METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

Oral language interpreter services, provided by enrolled providers (except inpatient hospitals) to persons with limited English proficiency, are paid the lesser of charges or $12.50 per 15-minute unit of service. Effective July 1, 2009, payment rates for these services rendered on or after July 1, 2009, are reduced by five percent. Effective for these services rendered on or after July 1, 2009, and before July 1, 2010 ~~2011~~, rates are reduced by an additional one and one half percent. Effective July 1, 2010, payment rates for these services rendered on or after July 1, 2010, are reduced by an additional seven percent.

Legislation governing maximum payment rates sets the calendar year at 1989, except that: (1) the calendar year for item 7, home health services, is set at 1982; and (2) the calendar year for outpatient mental health services is set at 1999 (payment is 75.6% of the 50th percentile of calendar year 1999 charges). Rates for services provided by community and public health clinics are increased by 20%, except for laboratory services.

Rate Decrease Effective July 1, 2002: Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2002, before third party liability and spenddown, is decreased by .5 percent from current rates.

Rate Decrease Effective March 1, 2003: Total payment paid to hospitals for outpatient hospital facility services provided on or after March 1, 2003 and through June 30, 2003, before third party liability and spenddown, is decreased by 5 percent from current rates.

Rate Decrease Effective July 1, 2003: Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2003, before third party liability and spenddown, is decreased by 5 percent from the rates in effect on February 28, 2003. This decrease does not include services provided by IHS or 638 facilities.

Rate Increase Effective January 1, 2004: Total payment for services provided on or after January 1, 2004 is increased by two percent if services are subject to outpatient hospital, surgical center, or health care provider taxes. The list of affected providers and services is found on page 1e.

Exceptions to the 50th percentile of the submitted charges occur in the following situations:

(1) There were less than 5 billings in the calendar year specified in legislation governing maximum payment rates;
(2) The service was not available in the calendar year specified in legislation governing maximum payment rates;
(3) The payment amount is the result of a provider appeal.

2.a. Outpatient hospital services.

Payments for outpatient hospital services may not exceed in aggregate the total payments that would have been paid under Medicare.

Outpatient hospital facility services are paid in accordance with the most recent Ambulatory Payment Classification system rates published by the Centers for Medicare & Medicaid Services in the Federal Register, listed in the column marked "Payment Rate," except that:

(1) end-stage renal disease hemodialysis for outpatient, per treatment is paid in accordance with composite rate methodology for the Medicare Program in effect prior to April 1, 2005.

(2) partial hospitalization is paid the lower of the submitted charge or an hourly rate that is 75.6% of the 50th percentile of 1999 charges.

For outpatient end stage renal disease hemodialysis and outpatient hospital facility services, except outpatient facility mental health services, rendered on or after July 1, 2009, payment is reduced by three percent. Effective for services rendered on or after July 1, 2009, and before July 1, 2011, rates are reduced by an additional one and one half percent for outpatient end stage renal disease hemodialysis and outpatient hospital facility services services, except outpatient hospital facility mental health services.

Freestanding ambulatory surgical center facility services or facility components are paid in accordance with the methodology in item ~~6.d.C., Ambulatory surgical centers~~ 9, Clinic services.

Other outpatient hospital services as paid using the same methodology in item 5.a., Physicians' services.

Laboratory services are paid using the same methodology in item 3, Other laboratory and x-ray services.

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the administration of vaccines.

Vaccines are paid the lower of:

(1) submitted charge; or

(2) the average wholesale price plus $1.50 for administration.

Vaccines available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid the lower of:

(1) submitted charge; or

(2) the $8.50 administration fee.

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Except as noted, effective July 1, 2009, payment rates for services rendered on or after July 1, 2009, are reduced by five percent. Effective for services rendered on or after July 1, 2009, and before July 1, 2010 ~~2011~~, the affected payment rates are reduced by an additional one and one half percent. Except as noted, effective July 1, 2010, payment rates for services rendered on or after July 1, 2010, are reduced by an additional seven percent.

Effective July 1, 2010, payment rates for services rendered by psychiatrists and advanced practice nurses with a specialty in mental health on or after July 1, 2010, are increased by one and one half percent.

Effective for services rendered on or after July 1, 2010, payment rates as otherwise calculated in this item, 5.a, shall not exceed the Medicare rate for the same service, except for payment rates for physicians' services provided by a psychiatrist or an advanced practice registered nurse with a specialty in mental health; optimal diabetic and/or cardiovascular care; and health care home services.

The rate reductions effective for services rendered on or after July 1, 2009, do **not** apply to HCPCS codes titled "office and other outpatient services", "preventive medicine new and established patient" and to "family planning services" when provided by primary care physicians and primary care advanced practice nurses.

With the exception listed below, for level one HCPCS codes titled "office and other outpatient services", "preventive medicine new and established patient", "delivery, antepartum and postpartum care" (except as listed in (2)(c) below), "critical care", "complicated cesarean delivery" and, through June 30, 2001, "pharmacological management" provided to psychiatric patients; and HCPCS level three codes for enhanced services for prenatal high risk, payment is the lower of:

(1) submitted charges; or
(2) (a) 80% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community based waiver services providers, IEP providers, dentists, and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or
(b) State agency established rate; or
(c) For delivery services, including cesarean delivery services that are not complicated:

59400, 59510, 59610:	$867.37
59409, 59514, 59612	$560.43
59410, 59515, 59614	$585.15

Effective January 1, 2000, the rate is increased by three percent.

Effective July 1, 2007, "office and other outpatient services" and "preventive medicine new and established patient services"

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

complete clinical results per recipient that meet the criteria of optimal diabetic an/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

Effective July 1, 2007, the State agency established rate is increased five percent for physical therapy services, occupational therapy services, speech-language therapy services, and respiratory therapy services.

Effective July 1, 2010, payment rates for physical therapy services, occupational therapy services, and speech-language therapy services rendered on or after July 1, 2010, are increased by two percent.

Effective July 1, 1998, the rate is increased three percent for these services; effective January 1, 2000, the rate is increased another three percent; effective October 1, 2005, and October 1, 2006, the rate is increased by 2.2553 percent, excluding respiratory therapy services. Effective October 1, 2007, the rate is increased by two percent, excluding respiratory therapy services. Effective October 1, 2008, the rate is increased by two percent, excluding respiratory therapy services.

The rates for respiratory therapy services are as follows:

Procedure Code	Rate
94640	$ 15.02
94642	19.02
94650	16.70
94651	14.48
94652	140.34
94656	100.24
94657	43.43
94660	100.24
94664	18.78
94665	12.93
94667	16.19
94668	16.19

If the service is provided by an **enrolled physician assistant**, the service is paid the lower of:

1) submitted charge; or

6.d. Other practitioners' services. (continued)

E. With the exception noted below for the provision of optimal diabetic and/or cardiovascular care, **nurse practitioner services** (independently enrolled)are paid the lower of:

1) submitted charge; or

2) 90% of the rate established for a physician providing the same procedure, using the same methodology as Item 5.a, Physicians' services.

Effective July 1, 2007, through June 30, 2009, providers are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 130/80; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are those nurse practitioners who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

Nurse practitioners who provide ~~provider-directed care coordination~~ health care home services are paid using the same methodology as item 5.a., Physicians' Services.

Nurse practitioner services (physician extenders) are paid the lower of:

6.d. Other practitioners' services. (continued)

I. **Medication therapy management services.**

Medication therapy management services are paid the lower of submitted charges or:

A. for the first encounter, $52.00 for the first 15 minutes, then $24,00 for each additional 15-minute unit

1. for each provider a recipient visits, the first encounter is limited to one every 365 days

2. for each additional 15-minute unit, a maximum of four per encounter

B. for subsequent encounters, $34.00 for the first 15 minutes, then $24.00 for each additional 15-minute unit

1. for each subsequent encounter, a maximum of seven per recipient, every 365 days

2. for each additional 15-minute unit, a maximum of four per encounter.

Effective July 1, 2009, payment rates for services rendered on or after July 1, 2009, are reduced by five percent. Effective for services rendered on or after July 1, 2009, and before July 1, 2010 ~~2011~~, rates are reduced by an additional one and one half percent. Effective July 1, 2010, payment rates for services rendered on or after July 1, 2010, are reduced by an additional seven percent.

7.c. Medical supplies, equipment, and appliances suitable for use in the home.

Hearing aids, eyeglasses and oxygen are purchased on a volume basis through competitive bidding.

Effective for all of the following medical supplies, equipment and appliances provided on or after July 1, 2009, payment is reduced by three percent. Effective for medical supplies, equipment and appliances provided on or after July 1, 2009, and before July 1, 2011, rates are reduced by an additional one and one half percent.

Medical supplies and equipment that are not purchased on a volume basis are paid the lower of:

(1) submitted charge;
(2) Medicare fee schedule amount for medical supplies and equipment; or
(3) if Medicare has not established a payment amount for the medical supply or equipment, an amount determined using one of the following methodologies:
  (a) 50th percentile of the usual and customary charges submitted for the previous two calendar years minus 20 percent, plus current calendar year Medicare inflation factors for the medical supply or equipment;
  (b) if no information about usual and customary charges exists, payment is based upon the manufacturer's suggested retail price minus 20 percent; or
  (c) if no information exists about manufacturer's suggested retail price, payment is based on cost (wholesale) plus 20 percent.

Effective for services provided on or after July 1, 2010, medical supplies and equipment manufactured for pediatric patients, medical supplies and equipment manufactured for bariatric patients, and HCPCS codes A7520, A7521, B4088, and E0202, are paid the lower of:

(1) submitted charge; or
(2) a payment amount determined by using one of the following methodologies:
  (a) 50th percentile of the usual and customary charges submitted for the previous two calendar years minus 20 percent, plus current calendar year Medicare inflation factors for the medical supply or equipment;
  (b) if no information about usual and customary charges exists, payment is based upon the manufacturer's suggested retail price minus 20 percent; or
  (c) if no information exists about manufacturer's suggested retail price, payment is based on cost (wholesale) plus 20 percent.

Augmentative and alternative communication device manufacturers and vendors are paid the manufacturers's suggested retail price.

Enteral products are paid the lower of:

(1) submitted charge; or
(2) Medicare fee schedule amount for enteral products.
  • Pediatric enteral products may be paid at the average wholesale price.

Parental products are paid using the methodology in items 12.a., Prescribed drugs, for drugs dispensed by a pharmacy.