Other services provided on the same date may be reimbursed.

Medicare designated a sub-group of inpatient procedures as Separate Procedures. Under certain circumstances these procedures trigger OCE Edit 045 instead of OCE Edit 018. If an inpatient procedure occurs on the Separate Procedures List, OCE Edit 045 will be assigned to this procedure as long as
there is another service on the same date with Payment Status Indicator T or J1. Otherwise, if Payment Status Indicator T or J1 is not assigned to any procedure that occurs on the same date, OCE Edit 018 will be assigned.

G.1.45.1 Example:
OCE Edit 045 will be returned for a claim containing inpatient only procedure code 27005 and a Payment Status Indicator T or J1 procedure such as 27006 provided on the same day. OCE Edit 045 will apply to the 27005 claim line.

G.1.45.2 APC Assistant™:
Procedure codes that may generate OCE Edit 045 are listed in the 045-Inpt Sep Proc list located under the Criteria drop-down on the Procedures page. All inpatient procedures are listed in the 018-Inpatient Only list located under the Pay Stat drop-down on the Procedures page. Payment Status Indicator T procedures are listed in the T - Procedure or Service, Multiple Reduction Applies list located under the Pay Stat drop-down on the Procedures page.

G.1.46 OCE Edit 046
Partial Hospitalization Condition Code 41 Not Approved for Type of Bill (Claim Returned to Provider)
The purpose of this edit is to identify incorrect partial hospitalization claims. This edit is triggered if a claim with UB-04 Bill Type 012X (Hospital Inpatient (Medicare Part B Only)) or 014X (Hospital - Laboratory Services Provided to Non-Patients) is submitted with Condition Code 41 (Partial Hospitalization).

G.1.46.1 Example:
OCE Edit 046 will be returned for a claim with UB-04 Bill Type 012X and Condition Code 41.

G.1.47 OCE Edit 047
Service is Not Separately Payable (Line Item Rejection)
The purpose of this edit is to identify claims with services that are not separately payable by Medicare. OCE Edit 047 occurs when a claim entirely consists of:

1. One or more line item denials and/or rejections, and
2. One or more line items classified as incidental or packaged. These claim lines include procedure codes with a Payment Status Indicator of N, as well as packaged revenue codes reported with charges only (no procedure), also assigned to Payment Status Indicator N. OCE Edit 047 is assigned to each of these claim lines.

G.1.47.1 Example:
OCE Edit 047 will be returned for claims with procedure code 78351 and a line item with charges only (no procedure) for Revenue Code 0252 (Pharmacy Nongeneric Drugs). The line item with charges only and no procedure code will receive OCE Edit 047. The line with 78351 will receive OCE Edit 009.
G.1.47.2 APC Assistant™:
All services classified by Medicare as incidental are included in the N - Packaged/incidental service list located under the Pay Stat drop-down on the Procedures page. For lines without procedure codes, all revenue codes classified as packaged can be shown by utilizing the Packaged drop-down on the Revenue Codes page.

G.1.48 OCE Edit 048
Revenue Center Requires HCPCS Code (Returned to Provider (RTP))
The purpose of this edit is to identify claim lines containing charges only (no procedure) with revenue codes that are not considered by the OCE to be packaged. If the revenue code is on a list of non-covered or non-allowed revenue codes, the charges associated with this line will be excluded from any outlier payments or hold harmless adjustment calculations.

G.1.48.1 Example:
OCE Edit 048 will be returned for UB-04 Bill Type 0131 (Hospital Outpatient) claim line items without an associated procedure code, billed with Revenue Code 0320 (Radiology Diagnostic General Classification).

G.1.48.2 APC Assistant™:
The non-covered revenue codes that generate OCE Edit 048 can be found by utilizing the Non-covered drop-down on the Revenue Codes page. The non-allowed revenue codes that generate this edit can be found by utilizing the Non-allowed drop-down on the Revenue Codes page. The revenue codes that will not generate OCE Edit 048 when submitted without a procedure code can be found by utilizing the Packaged drop-down on the Revenue Codes page.

G.1.49 OCE Edit 049
Service on Same Day as Inpatient Procedure (Line Item Denial)
The presence of a service on an outpatient claim which Medicare considers to be inpatient only causes Medicare to deny all services provided on the same service date. Services provided on the same date as an inpatient only service are all assigned to OCE Edit 049, and flagged for line item denial. Since OCE Edit 018 initiates the assignment of OCE Edit 049, no other edits will be performed on lines with OCE Edit 049.

G.1.49.1 Example:
OCE Edit 049 will be returned for claims lines containing procedure codes 00176 (Payment Status Indicator C) and 36514 (Payment Status Indicator S) with the same service date (refer to OCE Edit 045).

G.1.49.2 APC Assistant™:
All inpatient services are listed in the C - Inpatient service, not paid under OPPS list located under the Pay Stat drop-down on the Procedures page. Separate inpatient procedures are listed in the 045 - Inpt Sep Proc list located
under the **Criteria** drop-down on the **Procedures** page (refer to **OCE Edit 045**).

**G.1.50 OCE Edit 050**

**Non-Covered Under Any Medicare Outpatient Benefit, Based on Statutory Exclusion (Returned to Provider (RTP))**

Certain services that are not covered under any Medicare outpatient benefit due to a statutory requirement, have been separated from the other non-covered services and assigned to OCE Edit 050. In addition, when Revenue Code 0637 is submitted without a procedure code, OCE Edit 050 is assigned.

**G.1.50.1 Example:**

OCE Edit 050 will be returned for claims containing procedure code V5241 which is a non-covered service based on statutory exclusion.

**G.1.50.2 APC Assistant™:**

All services that trigger OCE Edit 050 are listed in the **050-Non-Cov Stat Excl** list located under **Criteria** drop-down on the **Procedures** page.

**G.1.51 OCE Edit 051**

**Multiple Observations Overlap in Time (Not Active)**

Historically, OCE Edit 051 identifies overlapping periods of observation.

**G.1.52 OCE Edit 052**

**Observation Does Not Meet Minimum Hours, Qualifying Diagnoses, and/or type “T” Procedure Conditions (Not Active as of 01/01/06)**

**G.1.52.1 Prior to January 01, 2006**

Observation services are eligible for additional payment under the OPPS in certain limited circumstances. These observation services are identified by procedure code G0244. This procedure code is allowed on a hospital outpatient claim only if all of the following are true (Refer to **OCE Edit 056** and **OCE Edit 057**):

1. One of the diagnoses on the claim is related to chest pain, congestive heart failure, or asthma. Medicare has specified a list of diagnoses that correspond to each condition. The diagnosis code can be in any position on the claim. The admit diagnosis is also considered for this requirement.

2. The units associated with G0244 must be greater than or equal to 8 hours of observation. Less than 8 hours of observation services are not separately payable.

3. There can be no service assigned to Payment Status Indicator T present on the claim with a service date equal to, or one day prior to, the G0244 service date.
G.1.52.2 As of January 01, 2006
OCE Edit 052 is no longer active. However, requirements for separately payable observation services have not changed. Observation services are reported with procedure code G0378. Observation services not meeting the hours, diagnosis, or Payment Status Indicator T criteria of OCE Edit 052 will be packaged, rather than designated as separately payable, but OCE Edit 052 will no longer be assigned.

G.1.53 OCE Edit 053
Codes G0378 and G0379 Only Allowed with Bill Type 013X (Line Item Rejection)
Procedure codes G0378 and G0379 are not allowed on any claim except those with a UB-04 Bill Type of 013X.

G.1.53.1 Example:
OCE Edit 053 will be returned on a claim with a UB-04 Bill Type of 0341 (Home Health Services Not Under a Plan of Treatment) that contains procedure code G0378.

G.1.53.2 APC Assistant™:
Observation service codes can be identified from the OBSCD - Observation Room Code list under the Criteria drop-down on the Procedures page.

G.1.54 OCE Edit 054
Multiple Codes for the Same Service (Not Active)
Historically, OCE Edit 054 identified two codes that were not allowed to be coded together on the same day. Both codes received the edit. This edit involved only a small set of code pairs describing blood components.

G.1.55 OCE Edit 055
Non-Reportable for Site of Service (Returned to Provider (RTP))
Procedure codes beginning with C (generally codes representing high tech pass-through devices) are created solely for use on OPPS outpatient claims. If a procedure code beginning with a C is submitted on a claim where the UB-04 Bill Type is not 012X - 014X, the claim is flagged with OCE Edit 055 and the claim is returned to the provider for correction.

G.1.55.1 Example:
OCE Edit 055 will be returned on claims with a UB-04 Bill Type of 0341 (Home Health Services Not Under a Plan of Treatment) along with procedure code C1760.

G.1.55.2 APC Assistant™:
All procedure codes that generate OCE Edit 055 are listed in the 055-OPPS Specific Proc list located in the Criteria drop-down on the Procedures page.
**G.1.56 OCE Edit 056**

**E/M Condition Not Met and Line Item Date for Observation Code G0244 is Not 12/31 or 1/1 (Not Active as of 01/01/06)**

OCE Edit 056 identifies claims where observation services are reported separately, but without the required Evaluation & Management (E&M) services, and the service date is not the first or last day of any calendar year.

The claim must contain E&M services or critical care services on the same date, or one day prior to, the G0244 service date. These services must map to one of the following APCs:

- 00600 (Low Level Clinic Visits)
- 00601 (Mid Level Clinic Visits)
- 00602 (High Level Clinic Visits)
- 00610 (Low Level Emergency Visits)
- 00611 (Mid Level Emergency Visits)
- 00612 (High Level Emergency Visits)
- 00620 (Critical Care)

**G.1.56.1 Beginning in January 2003**

A direct admit to observation for a patient with asthma, CHF, or chest pain as represented by procedure code G0263 on the same date as the G0244 service date will also meet this E&M requirement, even though the services represented by this code are packaged.

**G.1.56.2 Prior to January 01, 2005**

In previous OCE releases for each condition (chest pain, CHF, asthma), Medicare had identified additional ancillary services that must be on the claim with the same service date, or one day prior to the G0244 service date.

**G.1.56.3 After January 01, 2006**

OCE Edit 056 is no longer active, however requirements for separately payable observation services have not changed. Observation services are reported with procedure code G0378 and direct admission to observation is reported with procedure code G0379. Observation services not meeting the E&M criteria of OCE Edit 056 will be packaged, rather than designated as separately payable, but OCE Edit 056 will no longer be assigned.

**G.1.57 OCE Edit 057**

**E&M Condition Not Met for Observation and Line Item Date for Code G0378 is 1/1 (Claim Suspended)**

OCE Edit 057 identifies claims where at least eight units of observation services are reported on the first day of any calendar year without a Payment Status Indicator T service on the same day or day before, and without the required E&M service on the same day or the day before. Before January 01,
2006, this edit also applied to observation services provided on the last day of December.

G.1.57.1 Prior to January 01, 2005
Medicare only provides separate payment for observation services for patients with specific conditions (i.e., chest pain, CHF, and asthma). For each of these conditions, Medicare requires that specific ancillary services must be billed on the same day or the day before the observation service. OCE Edit 057 identifies claims that contain the proper condition and observation service, but do not contain the required ancillary services.

G.1.57.2 Example:
OCE Edit 057 will be returned for the G0378 for claims that contain eight units of procedure code G0378 with a service date of January 1st, and procedure code 95250 also on January 1st. Please note that at least one payable service (not an E&M service) must also be billed on the same claim.

G.1.57.3 APC Assistant™:
All E&M services that will trigger this edit are tagged with a List ID of A on the Conditional APCs page.

G.1.58 OCE Edit 058
G0379 Only Allowed with G0378 (Returned to Provider (RTP))
As of January 01, 2006, OCE Edit 058 identifies claims where procedure code G0379 is reported on a claim with a UB-04 Bill Type of 013X (Hospital, Outpatient), but without procedure code G0378.

G.1.58.1 Example:
OCE Edit 058 will be returned on claims containing procedure code G0379 without procedure code G0378.

G.1.59 OCE Edit 059
Clinical Trial Requires Diagnosis Code V707 as Other Than Primary Diagnosis (Not Active)
OCE Edit 059 identifies claims where clinical trial services are present, but ICD-10-CM diagnosis code Z00.6 is not submitted as the admitting diagnosis or a secondary diagnosis. Clinical trial services are represented by the following procedure codes:

• G0292
• G0293
• G0294
G.1.60 OCE Edit 060
Use of Modifier CA with More Than One Procedure Not Allowed (Returned to Provider (RTP))

OCE Edit 060 identifies claims in which Modifier CA (Procedure Payable Only in the Inpatient Setting When Performed Emergently on an Outpatient Who Expires Prior to Admission) is used to identify an inpatient-only service performed on an emergency room patient who dies before being admitted or transferred. It cannot be used more than once for the same date on the same claim. Also, units must equal 1 for any service billed with Modifier CA.

G.1.60.1 Example:
OCE Edit 060 will be returned for claims containing 2 units of procedure code 62258 billed with Modifier CA.

G.1.61 OCE Edit 061
Service Can Only be Billed to the DMERC (Returned to Provider (RTP))

This edit was new with the Version 5.0 OCE and was effective January 01, 2004. OCE Edit 061 identifies codes representing non-implantable durable medical equipment that should be billed separately to the regional carrier (DMERC). These services are generally assigned to Payment Status Indicator Y. This edit does not apply to Comprehensive APC claims.

G.1.61.1 Example:
OCE Edit 061 will be returned on claims containing procedure code Q4074 billed to an Fiscal Intermediary (FI).

G.1.61.2 APC Assistant™:
All procedure codes that generate OCE Edit 061 are classified as 061-DME under the Criteria drop-down on the Procedures page.

G.1.62 OCE Edit 062
Code Not Recognized by OPPS; Alternate Code for Same Service May be Available (Returned to Provider (RTP))

This edit was new with the Version 5.0 OCE and was effective January 01, 2004. OCE Edit 062 identifies codes that are not recognized by Medicare under the OPPS. Alternate and acceptable codes (usually Level II procedure codes) may be available for the same service. Most of the codes under this edit were previously reported under OCE Edit 028.

G.1.62.1 Example:
OCE Edit 062 will be returned on claims containing procedure code 99183 which is not recognized by Medicare under OPPS. Use procedure code C1300 instead.

G.1.62.2 APC Assistant™:
All procedure codes that generate OCE Edit 062 are classified as 062-Not Recognized under the Criteria drop-down on the Procedures page.
G.1.63 OCE Edit 063

OT (Occupational Therapy) Code Only Billed on Partial Hospitalization Claims (Returned to Provider (RTP))

This edit was new with the Version 5.0 OCE and was implemented retroactively to August 01, 2000. OCE Edit 063 identifies occupational therapy services on a non-partial hospitalization claim (for example, a standard UB-04 Bill Type of 013X (Hospital, Outpatient) without Condition Code 41 (Partial Hospitalization)).

Note
With the January 2013 IOCE, CMS has deactivated OCE Edit 063, effective January 01, 2013. This edit is still valid for claims billed on or before December 31, 2012.

G.1.64 OCE Edit 064

AT (Activity Therapy) Service Not Payable Outside the Partial Hospitalization Program (Line Item Rejection)

This edit was new with the Version 5.0 OCE and was implemented retroactively to August 01, 2000. OCE Edit 064 identifies activity therapy services on a non-partial hospitalization claim (for example, a standard UB-04 Bill Type of 0131 (Hospital, Outpatient) without Condition Code 41 (Partial Hospitalization)).

Note
With the January 2013 IOCE, CMS has deactivated OCE Edit 064, effective January 01, 2013. This edit is still valid for claims billed on or before December 31, 2012.

G.1.65 OCE Edit 065

Revenue Code Not Recognized by Medicare (Line Item Rejection)

This edit was new with the Version 5.2 OCE and was implemented retroactively to August 01, 2000. Line items with these revenue codes are rejected for payment by Medicare, when no procedure codes are present.

G.1.65.1 Example:
OCE Edit 065 will be returned on claims containing Revenue Code 0905 (Psychiatric/Psychological Treatments of Intens OP Services - Psychiatric). Revenue Code 0905 is not recognized by Medicare and would generate Edit 065 if no procedure code was provided on the claim line.

G.1.65.2 APC Assistant™:
Revenue codes not recognized by Medicare can be identified from the Not Recognized list on the Revenue Codes page.
G.1.66 OCE Edit 066

**Code Requires Manual Pricing (Claim Suspended)**

This edit was new with the Version 5.2 OCE and was implemented retroactively to January 01, 2004. Services provided after FDA approval, but prior to designation of a new procedure code are billed using procedure code C9399. This procedure code causes a claim suspension, so that the service can be manually priced based on 95% of the Average Wholesale Price (AWP). Supporting information including National Drug Code (NDC), units, and date of service may be required in the remarks section of the claim.

**G.1.66.1 Example:**

OCE Edit 066 will be returned for claims containing procedure code C9399, which represents a drug or biological that has received FDA approval, but has not yet been assigned a unique procedure code.

**G.1.66.2 APC Assistant™:**

Procedure codes which can be used to identify drugs or biologicals receiving FDA approval, but not yet assigned unique procedure codes can be found in the [066-Unclassified drug or biological procedure codes that require manual pricing](#) list under the Criteria drop-down on the Procedures page.

G.1.67 OCE Edit 067

**Service Provided Prior to FDA Approval (Line Item Denial)**

This edit was new with the Version 5.2 OCE, and was implemented retroactively to January 01, 2004 and updated with the Version 6.1 OCE. Any new drug or biological which is provided after designation of a new procedure code, but prior to FDA approval is flagged with OCE Edit 067 and denied for payment.

**G.1.67.1 Example:**

OCE Edit 067 will be returned for claims containing procedure code 90620 billed with service dates prior to the date in which FDA approval was received, which was January 23, 2015.

**G.1.67.2 APC Assistant™:**

Procedure codes subject to this edit can be found on the [067-FDA](#) list under the Criteria drop-down on the Procedures page.

G.1.68 OCE Edit 068

**Service Provided Prior to Date of National Coverage Determination (NCD) Approval (Line Item Denial)**

This edit was new with the Version 6.0 OCE and was effective January 01, 2005. Any service which is provided prior to National Coverage Determination (NCD) approval is flagged with OCE Edit 068 and is denied for payment.
G.1.68.1 Example:
OCE Edit 068 will be returned on claims containing procedure code 0002U billed with service dates prior to the date in which NCD approval was received, which was on February 01, 2017.

G.1.68.2 APC Assistant™:
Procedure codes subject to this edit can be found under the 068-NCD Coverage Date list under the Criteria drop-down on the Procedures page.

G.1.69 OCE Edit 069
Service Provided Outside Approval Period (Line Item Denial)

This edit was new with the Version 6.0 OCE and was implemented retroactively to October 01, 2004. Specific services which are billed outside of a limited clinical trial/approval period are flagged with OCE Edit 069 and denied for payment.

G.1.69.1 Example:
OCE Edit 069 will be returned for claims containing procedure code G2000 billed outside of the approval period. This procedure code is approved for use under a clinical trial only during the time period of August 01, 2018 – December 31, 2026.

G.1.69.2 APC Assistant™:
Procedure codes subject to this edit can be found under the 069-Approval Range list under the Criteria drop-down on the Procedures page.

G.1.70 OCE Edit 070
CA Modifier Requires Patient Discharge Status Indicating Expired or Transferred (Returned to Provider (RTP))

Services which have been designated as inpatient-only can be reimbursed when performed in the emergency room when the patient dies prior to admission or when the patient is transferred to another hospital. The service should be submitted with Modifier CA (Procedure Payable Only in the Inpatient Setting When Performed Emergently on an Outpatient Who Expires Prior to Admission), but this modifier will not be accepted unless the discharge status code is 02, 05, 20, 62, 63, 65, 66, 82, 85, 90, 91, 93, or 94.

G.1.70.1 Example:
OCE Edit 070 will be returned for claims containing procedure code 27470 because this code is an inpatient-only procedure. If performed in an emergency room on an outpatient basis and the patient dies prior to admission, the claim must include Modifier CA and discharge status code 20. Otherwise, OCE Edit 070 will be generated.
G.1.71 OCE Edit 071
Claim Lacks Required Device Code (Returned to Provider (RTP)) (Not Active as of 01/01/15)

This edit was new with the Version 6.1 OCE and was effective April 01, 2005. Hospitals paid under the OPPS that report procedure codes that require the use of devices must also report the applicable procedure codes and charges for all devices that are used to perform the procedures. Device coding is necessary so that the OPPS payment for these procedures will be correct in future years.

For October 2005 and again for January 2006, CMS made substantial changes to OCE Edit 071, significantly expanding the list of device/procedure pairs and adding a small set of procedures requiring two devices.

G.1.72 OCE Edit 072
Service Not Billable to the MAC (Returned to Provider (RTP))

This edit was new with the Version 6.1 OCE and was effective retroactive to January 01, 2005. Services assigned to Payment Status Indicator M cannot be billed to the Medicare Administrative Contractor (MAC), and claims containing these services will be returned to the provider for correction. Generally, this edit relates to IV infusion, chemotherapy, and chemotherapy assessment services provided by the physician.

G.1.72.1 Example:
OCE Edit 072 will be returned on hospital outpatient claims containing procedure code 88291. This procedure code should be reported on a physician claim.

G.1.72.2 APC Assistant™:
All procedure codes that generate OCE Edit 072 are listed under the 072-Not Billable list under the Pay Stat drop-down on the Procedures page.

G.1.73 OCE Edit 073
Incorrect Billing of Blood and Blood Products (Returned to Provider (RTP))

This edit was new with the Version 6.2 OCE and was effective July 01, 2005. If an OPPS provider pays for the actual blood or blood product itself, in addition to paying for processing and storage costs when blood or blood products are supplied by either a community blood bank or the OPPS provider’s own blood bank, the OPPS provider must separate the charge for the blood product(s) from the charge for processing and storage services. The OPPS provider reports charges for the blood or blood product itself using revenue code series 038X with the appropriate blood product procedure code and Modifier BL. The OPPS provider reports charges for processing and storage services on a separate line using Revenue Code 0390 or 0399 with the appropriate blood product procedure code and procedure Modifier BL (Special Acquisition of Blood and Blood Products).
Whenever an OPPS provider reports a charge for blood or blood products using Revenue Code 038X (Blood and Blood Components), the OPPS provider must also report a charge for processing and storage services on a separate line using Revenue Code 0390 (Blood Storage and Processing General Classification) or 0399 (Blood Storage and Processing Other). Further, the same date, units, procedure code, and Modifier BL must be reported on both lines.

Effective for services furnished on or after July 01, 2005, the OCE will return to providers any claim that reports a charge for blood or blood products using Revenue Code 038X without a separate line for processing and storage services using Revenue Code 0390 or 0399, and both lines must include the same line item date of service, units, and procedure code accompanied by Modifier BL.

G.1.73.1 Example:
OCE Edit 073 will be returned if procedure code P9010 is billed with Revenue Code 0381 (Blood Packed Red Cells), and there is not another line on the same claim with a matching date, unit(s), procedure code, and Revenue Code 039X (Administration, Processing, and Storage for Blood and Blood Components), or if there is a matching line, but both claim lines do not include Modifier BL.

G.1.73.2 APC Assistant™:
Blood products are listed in the 073-Blood Product list located under the Criteria drop-down on the Procedures page.

G.1.74 OCE Edit 074
Units Greater Than One for Bilateral Procedure Billed With Modifier 50 (Returned to Provider (RTP))

This edit was new to the Version 7.3 OCE and was effective October 01, 2006. This edit identifies conditionally or independently bilateral services with a Modifier 50 (Bilateral Procedure) and units of service greater than one on the same claim line.

Effective January 01, 2008 (Version 9.0 of the OCE), critical access claims (UB-04 Bill Type 085X (Critical Access Hospital)) that contain conditional or independently bilateral codes with Modifier 50 and more than one unit of service on the same line or multiple lines on the same day, with the same revenue code (either 096X (Professional Fees), 097X (Professional Fees), or 098X (Professional Fees)) will receive OCE Edit 074. If the bilateral service is billed with any other modifiers besides Modifier 50, the service will be excluded from this special critical access OCE Edit 074 logic.

G.1.74.1 Example:
OCE Edit 074 will be returned if procedure code 29345 is billed with Modifier 50, 2 units, and a service date on or after October 01, 2006.
G.1.74.2 APC Assistant™:
All bilateral procedures are indicated on the Procedures page under the Bil Ind drop-down. This drop-down menu allows for searches on conditional, independent, and inherently bilateral procedures.

G.1.75 OCE Edit 075
Incorrect Billing of Modifier FB or FC (Returned to Provider (RTP)) (Not Active as of 01/01/15)
This edit was new with the Version 8.0 OCE. Effective January 01, 2007 through December 31, 2013, this edit identifies claim lines where Modifier FB (Item Provided Without Cost to Provider, Supplier or Practitioner, or Full Credit Received for Replaced Device (Examples, But Not Limited to, Covered Under Warranty, Replaced Due to Defect, Free Samples)) or Modifier FC (Partial Credit Received for Replaced Device) is submitted for a service which is not assigned to Payment Status Indicators S, T, V, Q3, or X.
Effective January 01, 2014, this edit identifies any claim line billed with Modifier FB or FC.

G.1.76 OCE Edit 076
Trauma Response Critical Care Code without Revenue Code 068X and CPT® 99291 (Line Item Rejection)
This edit was new with the Version 8.0 OCE and was effective January 01, 2007. It identifies line items where procedure code G0390 and without at least one claim line that contains Revenue Code 068X (Trauma Response) on the same date of service.

G.1.76.1 Example:
OCE Edit 076 will be returned if procedure code G0390 and procedure code 99291 are billed on the same date of service without any claim lines that contain Revenue Code 068X.

G.1.77 OCE Edit 077
Claim Lacks Allowed Procedure Code (Returned to Provider (RTP)) (Not Active as of 01/01/15)
This edit was new with the Version 8.1 OCE and was effective January 01, 2007. This edit identifies certain devices billed without specific accompanying procedure codes.

G.1.78 OCE Edit 078
Claim Lacks Required Radiolabeled Product (Not Active as of 01/01/14)
Medicare has determined that the costs of diagnostic radiolabeled products should be reported on the same claim with the associated nuclear medicine procedure. When a claim contains one of a specific list of separately payable nuclear medicine services, it must also contain at least one of a designated list of diagnostic or therapeutic radiolabeled products. This edit is not date
specific; the radiolabeled product does not need to be on the same date as the nuclear medicine service. Also, there is not a one-to-one correspondence between specific nuclear medicine procedures and specific radiolabeled products. If a nuclear medicine service receives OCE Edit 078, adding any diagnostic or therapeutic radiolabeled product on the list will correct the edit.

G.1.79 OCE Edit 079
Incorrect Billing of Revenue Code with HCPCS Code (Returned to Provider (RTP))

This edit was new with the Version 9.3 OCE and was effective October 01, 2008. It verifies that Revenue Code 0381 (Blood Packed Red Cells) is used only for the billing of packed red blood cells and that Revenue Code 0382 (Blood Whole Blood) is used only for the billing of whole blood.

G.1.79.1 Example:
OCE Edit 079 will be returned for claims containing Revenue Code 0381 (Blood Packed Red Cells) that is not billed with a procedure code for packed red blood cells.

G.1.79.2 APC Assistant™:
All procedure codes for packed red blood cells that can be billed with Revenue Code 0381 are listed in the 079-Packed RBC list located under the Criteria drop-down on the Procedures page. All procedure codes for whole blood that can be billed with Revenue Code 0382 are listed in the 079-Whole Blood list located under the Criteria drop-down on the Procedures page.

G.1.80 OCE Edit 080
Mental Health Code Not Approved for Partial Hospitalization Program (Returned to Provider (RTP))

This edit was new with the Version 9.3 OCE and was effective January 01, 2008. It verifies that mental health services which are not approved for the partial hospitalization program, are not submitted on claims with a UB-04 Bill Type of 013X (Hospital, Outpatient) and Condition Code 41 (Partial Hospitalization), or claims with a UB-04 Bill Type of 076X (Clinic - Community Mental Health Center).

G.1.80.1 Example:
OCE Edit 080 will be returned on UB-04 Bill Type 0131 claims containing procedure code 90839 billed with Condition Code 41.

G.1.80.2 APC Assistant™:
All procedure codes for mental health services that are not approved for the partial hospitalization program are listed in the 080-MH Not Approved list located under the Criteria drop-down on the Procedures page.
G.1.81 OCE Edit 081
Mental Health Service Not Payable Outside the Partial Hospitalization Program (Returned to Provider (RTP))

Effective January 01, 2009 (Version 10.0 of the OCE), certain psychotherapy services should only be provided as part of a partial hospitalization program and are not otherwise payable. If these services are submitted on a claim with a UB-04 Bill Type of 012X (Hospital Inpatient (Medicare Part B Only)) or 013X (Hospital, Outpatient) and without Condition Code 41 (Partial Hospitalization), the claim will be returned to the provider.

G.1.81.1 Example:
OCE Edit 081 will be returned on UB-04 Bill Type of 0131 claims containing procedure code G0129 billed without a Condition Code 41.

G.1.81.2 APC Assistant™:
All procedure codes for mental health services that are not payable outside the partial hospitalization program are listed in the 081-MH Approved list located under the Criteria drop-down on the Procedures page.

G.1.82 OCE Edit 082
Charge Exceeds Token Charge ($1.01) (Returned to Provider (RTP))

Effective January 01, 2009 (Version 10.0 of the OCE), if procedure code C9898 is billed with charges greater than $1.01, the claim will be returned to the provider.

G.1.82.1 Example:
OCE Edit 082 will be returned on claims containing procedure code C9898 billed with $1.02 in charges with any other separately payable procedure code (for example, 31500) on a single date of service.

G.1.83 OCE Edit 083
Service Provided on or After Effective Date of NCD Non-Coverage (Line Item Denial)

If a service is provided on or after the effective date of NCD non-coverage and before the service is assigned to a non-covered payment status, the service is denied for payment with OCE Edit 083.

Note
OCE Edit 083 is typically applied to services for very short time periods.

Effective October 01, 2019, there are not any services that would receive this edit.

G.1.83.1 Example:
OCE Edit 083 will be returned for claims containing procedure code L0430 with a date of service on or after November 17, 2012 - December 31, 2012.
G.1.83.2 APC Assistant™:
All procedure codes subject to this edit are listed in the 083-NCD Non-Cov Date list located under the Criteria drop-down on the Procedures page.

G.1.84 OCE Edit 084
Claim Lacks Required Primary Code (Returned to Provider (RTP))
Effective January 01, 2012, if a specified add-on code is submitted without a required primary procedure code on the same date of service, the claim line will receive OCE Edit 084, and the claim will be returned to the provider.
Effective January 01, 2013 - March 31, 2017, if a Partial Hospitalization Program (PHP) claim (UB-04 Bill Type 013X (Hospital, Outpatient) with Condition Code 41 (Partial Hospitalization), or UB-04 Bill Type 076X (Clinic - Community Mental Health Center)), is billed with a secondary psychiatric add-on code without a required primary procedure code, the claim line will receive OCE Edit 084, and the claim will be returned to the provider.
Effective April 01, 2012 - March 31, 2015, if a Federally Qualified Health Center (FQHC) Claim (UB-04 Bill Type 077X without Condition Code 65 (Non-PPS Claim)), is billed with a secondary psychiatric add-on code without a required FQHC mental health payment code, the claim line will receive OCE Edit 084, and the claim will be returned to the provider.

G.1.84.1 Example:
OCE Edit 084 will be returned on claims with add-on procedure code 90785 and an OPPS payable code such as 99291 without a required primary code.

G.1.84.2 APC Assistant™:
All procedure codes subject to this edit are listed in the 084-Add-on/Prim Coding list located under the Criteria drop-down on the Procedures page.
Certain procedure codes eligible for OCE Edit 084, which are psychiatric add-on codes, will only have OCE Edit 084 applied on Partial Hospitalization Program (PHP) claims. In APC Assistant™, the psychiatric add-on codes can be viewed by going to the Conditional APCs page, and in the Other Criteria drop-down menu, choosing: 1-Not Counted toward Num Req.

G.1.85 OCE Edit 085
Claim Lacks Required Device Code or Required Procedure Code (Not Active as of 01/01/14)
Effective January 01, 2012 - June 30, 2012, if procedure code C9732 and procedure code C1840 are not submitted together on the same day of service, the claim line will receive OCE Edit 085 and the claim will be returned to the provider.
Effective July 01, 2012, if procedure code 0308T and procedure code C1840 are not submitted together on the same day of service, the claim line will receive OCE Edit 085 and the claim will be returned to the provider.
G.1.86 OCE Edit 086
Manifestation Code Not Allowed As Principal Diagnosis Code (Returned to Provider (RTP))

If a manifestation diagnosis code is submitted as the principal diagnosis code, the principal diagnosis code will receive OCE Edit 086, and the claim will be returned to the provider. This edit applies to UB-04 Bill Types 081X (Hospice (Non-Hospital Based)) and 082X (Hospice (Hospital Based)), effective October 01, 2014 and UB-04 Bill Type 032X (Home Health Services Under a Plan of Treatment), effective January 01, 2015.

G.1.86.1 Example:
OCE Edit 086 will be returned on UB-04 Bill Type 0811 (Hospice (Non-Hospital Based)) claims containing ICD-10-CM diagnosis code D75.81 reported as a principal diagnosis.

G.1.86.2 APC Assistant™
All diagnosis codes that generate OCE Edit 086 are listed in the MDX - Manifestation Diagnosis Codes list located under Other Criteria drop-down on the Diagnoses page.

G.1.87 OCE Edit 087
Skin Substitute Application Procedure Without Appropriate Skin Substitute Product Code (Returned to Provider (RTP))

Effective January 01, 2014, if a low cost skin substitute application procedure code is submitted without a low cost skin substitute product procedure code, or a high cost skin substitute application procedure code is submitted without a high cost skin substitute product procedure code, the skin substitute application procedure line will receive OCE Edit 087, and the claim will be returned to the provider.

G.1.87.1 Example:
OCE Edit 087 will be returned on claims containing low cost skin substitute application procedure code C5271 billed without a low cost skin substitute product procedure code, such as Q4100.

G.1.87.2 APC Assistant™
All procedure codes subject to this edit are listed in the 087-High Cost Skin Prod or 087-Low Cost Skin Proc list located under the Criteria drop-down on the Procedures page.

G.1.88 OCE Edit 088
FQHC Payment Code Not Reported for FQHC Claim (Returned to Provider (RTP))

Effective October 01, 2014, when at least one FQHC payment code is not reported on any day of a Federally Qualified Health Center (FQHC) claim (UB-04 Bill Type 077X (Clinic - FQHC) (not including UB-04 Bill Type 0770),
without Condition Code 65 (Non-PPS Claim)), that includes other services, OCE Edit 088 will be issued, and the claim will be returned to the provider.

**G.1.88.1 Example:**
OCE Edit 088 will be returned for UB-04 Bill Type 0771 claims containing an FQHC approved procedure code such as 92002 without an FQHC payment code.

**G.1.88.2 APCAssistant™**
The list of FQHC payment codes can be obtained from the 088/089-FQHC Pay Code list under the Criteria drop-down on the Procedures page.

**G.1.89 OCE Edit 089**
FQHC Claim Lacks Required Qualifying Visit Code (Returned to Provider (RTP))

Effective October 01, 2014, when a FQHC payment code is billed on a FQHC claim (UB-04 Bill Type 077X (not including UB-04 Bill Type 0770), without Condition Code 65 (Non-PPS Claim)) without a qualifying visit code on the same day, the claim will receive OCE Edit 089 and the claim will be returned to the provider.

**G.1.89.1 Example:**
OCE Edit 089 will be returned on claims containing FQHC payment code G0466 billed on a FQHC claim line by itself with procedure code 92012. Procedure code 92012 is not a qualifying visit code for payment code G0466.

**G.1.89.2 APCAssistant™**
The list of FQHC payment codes can be obtained from the 088/089-FQHC Pay Code list under the Criteria drop-down on the Procedures page. This page will display acceptable payment code/qualifying visit pairings.

**G.1.90 OCE Edit 090**
Incorrect Revenue Code Reported for FQHC Payment Code (Returned to Provider (RTP))

Effective October 01, 2014, when a FQHC payment code is billed on a FQHC claim line (UB-04 Bill Type 077X (not including UB-04 Bill Type 0770), without Condition Code 65 (Non-PPS Claim)) and the appropriate Revenue Code (as shown in Table G-1) the claim line will receive OCE Edit 090 and the claim will be returned to the provider.
G.1.90.1 Example:
OCE Edit 090 will be returned on claims containing FQHC payment code G0466 and qualifying visit procedure code 92002 billed on a FQHC claim with Revenue Code 0270 (Medical/Surgical Supplies General Classification).

<table>
<thead>
<tr>
<th>FQHC Payment Code</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0466</td>
<td>052X (Preventive Service Code) or 0519 (Clinic Other)</td>
</tr>
<tr>
<td>G0467</td>
<td>0519 (Clinic Other) or 0900 (Psychiatric/Psychological Treatments General Classification)</td>
</tr>
<tr>
<td>G0468</td>
<td>0519 (Clinic Other) or 0900 (Psychiatric/Psychological Treatments General Classification)</td>
</tr>
</tbody>
</table>

G.1.90.2 APC Assistant™
The list of FQHC payment codes can be obtained from the 088/089-FQHC Pay Code list under the Criteria drop-down on the Procedures page.

G.1.91 OCE Edit 091
Item or Service Not Covered Under FQHC PPS or Rural Health Clinic (RHC) (Line Item Rejection (LIR))

Effective October 01, 2014, when a FQHC claim (UB-04 Bill Type 077X (not including UB-04 Bill Type 0770)) or effective April 01, 2016 when a RHC claim (UB-04 Bill Type 071X), without Condition Code 65 (Non-PPS Claim) contains a non-covered service, OCE Edit 091 will be issued and the claim line will be rejected. Non-covered services are Durable Medical Equipment (DME), laboratory services (except procedure code 36415 ambulance services, hospital-based care services, and non face-to-face services.

G.1.91.1 Example:
OCE Edit 091 will be returned on FQHC claims containing procedure code Q0115.

G.1.91.2 APC Assistant™
Individual procedure codes subject to this edit are identified from the 091-FQHC Non-Covered list under the Criteria drop-down on the Procedures page. In addition, any line submitted with Revenue Code 029X (Durable Medical Equipment (Other Than Renal)) or 054X (Ambulance General Classification), will receive OCE Edit 091.

G.1.92 OCE Edit 092
Device-Dependent Procedure Code Billed Without Device Code (Returned to Provider (RTP))

Effective January 01, 2015, this edit is returned when a device-dependent procedure code is reported without a device code on the same date of service. When this edit is returned for one claim line, all other claim lines on the same
date of service will receive OCE Edit 049. Effective January 01, 2019, certain
device-dependent procedure codes billed with Modifier CG (Policy Criteria
Applied) will not receive OCE Edit 092.

G.1.92.1 Example:
OCE Edit 092 will be returned on claims containing procedure code 0100T
billed without a device code.

G.1.92.2 APC Assistant™
Codes subject to this edit are identified from the 092-Device Required list
under the Criteria drop-down on the Procedures page. To obtain a list of
devices required for a particular procedure code, select the 092-Device
Required link under the Criteria heading for that procedure.

G.1.93 OCE Edit 093
Corneal Tissue Processing Reported Without Cornea Transplant Procedure
(Line Item Rejection (LIR))

Effective January 01, 2016, this edit will be returned when procedure code
V2785 is present without one of the cornea transplant procedure codes shown
below in Table G-2.

Table G-2: Corneal Transplant Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>65710</td>
<td>Keratoplasty (Corneal Transplant); Anterior Lamellar</td>
</tr>
</tbody>
</table>
| 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 |
| 65757          | Backbench Preparation of Corneal Endothelial Allograft Prior to
|               | Transplantation (List Separately in Addition to Code for Primary
|               | Procedure) |

G.1.93.1 Example:
OCE Edit 093 will be returned on claims containing procedure code V2785
without a cornea transplant procedure code.

G.1.93.2 APC Assistant™
Codes subject to this edit are identified from the 093-Corneal Proc list under
the Criteria drop-down on the Procedures page.
G.1.94 OCE Edit 094

**Biosimilar HCPCS Reported Without Biosimilar Modifier (Returned to Provider (RTP)) (Not Active as of 04/01/18)**

Effective January 01, 2016, this edit will be returned when a biosimilar injection procedure code is billed without a corresponding biosimilar manufacturing modifier.

G.1.95 OCE Edit 095

**Weekly Partial Hospitalization Services Require a Minimum of 20 Hours of Service as Evidenced in PHP Plan of Care (Line Item Rejection (LIR))**

Effective October 01, 2017, OCE Edit 095 will be returned when a Partial Hospitalization Program (PHP) claim contains less than twenty total hours of qualified Partial Hospitalization (PH) services per a seven day period. OCE Edit 095 will not be returned during the first and last week of the claim.

This OCE Edit applies to UB-04 Bill Type 013X (Hospital, Outpatient) claims that contain Condition Code 41 (Partial Hospitalization) or UB-04 Bill Type 076X (Clinic, Community Mental Health) claims.

**G.1.95.1 Example:**

OCE Edit 095 will be returned when procedure codes 90837, 90865, and G0411 are billed on the eighth day of a twenty-one day partial hospitalization claim.

**Note**

OCE Edit 095 is for informational purposes only and has no impact on payment.

G.1.96 OCE Edit 096

**Partial Hospitalization Interim Claim From and Through Dates Must Span More Than 4 Days (Returned to Provider (RTP)) (Not Active as of 07/01/16)**

Effective July 01, 2016, OCE Edit 096 will be returned when a partial hospitalization interim claim contains From and Thru dates that span less than five days. A partial hospitalization interim claim is identified by UB-04 Bill Type 0763 (Clinic, Continuing Interim Claim) or UB-04 Bill Type 0133 (Hospital, Outpatient, Continuing Interim Claim) with Condition Code 41 (Partial Hospitalization).

G.1.97 OCE Edit 097

**Partial Hospitalization Services are Required to be Billed Weekly (Returned to Provider (RTP)) (Not Active as of 07/01/16)**

Effective July 01, 2016, OCE Edit 097 will be returned when the From and Thru dates span more than seven days.
This OCE Edit applies to UB-04 Bill Type 013X (Hospital, Outpatient) claims that contain Condition Code 41 (Partial Hospitalization) and UB-04 Bill Type 076X (Clinic, Community Mental Health) claims.

G.1.98 OCE Edit 098
Claim With Pass-Through Device Lacks Required Procedure (Returned to Provider (RTP))

Effective January 01, 2016, OCE Edit 098 will be returned when a claim containing a pass-through device does not contain the required associated device-intensive procedure code on the same date of service.

G.1.98.1 Example:
OCE Edit 098 will be returned when procedure code C1823 is reported on a claim without the associated device-intensive procedure on the same date of service.

G.1.98.2 APC Assistant™
Codes subject to this edit are listed in the 098 - Pass-Thru Device list under the Criteria drop-down on the Procedures page.

G.1.99 OCE Edit 099
Claim With Pass-Through or Non-Pass-Through Drug or Biological Lacks OPPS Payable Procedure (Returned to Provider (RTP))

Effective January 01, 2016, OCE Edit 099 will be returned when a claim containing a pass-through (i.e., procedures with a Payment Status Indicator of G) or non-pass-through (i.e., procedures with a Payment Status Indicator of K) drug or biological does not contain an OPPS payable procedure (i.e., procedures with a Payment Status Indicator of J1, J2, P, Q1, Q2, Q3, R, S, T, U, or V).

Note
OCE Edit 099 does not apply to certain blood clotting factors.

G.1.99.1 Example:
OCE Edit 099 will be returned when procedure code J8655 is reported on a claim without an OPPS payable procedure.

G.1.99.2 APC Assistant™
Codes subject to this edit are listed in the 099 - Excluded Drug/Bio list under the Criteria drop-down on the Procedures page.

G.1.100 OCE Edit 100
Claim for HSCT Allogeneic Transplantation Lacks Required Revenue Code Line for Donor Acquisition Services (Returned to Provider (RTP))

Effective January 01, 2017, OCE Edit 100 will be returned when a claim containing procedure code 38240 is reported without an additional line that contains Revenue Code 0815 (Allogeneic Stem Cell Acquisition Services).
Claims that contain procedure code 38240 must also contain an additional line on the claim that represents the donor acquisition costs (identified with Revenue Code 0815).

**G.1.100.1 Example:**
OCE Edit 100 will be returned when procedure code 38240 is reported on a claim that does not contain any claim lines with Revenue Code 0815.

**G.1.101 OCE Edit 101**
*Item or Service With Modifier PN Not Allowed Under PFS (Returned to Provider (RTP))*

Emergency department visits or critical care encounters that have standard assignment under Payment Status Indicator V or S are not allowed to be billed with Modifier PN (Nonexcepted Service Provided at an Off-Campus, Outpatient, Provider-Based Department of a Hospital). In these circumstances, OCE Edit 101 will be triggered and the claim will be returned to provider.

OCE Edit 101 is also returned when a claim line containing Payment Status Indicator P is billed with Modifier PN on an UB-04 Bill Type 076X (Clinic - Community Mental Health) claim.

**G.1.101.1 Example:**
OCE Edit 101 will be returned on UB-04 Bill Type 0761 claims containing procedure code 90832 with 3 units, billed with Modifier PN.

**G.1.102 OCE Edit 102**
*Modifier Pairing Not Allowed on the Same Line (Returned to Provider (RTP))*

Effective January 01, 2017, CMS issued a list of modifier pairs (shown below in Table G-3) that have conflicting definitions and should not be reported together. OCE Edit 102 will now be returned if any of these modifier pairs are billed on the same claim line.

**Table G-3: Modifier Pairs for OCE Edit 102**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Modifier</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>FX (X-Ray Taken Using Film)</td>
<td>January 01, 2017</td>
</tr>
<tr>
<td>PN (Non-Excepted Service Provided at an Off-Campus, Outpatient, Provider-Based Department of a Hospital)</td>
<td>PO (Excepted Service Provided at Off-Campus, Outpatient, Provider-Based Outpatient Department of a Hospital)</td>
<td>January 01, 2017</td>
</tr>
</tbody>
</table>
Table G-3: Modifier Pairs for OCE Edit 102

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Modifier</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>FY (X-Ray Taken Using Computed Radiography Technology/Cassette-Based Imaging)</td>
<td>January 01, 2018</td>
</tr>
<tr>
<td>FX</td>
<td>FY</td>
<td>January 01, 2018</td>
</tr>
<tr>
<td>ER (Items and Services Furnished by a Provider-Based Off-Campus Emergency Department)</td>
<td>PN</td>
<td>January 01, 2019</td>
</tr>
<tr>
<td>ER</td>
<td>PO</td>
<td>January 01, 2019</td>
</tr>
</tbody>
</table>

G.1.102.1 Example:
OCE Edit 102 will be returned if procedure code 99291 is billed with Modifiers PO and PN.

G.1.103 OCE Edit 103
Modifier Reported Prior to FDA Approval Date (Line Item Denial (LID)) (Not Active as of 04/01/18)

Effective July 01, 2017, OCE Edit 103 will be returned when a biosimilar modifier is billed with a biosimilar procedure code prior to the mid-quarter activation date, which is associated to the FDA approval.

G.1.104 OCE Edit 104
Service Not Eligible for All-Inclusive Rate (Line Item Rejection (LIR))

Effective April 01, 2018, OCE Edit 104 will be returned when procedure codes that are not eligible for the Rural Health Center (RHC) all-inclusive rate are billed with Modifier CG (Policy Criteria Applied) on a UB-04 Bill Type 071X (Clinic - Rural Health) claim.

G.1.104.1 Example:
OCE Edit 104 will be returned if procedure code 36415 is billed with Modifier CG on a UB-04 Bill Type 071X claim.

G.1.104.2 APC Assistant™:
All procedure codes that generate OCE Edit 104 are listed in the 104-All-Inc Rate Not Elig list located in the Criteria drop-down on the Procedures page.

G.1.105 OCE Edit 105
Claim Reported With Pass-Through Device Prior to FDA Approval for the Procedure (Line Item Denial (LID))

Pass-through devices must be billed with a device-intensive procedure. Some pass-through devices have mid-quarter activation dates associated to FDA approval. Effective July 01, 2017, OCE Edit 105 will be returned when a pass-
through device is billed prior to it’s FDA approval date with an appropriate
device-intensive procedure.

G.1.105.1 Example:
Since device-intensive procedure 36902 received FDA approval on August
25, 2017, OCE Edit 105 will be returned if procedure codes C2623 and 36902
are billed on the same day between July 01, 2017 and August 24, 2017.

G.1.105.2 APC Assistant™:
All procedure codes that generate OCE Edit 105 are listed in the 105-Device
FDA Date list located in the Criteria drop-down on the Procedures page.

G.1.106 OCE Edit 106
Add-On Code Reported Without Required Primary Procedure Code (Line Item
Denial (LID))
Effective April 01, 2018, for drug administration services only, line-level OCE
Edit 106 will be returned if the primary drug administration procedure code is
not present on the same claim as the drug administration add-on code. OCE
Edit 106 will continue to return as it did previously for all other non-drug
administration services.

G.1.106.1 Examples:
• Non-drug administration service claim:
  OCE Edit 106 is returned for a UB-04 Bill Type 022X (Skilled Nursing Facility)
  claim if procedure code 0076T is billed without primary procedure code 0075T
  on the same day or the day before.
• Drug administration service claim:
  OCE Edit 106 is returned if drug administration primary procedure code 96422
  is not billed on the same UB-04 Bill Type 022X (Skilled Nursing Facility) claim
  as drug administration procedure code 96423.

G.1.106.2 APC Assistant™:
All procedure codes that generate OCE Edit 106 are listed in the 106-Type I
Add-on list located in the Criteria drop-down on the Procedures page.

G.1.107 OCE Edit 109
Code First Diagnosis Present Without Mental Health Diagnosis as the First
Secondary Diagnosis (Returned to Provider (RTP))
Effective October 01, 2018, OCE Edit 109 will be returned when a partial
hospitalization claim (claims with a UB-04 Bill Type of 076X or 013X with
Condition Code 41) is billed with a Code First diagnosis code as the principal
diagnosis code, without a mental health diagnosis in the first secondary
diagnosis position.
G.1.107.1 Example:
OCE Edit 109 will be returned on UB-04 Bill Type 076X claims containing principal diagnosis code T14.91XA (Suicide Attempt, Initial Encounter) and no other diagnosis codes.

G.1.108 OCE Edit 110
Service Provided Prior to Initial Marketing Date (Line Item Rejection (LIR))
Effective July 01, 2018, OCE Edit 110 will be returned when a procedure code is billed after the effective date of the code, but prior to the initial marketing date of the item.

G.1.108.1 Example:
OCE Edit 110 will be returned on claims containing procedure code Q5108 with a service date on or after the effective date of July 01, 2018 and prior to the initial marketing date of the item (July 12, 2018).

G.1.108.2 APC Assistant™:
All procedure codes that generate OCE Edit 110 are listed in the 110-Market Date list located in the Criteria drop-down on the Procedures page.

G.1.109 OCE Edit 111
Service Cost is Duplicative; Included in Cost of Associated Biological (Line Item Rejection (LIR))
Effective January 01, 2018, OCE Edit 111 was added and is returned for any service used to identify a method used in manufacturing a drug or biological. These services are bundled into the total cost of the drug or biological and are not paid separately. Previously, these services received OCE Edit 062 (Code Not Recognized by OPPS; Alternate Code for Same Service May be Available).

In addition, OCE Edit 111 is returned when UB-04 Revenue Code 0870, 0871, 0872, or 0873 (Cell/Gene Therapy) is billed without a procedure code. The charges associated with the revenue center are bundled into the cost of the drug or biological.

G.1.109.1 Example:
OCE Edit 111 is returned if UB-04 Revenue Code 0870 is billed without a procedure code on a UB-04 Bill Type 0131 claim.

G.1.109.2 APC Assistant™:
All procedure codes that generate OCE Edit 111 are listed in the 111-Duplicative Bio Service list located in the Criteria drop-down on the Procedures page.
G.1.110 OCE Edit 112
Information Only Service(s) (Line Item Rejection (LIR))

Effective January 01, 2020, line-level OCE Edit 112 is returned for any service that is identified as being non-covered and is meant for informational reporting purposes only.

G.1.110.1 Example:
OCE Edit 112 is returned if procedure code G1001 is reported on a UB-04 Bill Type 0131 (Hospital, Outpatient) claim on or after January 01, 2020.

G.1.111 OCE Edit 113
Supplementary or Additional Code Not Allowed as Principal Diagnosis (Return to Provider (RTP))

Effective October 01, 2019, diagnosis-level OCE Edit 113 will be returned when an unacceptable diagnosis code is billed as the principal diagnosis on a claim.

G.1.111.1 Example:
OCE Edit 113 is returned if diagnosis code B95.0 (Streptococcus, Group A, as the Cause of Diseases Classified Elsewhere) is billed as the principal diagnosis code on a UB-04 Bill Type 0131 (Hospital, Outpatient) claim.

G.1.112 OCE Edit 114
Item or Service Not Allowed With Modifier CS (Return to Provider (RTP))

Effective March 18, 2020, line-level OCE Edit 114 will be returned when Modifier CS (COVID-19 Testing-Related Service) is reported on an item or service that is not on the coinsurance waiver eligible list.

G.1.112.1 Example:
OCE Edit 114 is returned if Modifier CS is reported with procedure code 0001U, Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported, on a UB-04 Bill Type 0131 claim.

G.2 Correct Coding Initiative (CCI) Edits

If requested, CCI Edits are performed on every possible pairing of procedure codes input to the Ambulatory Code Editor™ (ACE). These codes are assumed to be the entire set of procedure codes that together describe the services provided during a single outpatient visit.

Note
CCI Edits are performed when the Editor Request field in the ECB [ezg_cntl_block]/ECB-EZG-CNTL-BLOCK structure is set to 1 for CCI. Select OCEs (Edits 001, 002, 003, 005, 006, 008, 022, 023, 024, 025, and 026) and MUE (Edit 015) will be applied along with the CCI Edits.
G.2.1 CCI Edit 901:

Standards of Medical/Surgical Practice

There are many basic activities that occur when performing certain procedures. These activities may include skin preparation, anesthetic administration by the physician, wound cleansing, or inserting an intravenous line for medication. Coding these services, as well as the primary procedure, would be inappropriate. This Edit indicates that services essential to a procedure should not be separately coded.

G.2.2 CCI Edit 902:

CPT® Separate Procedure Definition

Some procedures, although they can be performed separately, are generally included in other more comprehensive procedures. These services may not be reported when a related, more comprehensive, service is performed. When a related procedure is performed, a code with the designation of Separate Procedure may not be reported with the primary procedure.

G.2.3 CCI Edit 903:

More Extensive Procedure

When procedures performed together are basically the same, or are performed on the same site, but with an increased level of complexity, the less extensive procedure is included in the more extensive procedure. Code only the more extensive service for the same site.

G.2.4 CCI Edit 904:

“With” Versus “Without” Services

There are numerous procedures in CPT®, where the only definitional difference is the words “with” or “without.” It is inappropriate to report both procedure codes. When done together, the “without” procedure is bundled into the “with” procedure. This Edit indicates that “with” and “without” codes should not be used together.

G.2.5 CCI Edit 905:

Anesthesia Included in Surgical Procedures

When the same doctor provides anesthesia and performs the medical or surgical procedure, reimbursement for the anesthesia is included in the global package for the surgery. Anesthesia administered by the operating physician should not be reported.

G.2.6 CCI Edit 906:

Laboratory Panels

Individual lab tests should not be reported separately, when a lab panel exists that contains all of the tests. The lab panel code should be reported instead.
G.2.7 CCI Edit 907: Sequential Procedures
An initial approach to a procedure may be followed by a second, more invasive approach during the same encounter. The more invasive procedure is usually performed because the initial approach was not medically adequate. Only the code for the more invasive service should be reported.

G.2.8 CCI Edit 908: Standard Preparation and Monitoring Guidelines
Preparation and monitoring services that are integral to the performance of a procedure should not be coded in addition to the procedure.

G.2.9 CCI Edit 909: CPT® Coding Manual Instructions/Guidelines
The sections and subsections of the CPT® include coding guidelines that are unique to that particular section. These guidelines should be followed when coding a procedure or service from that section.

G.2.10 CCI Edit 910: CPT® Procedure Code Definition
To conserve space, the format of CPT® includes partial, indented code descriptions, located under a main entry. The main entry includes the common portion of both codes ended by a semicolon (;). The description preceding the semicolon applies to the indented codes. In the course of other procedure descriptions, the code definition specifies other procedures that are included in the comprehensive code.

G.2.11 CCI Edit 911: Misuse of Column 2 Code with Column 1 Code
Certain procedures are not typically performed together. Also, some codes are not reported together because another code more accurately describes the services performed. Additionally some procedures inherently include the use of equipment that should not be reported separately.

G.2.12 CCI Edit 912: Mutually Exclusive Services
Services that would be reasonably impossible or improbable to perform on the same patient at the same time cannot be reported together for the same patient visit.
G.2.13 CCI Edit 913:
Designation of Sex Procedures
Some procedures have a sex designation within their description. Two codes with opposing sex designations cannot be reported for the same patient visit.

G.2.14 CCI Edit 914:
Mutually Exclusive Procedures
Procedures that would be reasonably impossible or improbable to perform on the same patient at the same time cannot be reported together for the same patient visit.

G.2.15 CCI Edit 915:
Column 1/Column 2 Correct Coding Edits
Comprehensive or component procedures that are not typically performed together. Also, some codes are not reported together because another code more accurately describes the services performed. Additionally some procedures inherently include the use of equipment that should not be reported separately.

G.3 Medically Unlikely Edits (MUEs)
CMS developed the MUE program to reduce errors in Part B claims by identifying unreasonable units values for specific services. For all applicable procedure codes, CMS identified the maximum number of units which could reasonably be provided in a single day based on clinical or anatomic considerations, physical/equipment limitations, coding guidelines, and CMS coverage policies. The first MUEs were implemented on January 01, 2007. Due to of fraud concerns, Medicare did not initially publish the details behind these Edits. However, on October 01, 2008, CMS published most of the MUE maximum values on the CMS web site.

There are two sets of MUE Edits:
- One set for facility claims
- One set for professional claims

If a facility submits a Part B claim which contains, for a particular procedure code, a units value that is higher than the facility MUE maximum value for that code, CMS denies payment for that code.

For professional claims, units that exceed the MUE maximums are ignored and payment for the affected service is capped at the MUE units maximum times the unit price.

Since the inception of the Medicare OPPS, CMS has implemented units editing for facility outpatient claims using OCE Edit 015 (Units Exceed Maximum Value). In 2008, this Edit was discontinued as it was effectively replaced by the MUE Program. The MUEs are applied by MACs/FIs to
hospital outpatient claims prior to running them through the OCE. All facility outpatient claims which are subject to the OCE Edits are also subject to the MUEs. For facility claims with service dates on or after January 01, 2009, if a claim line contains units that exceed the MUE for a given procedure code, ACE will assign OCE Edit 015 which has a disposition of 02 (Line Item Denial).

For professional claims with service dates on or after July 01, 2010 if a claim line contains units that exceed the MUE for a given procedure code, ACE will assign OCE Edit 015 which has a disposition of 02 (Line Item Denial).

Beginning January 01, 2012, CMS began assigning MUE maximum values of 0 to some E&M codes (inpatient-only services). For claims with service dates on or after January 01, 2012, these codes will generate OCE Edit 015 when billed with a unit of 1 or more.

Beginning January 01, 2013, CMS began assigning MUE maximum values of 0 to some practitioner codes. For claims with service dates on or after January 01, 2013, these codes will generate OCE Edit 015 when billed with a unit of 1 or more.

Beginning July 01, 2014, some MUEs are applied at the day-level rather than the line-level. A MUE Adjudication Indicator (MAI) is used to determine when a MUE is a day-level edit or a line-level edit. Each procedure code that is assigned a MUE is also assigned a MAI. Some procedure codes will have a different MAI based on the care setting (outpatient or practitioner).

- A MAI of 1 indicates the MUE is a line-level edit. The units on each line are compared to the MUE maximum units.
- A MAI of 2 indicates the MUE is a day-level edit based on policy.
- A MAI of 3 indicates a day-level edit based on clinical benchmarks.

For a MAI of 2 and 3: units on each line of the claim with the same procedure code and service date are added together (per day) to determine if the total units exceed the assigned MUE for the procedure code. If the total units for that date exceed the MUE, all claim lines with that procedure code for that date will receive OCE Edit 015 and the line will be rejected. Modifiers 55 (Postoperative Management Only), GX (Notice of Liability Issued, Voluntary Under Payer Policy), GY (Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit or, for Non-Medicare Insurers, is Not a Contract Benefit), or GZ (Item or Service Expected to be Denied as Not Reasonable and Necessary) can override OCE Edit 015 for all three of the above-mentioned MAIs.

Since ASC providers are unable to report a Modifier of 50 (Bilateral Procedure), the MUE value used for editing will be doubled for conditionally bilateral procedure codes that have a MAI of 2 or 3.
G.4 National Medicaid CCI/MUE Edits

Section 6507 of The Patient Protection and Affordable Care Act of 2010 requires that state Medicaid programs utilize National Correct Coding Initiative (NCCI) policies and procedures for claim processing, effective October 01, 2010. As such, CMS has developed the National Correct Coding Initiative (NCCI) for Medicaid programs (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).

This Medicaid NCCI involves two types of edits:

- CCI Edits, which identify procedure code combinations that should not be simultaneously reported to ensure proper payment, as previously discussed in the Correct Coding Initiative (CCI) Edits section.

- Medically Unlikely Edits (MUE), which identify the billing of unreasonable units, as is previously discussed in the Medically Unlikely Edits (MUEs) section.


To request the National Medicaid CCI/MUE editing functionality, users must set the State CCI field to U2 for any facility, pay source, or time period in Rate Manager.
H  Default ACE Edits

This chapter includes the following section:

- Default ACE Edits for C & COBOL Platforms
H.1 Default ACE Edits for C & COBOL Platforms

If no specific edits are requested through the Editor Requests switch in the ECB [ezg_cntl_block] structure for C or the ECB-EZG-CNTL-BLOCK structure for COBOL, when processing an outpatient (Patient Type = 02) or SNF (Patient Type = 06) claim using the Ambulatory Code Editor™ (ACE), edits will be performed by default depending on the Pricer Type and/or Grouper Type (if provided).

Information on the types of edits performed by ACE for each Pricer Type, Grouper Type, and/or Patient Type is provided in the table below.

<table>
<thead>
<tr>
<th>Payment System</th>
<th>Pricer Type</th>
<th>Grouper Type</th>
<th>Patient Type</th>
<th>Default Edits Applied</th>
<th>Default Edit Request in ECB Block for C</th>
<th>Default Edit Request in ECB Block for COBOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama BCBS APG</td>
<td>44</td>
<td>61</td>
<td>02 (Outpatient)</td>
<td>CCI</td>
<td>edit_req[3] = 1</td>
<td>N/A</td>
</tr>
<tr>
<td>APC Pro</td>
<td>57</td>
<td>N/A</td>
<td>02 (Outpatient)</td>
<td>OCE/CCI</td>
<td>edit_req[5] = 1</td>
<td>ECB-EDIT-OCE-CCI-SW = 1</td>
</tr>
<tr>
<td>ASC Pro</td>
<td>64</td>
<td>N/A</td>
<td>02 (Outpatient)</td>
<td>CCI</td>
<td>edit_req[3] = 1</td>
<td>ECB-EDIT-CCI-SW = 1</td>
</tr>
<tr>
<td>Florida Medicaid APG</td>
<td>44</td>
<td>61</td>
<td>02 (Outpatient)</td>
<td>CCI</td>
<td>edit_req[3] = 1</td>
<td>N/A</td>
</tr>
<tr>
<td>Illinois Medicaid APG</td>
<td>38</td>
<td>61</td>
<td>02 (Outpatient)</td>
<td>CCI</td>
<td>edit_req[3] = 1</td>
<td>N/A</td>
</tr>
<tr>
<td>Massachusetts Medicaid APG</td>
<td>44</td>
<td>61</td>
<td>02 (Outpatient)</td>
<td>CCI</td>
<td>edit_req[3] = 1</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicare ASC</td>
<td>55</td>
<td>57</td>
<td>02 (Outpatient)</td>
<td>CCI</td>
<td>edit_req[3] = 1</td>
<td>ECB-EDIT-CCI-SW = 1</td>
</tr>
<tr>
<td>Medicare ESRD</td>
<td>60</td>
<td>60</td>
<td>02 (Outpatient)</td>
<td>OCE/CCI</td>
<td>edit_req[5] = 1</td>
<td>ECB-EDIT-OCE-CCI-SW = 1</td>
</tr>
<tr>
<td>Medicare FQHC</td>
<td>39</td>
<td>N/A</td>
<td>02 (Outpatient)</td>
<td>OCE</td>
<td>edit_req[4] = 1</td>
<td>ECB-EDIT-OCE-SW = 1</td>
</tr>
<tr>
<td>Medicare HHA</td>
<td>62</td>
<td>62</td>
<td>02 (Outpatient)</td>
<td>OCE/CCI</td>
<td>edit_req[5] = 1</td>
<td>ECB-EDIT-OCE-CCI-SW = 1</td>
</tr>
</tbody>
</table>

Note: C Platform Only.
### Table H-1: Default ACE Edits Table

<table>
<thead>
<tr>
<th>Payment System</th>
<th>Pricer Type</th>
<th>Grouper Type</th>
<th>Patient Type</th>
<th>Default Edits Applied</th>
<th>Default Edit Request in ECB Block for C</th>
<th>Default Edit Request in ECB Block for COBOL</th>
<th>Note</th>
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<tbody>
<tr>
<td>Medicare OPPS</td>
<td>56</td>
<td>55</td>
<td>02 (Outpatient)</td>
<td>OCE/CCI</td>
<td>edit_req[5] = 1</td>
<td>ECB-EDIT-OCE-CCI-SW = 1</td>
<td></td>
</tr>
<tr>
<td>Medicare SNF</td>
<td>22</td>
<td>22</td>
<td>06 (SNF)</td>
<td>OCE/CCI</td>
<td>edit_req[5] = 1</td>
<td>ECB-EDIT-OCE-CCI-SW = 1</td>
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<tr>
<td>Ohio Medicaid APG</td>
<td>44</td>
<td>61</td>
<td>02 (Outpatient)</td>
<td>CCI</td>
<td>edit_req[3] = 1</td>
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<td>C Platform Only.</td>
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<td>Virginia Medicaid APG</td>
<td>41</td>
<td>61</td>
<td>02 (Outpatient)</td>
<td>CCI</td>
<td>edit_req[3] = 1</td>
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<td>Wisconsin Medicaid APG</td>
<td>40</td>
<td>61</td>
<td>02 (Outpatient)</td>
<td>CCI</td>
<td>edit_req[3] = 1</td>
<td>N/A</td>
<td>C Platform Only.</td>
</tr>
</tbody>
</table>
I Descriptions of Medicaid Outpatient Edits

Detailed descriptions and examples for all of the different types of edits that are applicable to prospective payment are provided in this appendix, for use with the Medicaid Outpatient Editor (MOE). This appendix includes the following section:

• Medicaid Outpatient Edits
I.1 Medicaid Outpatient Edits

I.1.1 MOE 001:
Invalid Date (Claim Returned to Provider (RTP) or Line Returned to Provider)
Identifies a From, Thru, or line item service date that is not within the normal calendar range. In addition, this edit flags claims with a missing From or Thru date, a From date that is greater than the Thru date, a missing line item service date with procedure code, or line item service dates that are not within the claim’s From/Thru date range.

I.1.2 MOE 002:
Date Out of Range (Claim Suspension)
This edit identifies any claims prior to January 01, 2019.

I.1.3 MOE 003:
Invalid Age (Claim Returned to Provider (RTP))
Indicates that the reported age is not between 0 and 124 years.

I.1.4 MOE 004:
Invalid Sex (Claim Returned to Provider (RTP))
The MOE requires a patient sex of Male (1 or M), Female (2 or F), or Unknown (0, 3, or U).

I.1.5 MOE 005:
Invalid Diagnosis Code (Claim Returned to Provider (RTP))
Each ICD-10-CM diagnosis code is edited for completeness and validity. ICD-10-CM diagnosis codes without a required fourth, fifth, sixth, or seventh digit, are considered invalid. Codes are also checked to ensure that they were valid at the time of the patient’s visit. Date validity is tested using the From Date on the claim.

I.1.5.1 Examples:
- A12.3 is an invalid code.
- A01.0 needs a fifth digit.

I.1.6 MOE 006:
Diagnosis and Age Conflict (Claim Returned to Provider (RTP))
Indicates that the ICD-10-CM diagnosis code is inconsistent with the patient’s age. Age categories are as follows:
- Newborn (age = 0)
- Pediatric (age = 0 to 17 years)
- Maternity (age = 12 to 55 years)
- Adult (age > 14)

I.1.6.1 Examples:
- P03.810 (Newborn (Suspected to be) Affected by Abnormality in Fetal (Intrauterine) Heart Rate or Rhythm Before the Onset of Labor) is appropriate only for newborn patients.
- G93.7 (Reyes Syndrome) is appropriate for pediatric patients only.
- O00.9 (Pregnancy Without Intrauterine Pregnancy) is appropriate for maternity patients only.
- J6.1 (Pneumoconiosis Due to Asbestos and Other Mineral Fibers) is appropriate only for adults.

Note
MOE 006 will not be issued when MOE 003 (Invalid Age) is issued.

I.1.7 MOE 007:
Diagnosis and Sex Conflict (Claim Returned to Provider (RTP))
Indicates that the ICD-10-CM diagnosis code is inconsistent with the patient’s sex.

I.1.7.1 Examples:
- C53.8 (Malignant Neoplasm of Overlapping Sites of Cervix Uteri) is considered appropriate only for female patients.
- Z98.52 (Vasectomy Status) is considered appropriate only for male patients.

I.1.8 MOE 008:
Invalid Procedure Code (Claim Returned to Provider (RTP))
Each Level I or Level II procedure code is edited for validity. This edit indicates that the procedure code is invalid or was not valid for the patient’s dates of service. Date validity is verified using the line date. If the procedure code is invalid it will be assigned Payment Status Indicator W.

I.1.8.1 Examples:
- 1234 is an invalid procedure code.
- 01042, Hered pan ca pnl 32 genes, not effective until July 07, 2019.
I.1.9 MOE 009:  
Invalid Revenue Code (Returned to Provider (RTP))  
The UB-04 Revenue Code reported was not valid for the patient’s dates of service or has never been valid, or the claim line was submitted without a revenue code.  
Claim lines with no procedure code and an invalid revenue code will be assigned to Payment Status Indicator W.  
I.1.9.1 Example:  
MOE 009 will be returned for claim lines with UB-04 Revenue Code 0184 (Leave of Absence) with or without a procedure code.

I.1.10 MOE 010:  
Invalid Modifier (Claim Returned to Provider (RTP))  
Indicates that the two-character modifier associated with the procedure code is not valid for the service date or has never been valid.

I.1.11 MOE 011:  
Procedure and Sex Conflict (Claim Returned to Provider (RTP))  
This edit indicates that the procedure code is not valid for the patient’s sex.  
I.1.11.1 Examples:  
- 53430, Urethroplasty, reconstruction of female urethra, is considered valid for female patients only.  
- 55250, Removal of sperm duct(s), is considered valid for males only.

I.1.12 MOE 012:  
Medically Unlikely Edit (MUE) (Line Item Denial (LID))  
MOE will check claims for MUEs and flag any claim line that contains units that exceed the MUE maximums. If a claim line contains units that exceed the MUE maximum for a given procedure code, MOE will assign MOE Edit 012. Note that the MUE Edits are applied separately to each individual claim line.

I.1.13 MOE 013:  
Column 1/Column 2 Correct Coding Initiative (CCI) Edits (Line Item Rejection (LIR))  
Identifies the column 2 code of a column1/column2 CCI edit, indicating that this code should not be reported along with the column 1 code on the same service date. Often, the column 2 code is component of a procedure that is billed on the same date as the comprehensive procedure. Services that are normally a component of a more comprehensive procedure cannot be billed separately, but must be considered as included in the more comprehensive procedure. The presence of a modifier will not eliminate this edit under any circumstances.
I.1.13.1 Example:
If procedure code 93015, *Cardiovascular stress test; physician supervision, interpretation and report*, was reported with procedure code 93016, *Cardiovascular stress test; physician supervision only*, then procedure code 93016 would receive Medicaid Outpatient Edit 013.

I.1.14 MOE 014:
Column 1/Column 2 Allow Modifier (Line Item Rejection (LIR))

Identifies the column 2 code of a column1/column2 CCI edit, indicating that this code should not be reported along with the column 1 code on the same service date. Often, the column 2 code is a component of a procedure that is billed on the same date as the comprehensive procedure. Services that are normally a component of a more comprehensive procedure cannot be billed separately, but must be considered as included in the more comprehensive procedure.

Certain modifiers can override this edit. They are 24, 25, 27, 57, 59, 78, 79, and 91 for Level I. For Level II, they are E1-E4, F1-F9, FA, LC, LD, LM, LT, RC, RI, RT, T1-T9, TA, XE, XP, XS, and XU.

I.1.14.1 Example:
If procedure code 77412, *Radiation, three or more treatment areas; up to 5 MEV*, were reported with procedure code 77402, *Radiation, single treatment area; up to 5 MEV, without the appropriate modifier*, procedure code 77402 would receive Medicaid Outpatient Edit 014.

I.1.15 MOE 015:
Supplementary or Additional Code Not Allowed as Principal Diagnosis (Return to Provider (RTP))

Effective October 01, 2019, diagnosis-level MOE 015 will be returned when an unacceptable diagnosis code is billed as the principal diagnosis.

I.1.15.1 Example:
If diagnosis code B95.0 (Streptococcus, Group A, as the Cause of Diseases Classified Elsewhere) is billed as the principal diagnosis code, MOE 015 is returned.
J Descriptions of Physician Edits

Detailed descriptions and examples for all of the different types of Edits that are applicable to the Medicare Physician Payment System are provided in this appendix, for use with the Medicare Physician Editor. This appendix includes the following section:

• Physician Edits

Note

Edits below presented in gray font are listed as not active.
J.1 Physician Edits

J.1.1 Physician Edit 001
Invalid Date (Claim Returned to Provider (RTP))
Identifies a from, thru, or line item service date that is not within the normal calendar range. In addition, this Edit flags claims with a missing from or thru date, a from date that is greater than the thru date, a missing line item service date with procedure code, or line item service dates that are not within the claim’s from/thru date range.

J.1.2 Physician Edit 002
Date Out of Range (Claim Suspension)
The Physician Editor maintains twenty-eight consecutive quarters of editing data. This edit identifies claims outside of this time period.

J.1.3 Physician Edit 003
Invalid Age (Claim Returned to Provider (RTP))
The reported age is not between 0 and 124 years.

J.1.4 Physician Edit 004
Invalid Sex (Claim Returned to Provider (RTP))
The Physician Editor requires a patient sex of Male (1 or M), Female (2 or F), or Unknown (0, 3, or U).

J.1.5 Physician Edit 005
Invalid Diagnosis Code (Claim Returned to Provider (RTP))
Each ICD-10-CM diagnosis code is edited for completeness and validity. ICD-10-CM diagnosis codes without a required fourth, fifth, sixth, or seventh digit, are considered invalid. Codes are also checked to ensure that they were valid at the time of the patient’s visit. Date validity is tested using the From Date on the claim. If the claim does not contain at least one diagnosis code, Edit 005 is generated.

J.1.5.1 Examples:
- A12.3 is an invalid code.
- A01.0 needs a fifth digit.
- 567.8 (Peritonitis NEC) is invalid for service dates on or after October 01, 2005 (ICD-9-CM).
J.1.6 Physician Edit 006
Diagnosis and Age Conflict (Claim Returned to Provider (RTP))
Indicates that the ICD-10-CM diagnosis code is inconsistent with the patient’s age. Age categories are as follows:
- Newborn (age = 0)
- Pediatric (age = 0 to 17 years)
- Maternity
  - Age = 12 - 55 years (prior to October 01, 2019)
  - Age = 9 - 64 years (effective October 01, 2019)
- Adult (age > 14)

J.1.6.1 Examples:
- P03.810 (Newborn (Suspected to be) Affected by Abnormality in Fetal (Intrauterine) Heart Rate or Rhythm Before the Onset of Labor) is appropriate only for newborn patients.
- G93.7 (Reyes Syndrome) is appropriate for pediatric patients only.
- O00.9 (Pregnancy Without Intrauterine Pregnancy) is appropriate for maternity patients only.
- J61 (Pneumoconiosis Due to Asbestos and Other Mineral Fibers) is appropriate only for adults.

Note
Physician Edit 006 will not be issued when Physician Edit 003 (Invalid Age) is issued.

J.1.7 Physician Edit 007
Diagnosis and Sex Conflict (Claim Returned to Provider (RTP))
Indicates that the ICD-10-CM diagnosis code is inconsistent with the patient’s sex.

J.1.7.1 Examples:
- C53.8 (Malignant Neoplasm of Overlapping Sites of Cervix Uteri) is considered appropriate only for female patients.
- Z98.52 (Vasectomy Status) is considered appropriate only for male patients.

J.1.8 Physician Edit 008
External Causes of Morbidity Code Cannot be Used as Principal Diagnosis (Claim Returned to Provider (RTP))
ICD-10-CM External Causes of Morbidity codes are equivalent to ICD-9-CM E-codes. These codes describe the circumstances that caused an injury, not
the nature of the injury. The ICD-10-CM codes are prefixed with V, W, X, or Y. These codes are not acceptable billed by themselves or as the primary diagnosis, however, they can be billed as the secondary diagnosis. If one of these codes is billed as a primary diagnosis, Physician Edit 008 will be issued, and the claim will be Returned to Provider (RTP).

J.1.8.1 Examples:
- Y83.9 (Abnormal Reaction Surgical Procedure NOS).
- T40.7X5A (Adverse Effect of Cannabis (Derivatives), Initial Encounter).

J.1.9 Physician Edit 009
Invalid Procedure Code (Claim Returned to Provider (RTP))
Each Level I or Level II procedure code is edited for validity. This Edit indicates that the procedure code is invalid or was not valid for the patient’s dates of service. Date validity is verified using the From Date on the claim.

J.1.9.1 Examples:
- 1234 is an invalid procedure code.
- S9075, Smoking cessation treatment, is not valid after June 30, 2011.

J.1.10 Physician Edit 010
Procedure and Sex Conflict (Claim Returned to Provider (RTP))
This Edit indicates that the procedure code is not valid for the patient’s sex.

J.1.10.1 Examples:
- 53430, Urethroplasty, reconstruction of female urethra, is considered valid for female patients only.
- 55250, Removal of sperm duct(s), is considered valid for males only.

J.1.11 Physician Edit 011
Medically Unlikely Edit (Line Item Denial)
Effective for claims with service dates on or after July 01, 2014, a MUE Adjudication Indicator (MAI) is used to determine when a MUE is a day-level edit or a line-level edit. For claims with service dates prior to July 01, 2014, the MUE is a line–level edit.

• For a MAI of 1: the MUE is a line-level edit. If the claim line units exceed the assigned MUE value for the claim line procedure code, a Physician Edit 011 will be generated.

• For a MAI of 2 and 3: the MUE is a day-level edit. Units on each line of the claim with the same procedure code and service date (per day) are added together to determine if the total units exceed the assigned MUE value for that procedure code. If the total units for that procedure code exceed the assigned MUE, all claim lines with that procedure code and that service date will receive Physician Edit 011.
Medicare publishes separate MUEs for Durable Medicare Equipment (DME) suppliers and for all other practitioners. For each service, the choice of which MUE edit to apply (DME or practitioner) is determined based on configuration settings.

Option 1: Use the taxonomy code associated with the most specific NPI on the claim (rendering, service, or billing). DME MUEs are applied to services provided by DME suppliers, and practitioner MUEs are applied to all other eligible services. To request this option, set the Editor Requests 2 (edit_req2; ECB-EDIT-PHYS-SW (position 86)) field to 1 (Request Physician Edits, MUEs Applied Based on Taxonomy) in the ECB [ezg_cntl_block]/ECB-EZG-CNTL-BLOCK structure or the Physician Configuration File (cfgphys.dat; cnfg04.dat). The list of taxonomy codes that trigger the DME MUEs is maintained within the Physician Editor and are shown below in Table J-1.

Option 2: For each service on the DMEPOS fee schedule, evaluate the maximum units allowed for DME suppliers and for all other practitioners, and use the maximum of the two limits when applying the MUE edits for each service. If there is no published DME maximum units for that service, no edits would apply. For services not on the DMEPOS fee schedule, use the practitioner MUEs as appropriate. To request this option, set the Editor Requests 2 (edit_req2; ECB-EDIT-MAXMUE (position 88)) field in the Physician Configuration File (cfgphys.dat; cnfg04.dat) or the ECB [ezg_cntl_block]/ECB-EZG-CNTL-BLOCK structure to 1 (Request Physician Edits, Max of DME and Practitioner MUE Applied).

Table J-1: Taxonomy Codes That Trigger DME MUEs

<table>
<thead>
<tr>
<th>Taxonomy Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>332B00000X</td>
<td>Durable Medical Equipment and Medical Supplies</td>
</tr>
<tr>
<td>332BC3200X</td>
<td>Customized Durable Medical Equipment Supplier</td>
</tr>
<tr>
<td>332BD1200X</td>
<td>Dialysis Equipment and Supplies</td>
</tr>
<tr>
<td>332BN1400X</td>
<td>Nursing Facility Supplier</td>
</tr>
<tr>
<td>332BP3500X</td>
<td>Parenteral and Enteral Nutrition Supplier</td>
</tr>
<tr>
<td>332BX2000X</td>
<td>Oxygen Supplier</td>
</tr>
<tr>
<td>335E00000X</td>
<td>Prosthetic/Orthotic Supplier</td>
</tr>
</tbody>
</table>

J.1.11.1 Example
Procedure code 85041, Automated red blood cell count, is assigned a MAI value of 1 and MUE value of 2. A claim line with procedure code 85041 and a unit value of 3 will violate the Medically Unlikely Edit for that code and will receive Physician Edit 011.
J.1.12 Physician Edit 012

**Invalid Modifier (Claim Returned to Provider (RTP))**

Indicates that the two-character modifier associated with the procedure code is not valid for the service date or has never been valid.

**J.1.12.1 Example:**
CMS deleted Modifier 4D, effective January 01, 2011. Any claim that contains Modifier 4D with a service date after December 31, 2010 would generate Edit 012.

J.1.13 Physician Edit 013

**Mutually Exclusive Procedure That is Not Allowed by NCCI Even if Appropriate Modifier is Present (Not Active)**

Mutually exclusive procedures cannot be billed together on the same claim for the same day. This Edit is based upon Correct Coding Initiative (CCI) logic and identifies the unpaid procedure of the mutually exclusive pair. The unpaid procedure of the mutually exclusive procedure pair is often but not always the more expensive procedure. The presence of a modifier will not eliminate this Edit under any circumstances.

**J.1.13.1 Example:**
If CPT® code 92607, *Evaluation for speech device RX 1 hour*, was reported with CPT® code 92597, *Oral speech device eval*, CPT® code 92597 would generate Edit 013.

**Note**

Retroactive to August 1, 2000, CMS has deactivated Mutually Exclusive edits and incorporated the respective code pairs into existing Code 1/Code 2 edits. As a result, the code pairs that were previously eligible for Edit 013 are now incorporated into Edit 015.

J.1.14 Physician Edit 014

**Mutually Exclusive Procedure That Would be Allowed by NCCI if Appropriate Modifier Were Present (Not Active)**

Identifies a procedure code that is one of a pair of mutually exclusive procedures. Such procedures would not ordinarily be paid, but would be allowed if the appropriate modifier were present.

Only certain modifiers will override this Edit. They are: 58, 59, 78, 79, and 91 for Level I. For Level II, they are E1-E4, F1-F9, FA, LC, LD, LT, RC, RT, T1-T9, and TA.

**J.1.14.1 Example:**
If 61001, *Remove cranial cavity fl*, were reported with 61000, *Remove cranial cavity fl*, without the appropriate Modifier, 61000 would receive this Edit.
Note
Retroactive to August 1, 2000, CMS has deactivated Mutually Exclusive edits and incorporated the respective code pairs into existing Code 1/Code 2 edits. As a result, the code pairs that were previously eligible for Edit 014 are now incorporated into Edit 016.

J.1.15 Physician Edit 015
Code 2 of a Code Pair That is Not Allowed by NCCI Even if Appropriate Modifier is Present (Line Item Rejection)
Identifies the column 2 code of a column1/column2 Correct Coding Edit, indicating that this code should not be reported along with the column 1 code on the same service date. Often, the column 2 code is a component of a procedure that is billed on the same date as the comprehensive procedure. Services that are normally a component of a more comprehensive procedure cannot be billed separately, but must be considered as included in the more comprehensive procedure. This Edit is also based on CCI logic. The presence of a modifier will not eliminate this Edit under any circumstances.

J.1.15.1 Example:
If procedure code 93015, Cardiovascular stress test; physician supervision, interpretation and report, was reported with procedure code 93016, Cardiovascular stress test; physician supervision only, then procedure code 93016 would receive Edit 015.

J.1.16 Physician Edit 016
Code 2 of a Code Pair That Would be Allowed by NCCI if Appropriate Modifier Were Present (Line Item Rejection)
Identifies the column 2 code of a column1/column2 Correct Coding Edit, indicating that this code should not be reported along with the column 1 code on the same service date. Often, the column 2 code is a component of a procedure that is billed on the same date as the comprehensive procedure. Services that are normally a component of a more comprehensive procedure cannot be billed separately, but must be considered as included in the more comprehensive procedure. This Edit is based on CCI logic. Only certain modifiers will override this Edit. They are 24, 25, 57, 58, 59, 78, 79, and 91 for Level I. For Level II, they are E1-E4, F1-F9, FA, LC, LD, LM, LT, RC, RI, RT, T1-T9, and TA.

J.1.16.1 Example:
If procedure code 77412, Radiation, three or more treatment areas; up to 5 MEV were reported with procedure code 77402, Radiation, single treatment area; up to 5 MEV, without the appropriate modifier, procedure code 77402 would receive this Edit.
J.1.17 Physician Edit 017
Biosimilar HCPCS Reported Without Biosimilar Modifier (Returned to Provider (RTP)) (Not Active)

Effective January 01, 2016, this edit will be returned when a biosimilar injection procedure code is billed without a corresponding biosimilar manufacturing modifier.

J.1.17.1 Example:
Procedure code Q5101, *Injection, filgrastim (C-CSF), biosimilar, 1 microgram*, is reported without a modifier, Physician Edit 017 will be returned.

J.1.18 Physician Edit 018
Claim Lacks Required Primary Code (Returned to Provider (RTP))

An add-on procedure code is a service that is always performed in conjunction with another primary service. Effective January 01, 2016, if an add-on procedure code is not billed on the same date of service as the associated eligible primary procedure code, then Physician Edit 018 will be returned and payment will not be made.

J.1.18.1 Example:
Procedure code 0443T, *Real time spectral analysis of prostate tissue by fluorescence spectroscopy*, is reported without primary procedure code 55700, *Biopsy, prostate; needle or punch, single or multiple, any approach*, Physician Edit 018 will be returned.

J.1.19 Physician Edit 019
Supplementary or Additional Code Not Allowed as Principal Diagnosis (Return to Provider (RTP))

Effective October 01, 2019, diagnosis-level Physician Edit 019 will be returned when an unacceptable diagnosis code is billed as the principal diagnosis on a claim.

J.1.19.1 Example:
Diagnosis code B95.0 (Streptococcus, Group A, as the Cause of Diseases Classified Elsewhere) is billed as the principal diagnosis code, Physician Edit 019 will be returned.

J.1.20 Physician Edit 020
Item or Service Not Allowed With Modifier CS (Return to Provider (RTP))

Effective March 18, 2020, line-level Physician Edit 020 will be returned when Modifier CS (COVID-19 Testing-Related Service) is reported on an item or service that is not on the coinsurance waiver eligible list.

J.1.20.1 Example:
Modifier CS is reported with procedure code 0001U, *Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11*
blood groups, utilizing whole blood, common RBC alleles reported, Physician Edit 020 will be returned.
K Descriptions of Date-Sensitive Code Edits

Detailed descriptions for all of the different types of edits that are applicable to prospective payment are provided in this section, for use with the DSC Editor. This section includes the following:

• Date-Sensitive Code Edits

Note
Edits below presented in gray font are listed as not active.
K.1 Date-Sensitive Code Edits

The DSC Editor provides comprehensive clinical edits, including all Medicare Code Edits (MCEs) used by Fiscal Intermediaries (FIs) to review claim submissions. The following section provides a complete list of the edits that are performed by the DSC Editor.

**Note**
For a list of the values that may be returned in the below-mentioned fields, please refer to the Input and Output Block Parameters User’s Guide.

K.1.1 DSC Edit 001:

**Invalid DX**

This ICD-10-CM principal, secondary, or admit diagnosis code is not a valid code, or is invalid for the patient date of discharge. Invalid diagnosis codes are reported in the following fields:

- For principal and secondary diagnosis codes: MEB\_DX [mce\_dx\_edits]: 
  *invalid*
- MEB2-MCE-EDITOR-BLOCK2: MEB2-DX-INVALID
- For admit diagnosis codes: MEB1 [mce\_editor\_block1]: adm\_dx\_invalid
- MEB1-MCE-EDITOR-BLOCK1: MEB1-ADMDX-INVALID

K.1.2 DSC Edit 002:

**Invalid PX**

This ICD-10-PCS procedure code is not a valid code, or is invalid for the patient date of discharge. Invalid procedure codes are reported in the following fields:

- MEB\_OP [mce\_op\_edits]: invalid
- MEB3-MCE-EDITOR-BLOCK3: MEB3-OP-INVALID

K.1.3 DSC Edit 003:

**Duplicate of PDX**

This ICD-10-CM secondary diagnosis code is a duplicate of the principal ICD-10-CM diagnosis code. Duplicate diagnosis codes are reported in the following fields:

- MEB\_DX [mce\_dx\_edits]: *dupdx*
- MEB2-MCE-EDITOR-BLOCK2: MEB2-DX-DUPDX

K.1.4 DSC Edit 004 & 005:

**Age Conflict and Sex Conflict**

This ICD-10-CM/PCS diagnosis code and/or procedure code is inconsistent with the patient’s sex, or this ICD-10-CM diagnosis code is inconsistent with
the patient’s age. Diagnosis codes may be grouped into one of four age
groups: Newborn (age = 0), Pediatric (age = 0 - 17), Maternity (age = 12 - 55),
or Adult (age > 14).

Effective October 1, 2010, the Sex Conflict Edit will not be applied to claims
that contain condition code 45 (Ambiguous Gender Category). Inconsistent
diagnosis/procedure codes and patient sex/age combinations are reported in
the following fields:

- For principal and secondary diagnosis codes: MEB_DX [mce_dx_edits]:
  agesex
- For diagnosis codes: MEB2-MCE-EDITOR-BLOCK2: MEB2-DX-
  AGEXE
- For admit diagnosis codes: MEB1 [mce_editor_block1]: admex_agesex
- For admit diagnosis codes: MEB1-MCE-EDITOR-BLOCK1: MEB1-
  ADMEX_AGESEX
- For procedure codes: MEB_OP [mce_op_edits]: sex
- For procedure codes: MEB3-MCE-EDITOR-BLOCK3: MEB3-OP-SEX

K.1.5 DSC Edit 006:

Manifestation as PDX

This ICD-10-CM principal diagnosis code is a manifestation code. Manifestation
codes describe the underlying cause of a disease, not the
disease itself. As such, manifestation codes should not be used as principal
diagnoses.

Invalid principal diagnosis codes are reported in the following fields:

- MEB1 [mce_editor_block1]: dx_pdx
- MEB1-MCE-EDITOR-BLOCK1: MEB1-DX-PDX

K.1.6 DSC Edit 007:

Non-Specific PDX (Not Active as of 10/01/07)

This ICD-9-CM principal diagnosis code is not specific. Invalid principal
diagnosis codes are reported in the following fields:

- MEB1 [mce_editor_block1]: dx_pdx
- MEB1-MCE-EDITOR-BLOCK1: MEB1-DX-PDX

K.1.7 DSC Edit 008:

Questionable Admission

This ICD-10-CM principal diagnosis code is not sufficient justification for
hospital admission (i.e., Obesity). Invalid principal diagnosis codes are
reported in the following fields:

- MEB1 [mce_editor_block1]: dx_pdx
K.1.8 DSC Edit 009:
Unacceptable PDX

This ICD-10-CM principal diagnosis code is unacceptable or may require a secondary diagnosis code to be acceptable. An example of an unacceptable diagnosis code is one that describes a circumstance that affects the patient’s health, but does not describe the patient’s current illness (i.e. history of tobacco use). Invalid principal diagnosis codes are reported in the following fields:

- MEB1 [mce_editor_block1]: dx_pdx
- MEB1-MCE-EDITOR-BLOCK1: MEB1-DX-PDX

K.1.9 DSC Edit 010:
All Non-Specific O.R. PDX (Not Active as of 10/01/07)

All of the Operating Room (O.R.) ICD-9-CM procedure codes provided are non-specific. At least one specific O.R. procedure code is required. Non-specific O.R. procedure codes are reported in the following fields:

- MEB1 [mce_editor_block1]: op_nonspec
- MEB1-MCE-EDITOR-BLOCK1: MEB1-OP-NONSPEC

K.1.10 DSC Edit 011:
Non-Covered Procedure

Medicare does not provide reimbursement for this ICD-10-PCS procedure code or does not provide reimbursement for this procedure code unless certain ICD-10-CM diagnosis codes are used. Effective April 1, 2010, this edit is bypassed if the bill type equals 0110. Non-covered procedure codes are reported in the following fields:

- MEB_OP [mce_op_edits]: ncbiop
- MEB3-MCE-EDITOR-BLOCK3: MEB3-OP-NCBIOP

K.1.11 DSC Edit 012:
Open Biopsy Check (Not Active as of 10/01/10)

This ICD-9-CM procedure code is for an open biopsy. Check to ensure that the biopsy performed was actually open. If not, replace this procedure code with the corresponding closed biopsy procedure code. Open biopsy procedure codes are reported in the following fields:

- MEB_OP [mce_op_edits]: ncbiop
- MEB3-MCE-EDITOR-BLOCK3: MEB3-OP-NCBIOP

The corresponding closed biopsy code is reported in the following fields:

- MEB_OP [mce_op_edits]: clsdbiop
K.1.12 DSC Edit 013:

**Bilateral Procedures (Not Active as of 10/01/15)**

Certain codes do not accurately reflect procedures performed in one admission on two or more different bilateral joints of the lower extremities. A combination of these codes shows a bilateral procedure when they could be procedures performed on a single joint. For example, if 8151 (Total Hip Replacement) and 8152 (Partial Hip Replacement) are both coded on a claim, this claim will receive Edit 13. However, if 8151 is coded twice on a claim, this claim will not receive Edit 13. This edit is only triggered if the claim is either assigned to MDC 8 or has not yet been assigned to an MDC. Bilateral procedures are reported in the following fields:

- MEB1 [mce_editor_block1]: op_bilat
- MEB1-MCE-EDITOR-BLOCK1: MEB1-OP-BILAT

All bilateral procedure codes are reported in the following fields, regardless of whether Edit 13 is present on the claim:

- MEB_OP [mce_op_edits]: bicode
- MEB3-MCE-EDITOR-BLOCK3: MEB3-OP-BICODE

K.1.13 DSC Edit 014:

**Invalid Age**

This patient’s age is not between 0 years and 124 years and is, therefore, assumed to be invalid. Invalid ages are reported in the following fields:

- MEB1 [mce_editor_block1]: demo_age
- MEB1-MCE-EDITOR-BLOCK1: MEB1-DEMO-AGE

K.1.14 DSC Edit 015:

**Invalid Sex**

This patient’s sex is not reported as 1 or M (Male) or 2 or F (Female). Effective October 1, 2010, Edit 15 will not be applied to claims that contain condition code 45 (Ambiguous Gender Category). Invalid sex is reported in the following fields:

- MEB1 [mce_editor_block1]: demo_sex
- MEB1-MCE-EDITOR-BLOCK1: MEB1-DEMO-SEX
K.1.15 DSC Edit 016: Invalid Discharge Status

This patient’s discharge status is either not provided and is required or is provided, but is not valid.

**Note**

For a list of valid Discharge Status Codes, please refer to the Input and Output Parameter’s User’s Guide.

Invalid discharge status codes are reported in the following fields:
- MEB1 [mce_editor_block1]: demo_dstat
- MEB1-MCE-EDITOR-BLOCK1: MEB1-DEMO-DSTAT

K.1.16 DSC Edit 017: Limited Coverage

Medicare limits the coverage of this ICD-10-PCS procedure code due to the extraordinary associated costs (i.e., lung transplant). Limited coverage procedure codes are reported in the following fields:
- MEB_OP [mce_op_edits]: ncbiop
- MEB3-MCE-EDITOR-BLOCK3: MEB3-OP-NCBIOP

K.1.17 DSC Edit 018: Invalid Birth Weight

If this patient’s age is 0 years, then a birth weight, if submitted must be valid. Valid birth weights include 0000, 9999, and any value between 100 and 9000 grams. If the patient’s age is greater than 0 years, this edit is not applied. Invalid birth weights are reported in the following fields:
- MEB1 [mce_editor_block1]: demo_bwt
- MEB1-MCE-EDITOR-BLOCK1: MEB1-DEMO-BWGT

K.1.18 DSC Edit 019: External Causes of Morbidity Code as PDX

This ICD-10-CM principal diagnosis code is an external cause of morbidity code, meaning that it describes the circumstance that caused an injury, not the injury itself. As such, this code should not be used as the principal diagnosis. For ICD-9-CM, external cause of morbidity codes are prefixed with the letter E (i.e. E-codes). For ICD-10-CM, external cause of morbidity codes are prefixed with the letter V, W, X, or Y. Invalid principal diagnosis codes are reported as follows:
- MEB.DX [mce_dx_edits]: dx_pdx
- MEB1-MCE-EDITOR-BLOCK1: MEB2-DX-PDX
K.1.19 DSC Edit 020:
Duplicate of Another SDX
This ICD-10-CM secondary diagnosis code is used twice as a secondary diagnosis. Duplicate secondary diagnosis codes are reported in the following fields:
- MEB_DX [mce_dx_edits]: \textit{dupsecdx}
- MEB2-MCE-EDITOR-BLOCK2: \texttt{MEB2-DX-DUPSECDX}

K.1.20 DSC Edit 021:
External Causes of Morbidity Code as Admit DX
This ICD-10-CM admit diagnosis code is an external cause of morbidity code, meaning that it describes the circumstance that caused an injury, not the injury itself. As such, this code should not be used as the admit diagnosis. For ICD-9-CM, external cause of morbidity codes are prefixed with the letter E (i.e. E-codes). For ICD-10-CM, external cause of morbidity codes are prefixed with the letter V, W, X, or Y. Invalid admit diagnosis codes are reported in the following fields:
- MEB1 [mce_editor_block1]: \textit{dx_admem}
- MEB1-MCE-EDITOR-BLOCK1: \texttt{MEB1-DX-ADMEM}

K.1.21 DSC Edit 022:
Manifestation Code as Admit DX
This ICD-10-CM admit diagnosis code is a manifestation code. Manifestation codes describe the underlying cause of a disease and not the disease itself. As such, manifestation codes should not be used as admit diagnoses. Invalid admit diagnosis codes are reported in the following fields:
- MEB1 [mce_editor_block1]: \textit{dx_admem}
- MEB1-MCE-EDITOR-BLOCK1: \texttt{MEB1-DX-ADMEM}

K.1.22 DSC Edit 023:
Invalid POA Coding
Present on Admission (POA) indicators must be provided for all ICD-10-CM principal and secondary diagnosis codes. This edit is assigned to any claim that does not contain a valid POA indicator for every diagnosis code. This edit checks the following:
1. A POA indicator is provided for every diagnosis code.
2. The provided POA indicator is valid. Valid POA values are as follows:
   - For codes subject to POA reporting:
     - \texttt{Y = Yes} (present at the time of inpatient admission)
     - \texttt{N = No} (not present at the time of inpatient admission)
- **U = Unknown** (documentation is insufficient to determine if condition was present at the time of inpatient admission)

- **W = Clinically Undetermined** (provider is unable to clinically determine if condition is present on admission or not)

- For codes exempt from POA reporting:
  - **1 = Unreported/Not Used** (exempt from POA reporting on electronic claims (before June 30, 2012) and paper claims (on or after July 1, 2011)). For a list of diagnosis codes that are exempt from POA reporting, refer to the EASYGroup™ Client Portal.
  
  - **Blank = Unreported/Not Used** (exempt from POA reporting on paper claims (before June 30, 2011) and on electronic claims (on or after January 1, 2011)). For a list of diagnosis codes that are exempt from POA reporting, refer to the EASYGroup™ Client Portal.

**Note**

Invalid POA indicators are reported in the following fields:

- MEB_DX [mce_dx_edits]: **poa_invalid**

- MEB2-MCE-EDITOR-BLOCK2: **MEB2-DX-POA**

**Note**
Effective July 1, 2012, the DSC Editor returns DSC Edit 023 for claims with invalid POA indicators for diagnosis codes exempt from POA reporting.

Per the Texas Health and Human Services, DSC Edit 023 does not apply to Texas Medicaid claims (paper or electronic) for POA indicators that are reported with diagnosis codes that are exempt from POA reporting on Texas Medicaid claims.

**K.1.23 DSC Edit 024:**
**Hospital-Acquired Condition (HAC) / Health Care Acquired Condition (HCAC)**

A HAC or HCAC has been found on this claim. For additional information on this edit, please refer to Chapter 5.

**K.1.24 DSC Edit 025:**
**Wrong Procedure Performed**

This ICD-10-CM principal or secondary diagnosis code indicates that a wrong procedure has been performed. This edit was effective October 1, 2009. Wrong procedure diagnosis codes are reported in the following fields:
K.1.25 DSC Edit 026: Procedure Inconsistent With Length of Stay

When a claim contains a discharge date on or after October 01, 2015, ICD-10 procedure code 5A1955Z, *Respiratory ventilation, greater than 96 consecutive hours*, and a length of stay equaling less than or equal to four days, this edit will return. When the value in the UB-04 Occurrence Span Codes (*span_code*: PCB1-SPAN-CODE) field is equal to 74 (Non-Covered Level of Care/Leave of Absence Dates), the length of stay will be determined by calculating the number of days between the Procedure Date (when provided) and the Thru Date on the claim, and then subtracting the value in the UB-04 Occurrence Span Date #1 (*span_date1*: PCB1-SPAN-DATE1) field from the value in the UB-04 Occurrence Span Date #2 (*span_date2*: PCB2-SPAN-DATE2) field. When the Procedure Date is not provided, the From Date will be used.

When the above requirements are met, a 1 (Length of Stay and Procedure are Inconsistent) will be returned in the below fields:

- MEB_OP [mce_op_edits]: *pilos*
- MEB3-MCE-EDITOR-BLOCK3: MEB3-OP-PILOS

K.1.26 DSC Edit 027: Questionable Obstetric Admission

Effective October 01, 2018, when a claim contains procedure codes that describe a cesarean section or vaginal delivery and a corresponding secondary diagnosis code describing the outcome of delivery is not present, this edit will return.

Cesarean section or vaginal delivery procedure codes reported without a secondary diagnosis code that describes the outcome of the delivery will be returned with a value of 1 (Questionable Obstetric Admission for This Procedure Code) in the below fields:

- MEB.OP [mce_op_edits]: *qobadm*
- MCE-EDITOR-BLOCK3: MEB3-OP-QOBADM
L Descriptions of Conditional APCs

This section includes the following:

• Conditional APCs

Note

Non-active Conditional APCs are presented in gray font below.

L.1 Conditional APCs

Detailed descriptions and examples for all of the Conditional APCs are provided below and are also available on the OCExpert™>Conditional APCs tab within APC Assistant™.

Note

Optum APC Assistant™ is a comprehensive, web-based resource containing all the latest APC regulatory information to successfully navigate through the OPPS.

If you do not license Optum APC Assistant™, contact Optum Client Services.

L.1.1 APC 00034:

Mental Health Services Composite (Not Active as of 1/1/16)

For regular hospital outpatient claims (i.e., claims without condition code 41 and with UB-04 Bill Type 012X or 013X), Medicare has designed a payment limit for mental health services to be equal to the hospital-based level II payment under the partial hospitalization program. With this rule, Medicare effectively limits the amount a facility can receive for partial hospitalization services provided to a single patient, on a single service date to the hospital-based level II partial hospitalization payment.

For each unique service date the expected payment for all mental health services on the claim is calculated, and if it exceeds the hospital-based level II partial hospitalization payment amount, Composite APC 00034 is assigned to the first mental health service on that day. All other mental health services on the same service date are packaged into the Composite APC payment.
L.1.2.1 Example:
A claim with UB-04 Bill Type 0131 without condition code 41, a single service
date of January 01, 2012 and the following procedure codes:

Table L-1: APC 00034 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td>Psychiatric diagnostic interview examination</td>
<td>00034</td>
<td>S</td>
<td>Paid</td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90899</td>
<td>Unlisted psychiatric service or procedure</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>96101</td>
<td>Psychological testing</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid APC 00034 claim because the expected payment for all mental
health services on the claim exceeds the hospital-based level II partial
hospitalization payment. APC 00034 is assigned to procedure code 90801
because it is the first mental health service of the day. Notice that APC 00034
receives a payment status of S while all other mental health services receive a
payment status of N indicating that the payment for these services has been
packaged into the Composite APC reimbursement.

L.1.3.2 APC Assistant:
A complete list of all the mental health services that qualify for this APC is
available on the Conditional APC page.

L.1.4 APC 00172:

Level I Partial Hospitalization (3 Services) for CMHCs (Not Active as of 1/1/16)
Under the partial hospitalization benefit, patients requiring substantial mental
health services in an outpatient setting may be eligible for the partial
hospitalization per diem reimbursement. Community Mental Health Center
(CMHC) claims, with UB-04 Bill Type 076X that have a mental health principal
diagnosis, are eligible for this per diem reimbursement.

Partial hospitalization services are divided into two lists: List A and List B. List
A contains extended, family, and group psychotherapy services. List B
contains all services on List A and all other types of psychotherapy services,
neuropsychological testing services, activity therapy, occupational therapy,
and education and training services.

To be eligible for APC 00172, a single date of service on a claim must have
the following:

• Three qualifying partial hospitalization services from List B.
**Note**

Effective January 01, 2013, some List B services are add-on codes and are not counted toward meeting the numerical requirement for this composite APC assignment.

- At least one of those services is also on List A.

If four or more of the above partial hospitalization services are provided at a CMHC on a single date of service, then the claim may be eligible for the level II partial hospitalization per diem benefit (refer to APC 00173: below) instead. For each date of service that meets the requirements for APC 00172, the first partial hospitalization service provided on that day from List A will be assigned to APC 00172. All other partial hospitalization services provided on that date are packaged into the per diem rate.

**L.1.5.1 Example:**
A claim with UB-04 Bill Type 0761, a single service date of January 01, 2012, a mental health diagnosis, and the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0129</td>
<td>Occupational Therapy</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90818</td>
<td>Individual Psychotherapy</td>
<td>00172</td>
<td>P</td>
<td>Paid</td>
</tr>
<tr>
<td>96101</td>
<td>Psychological Testing</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid CMHC level I partial hospitalization claim since there are three partial hospitalization services occurring on the same date, and at least one of those services is from List A. APC 00172 is assigned to procedure code 90818, which is the only List A service on the day. Notice that APC 00172 receives a payment status of P while all other partial hospitalization services receive a payment status of N, indicating that the payment for these services has been packaged into the per diem reimbursement.

**L.1.6.2 APC Assistant**
Complete lists of all partial hospitalization services on List A and List B are available on the Conditional APC page.

**L.1.7 APC 00173:**

**Level II Partial Hospitalization (4 or More Services) for CMHCs (Not Active as of 1/1/16)**

Under the partial hospitalization benefit, patients requiring substantial mental health services in an outpatient setting may be eligible for the partial hospitalization per diem reimbursement. Community Mental Health Center
(CMHC) claims with UB-04 Bill Type 076X, that have a mental health principal diagnosis are eligible for this per diem reimbursement.

Partial hospitalization services are divided into two lists: List A and List B. List A contains extended, family, and group psychotherapy services. List B contains all services on List A and all other types of psychotherapy services, neuropsychological testing services, activity therapy, occupational therapy, and education and training services.

To be eligible for APC 00173, a single date of service on a claim must have the following:

- Four or more qualifying partial hospitalization services from List B.

**Note**

Effective January 01, 2013, some List B services are add-on codes and are not counted toward meeting the numerical requirement for this composite APC assignment.

- At least one of those services is also on List A.

If only three qualifying partial hospitalization services are provided at a CMHC on a single date of service, then the claim may be eligible for the level I partial hospitalization per diem benefit instead (refer to APC 00172: above). For each date of service that meets the requirements for APC 00173, the first partial hospitalization service provided on that day from List A will be assigned to APC 00173. All other partial hospitalization services provided on that date are packaged into the per diem rate.

**L.1.8.1 Example**

A claim with UB-04 Bill Type 0761, a single service date of January 01, 2012, a mental health diagnosis, and the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0129</td>
<td>Occupational Therapy</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90818</td>
<td>Individual Psychotherapy</td>
<td>00173</td>
<td>P</td>
<td>Paid</td>
</tr>
<tr>
<td>96101</td>
<td>Psychological Testing</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90801</td>
<td>Psychiatric Diagnostic Interview Examination</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid CMHC level II partial hospitalization claim since there are four partial hospitalization services occurring on the same date, and at least one of those services is from List A. APC 00173 is assigned to procedure code.
90818, which is the only List A service on the day. Notice that APC 00173 receives a payment status of P while all other partial hospitalization services receive a payment status of N, indicating that the payment for these services has been packaged into the per diem reimbursement.

L.1.9.2 APC Assistant
Complete lists of all partial hospitalization services on List A and List B are available on the Conditional APC page.

L.1.10 APC 00175:

Level I Partial Hospitalization (3 Services) for Hospital-Based PHPs (Not Active as of 1/1/16)

Under the partial hospitalization benefit, patients requiring substantial mental health services in an outpatient setting may be eligible for the partial hospitalization per diem reimbursement. Hospital-based Partial Hospitalization Program (PHP) claims with UB-04 Bill Type 013X, condition code 41, and a mental health principal diagnosis, are eligible for this per diem reimbursement.

Partial hospitalization services are divided into two lists: List A and List B. List A contains extended, family, and group psychotherapy services. List B contains all services on List A and all other types of psychotherapy services, neuropsychological testing services, activity therapy, occupational therapy, and education and training services.

To be eligible for APC 00175, a single date of service on a claim must have the following:

• Three qualifying partial hospitalization services from List B.

Note

Effective January 01, 2013, some List B services are add-on codes and are not counted toward meeting the numerical requirement for this composite APC assignment.

At least one of those services is also on List A. If four or more qualifying partial hospitalization services are provided in a hospital-based PHP on a single date of service, then the claim may be eligible for the level II partial hospitalization per diem benefit (refer to APC 00176: below) for Hospital-based PHPs below) instead. For each date of service that meets the requirements for APC 00175, the first partial hospitalization service provided on that day from List A will be assigned to APC 00175. All other partial hospitalization services provided on that date are packaged into the per diem rate.
L.1.11.1 Example:
A claim with UB-04 Bill Type 0131, condition code 41, a single service date of January 01, 2012, a mental health diagnosis, and the following procedure codes:

Table L-4: APC 00175 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC 00175</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0129</td>
<td>Occupational Therapy</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90818</td>
<td>Individual Psychotherapy</td>
<td>00175</td>
<td>P</td>
<td>Paid</td>
</tr>
<tr>
<td>96101</td>
<td>Psychological Testing</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid hospital-based PHP level I partial hospitalization claim since there are three partial hospitalization services occurring on the same date, and at least one of those services is from List A. APC 00175 is assigned to procedure code 90818, which is the only List A service on the day. Notice that APC 00175 receives a payment status of P while all other partial hospitalization services receive a payment status of N indicating that the payment for these services has been packaged into the per diem reimbursement.

L.1.12.2 APC Assistant
Complete lists of all partial hospitalization services on List A and List B are available on the Conditional APC page.

L.1.13 APC 00176:
**Level II Partial Hospitalization (4 or More Services) for Hospital-Based PHPs (Not Active as of 1/1/16)**

Under the partial hospitalization benefit, patients requiring substantial mental health services in an outpatient setting may be eligible for the partial hospitalization per diem reimbursement. Hospital-based Partial Hospitalization Program (PHP) claims with UB-04 Bill Type 013X, condition code 41, and a mental health principal diagnosis, are eligible for this per diem reimbursement.

Partial hospitalization services are divided into two lists: List A and List B. List A contains extended, family, and group psychotherapy services. List B contains all services on List A and all other types of psychotherapy services, neuropsychological testing services, activity therapy, occupational therapy, and education and training services.

To be eligible for APC 00176, a single date of service on a claim must have the following:

- Four or more qualifying partial hospitalization services from List B.
Note

Effective January 01, 2013, some List B services are add-on codes and are not counted toward meeting the numerical requirement for this composite APC assignment.

- At least one of those services is also on List A.

If only three qualifying partial hospitalization services are provided in a hospital-based PHP on a single date of service, then the claim may be eligible for the level I partial hospitalization per diem benefit instead (refer to APC 00175: above). For each date of service that meets the requirements for APC 00176, the first partial hospitalization service provided on that day from List A will be assigned to APC 00176. All other partial hospitalization services provided on that date are packaged into the per diem rate.

L.1.14.1 Example:
A claim with UB-04 Bill Type 0131, condition code 41, a single service date of January 01, 2012, a mental health diagnosis, and the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0129</td>
<td>Occupational Therapy</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90818</td>
<td>Individual Psychotherapy</td>
<td>00176</td>
<td>P</td>
<td>Paid</td>
</tr>
<tr>
<td>96101</td>
<td>Psychological Testing</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90801</td>
<td>Psychiatric Diagnostic Interview Examination</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid hospital-based PHP level II partial hospitalization claim since there are four partial hospitalization services occurring on the same date, and at least one of those services is from List A. APC 00176 is assigned to procedure code 90818, which is the only List A service on the day. Notice that APC 00176 receives a payment status of P while all other partial hospitalization services receive a payment status of N, indicating that the payment for these services has been packaged into the per diem reimbursement.

L.1.15.2 APC Assistant
Complete lists of all partial hospitalization services on List A and List B are available on the Conditional APC page.

L.1.16 APC 05851:
Level I Partial Hospitalization (3 Services) for CMHCs
Under the partial hospitalization benefit, patients requiring substantial mental health services in an outpatient setting may be eligible for the partial hospitalization per diem reimbursement. Community Mental Health Center (CMHC) claims, with UB-04 Bill Type 076X that have a mental health principal diagnosis, are eligible for this per diem reimbursement.

Partial hospitalization services are divided into two lists: List A and List B. List A contains extended, family, and group psychotherapy services. List B contains all services on List A and all other types of psychotherapy services, neuropsychological testing services, activity therapy, occupational therapy, and education and training services.

To be eligible for APC 05851, a single date of service on a claim must have the following:

- Three qualifying partial hospitalization services from List B.
- At least one of those services is also on List A.

If four or more of the above partial hospitalization services are provided at a CMHC on a single date of service, then the claim may be eligible for the level II partial hospitalization per diem benefit (refer to APC 05852: below) instead. For each date of service that meets the requirements for APC 05851, the first partial hospitalization service provided on that day from List A will be assigned to APC 05851. All other partial hospitalization services provided on that date are packaged into the per diem rate.

L.1.17.1 Example:
A claim with UB-04 Bill Type 0761, a single service date of February 01, 2016, a mental health diagnosis, and the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 Minutes With Patient and/or Family Member</td>
<td>05851</td>
<td>P</td>
<td>Paid</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 Minutes With Patient and/or Family Member</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 Minutes With Patient and/or Family Member</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid CMHC level I partial hospitalization claim since there are three partial hospitalization services occurring on the same date, and at least one of those services is from List A. Notice that APC 05851 receives a payment status of P while all other partial hospitalization services receive a payment status of N.
status of N, indicating that the payment for these services has been packaged into the per diem reimbursement.

L.1.18.2 APC Assistant
Complete lists of all partial hospitalization services on List A and List B are available on the Conditional APC page.

L.1.19 APC 05852:
Level II Partial Hospitalization (4 or More Services) for CMHCs

Under the partial hospitalization benefit, patients requiring substantial mental health services in an outpatient setting may be eligible for the partial hospitalization per diem reimbursement. Community Mental Health Center (CMHC) claims with UB-04 Bill Type 076X, that have a mental health principal diagnosis are eligible for this per diem reimbursement.

Partial hospitalization services are divided into two lists: List A and List B. List A contains extended, family, and group psychotherapy services. List B contains all services on List A and all other types of psychotherapy services, neuropsychological testing services, activity therapy, occupational therapy, and education and training services.

To be eligible for APC 05852, a single date of service on a claim must have the following:

• Four or more qualifying partial hospitalization services from List B.
• At least one of those services is also on List A.

If only three qualifying partial hospitalization services are provided at a CMHC on a single date of service, then the claim may be eligible for the level I partial hospitalization per diem benefit instead (refer to APC 05851: above). For each date of service that meets the requirements for APC 05852, the first partial hospitalization service provided on that day from List A will be assigned to APC 05852. All other partial hospitalization services provided on that date are packaged into the per diem rate.

L.1.20.1 Example
A claim with UB-04 Bill Type 0761, a single service date of February 01, 2016, a mental health diagnosis, and the following procedure codes:

Table L-7: APC 05852 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 Minutes With Patient and/or Family Member</td>
<td>05851</td>
<td>P</td>
<td>Paid</td>
</tr>
</tbody>
</table>
This is a valid CMHC level II partial hospitalization claim since there are four partial hospitalization services occurring on the same date, and at least one of those services is from List A. Notice that APC 05852 receives a payment status of P while all other partial hospitalization services receive a payment status of N, indicating that the payment for these services has been packaged into the per diem reimbursement.

L.1.21.2 APC Assistant
Complete lists of all partial hospitalization services on List A and List B are available on the Conditional APC page.

L.1.22 APC 05861:
Level I Partial Hospitalization (3 Services) for Hospital-Based PHPs

Under the partial hospitalization benefit, patients requiring substantial mental health services in an outpatient setting may be eligible for the partial hospitalization per diem reimbursement. Hospital-based Partial Hospitalization Program (PHP) claims with UB-04 Bill Type 013X, condition code 41, and a mental health principal diagnosis, are eligible for this per diem reimbursement.

Partial hospitalization services are divided into two lists: List A and List B. List A contains extended, family, and group psychotherapy services. List B contains all services on List A and all other types of psychotherapy services, neuropsychological testing services, activity therapy, occupational therapy, and education and training services.

To be eligible for APC 05861, a single date of service on a claim must have the following:

- Three qualifying partial hospitalization services from List B.
- At least one of those services is also on List A.

If four or more qualifying partial hospitalization services are provided in a hospital-based PHP on a single date of service, then the claim may be eligible for the level II partial hospitalization per diem benefit (refer to APC 05862: below) for Hospital-based PHPs below) instead. For each date of service that

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 Minutes With Patient and/or Family Member</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 Minutes With Patient and/or Family Member</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

Table L-7: APC 05852 Example
meets the requirements for APC 05861, the first partial hospitalization service provided on that day from List A will be assigned to APC 05861. All other partial hospitalization services provided on that date are packaged into the per diem rate.

**L.1.23.1 Example:**
A claim with UB-04 Bill Type 0131, condition code 41, a single service date of February 01, 2016, a mental health diagnosis, and the following procedure codes and modifiers:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Modifier</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 Minutes With Patient and/or Family Member</td>
<td>59</td>
<td>05861</td>
<td>P</td>
<td>Paid</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 Minutes With Patient and/or Family Member</td>
<td>59</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 Minutes With Patient and/or Family Member</td>
<td></td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid hospital-based PHP level I partial hospitalization claim since there are three partial hospitalization services occurring on the same date, and at least one of those services is from List A. Notice that APC 05861 receives a payment status of P while all other partial hospitalization services receive a payment status of N indicating that the payment for these services has been packaged into the per diem reimbursement.

**L.1.24.2 APC Assistant**
Complete lists of all partial hospitalization services on List A and List B are available on the [Conditional APC](#) page.

**L.1.25 APC 05862:**

**Level II Partial Hospitalization (4 or More Services) for Hospital-Based PHPs**

Under the partial hospitalization benefit, patients requiring substantial mental health services in an outpatient setting may be eligible for the partial hospitalization per diem reimbursement. Hospital-based Partial Hospitalization Program (PHP) claims with UB-04 Bill Type 013X, condition code 41, and a mental health principal diagnosis, are eligible for this per diem reimbursement.

Partial hospitalization services are divided into two lists: List A and List B. List A contains extended, family, and group psychotherapy services. List B contains all services on List A and all other types of psychotherapy services, neuropsychological testing services, activity therapy, occupational therapy, and education and training services.
To be eligible for APC 05862, a single date of service on a claim must have the following:

- Four or more qualifying partial hospitalization services from List B.
- At least one of those services is also on List A.

If only three qualifying partial hospitalization services are provided in a hospital-based PHP on a single date of service, then the claim may be eligible for the level I partial hospitalization per diem benefit instead (refer to APC 05861: above). For each date of service that meets the requirements for APC 05862, the first partial hospitalization service provided on that day from List A will be assigned to APC 05862. All other partial hospitalization services provided on that date are packaged into the per diem rate.

**L.1.26.1 Example:**
A claim with UB-04 Bill Type 0131, condition code 41, a single service date of February 01, 2016, a mental health diagnosis, and the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Modifier</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 Minutes With Patient and/or Family Member</td>
<td>59</td>
<td>05862</td>
<td>P</td>
<td>Paid</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 Minutes With Patient and/or Family Member</td>
<td>59</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 Minutes With Patient and/or Family Member</td>
<td>00000</td>
<td></td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
<td>00000</td>
<td></td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid hospital-based PHP level II partial hospitalization claim since there are four partial hospitalization services occurring on the same date, and at least one of those services is from List A. Notice that APC 05862 receives a payment status of P while all other partial hospitalization services receive a payment status of N, indicating that the payment for these services has been packaged into the per diem reimbursement.

**L.1.27.2 APC Assistant**
Complete lists of all partial hospitalization services on List A and List B are available on the Conditional APC page.

**L.1.28 APC 08000:**
Cardiac Electrophysiologic Evaluation and Ablation Composite (Not Active as of 1/1/15)
Composite APC 08000 provides a single payment for cardiac electrophysiologic evaluation and ablation procedures, which involve one set of procedure codes for electrophysiology evaluation services (Group A), a second set of procedure codes for ablation procedures (Group B), and a third set of treatment procedure codes (Group C). Composite APC 08000 is assigned if, on a single date of service, one of the below billing scenarios occurs:

- A patient receives one or more services from Group A, along with one or more services from Group B.
- A patient receives a minimum of one service from Group C.

If the first criteria above is met, the APC will be assigned to the Group A procedure code, and Payment Status Indicator N (Packaged/Incidental Service), along with an APC of zero, will be assigned to the Group B procedure code.

If the second criteria above is met, and more than one Group C procedure code is billed, the APC will be assigned to the Group C procedure code with the lowest numerical value. Any remaining Group C procedure codes (not receiving a line-level edit) will be assigned to Payment Status Indicator N (Packaged/Incidental Service) and an APC of zero. Any Group A or Group B procedure codes on the claim (not receiving a line-level edit) will be assigned to their standard APC and Payment Status Indicator, and will be paid separately.

If a terminated procedure code from Group A or B is billed with modifier 52 (Reduced Services) or 73 (Discontinued Outpatient Hospital/Ambulatory Surgical Center (ASC) Procedure Prior to the Administration of Anesthesia), it will be ignored during Composite APC assignment. If a terminated procedure code from Group C is billed with modifier 52 or 73, it will be included in Composite APC assignment.

**L.1.29.1 Example**

A claim with a single service date and the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>93619</td>
<td>Electrophysiology evaluation</td>
<td>08000</td>
<td>T</td>
<td>Paid</td>
</tr>
<tr>
<td>93650</td>
<td>Ablation</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid APC 08000 claim since there is at least one service from Group A and one service from Group B on the same date of service. APC 08000 is assigned to procedure code 93619, which is the only Group A service on the same day. Notice that APC 08000 receives a payment status of T while all...
other Group A and Group B services receive a Payment Status Indicator of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.

L.1.30.2 APC Assistant
Complete lists of all services on Group A, Group B, and Group C of this APC are available on the Conditional APC page.

L.1.31 APC 08001:
LDR Prostate Brachytherapy Composite (Not Active as of 1/1/18)
Composite APC 08001 provides a single payment for Low Dose Rate (LDR) prostate brachytherapy when reported with one procedure code for the application of the brachytherapy sources (List B), and a second procedure code for the placement of the sources into the prostate via needle or catheter (List A). Composite APC 08001 is assigned if, on a single date of service, a patient receives one or more services from List A, along with one or more services from List B. If the requirements are met, the Composite APC is assigned to the List A service with the lowest numerical value. All other List A and List B services on the same date of service are packaged into the Composite APC rate.

L.1.32.1 Example
A claim with a single service date and the following procedure codes:

This is a valid APC 08001 claim since there is at least one service from List A and one service from List B on the same date of service. APC 08001 is assigned to procedure code 55875, which is the only List A service on the day. Notice that APC 08001 receives a payment status of T while all other List A and List B services receive a payment status of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.

L.1.33.2 APC Assistant
Complete lists of all services on List A and List B of this APC are available on the Conditional APC page.

L.1.34 APC 08002:
Level I Extended Assessment & Management Composite (Not Active as of 1/1/16)

For claims before January 01, 2014, Composite APC 08002 describes an encounter for patient care that includes a Level 5 clinic visit or direct referral to observation (List A), in conjunction with at least eight hours of observation services (List B), as long as certain significant procedures were not provided on the day of or the day before the observation services. Only hospital outpatient claims with a UB-04 Bill Type of 013X are eligible for this Composite. Composite APC 08002 is assigned if, on a single date of service, a patient receives eight hours or more of List B services, along with one or more services from List A. Also, no payment status T services can be provided on the day of or the day before the observation service. If a claim is also eligible for Composite APC 08003 (APC 08003: below), that Composite APC will take precedence over Composite APC 08002. Only one Extended Assessment and Management Composite can be assigned to a claim. If the requirements are met, Composite APC 08002 is assigned to the List A service with the highest published APC rate. All other List A services except G0379 will be assigned to their standard APCs and paid separately. All additional G0379 and all List B services will be packaged into the Composite APC rate.

L.1.35.1 Example
A claim with UB-04 Bill Type 0131, a single service date, and the following procedure codes:

Table L-12: APC 08002 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Units</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0378</td>
<td>Hospital observation service, per hour</td>
<td>12</td>
<td>00000</td>
<td>V</td>
<td>Paid</td>
</tr>
<tr>
<td>99205</td>
<td>Office/Outpatient visit</td>
<td>1</td>
<td>08002</td>
<td>V</td>
<td>Paid</td>
</tr>
<tr>
<td>G0379</td>
<td>Direct referral to observation</td>
<td>1</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid APC 08002 claim since there is at least one service from List A and at least 8 hours of services from List B on the same date. Also, there is no payment status T service provided on the same day or the day before the List B service. APC 08002 is assigned to procedure code 99205, which is the highest paid List A service on the claim. Notice that APC 08002 receives a payment status of V while all List B services and G0379 receive a payment status of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.
L.1.36.2 APC Assistant
Complete lists of all services on List A and List B of this APC are available on the Conditional APC page. A list of all payment status T services is available on the Procedures page.

L.1.37 APC 08003:
Level II Extended Assessment & Management Composite (Not Active as of 1/1/16)

For claims before January 01, 2014, Composite APC 08003 describes an encounter for patient care that includes a Level 4 or 5 emergency room visit or critical care service (List A), in conjunction with at least eight hours of observation services (List B), as long as certain significant procedures were not provided on the day of or the day before the observation services. Only hospital outpatient claims with a UB-04 Bill Type of 013X are eligible for this Composite. Composite APC 08003 is assigned if, on a single date of service, a patient receives eight hours or more of List B services, along with one or more services from List A. Also, no payment status T services can be provided on the day of or the day before the observation service. If a claim is eligible for Composite APC 08003, it is never eligible for Composite APC 08002 (APC 08002: above).

If the requirements are met, Composite APC 08003 is assigned to the List A service with the highest published APC rate. All other List A services will be assigned to their standard APCs and paid separately. All List B services will be packaged into the Composite APC rate.

L.1.38.1 Example
A claim with UB-04 Bill Type 0131, a single service date and the following procedure codes:

Table L-13: APC 08003 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Units</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0378</td>
<td>Hospital observation service, per hour</td>
<td>8</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>99284</td>
<td>Emergency department visit</td>
<td>1</td>
<td>08003</td>
<td>V</td>
<td>Paid</td>
</tr>
</tbody>
</table>

This is a valid APC 08003 claim since there is at least one service from List A and at least 8 hours of services from List B on the same date. Also, there is no payment status T service provided on the same day or day before the List B service. APC 08003 is assigned to procedure code 99284, which is the highest paid List A service on the claim. Notice that APC 08003 receives a payment status of V while all List B services receive a payment status of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.
L.1.39.2 APC Assistant
Complete lists of all services on List A and List B of this APC are available on the Conditional APC page. A list of all payment status T services is available on the Procedures page.

L.1.40 APC 08004:
Ultrasound Composite

If more than one ultrasound procedure is performed on a single date of service, then Composite APC 08004 will be assigned to the highest-weighted eligible ultrasound procedure on the claim. All other eligible ultrasound procedures will be packaged into the Composite APC rate.

L.1.41.1 Example
A claim with a single service date and the following procedure codes:

Table L-14: APC 08004 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>76604</td>
<td>Chest ultrasound</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>76776</td>
<td>Transplanted kidney ultrasound</td>
<td>08004</td>
<td>S</td>
<td>Paid</td>
</tr>
<tr>
<td>76700</td>
<td>Abdominal ultrasound</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid APC 08004 claim since more than one ultrasound procedure was performed on the same date. Notice that APC 08004 receives a payment status of S while all other ultrasound procedures receive a payment status of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.

L.1.42.2 APC Assistant
A complete list of all the ultrasound procedures that qualify for this APC is available on the Conditional APC page.

L.1.43 APC 08005:
CT and CTA Without Contrast Composite

If more than one CT/CTA procedure without contrast is performed on a single date of service, then Composite APC 08005 will be assigned to the first CT/CTA procedure without contrast on the claim. All other CT/CTA procedures without contrast will be packaged into the Composite APC rate. If a CT/CTA procedure without contrast is performed on the same date of service as a CT/CTA procedure with contrast, then Composite APC 08006 (APC 08006: below) will be assigned instead of this Composite.
L.1.44.1 Example
A claim with a single service date and the following procedure codes:

Table L-15: APC 08005 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>74261</td>
<td>CT, colonography without dye</td>
<td>08005</td>
<td>S</td>
<td>Paid</td>
</tr>
<tr>
<td>70450</td>
<td>CT, head or brain without contrast</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid APC 08005 claim since more than one CT/CTA procedure without contrast was performed on the same date. APC 08005 is assigned to procedure code 74261, which is the first CT/CTA procedure without contrast on the claim. Notice that APC 08005 receives a payment status of S while all other CT/CTA procedures without contrast receive a payment status of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.

L.1.45.2 APC Assistant
A complete list of all the CT/CTA without contrast procedures that qualify for this APC is available on the Conditional APC page.

L.1.46 APC 08006:
CT and CTA With Contrast Composite

If more than one CT/CTA procedure with contrast is performed on a single date of service, then Composite APC 08006 will be assigned to the first CT/CTA procedure with contrast on the claim. All other CT/CTA procedures with contrast will be packaged into the Composite APC rate. If a CT/CTA procedure without contrast is performed on the same date of service as a CT/CTA procedure with contrast, then this Composite will be assigned instead of Composite APC 08005 (APC 08005: above).

L.1.47.1 Example
A claim with a single service date and the following procedure codes:

Table L-16: APC 08006 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>70460</td>
<td>CT, Head or Brain With Contrast</td>
<td>08006</td>
<td>S</td>
<td>Paid</td>
</tr>
<tr>
<td>75635</td>
<td>CTA, Abdominal Aorta and Bilateral Iliofemoral Lower Extremity Runoff With Contrast</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>
This is a valid APC 08006 claim since more than one CT/CTA procedure with contrast was performed on the same date. APC 08006 is assigned to procedure code 70460, which is the first CT/CTA procedure with contrast on the claim. Notice that APC 08006 receives a payment status of S while all other CT/CTA procedures with contrast receive a payment status of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.

L.1.48.2 APC Assistant
Complete lists of all the CT/CTA with contrast procedures and the CT/CTA without contrast procedures that qualify for this APC are available on the Conditional APC page.

L.1.49 APC 08007:
MRI and MRA Without Contrast Composite
If more than one MRI/MRA procedure without contrast is performed on a single date of service, then Composite APC 08007 will be assigned to the first MRI/MRA procedure without contrast on the claim. All other MRI/MRA procedures without contrast will be packaged into the Composite APC rate. If a MRI/MRA procedure without contrast is performed on the same date of service as a MRI/MRA procedure with contrast, then Composite APC 08008 (APC 08008: below) will be assigned instead of this Composite.

L.1.50.1 Example
A claim with a single service date and the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>70336</td>
<td>MRI, Temporomandibular Joints</td>
<td>08007</td>
<td>S</td>
<td>Paid</td>
</tr>
<tr>
<td>72146</td>
<td>MRI, Spinal Canal and Contents, Thoracic Without Contrast</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>73718</td>
<td>MRI, Lower Extremity Other Than Joint Without Contrast</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>C8919</td>
<td>MRA Without Contrast, Pelvis</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>C8932</td>
<td>MRA, w/o Dye, Spinal Canal</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>C8935</td>
<td>MRA, w/o Dye, Upper Extremity</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>
This is a valid APC 08007 claim since more than one MRI/MRA procedure without contrast was performed on the same date. APC 08007 is assigned to procedure code 70336, which is the first MRI/MRA procedure without contrast on the claim. Notice that APC 08007 receives a payment status of S while all other MRI/MRA procedures without contrast receive a payment status of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.

L.1.51.2 APC Assistant
A complete list of all the MRI/MRA without contrast procedures that qualify for this APC is available on the Conditional APC page.

L.1.52 APC 08008:
MRI and MRA With Contrast Composite
If more than one MRI/MRA procedure with contrast is performed on a single date of service, then Composite APC 08008 will be assigned to the first MRI/MRA with contrast procedure on the claim. All other MRI/MRA procedures with contrast will be packaged into the Composite APC rate. If a MRI/MRA procedure without contrast is performed on the same date of service as a MRI/MRA procedure with contrast, then this Composite will be assigned instead of Composite APC 08007 (APC 08007: above).

L.1.53.1 Example
A claim with a single service date and the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>70542</td>
<td>MRI, Orbit, Face, and/or Neck With Contrast</td>
<td>08008</td>
<td>S</td>
<td>Paid</td>
</tr>
<tr>
<td>72196</td>
<td>MRI, Pelvis With Contrast</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>C8933</td>
<td>MRA, w/o and w/ Dye, Spinal Canal</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>C8934</td>
<td>MRA, w/ Dye, Upper Extremity</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

This is a valid APC 08008 claim since more than one MRI/MRA procedure with contrast was performed on the same date. APC 08008 is assigned to procedure code 70542, which is the first MRI/MRA procedure with contrast on the claim. Notice that APC 08008 receives a payment status of S while all other MRI/MRA procedures with contrast receive a payment status of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.
L.1.54.2 APC Assistant
Complete lists of all the MRI/MRA with contrast procedures and MRI/MRA without contrast procedures that qualify for this APC are available on the Conditional APC page.

L.1.55 APC 08009:
Extended Assessment & Management (EAM) Composite (Not Active as of 1/1/16)

Effective January 01, 2014, Composite APC 08009 replaced Composite APC 08002 (Level 1 EAM Composite) and Composite APC 08003 (Level 2 EAM Composite). Composite APC 08009 describes an encounter for patient care that includes a clinic visit, Level 4 or 5 emergency room visit, critical care service, or direct referral to observation (List A), in conjunction with at least eight hours of observation services (List B), as long as certain significant procedures were not provided on the day of or the day before the observation services. Only hospital outpatient claims with a UB-04 Bill Type of 013X are eligible for this Composite. Composite APC 08009 is assigned if, on a single date of service, a patient receives eight hours or more of List B services, along with one or more services from List A. Also, no Payment Status T services can be provided on the day of or the day before the observation service. Only one Extended Assessment and Management Composite can be assigned to a claim.

If the requirements are met, Composite APC 08009 is assigned to the List A service with the highest published APC rate. All other List A services except G0379 will be assigned to their standard APCs and paid separately. All additional G0379 and all List B services will be packaged into the Composite APC rate.

L.1.56.1 Example
A claim with a UB-04 Bill Type of 0131, a single service date, and the following procedure codes:

Table L-19: APC 08009 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Units</th>
<th>APC</th>
<th>Pay Status</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0378</td>
<td>Hospital Observation Services, Per Hour</td>
<td>8</td>
<td>00000</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>99284</td>
<td>Emergency Department Visit for the Evaluation and Management of a Patient (Level 4)</td>
<td>1</td>
<td>08009</td>
<td>V</td>
<td>Paid</td>
</tr>
</tbody>
</table>

This is a valid APC 08009 claim since there is at least one service from List A and 8 hours of services from List B on the same date. Also, there is no payment status T service provided on the same day or day before the List B service. APC 08009 is assigned to procedure code 99284, which is the
highest paid List A service on the claim. Notice that APC 08009 receives a Payment Status of V while all List B services receive a Payment Status of N, indicating that the payment for these services has been packaged into the Composite APC reimbursement.

L.1.57.2 APC Assistant
Complete lists of all services on List A and List B of this APC are available on the Conditional APC page. A list of all payment status T services is available on the Procedures page.

L.1.58 APC 08010:
Mental Health Services Composite

For regular hospital outpatient claims (i.e., claims without condition code 41 and with UB-04 Bill Type 012X or 013X), Medicare has designed a payment limit for mental health services to be equal to the hospital-based level II payment under the partial hospitalization program. With this rule, Medicare effectively limits the amount a facility can receive for partial hospitalization services provided to a single patient, on a single service date to the hospital-based level II partial hospitalization payment.

For each unique service date the expected payment for all mental health services on the claim is calculated, and if it exceeds the hospital-based level II partial hospitalization payment amount, Composite APC 08010 is assigned to the first mental health service of the day. All other mental health services on the same service date are packaged into the Composite APC payment.

L.1.59.1 Example:
A claim with UB-04 Bill Type 0131 without condition code 41, a single service date of January 01, 2012 and the following procedure codes:

This is a valid APC 08010 claim because the expected payment for all mental health services on the claim exceeds the hospital-based level II partial hospitalization payment. APC 08010 is assigned to procedure code 90832 because it is the first mental health service of the day. Notice that APC 08010 receives a payment status of S while all other mental health services receive a
payment status of N indicating that the payment for these services has been packaged into the Composite APC reimbursement.

L.1.60.2 APC Assistant:
A complete list of all the mental health services that qualify for this APC is available on the Conditional APC page.

L.1.61 APC 08011
Comprehensive Observation Services
Effective January 01, 2016, Comprehensive APC 08011 has replaced Composite APC 08009 (Extended Assessment & Management Composite). For claims to qualify for Comprehensive APC 08011 the following criteria must be met:

• Procedure code G0378, Hospital observation service, per hour, is billed with 8 or more hours of service.

• No procedure code with a Payment Status Indicator of T (Procedure or Service, Multiple Reduction Applies) or J1 (Hospital Part B Services Paid Through a Comprehensive APC) is billed on the same claim.

• An eligible clinic or emergency room visit code is billed on the same day or on the day before procedure code G0378; or procedure code G0379, Direct admission of patient for hospital observation care, is billed on the same day as G0378.

L.1.62.1 Example:
A claim without Payment Status Indicator T (Procedure or Service, Multiple Reduction Applies) or J1 (Hospital Part B Services Paid Through a Comprehensive APC), a single service date of January 01, 2016, and the following procedure codes:

Table L-21: APC 08011 Example

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0378</td>
<td>Hospital observation service, per hour</td>
<td>8</td>
</tr>
<tr>
<td>99282</td>
<td>Emergency Department Visit</td>
<td>1</td>
</tr>
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</table>

L.1.63.2 APC Assistant:
A complete list of all the mental health services that qualify for this APC is available on the Conditional APC page.
M New York Medicaid APG Rate Codes

The table below lists valid New York Medicaid APG rate codes. This appendix includes the following section:

- New York Medicaid APG Rate Codes
# M.1 New York Medicaid APG Rate Codes

Table M-1: New York Medicaid APG Rate Codes

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Setting</th>
<th>Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
<td>Hospital</td>
<td>Episode</td>
<td>DOH OPD APG Art 28 INTSVC MR/DD/DD (IOS)</td>
</tr>
<tr>
<td>1003</td>
<td>DTC</td>
<td>Episode</td>
<td>DOH DTC APG Art 28 INTSVC MR/DD/TBI (IOS)</td>
</tr>
<tr>
<td>1042</td>
<td>DTC</td>
<td>Visit</td>
<td>OMH - Freestanding Intensive Outpatient Program (IOP)</td>
</tr>
<tr>
<td>1045</td>
<td>DTC</td>
<td>Visit</td>
<td>OMH - Freestanding Intensive Outpatient Program (IOP) SED</td>
</tr>
<tr>
<td>1048</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH - Hospital Intensive Outpatient Program (IOP) SED</td>
</tr>
<tr>
<td>1051</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH - Hospital Intensive Outpatient Program (IOP) SED</td>
</tr>
<tr>
<td>1054</td>
<td>Hospital</td>
<td>Visit</td>
<td>MA Cvrn Non-Care Service for Dual OPD-APG MR/DD/TBI</td>
</tr>
<tr>
<td>1057</td>
<td>DTC</td>
<td>Visit</td>
<td>MA Cvrn Non-Care CVRD Service for Dual DTC-APG MRDD/TBI</td>
</tr>
<tr>
<td>1060</td>
<td>DTC</td>
<td>Episode</td>
<td>DOH DTC APG Art 28 IS MR/DD/TBI (DSRIP)</td>
</tr>
<tr>
<td>1062</td>
<td>Hospital</td>
<td>Episode</td>
<td>DOH OPD APG Art 28 IS MR/DD/TBI (DSRIP)</td>
</tr>
<tr>
<td>1064</td>
<td>DTC</td>
<td>Episode</td>
<td>DOH DTC APG Art 28 IS School Based Health Project (DSRIP)</td>
</tr>
<tr>
<td>1072</td>
<td>DTC</td>
<td>Visit</td>
<td>OASAS DTC APG Clinic Peer Srv</td>
</tr>
<tr>
<td>1074</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS OPD APG Clinic Peer Srv</td>
</tr>
<tr>
<td>1076</td>
<td>DTC</td>
<td>Visit</td>
<td>OASAS DTC APG OTP Peer Srv</td>
</tr>
<tr>
<td>1078</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS OPD APG OTP Peer Srv</td>
</tr>
<tr>
<td>1102</td>
<td>DTC</td>
<td>Episode</td>
<td>DOH DTC APG Art 28 Integrated Service (DSRIP)</td>
</tr>
<tr>
<td>1104</td>
<td>Hospital</td>
<td>Episode</td>
<td>DOH OPD APG Art 28 Integrated Service (DSRIP)</td>
</tr>
<tr>
<td>1106</td>
<td>DTC</td>
<td>Visit</td>
<td>OMH DTC APG Art 31 Integrated Service (DSRIP)</td>
</tr>
<tr>
<td>1108</td>
<td>DTC</td>
<td>Visit</td>
<td>OMH DTC APG Art 31 Integrated Service-SED (DSRIP)</td>
</tr>
<tr>
<td>1110</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH OPD APG Art 31 Integrated Service (DSRIP)</td>
</tr>
<tr>
<td>1112</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH OPD APG Art 31 Integrated Service-SED (DSRIP)</td>
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Table M-1: New York Medicaid APG Rate Codes

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Setting</th>
<th>Type</th>
<th>Service</th>
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</thead>
<tbody>
<tr>
<td>1114</td>
<td>DTC</td>
<td>Visit</td>
<td>OASAS DTC APG Art 32 Integrated Service (Single License)</td>
</tr>
<tr>
<td>1116</td>
<td>DTC</td>
<td>Visit</td>
<td>OASAS DTC APG MMTP Integrated Service (DSRIP)</td>
</tr>
<tr>
<td>1118</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS OPD APG Art 32 Integrated Service (DSRIP)</td>
</tr>
<tr>
<td>1120</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS OPD APG MMTP Integrated Service (DSRIP)</td>
</tr>
<tr>
<td>1122</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH OPD APG - Article 31 Integrated Output Services (IOS)</td>
</tr>
<tr>
<td>1124</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH OPD APG - Article 31 Integrated Output Service-SED (IOS)</td>
</tr>
<tr>
<td>1126</td>
<td>Hospital</td>
<td>Visit</td>
<td>MA Cvrds Non-Medicare Cvrds Services For Duals- OPD-APG</td>
</tr>
<tr>
<td>1128</td>
<td>DTC</td>
<td>Visit</td>
<td>MA Cvrds Non-Medicare Cvrds Services For Duals- DTC-APG</td>
</tr>
<tr>
<td>1130</td>
<td>DTC</td>
<td>Visit</td>
<td>OASAS DTC - APG MMTP Integrated Output Services (IOS)</td>
</tr>
<tr>
<td>1132</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS OPD APG- Article 32 Integrated Output Services (IOS)</td>
</tr>
<tr>
<td>1134</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS OPD - APG MMTP Integrated Output Services (IOS)</td>
</tr>
<tr>
<td>1136</td>
<td>DTC</td>
<td>Visit</td>
<td>OMH - DTC Article 31 Clinic (UT Exempt) APG</td>
</tr>
<tr>
<td>1138</td>
<td>DTC</td>
<td>Visit</td>
<td>OMH - DTC Article 31 Clinic (SED) (UT Exempt) APG</td>
</tr>
<tr>
<td>1140</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH - Hospital Article 31 Clinic (UT Exempt) APG</td>
</tr>
<tr>
<td>1142</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH - Hospital Article 31 Clinic (SED) (UT Exempt) APG</td>
</tr>
<tr>
<td>1400</td>
<td>Hospital</td>
<td>Visit</td>
<td>Outpatient Department (OPD)</td>
</tr>
<tr>
<td>1401</td>
<td>Hospital</td>
<td>Visit</td>
<td>Surgery</td>
</tr>
<tr>
<td>1402</td>
<td>Hospital</td>
<td>Episode</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>1407</td>
<td>DTC</td>
<td>Visit</td>
<td>General Clinic</td>
</tr>
<tr>
<td>1408</td>
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<td>Surgery</td>
</tr>
<tr>
<td>1413</td>
<td>Hospital</td>
<td>Visit</td>
<td>OPD - Out of State</td>
</tr>
<tr>
<td>1416</td>
<td>Hospital</td>
<td>Visit</td>
<td>Surgery - Out of State</td>
</tr>
<tr>
<td>1419</td>
<td>Hospital</td>
<td>Episode</td>
<td>Emergency Department (ED) - Out Of State</td>
</tr>
<tr>
<td>1422</td>
<td>DTC</td>
<td>Episode</td>
<td>General Clinic - Episode Payment</td>
</tr>
</tbody>
</table>
## Table M-1: New York Medicaid APG Rate Codes

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Setting</th>
<th>Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1425</td>
<td>DTC</td>
<td>Episode</td>
<td>General Clinic MR/DD - Episode Payment</td>
</tr>
<tr>
<td>1428</td>
<td>DTC</td>
<td>Visit</td>
<td>Dental</td>
</tr>
<tr>
<td>1432</td>
<td>Hospital</td>
<td>Episode</td>
<td>OPD - Episode Payment</td>
</tr>
<tr>
<td>1435</td>
<td>DTC</td>
<td>Visit</td>
<td>General Clinic MR/DD</td>
</tr>
<tr>
<td>1438</td>
<td>DTC</td>
<td>Visit</td>
<td>Renal</td>
</tr>
<tr>
<td>1441</td>
<td>Hospital</td>
<td>Episode</td>
<td>OPD - Out Of State</td>
</tr>
<tr>
<td>1444</td>
<td>Hospital</td>
<td>Visit</td>
<td>School Based Health Project</td>
</tr>
<tr>
<td>1447</td>
<td>DTC</td>
<td>Visit</td>
<td>School Based Health Project</td>
</tr>
<tr>
<td>1450</td>
<td>Hospital</td>
<td>Episode</td>
<td>School Based Health Project - Episode</td>
</tr>
<tr>
<td>1453</td>
<td>DTC</td>
<td>Episode</td>
<td>School Based Health Project - Episode</td>
</tr>
<tr>
<td>1456</td>
<td>DTC</td>
<td>Episode</td>
<td>Renal - Episode</td>
</tr>
<tr>
<td>1459</td>
<td>DTC</td>
<td>Episode</td>
<td>Dental - Episode</td>
</tr>
<tr>
<td>1468</td>
<td>Non-Hospital</td>
<td>Visit</td>
<td>OASAS - Article 32 Clinic Medical Visit</td>
</tr>
<tr>
<td>1471</td>
<td>Non-Hospital</td>
<td>Visit</td>
<td>OASAS - MMTP Clinic Medical Visit</td>
</tr>
<tr>
<td>1474</td>
<td>Non-Hospital</td>
<td>Episode</td>
<td>Health Services (e.g., Health Monitoring, Health Physicals)</td>
</tr>
<tr>
<td>1477</td>
<td>DTC</td>
<td>Episode</td>
<td>OMH - Article 31 Medical Visit Type A (SED)</td>
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</tr>
<tr>
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<td>Visit</td>
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<td>OASAS - DTC APG Article 32 Integrated Output Services (IOS)</td>
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<td>OPD - MR/DD/TBI Patient - Episode</td>
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<td>1495</td>
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<td>Episode</td>
<td>General Clinic APG MR/DD (Edit Exempt)</td>
</tr>
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<td>DTC</td>
<td>Visit</td>
<td>General Clinic APG MR/DD (Edit Exempt)</td>
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<tr>
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<td>Visit</td>
<td>OPD - MR/DD/TBI Patient</td>
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</tr>
<tr>
<td>1507</td>
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<td>Visit</td>
<td>OMH - Free Standing Article 31 Clinic - Off-Site</td>
</tr>
<tr>
<td>1510</td>
<td>DTC</td>
<td>Visit</td>
<td>OMH - Free-Standing Article 31 Clinic (SED)</td>
</tr>
</tbody>
</table>
### Table M-1: New York Medicaid APG Rate Codes

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Setting</th>
<th>Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1513</td>
<td>DTC</td>
<td>Visit</td>
<td>OMH - Free-Standing Article 31 Clinic - Off-Site (SED)</td>
</tr>
<tr>
<td>1516</td>
<td>Hospital</td>
<td>Visit</td>
<td>Base Rate</td>
</tr>
<tr>
<td>1519</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH - Hospital Article 31 Clinic - Off-Site</td>
</tr>
<tr>
<td>1522</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH - Hospital Article 31 Clinic (SED)</td>
</tr>
<tr>
<td>1525</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH - Hospital Article 31 Clinic - Off-Site (SED)</td>
</tr>
<tr>
<td>1528</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS - Hospital Article 32 Clinic</td>
</tr>
<tr>
<td>1531</td>
<td>Hospital</td>
<td>Episode</td>
<td>OASAS - Hospital MMTP (Weekly)</td>
</tr>
<tr>
<td>1534</td>
<td>Hospital</td>
<td>Visit</td>
<td>OPWDD - Hospital Article 16 Clinic</td>
</tr>
<tr>
<td>1537</td>
<td>Hospital</td>
<td>Visit</td>
<td>OPWDD - Hospital Article 16 Clinic - Off Site</td>
</tr>
<tr>
<td>1540</td>
<td>Non-Hospital</td>
<td>Visit</td>
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</tr>
<tr>
<td>1543</td>
<td>Non-Hospital</td>
<td>Episode</td>
<td>OASAS - Free Standing MMTP (Weekly)</td>
</tr>
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<td>1546</td>
<td>Non-Hospital</td>
<td>Visit</td>
<td>OPWDD APG - Free Standing Article 16 Clinic</td>
</tr>
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<td>1549</td>
<td>Non-Hospital</td>
<td>Visit</td>
<td>OPWDD APG - Free Standing Article 16 Clinic</td>
</tr>
<tr>
<td>1552</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS - Article 32 Clinic Medical Visit</td>
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<tr>
<td>1555</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS - MMTP Clinic Medical Visit</td>
</tr>
<tr>
<td>1558</td>
<td>Non-Hospital</td>
<td>Visit</td>
<td>OASAS - Free Standing Article 32 Clinic OP Rehab Medical Visit</td>
</tr>
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<td>1561</td>
<td>Hospital</td>
<td>Visit</td>
<td>OASAS - Hospital Article 32 Outpatient Rehab</td>
</tr>
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<td>1564</td>
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<td>Visit</td>
<td>OASAS - Free Standing Article MMTP (Weekly Visit-Based)</td>
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<td>Visit</td>
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</tr>
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<td>OASAS - Article 32 Outpatient Rehab</td>
</tr>
<tr>
<td>1576</td>
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<td>Visit</td>
<td>OMH - Hospital Article 32 Clinic (Crisis)</td>
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<td>Visit</td>
<td>OMH - Free-Standing Article 31 Clinic (Crisis)</td>
</tr>
<tr>
<td>1582</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH - Hospital Article 31 Clinic (Crisis) (SED)</td>
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</tbody>
</table>
Table M-1: New York Medicaid APG Rate Codes

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Setting</th>
<th>Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1585</td>
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<td>OMH - Free Standing Article 31 Clinic (Crisis) (SED)</td>
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<tr>
<td>1588</td>
<td>Hospital</td>
<td>Visit</td>
<td>Health Services (e.g., Health Monitoring, Health Physicals)</td>
</tr>
<tr>
<td>1591</td>
<td>Hospital</td>
<td>Visit</td>
<td>OMH - Hospital Article 31 Medical Visit (SED)</td>
</tr>
<tr>
<td>1594</td>
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<tr>
<td>1597</td>
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<td>Episode</td>
<td>DOH DTC APG Art 28 Integrated Outpatient Service</td>
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</table>
Fiscal Intermediary (FI), Carrier, and Medicare Administrative Contractors (MACs) Codes

This chapter provides a list of FIs/MACs, Carriers, and National Coverage Determination (NCD) codes. This chapter includes the following sections:

• MAC Part A Codes
• MAC Part B Codes
• National Coverage Determination (NCD) Code
## N.1 MAC Part A Codes

### Table N-1: MAC Part A Code List

<table>
<thead>
<tr>
<th>State(s)</th>
<th>FI ID</th>
<th>Contractor</th>
<th>MAC ID</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>AL</td>
<td>Palmetto GBA, LLC (MAC) (10111)</td>
<td>1J</td>
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<tr>
<td>Alaska</td>
<td>AK</td>
<td>Noridian Administrative Services (MAC) (02101)</td>
<td>1F</td>
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<tr>
<td>Arizona</td>
<td>AZ</td>
<td>Noridian Administrative Services (MAC) (03101)</td>
<td>1F</td>
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<tr>
<td>Arkansas</td>
<td>AR</td>
<td>Novitas Solutions, Inc. (MAC) (07101)</td>
<td>1H</td>
</tr>
<tr>
<td>California</td>
<td>CA</td>
<td>Noridian Administrative Services (MAC) (01111)</td>
<td>1E</td>
</tr>
<tr>
<td>Colorado</td>
<td>CO</td>
<td>Novitas Solutions, Inc. (MAC) (04111)</td>
<td>1H</td>
</tr>
<tr>
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<td>CT</td>
<td>National Government Services, Inc. (MAC) (13101)</td>
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<td>DE</td>
<td>Novitas Solutions, Inc. (MAC) (12101)</td>
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<tr>
<td>Florida</td>
<td>FL</td>
<td>First Coast Service Options, Inc. (MAC) (09101)</td>
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<td>GA</td>
<td>Palmetto GBA, LLC (MAC) (10211)</td>
<td>1J</td>
</tr>
<tr>
<td>Hawaii</td>
<td>HI</td>
<td>Noridian Administrative Services (MAC) (01211)</td>
<td>1E</td>
</tr>
<tr>
<td>Idaho</td>
<td>ID</td>
<td>Noridian Administrative Services (MAC) (02201)</td>
<td>1F</td>
</tr>
<tr>
<td>Illinois</td>
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<td>National Government Services, Inc. (06101)</td>
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<tr>
<td>Indiana</td>
<td>IN</td>
<td>Wisconsin Physicians Service Insurance Corporation (MAC) (08101)</td>
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<tr>
<td>Iowa</td>
<td>IA</td>
<td>Wisconsin Physicians Service Insurance Corporation (MAC) (05101)</td>
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<tr>
<td>Kansas</td>
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N.2 MAC Part B Codes

Note
The following table lists carrier/MAC Part B IDs that Optum currently distributes. To order other Part B rule sets, please contact Optum Client Services or your IT Vendor.

Table N-2: Carrier/MAC Part B Code List

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<thead>
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<th>State</th>
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Table N-2: Carrier/MAC Part B Code List

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N.3 National Coverage Determination (NCD) Code

Table N-3: NCD Code List

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