

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



TO: Medicaid Providers

Transmittal No. 12-04

FROM: Linda Elam, PH.D., MPH
Deputy Director/Medicaid Director

A handwritten signature in black ink, appearing to read 'Linda Elam', is written over the printed name.

DATE: February 2, 2012

RE: Notification of Payment Related Changes

The purpose of this Transmittal is:

- To explain recent and proposed changes in Medicaid reimbursement rates for physician and specialty services.
- To notify you of implementation of the National Correct Coding Initiative (NCCI) related edits that are mandated by the Center for Medicare and Medicaid Services (CMS).
- To notify you of adjustments for claims subject to Utilization Review Limits
- To make you aware of upcoming reprocessing of claims related to the above issues

I. CHANGES IN MEDICAID REIMBURSEMENT RATES

Implementing the October 17, 2011 State Plan Amendment

On October 8, 2010, the District of Columbia published a notice of emergency and proposed rulemaking to reduce Medicaid reimbursement rates for fee-for-service physician and specialty services to eighty percent (80%) of the Medicare rate. The rule was to become effective on or after October 9, 2010, or the effective date of the corresponding State Plan Amendment approved by the Center for Medicare and Medicaid Services (CMS), whichever is later. The State Plan Amendment was approved by CMS on October 17, 2011. The approved State Plan provides:

Effective January 1, 2011, the Department will use the Medicare rates to determine the Medicaid rates for services on or after that date. Beginning January 1, 2011, physician and specialty service rates will be reimbursed at eighty percent (80%) of the Medicare rate. All rates will be updated annually pursuant to the Medicare fee schedule. Except as otherwise noted in the Plan,

the District-developed fee schedule rates are the same for both government and private.

On January 13, 2011, the Notice of Final Rulemaking was published in the D.C. Register. Accordingly, the Department intends to implement the approved State Plan Amendment with an effective date of January 1, 2011. We will begin processing claims using the new rates on March 1, 2012.

II. IMPLEMENTATION OF NCCI EDITS

Effective immediately, the Department of Healthcare Finance (DHCF) is implementing CMS' National Correct Coding Initiative (NCCI) standard payment methodologies. This significant change complies with the federal Patient Protection and Affordable Care Act and requires that state Medicaid agencies integrate the NCCI payment methodologies in their claims payment systems for qualifying claims with dates of service on or after October 1, 2010.

Detailed descriptions of the payment methodologies as well as guides to NCCI coding tools can be located at <http://www.cms.gov/NationalCorrectCodinitED/>. NCCI will enhance code editing and identify claims where coding methods do not adhere to guidelines established by CMS.

NCCI edits consist of two types of edits:

- 1) NCCI procedure-to-procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and
- 2) Medically Unlikely Edits (MUE), units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct (e.g., claims for excision of more than one gallbladder or more than one pancreas).

As part of the federal mandate for implementing these edits, DHCF is required to re-adjudicate all claims for service dates on or after October 1, 2010, that could be impacted by these edits. Implementation of these edits applies immediately to any new claims submitted. In the coming months we will begin the process of adjusting any previously submitted claims so that these edits can be applied against previous submissions. The NCCI implementation will ensure that services are paid correctly in accordance with state and federal policy and regulations.

III. CHANGES RELATED TO UTILIZATION REVIEW PROCESSING

As part of an ongoing Quality Assurance Initiative it has been discovered that limits related to some services subject to Utilization Review have been incorrectly applied. System changes to apply these limits correctly have been made. In order to ensure that all claims subject to UR limits have these limits correctly applied, it is necessary to reprocess these claims in date of service sequence back to January, 2009.

We are developing a process for adjusting the claims impacted by these three changes. Our goal is to minimize the financial impact on providers who will owe money as a result of these adjustments. Once we have finalized the process, we will send out another transmittal to provide notice regarding the process for adjusting the claims.

If you have any questions regarding this transmittal, please contact the DHCF, Provider Services Department at 202-698-2000.