

## Updates Regarding UCare's Implementation of Medicare Pricing Software

### Updated Implementation Date for Minnesota Seniors Health Options (MSHO) and UCare Connect + Medicare

On Jan. 18, 2017, a [Provider Bulletin](#) explained how UCare was implementing third-party software to calculate pricing for Medicare professional services. This software was successfully implemented for *UCare for Seniors* and *EssentiaCare* on March 1, 2017. However, the implementation date for MSHO and *UCare Connect + Medicare* has been delayed.

MSHO and *UCare Connect + Medicare* claims for most Medicare-covered professional services received by UCare on or after **July 1, 2017**, with dates of service on or after July 1, 2017, will be priced using the pricing software.

### Tips for Interpreting Explanations of Payment and Remits with UCare's New Medicare Pricing Software

On Jan. 18, 2017, UCare issued a Provider Bulletin titled "[Notice of UCare Implementation of Medicare Pricing Software](#)." That bulletin outlined the payment methodologies, including Multiple Procedure Payment Reductions (MPPR) that UCare will apply to certain Medicare services. The pricing software was implemented for *UCare for Seniors* and *EssentiaCare* claims on March 1, 2017.

While the previous communication explained the payment methodology, we have received several questions on how pricing is coming across on the UCare Explanation of Payment or remits for applicable service lines. Below we wanted to clarify the information providers should expect to see on remits for specific claim scenarios priced through the Medicare pricing software.

#### **Automated Multi-Channel Chemistry (AMCC) and Panel Tests**

Medicare has special pricing logic for claims that contain more than one AMCC test and/or panel test. "Panel" tests are a grouping of AMCC tests that are typically performed automatically on a single piece of testing equipment and consequently may be less expensive than tests that cannot be completed using this equipment. Each panel test is made up of multiple AMCC tests. Per [Section 90.2 and 90.3 of Chapter 16 of the Medicare Claims Processing Manual](#), AMCC 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 Automated Test Listing (ATP) rate or the total of the payments for each individual AMCC test.

Following is an illustrative example of the information providers should expect to see on remits for service lines associated with AMCC and panel tests billed on the same date of service.

Line #	Procedure Code	Units	Total Rate	CARC	RARC
1	80048	1	\$14.87	45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	MA125: Per legislation governing this program, payment constitutes payment in full.
2	80051	1	\$0.00	97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M15: Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
3	82374	1	\$0.00	97 (see description above)	M15 (see description above)
4	82977	1	\$0.00	97 (see description above)	M15 (see description above)
Total Reimbursement:			\$14.87		

### Multiple Procedure Payment Reductions (MPPR) for Endoscopy

Starting on page 3 of the Jan. 18, 2017, bulletin, the MPPR methodology for Medicare endoscopy services is outlined. Payment discounts are 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 (High Rate) plus the difference of the fee schedule rate for the service with the second highest rate (2nd High Rate) minus the fee schedule rate for the endoscopic base code (Base Code Rate).

The payment applied to each service line priced using MPPR methodology will not display on each service line on the UCare EOP/remit. Total payment for all MPPR lines is “bundled” on the line for the highest rate or primary procedure claim line.

Below is an illustrative example of the information providers should expect to see on remits for endoscopy service lines priced using the MPPR methodology. Note the grayed out boxes do not appear on the UCare EOP/remit, but are included here for illustrative purposes.

In this example, the CPT 45378 is the family grouping or category associated with the endoscopy codes billed on the claim; therefore, the fee schedule rate for CPT 45378 is leveraged to determine the Base Code Rate.

	Procedure Code	Units	Fee Schedule Rate	Base Code (Fee Schedule Rate)	MPPR Rate <i>Note: These values will not appear on the remit</i>	Allowed Amount on EOP (with MPPR applied)	CARC	RARC
1	45385	1	\$255.34	45378 (\$185.10)	\$255.34	\$271.70*	45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	MA125: Per legislation governing this program, payment constitutes payment in full.

2	45380	1	\$201.46	45378 (\$185.10)	\$16.36	\$0.00	97: The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	M15: Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
Total Allowed Amount:						\$271.70		
*Total MPPR Rate of \$271.70 = \$255.34 (100% fee schedule for highest rate procedure) +\$16.36 (second highest rate \$201.46 - base code fee schedule rate \$185.10)								

### Bilateral Procedures

Medicare applies special pricing logic for certain bilateral procedures performed on both sides of the body during the same operative session or on the same day. [Per Section 40.7 of Chapter 12 of the Medicare Claims Processing Manual](#), the bilateral procedure will be priced at 150% of the fee schedule rate under the following scenarios:

- Submission of modifier -50 or the same code on separate lines reported once with modifier –LT and once with modifier –RT.  
*And*
- Service is assigned to a Bilateral Indicator of “1” within the Medicare Physician Fee Schedule.

Below is an illustrative example of the information providers should expect to see on remits for Bilateral Indicator “1” services billed on the same date of service.

### Bilateral Procedure Submitted with Modifier -50

Line #	Procedure Code	Units	Fee Schedule Rate	150% of Fee Schedule Rate	Allowed Amount on EOP (with Bilateral applied)	CARC	RARC
1	66821-50	1	\$332.18	\$498.27	\$498.27	45: Charge exceeds fee schedule/ maximum allowable or contracted/ legislated fee arrangement.	MA125: Per legislation governing this program, payment constitutes payment in full.
Total Allowed Amount:					\$498.27		

**Bilateral Procedure Submitted on Separate Lines**

Line #	Procedure Code	Units	Fee Schedule Rate	150% of Fee Schedule Rate	Allowed Amount on EOP (with Bilateral applied)	CARC	RARC
1	66821-LT	1	\$332.18	\$498.27	\$498.27	45: Charge exceeds fee schedule/ maximum allowable or contracted/ legislated fee arrangement.	MA125: Per legislation governing this program, payment constitutes payment in full.
2	66821-RT	1	\$332.18	\$0.00	\$0.00	97: The benefit for this service is included in the payment/ allowance for another service/procedure that has already been adjudicated.	M15: Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
Total Allowed Amount:					\$498.27		

For more information regarding Medicare reimbursement methodologies, please reference the Medicare Claims Processing Manual and other CMS guidance. If you have questions, please call UCare’s Provider Assistance Center at 612-676-3300 or 1- 888-531-1493 toll free.