SD Medicaid APC FAQs		
	Question	**SD Medicaid Response**
1	How will SD Medicaid reimbursement change under Ambulatory Payment Classification (APC) methodology?	SD Medicaid is moving away from reimbursing with a percentage of charges.
2	How frequently will SD Medicaid update the APC Methodology? Will DSS make retrospective adjustments if there is a delay in implementation for new APC regulations or payment rates?	SD Medicaid will make updates to the APC methodology quarterly. SD Medicaid will pay under the existing methodology until the updates can be implemented into the system; SD Medicaid will not make retrospective adjustments.
3	What claims level data is required to be submitted for claims adjudication under APC?	Please follow Medicare guidelines and refer to the UB-04 instructions in the Institutional Billing Manual.
4	How will the APC based payment system impact claim payment timeframes?	APC will not impact claims payment timeframes.
5	How was “budget neutral” reimbursement calculated?	SD Medicaid identified the hospital specific conversion factor based on provider claims data and payment levels from SFY2015.
6	Will there be year-end retro-adjustments?	No.
7	How will items or covered services not part of APCs be paid under the new APC methodology?	Covered services with a fee listed on the fee schedule will be paid according to the fee schedule. Covered services that do not have a fee will be paid at a percentage of charges.
8	What edits will be used to adjudicate facility outpatient claims?	SD Medicaid will use OCE and CCI edits, in addition to existing edits.
9	Are all of the same services covered under APCs as were covered under the old payment methodology? If not, what are the differences?	SD Medicaid’s coverage has not changed with the APC implementation. Please refer to the Administrative Rule of South Dakota for more specific information.
10	How does SD Medicaid APCs differ from Medicare?	Please refer to the Exception Code List on the Provider Fee Schedules.
11	Who should I contact with questions about APC claim level payments?	Please contact Provider Reimbursement and Audits with questions about rates at (605)773-3643; claims processing questions may be directed to SD Medicaid’s Telephone Service Unit at 1-800-452-7691.
12	Where do I locate the DSS Fee Schedules?	Fee Schedules are located on SD Medicaid’s website: https://dss.sd.gov/medicaid/providers/feeschedules/
13	Have Prior Authorization policies changed with the move to APC?	No, please refer to the Prior Authorization webpage for more information regarding prior authorization.
14	Have electronic claims submission policies changed?	No.
15	Why are there different payments for the same service when I submit under different provider groups?	APC calculates payments individually through facility-specific conversion factors.
17	Are all facility outpatient services paid under the APC methodology and related fee schedule? If not, what services are excluded?	No; excluded services include dialysis, ambulance, behavioral health. For a complete list refer to the Exception Code List.

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18	What is the claim level appeals process for an APC claim payment?	The APC claim level appeals process does not differ from the appeals process for other claims. Please see the Institutional Billing Manual for further instruction.
19	Is cost sharing different for APC services?	No. Cost sharing amounts are listed on SD Medicaid's Cost Sharing Website.
20	How will Observation claims be paid?	Observation claims must follow CMS requirements and will be paid following CMS guidelines. Primary differences are coverage requirements. Please bill using the G-codes that Medicare uses.
21	What does OCE stand for?	OCE stands for Outpatient Code Editor.
22	If Medicare packages a service will Medicaid package that same service?	Yes, Medicaid will package the same services as Medicare.
23	If Medicare assigns a specific weight, will Medicaid assign that same weight?	Yes, Medicaid will assign the same weight as Medicare.
24	Will devices continue to be paid at Cost plus 20% OR will Medicaid pay only the APC payment?	For those services that are paid on an APC, the payment will be the APC payment. For medical devices that may be eligible for transitional pass-through payment under the Medicare hospital outpatient prospective payment system, Medicaid will follow CMS guidelines.
26	If the 25 modifier is on the claim, will the presence of the modifier stop the claim?	No, the modifier will not be recognized.
27	How many years before all PPS facilities are paid at the same level?	This is estimated to be a maximum of five years.
28	How will the statewide conversion factors be phased in?	As we go through this process, this schedule may change depending on the results of our analysis. The current plan to phase in conversion factors is as follows: Year 1 - Hospital specific Year 2 - 75% Hospital specific; 25% statewide average Year 3 - 50% Hospital specific; 50% statewide average Year 4 - 25% Hospital specific; 75% statewide average Year 5 – Statewide conversion factor
29	What is meant by hospital based stand-alone clinics?	This applies to rural health clinics. Provider based clinics that are billed under the facility NPI are included.
30	Can late charge claims be submitted?	No, late charge claims are not allowed. The entire claim must be adjusted.
31	When will the APC rules begin to apply?	APC rules start and are applicable to all claims with a date of service as of August 1, 2016.

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32	How will crossover claims be handled?	There will be no change to how crossover claims are handled. They will remain the same as they are today.
33	Will the Medicaid have its own “Inpatient Only” list?	No, Medicaid will use the same Inpatient Only list as Medicare.
34	Will there be a pass through reimbursement for Medicaid?	No, this does not apply. There is no change to the existing inpatient reimbursement methodology at this time.
35	Since the methodology is changing and several of the rules are changing, how can the payment really be budget neutral to a specific facility?	Budget neutrality starts with the total dollars Medicaid paid to the provider population in a specific timeframe. Those same dollars have then been spread across the providers impacted by the move to the
36	Will Medicaid reimburse separately for high dollar implants?	Implants will be included in the APC payment. There will be no carve outs. For medical devices that may be eligible for transitional pass- through payment under the Medicare hospital outpatient prospective payment system
37	CMS does not publish APC weights for new technology APCs or APCs with payment status indicators (PSI) G [Pass through drugs and biologicals] or K [Non pass through drugs and biologicals]. How does SD DSS compute the weights for these APCs?	CMS does publish a payment rate for new technology, PSI G, ad PSI K APCs. SD DSS computes the weight for each of these APCs by taking the CMS payment rate for the APC in question and dividing it by the CMS national conversion factor for the quarter in question. The CMS national conversion factor for 2016 is $73.725. As an example, the weight for APC 0849 (Rituximab injection) is computed by dividing the payment rate for the APC ($791.40) by the CMS national conversion factor ($73.725) yielding a weight for APC 0849 of 10.7345. This APC weight is multiplied by the provider specific conversion factor and the number of units billed for the drug code (J9310 for Rituximab).

Other key points to remember:

Whenever you bill Medicaid, you must submit the claim with all of the same data you would provide Medicare. Another important factor is to be sure your units billed are reported accurately.