RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

September 28, 2009

Re: Outpatient Pricing Changes

Dear Hospital Provider,

Effective with dates of service October 1, 2009 onward, RI Medical Assistance will be pricing outpatient claims utilizing a version of the Medicare Fee Schedule and with Ambulatory Payment Classification (APC) codes. This implementation will occur on October 5, 2009.

Hospitals will be paid according to the CPT/HCPCS procedure code listed on a claim. If a claim line has no procedure code, then no payment will be made for that line. If a claim line has a procedure code, then the payment for that line will equal the Fee Schedule fee multiplied by the units billed, with a few exceptions, which are outlined in the Frequently Asked Question (FAQ's) that are attached.

Please note:

- Revenue codes 037X and 071X will always reimburse at zero, as those services are considered packaged and are not eligible for separate reimbursement.
- Bilateral Services should be billed with a "50" modifier (in the first modifier position) and 1 unit, that procedure will be reimbursed at 150% of the allowed amount on the APC fee schedule.
- Significant procedures with an APC status of "T" will be subject to the multi-procedure discounting. The highest paid procedure will reimburse at 100%, the second highest at 50%, the third highest at 25% and all other procedures will reimburse at zero.
- Imaging services with an APC status of "Z1-Z6" will also be subject to multi-procedure discounting within "families." The same logic will apply to imaging as it does to the significant procedures. Please see question 16 in the FAQ's for more information.
- Observation services should be billed with procedure code G0378, payment will be $25.00 per hour for hours 8 through 48. One unit will equal one hour.
- 340B Hospitals will continue to bill with the "UD" modifier, and at their acquisition cost for those procedures requiring NDC information. Those details will continue to be paid at 100% of charge.

The new pricing will not be applied to Medicare Crossover claims, Rite Share claims or claims processed through the Managed Care plans.

The APC fee schedule has been sent out previously. If you have not received this spreadsheet, please contact me and I will email it to you. Once we have implemented the new processing, the APC fee schedule will also be available on the DHS website. This fee schedule that has been implemented is based on the "Boston Area Wage Index."

We have also created some new edits and explanation of benefit(EOB) codes. They are as follows:

Edit 339 – Procedure Code Exceeds Maximum Units Allowed – this will set when a procedure code is billed and the units exceed the maximum number of units allowed on the APC fee schedule.

This edit will result in the EOB denial of 340 – Procedure Code Exceeds Maximum Units Allowed.

EOB 663 – Paid Amount is Zero, Service is Considered Packaged – this EOB will be reported on an Outpatient claim when a procedure code billed has been assigned an APC status of "N" – "Packaged Incidental Services" for the dates of service and will be priced at zero because it is packaged.

EOB 664 – Charge Cap Cutback Reduction – this EOB will be reported on an Outpatient claim when the claims paid amount was cutback at the header as a result of the totals of the paid details being greater than the billed amount on the header of the claim.

EOB 665 – Payment Adjusted for Bilateral Procedure – this EOB will be reported on an Outpatient claim when a procedure code is billed with a modifier "50" (bilateral procedure) in the first modifier position, and the payment is 1.5 times the APC fee schedule.

If you have any questions, please contact me at 401-784-3823 or kelly.leighton@eds.com . Thank you.

Sincerely

Kelly Leighton

Kelly Leighton

Provider Representative Supervisor