Provider News Bulletin
August 2014

Molina Healthcare of New Mexico, Inc.
UPDATE: Outpatient Prospective Payment System (OPPS)

Molina Healthcare of New Mexico, Inc. (Molina Healthcare) has received Supplement 14-04 (included in this bulletin) from the State of New Mexico Medical Assistance Division (MAD) that addresses Outpatient Prospective Payment System (OPPS) Changes that have affected payment of some procedures in the outpatient setting. One of the major issues was $0 payment for laboratory services. In addition, reimbursement for hospital services when a recipient enrolls in Managed Care during the hospital stay is included in this Supplement.

Please note that it was not the intent of MAD to decrease overall reimbursement to hospitals, and because the number of codes that became packaged was so significant, MAD restored the packaging a pricing rules that were in effect on December 31, 2013.

These changes are retroactively effective to January 1, 2014.

Once the NM Human Services Division has this retroactive fee schedule loaded into their production environment, Molina Healthcare will update our claims payment system and will adjust claims for correct payment. Resubmission of these claims is not required.

In addition, hospitals are not required to use Modifier L1 for laboratory codes.

If you have immediate questions, please contact the Provider Services Department toll free at (800) 377-9594. In addition, your dedicated Provider Service Representative's contact information can be located on the Provider Services Territory Grid that on the Molina Healthcare Provider Website at www.molinahealthcare.com under "Contact Us."

Molina Healthcare Quality Assurance Department
Molina Healthcare of New Mexico, Inc.

Enclosure

State of New Mexico
Medical Assistance Program Manual

Supplement

HUMAN SERVICES DEPARTMENT

DATE: July 11, 2014 **NUMBER: 14-04**

TO: HOSPITALS AND SPECIALTY HOSPITALS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: JULIE B. WEINBERG, DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECTS: **(1) OUTPATIENT PROSPECTIVE PAYMENT SYSTEM AND LABORATORY SERVICES**
(2) PAYMENT FOR HOSPITAL SERVICES WHEN A RECIPIENT ENROLLS IN MANAGED CARE DURING THE HOSPITAL STAY

I. OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) CHANGES

On January 1, 2014, the Medicaid program made changes to the OPPS reimbursement methodology that followed changes made by Medicare at the same time, that began to consider approximately 1450 procedure codes as "packaged" for reimbursement purposes, that had not been considered packaged in 2013. Since Medicaid does not update OPPS rates annually, OPPS rates were not updated to offset the decrease in payments hospitals experience because of the number of procedure codes that suddenly came to be considered "packaged" under Medicare rules. The majority of these codes were for laboratory services.

It was not the Department's intention to decrease overall reimbursement to hospitals. Because the number of codes that became packaged was so significant, MAD has restored the packaging and pricing rules that were in effect on December 31, 2013. This change involved 1449 procedure codes including CPT code 36415 which has been restored to a payable service.

The OPPS fee schedule can be found on the HSD website at the following link. It is necessary to go to the bottom of that page and click on the "I AGREE" button in order to proceed to the fee schedule portion of the website.

http://www.hsd.state.nm.us/providers/fee-schedules.aspx

These changes are retroactively effective to January 1, 2014. For hospital outpatient claims that were affected by the changes originally made January 1, 2014, MAD will

automatically adjust the fee-for-service claims as necessary to use the corrected OPPS packaging and reimbursement. The provider does not need to take any action to have the claims adjusted .

Managed care organizations have been informed of changes to the Medicaid OPPS fee schedule. Hospital providers should work with the MCO's directly regarding any claim adjustments.

Hospital providers do not need to use the Medicare modifier L1 on their claims for the Medicaid Fee-For-Service program to obtain the correct payment for laboratory codes.

II. PAYMENT FOR HOSPITAL SERVICES WHEN A RECIPIENT ENROLLS IN MANAGED CARE DURING THE HOSPITAL STAY

There are a few instances under which an individual may be enrolled in managed care while in a hospital facility but the enrollment in the managed care organization (MCO) is not retroactive to include the date of admission; thus there is a fee for service time period and a managed care enrollment time period during the hospital stay. Examples are when (1) an individual was admitted to a hospital prior to January 1, 2014 and became enrolled in managed care prior to being discharged but enrollment in an MCO does not go back prior to January 1, 2014; or (2) a Native American individual opts into managed care while in the hospital. Also, a recipient may change MCOs during a hospital stay.

Under Centennial Care, this is the expectation for payment:

- The FFS program or the relinquishing MCO, whichever is applicable on the date of admission, is responsible for both the hospital stay and the associated professional and other charges until the recipient is discharged or changes to a different level of care. A different level of care is considered to have taken place when a recipient is transferred to a different hospital, or to a different facility such as to a nursing facility. A different level of care is also considered to have taken place if the recipient is transferred from an acute care hospital to a specialty hospital, meaning a rehab hospital or separately recognized rehab unit within the acute care hospital, a long term acute care hospital, a children's specialty hospital, or to an IHS or tribal facility.

  Likewise, transfer from a specialty hospital to an acute care hospital is considered a change in level of care.

  The MCO responsibility for professional services and other services provided during the inpatient hospital stay may also include services such as meals and lodging for a parent or guardian when appropriately covered.

- For free-standing psych hospitals and separately recognized inpatient psych units in an acute care hospital, the FFS program or any MCO is responsible for paying services only for the dates that the recipient is enrolled in the FFS or the specific MCO, respectively. A transfer from a separately recognized psych unit or free standing psych hospital to an acute care hospital or unit constitutes a new admission for which the MCO

at the time of the new admission becomes responsible for acute care hospital stay. Likewise, the transfer from an acute care hospital or acute care unit to a free-standing psych hospital or separately recognized inpatient psych unit is also considered to be a level of care change.

- Residential Treatment Centers (Accredited, Non-Accredited, and Group Homes) do not fall under this rule but are treated the same as nursing facilities, with the MCO responsible only for the days during which the recipient is enrolled in the MCO.

The Medical Assistance Division is considering amending its policies to assure that MCOs are appropriately reimbursed when there are lengthy hospital stays for which the relinquishing MCO may not be receiving capitations. In the interim, this is the way the rule will be applied as outlined in this supplement.

We appreciate your participation in the Medicaid program.