"Other" Project Q &A's

OPFS – under 51X will a new price be published, or will health plans we responsible for calculating and paying the difference between facility and non-facility? - We will establish and publish an additional fee schedule outlining 051X associated specific rates for your use.

Peer Groups – changed percentages, new PGM greater than 100 PEDs bed– which hospital would these be? PCH or Cardons? - These will come across as %'s effective 10/1/2011 on your weekly provider specific rate schedule extracts. The only facility to current qualify for the 100 Peds bump to the PGM (it is not technically an additional type of PGM) at this time is Cardon's.

POA indicators. Pls confirm our understanding: As inpatient claims are paid per-diem, not DRG, if a POA indicator is listed on the claim, the claim will have to be denied for medical record review, determine the days/charges related to the hospital-acquired condition, deny those days, while remaining days may be payable. As the claim is submitted thru encounters, will any encounter edits be placed on the CRN, as the POA indicator will still be listed? - Further direction on POA processing will be forthcoming. AHCCCS does not at this time intend to implement this prior to 7/1/2012.

From CCI team: what I will need to know is whether or not AHCCCS will be following national standards. Specifically:

1. For MUE, will AHCCCS require that we edit for Medicaid MUE frequencies, and then gap fill with its own frequencies for services that don't have an MUE?

AHCCCS and the plans will be required to edit for the Medicaid MUE's as distinct editing. MUE editing will not take the place of current frequency limit editing which should continue to be employed.

Are there any code pairs outside of the Medicaid NCCI code pairs published by CMS that AHCCCS will be asking us to edit against? - AHCCCS currently has, and will continue to have some required policy based code pairs (i.e. For OPFS, Maternity, etc…) that will be included with source designation as policy based in the NCCI extract we will supply the plans. Additionally if necessary AHCCCS may adopt and require some Medicare based code pairs which are not included in Medicaid CCI's. These pairs will also be included with source designation on supplied extracts.

Also, are the modifier overrides allowed by CMS going to be used by AHCCCS? - It is our intention to implement these rules as outlined by CMS.

Observation Bundling for services not associated with an ER or Surgery - which tables are the screens RF797 and RFC97 referring to? And which table is the new table referred to? - New Observation bundling triggers table is RFC97. If an OPFS claim does not trigger bundling under either ER or Surgery, a second bundling check for Observation triggers will occur. Bundling logic under this second bundling check will be equal to ER in the types of revenue codes bundled, etc...

For 10/1/2011 we expect RF797 (annual changes and updates only) and RF796 (no changes for this year) table updates. Are there any structural changes to these tables? (No) If so, is a specification (table format) available? (N/A)

Observation Bundling for services not associated with an ER or Surgery, what table(s) is being modified for this process? (This will be a new table).

According to the documentation, it appears as there is a new table being created behind screen RFC97 (Yes). Is that a table that we will be receiving or is that table specific to the State's system only? (You will be receiving this new table extract as noted above)

Are there any special rules to observation bundling that differ from surgical or ER bundling? (No, rules are equal to ER) For example, some services are excluded from surgical bundling but not ER bundling. Would observation bundling be treated like surgical bundling rules, ER bundling rules, or a unique rule for observation itself different than ER or surgical bundling? (No rules are equal to ER. Surgical bundling exceptions do not apply).

RF128 table updates. What changes should we expect for the table change? Are there new fields, structural changes, additional logic in the table? How is the table going to change to identify if it is a State code or CMS Code? A source indicator on the table will designate if a relationship is Medicaid, Policy, or Medicare defined).

In regards to the payment methodology changes for the clinic revenue codes 0510-0519, will the new fee schedule continue to be submitted via the REF03 file? (Yes) Do we need to point to a different or additional table to get the new pricing? (Yes, you will need to use this additional table for clinic related services pricing).

When OPFS claim with 0510 to 0519 revenue code range is encountered use new procedure code based RF133 table for pricing. (Yes, and if not found default to current OPFS fee schedule).

Is AHCCCS adding MUEs to the current MSD tables? (No this will be a new table – RF129 of CMS Medicaid MUE's with future ability add policy specific or Medicare source data as needed). How frequently can we expect to receive this table? (Bi-weekly as a component of the regular Reference extracts process).

Will AHCCCS follow CMS in allowing modifier overrides (59, 76, 91)? (Yes, refer to table RF131). How frequently can we expect to receive this table? (Bi-weekly as a component of the regular Reference extracts process).

For NCCI modifiers - AHCCCS indicates that "It is our intention to implement these rules as outlined by CMS". Can we clarify that the modifier list includes the following: 25, 58, 59, 78, 79, 91, E1, E2, E3, E4, LC, LD, LT, RC, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8 and F9 (We will include all values outlined by CMS as applicable to Medicaid NCCI processing, unless otherwise restricted by AHCCCS policy).
Need confirmation of table layout changes for RF128 since we believe that a column is being added for an indicator. (Revised layout including form type and source.

- AHCCCS has indicator that it will be applying Multiple Surgical Reduction to codes outside of the 10000-69999 range. Will it be using the CMS MSR indicators 1, 2, and 3 to define services eligible for reduction, or will it be defining those services in some way? (Multiple procedure indicators 2/3 from the Medicare Physician's Fee Schedule will be utilized).
  New table RF724: (New values to an existing table that the plans do not currently use or receive). How frequently will we receive the table? (Bi-weekly as a component of the regular Reference extracts process).

  It sounded like the RF131 was possibly replacing the RF723 which was used for Modifier Overrides previously, but when AHCCCS released the layout for RF131 it appears that there is no action code like the RF723 has indicating what rules are overridden with what modifiers. Can you verify if RF723 is still going to be used for Modifier Overrides of OPFS? -

- Table RF723 actually has a couple functions as designated by the action code. Those items formally associated with action code 04 will now reside on the new NCCI modifier table RF131, the remaining action codes on RF723 will continue to function as currently outlined on the table.

My question is if there are procedures with quantities in the MUE file that are not represented in RF128 and/or RF113? If that is not the case, then what is the value for putting the MUE file in the edit process? - The MUE's will be contained on RF129. We are required by law to implement them.

However we are not required to supplant our current daily limits so we are doing these as a separate table and edits. Therefore daily limits on RF113 and RF127 will remain and may as appropriate differ from the MUE for the procedure.

We have performed a detailed comparison from our daily limits on RF113 and RF127 to MUE's, and while there are some documented appropriate differences between the two, there are a lot less MUE's than daily limits (impacting fewer codes).

Will AHCCCS be requiring admit/discharge hour on outpatient claims to enforce the episode of care payment logic? - No, episode of care is just another way of saying within a claim.

When re-reviewing Configuration updates, I noticed Public/Former Public Peer Group has an expiration date for the majority of the codes with no updated % (I was expecting the 10/1/11 % to be 141). Since not ALL of the codes have an expiration date, confused at the intent. Is the intention that since there are no Facilities that fall under this group to do away with the Public/Former Public group? Or is the intent that this group only gets the 5 codes not expired. Since there is not a facility that falls under this group, it won't make a payment difference….but I want to be sure my Configuration Update is correct in case a facility does happen to fall under this category later in the year. - There was one hospital in this category and it was reclassified into another category.