Physician UPL Supplemental Payment Program- Full Medicaid Pricing (FMP) Instructions and Frequently Asked Questions – Revised 02/05/2024 Latest Approved State Plan Amendment - #17-0011

The purpose of this program is to enhance payments to practitioners employed or contracted by public hospitals. This document has been revised to provide instructions and a recommended approach to gathering documents and completing the forms necessary to participate in the Physician UPL payment program. We have included instructions, Q&A's and examples within each section accordingly.

Steps and Recommended Approach:

I. Determine practitioner(s) or groups eligible to participate in the Physician UPL Supplemental Payment program.

II. Complete the La Commercial Data Request Form – Practitioner Information Tab(s).

III. For each Medicaid Billing number identified in Section II, identify the Top 3 commercial payers for the Group or Practitioner ID.

IV. Identify the CPT codes with Medicaid activity for the volume period used to calculate the Average Commercial to Medicare conversion factor.

V. For each Medicaid Billing number identified in Section II, complete the LA Commercial Data Request Form - Average Commercial Rate Tab to include the CPT fee schedule rates for the applicable payers identified in Sections III. (Note: only necessary to submit CPT codes identified in Section IV)

Timely submit all required documents to LDH at PhysicianUPL@La.gov. Submission questions may be made to the LDH contractor Brittany.fox@lrcaudit.com

Necessary forms and a copy of the State Plan Amendment can be found at www.lrcaudit.com/#physician.

VI. Other General Questions and Sample Supplemental Payment Calculation.

Section I

Determine practitioner(s) or groups eligible to participate in the Physician UPL Supplemental Payment program

Section I - Determine practitioner(s) or groups eligible to participate in the Physician UPL Supplemental Payment program

In accordance with the State Plan amendment – Section 4.19-B, in order to receive supplemental payments, physicians and other eligible practitioners must be:

Qualifying Criteria

1) Licensed by the State of Louisiana,
2) enrolled as a Louisiana Medicaid Provider
3) Non-State Owned or operated Governmental entity (NS Governmental) employed by, or under contract to provide services at or in affiliation with a non-state owned governmental entity and identified by the non-state owned or operated governmental entity as such.

For reference and review purposes, contract arrangements have been grouped into types using the Medicaid claim and Supplemental payment payee designation as a basis:

a. Type A -employed directly by the NS Governmental Entity (on payroll as W-2 employee) (NS Governmental is payee on both the Medicaid claim and Supplemental payment) All eligible services billed to the submitted Medicaid ID are filed for participation.

b. Type B-under contract with NS Governmental with Medicaid claim payment assigned to the NS Governmental. (NS Governmental is payee on both the claim and Supplemental payment) All eligible services billed to the submitted Medicaid ID are filed for participation.

c. Type C-under contract with, or to provide services at, NS Governmental with Medicaid claim billed directly by the Practitioner (Group). Eligible services are limited to NS Governmental patient services only.

d. Type D-under contract with NS Governmental with Medicaid claim billed directly by the Practitioner (Group), other than as described in types "C" and "G". All eligible services billed to the submitted Medicaid ID are filed for participation.

e. Type G-under contract with the NS Governmental with Medicaid claims billed directly by the Practitioner (Group). Eligible services are limited to NS Governmental services only.

State-Owned or Operated Entities (State Governmental) employed by, or under contract to provide services at or in affiliation with a state owned or operated governmental entity and designated as an essential provider.

f. Type E – Employed by or under contract with State Owned Designated Provider. Providers include: LSU School of Medicine – New Orleans, LSU School of Medicine – Shreveport, LSU School of Dentistry, LSU/State Operated Hospitals (Lallie Kemp Regional Medical Center and Villa Feliciana Geriatric Hospital). Medicaid claims billed by state-owned entity (State Non-Governmental is payee on both the Medicaid claim and Supplemental Payment)

g. Type F- Under contract with State Owned Designated Provider. Providers include: LSU School of Medicine – New Orleans, LSU School of Medicine – Shreveport, LSU School of Dentistry, LSU/State Operated Hospitals (Lallie Kemp Regional Medical Center and Villa Feliciana Geriatric

Hospital). Medicaid claim billed directly by the Practitioner (Group). The State Governmental identifies the Practitioner as eligible to receive the Supplemental payment. (Practitioner is payee on both the claim and Supplemental payment)

Eligible practitioner types:

1) Physician
2) Physician Assistant
3) Certified Registered Nurse Practitioner
4) Certified Registered Nurse Anesthetist
5) Dentist (Type E only)

State Owned: Essential Providers defined in SPA #17-0011

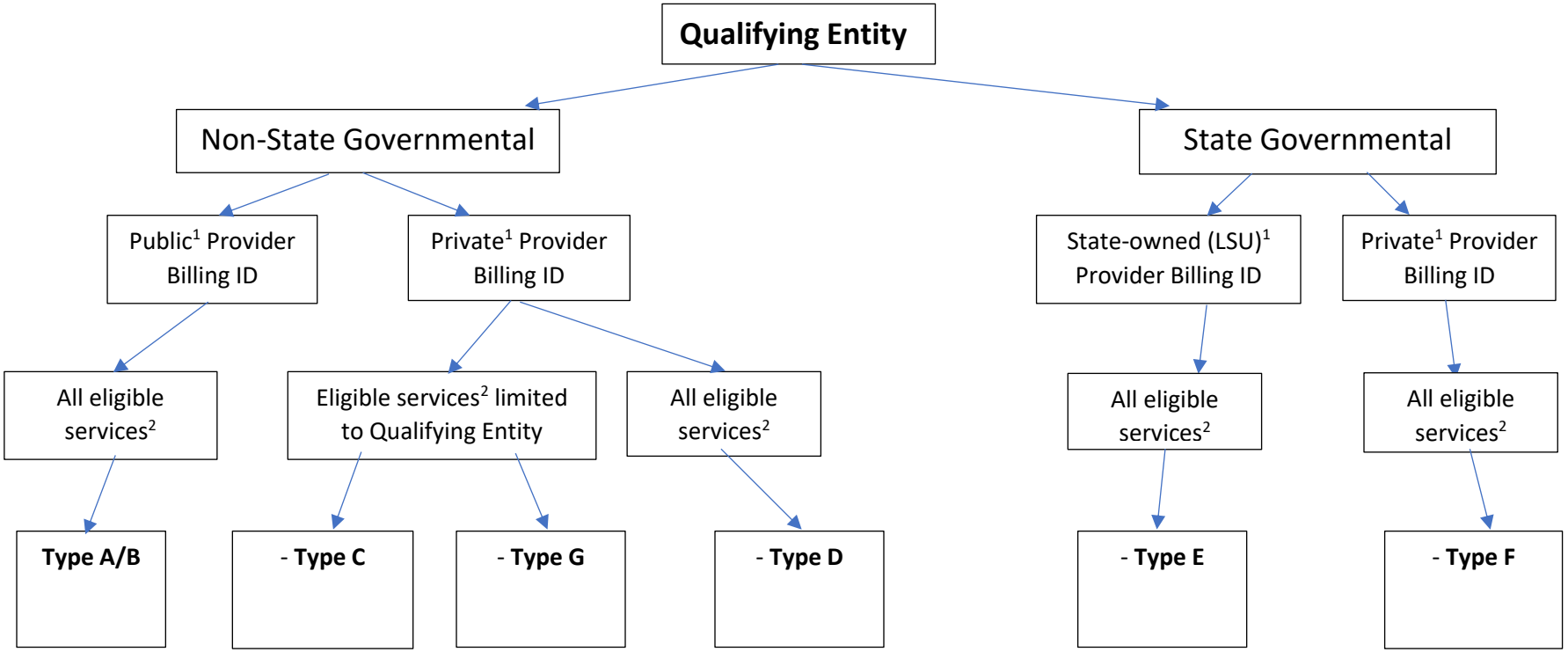
i. LSU School of Medicine – New Orleans;
ii. LSU School of Medicine – Shreveport;
iii. LSU School of Dentistry;
iv. LSU/State Operated Hospitals (Lallie Kemp Regional Medical Center and Villa Feliciana Geriatric Hospital)

Non-State Gov't – Qualifying Entity: Providers listed in the SPA #17-0011

1. Abbeville General Hospital
2. Acadia St. Landry Hospital
3. Allen Parish Hospital
4. Beauregard Memorial Hospital
5. Bunkie General Hospital
6. Citizens Medical Center
7. Claiborne Memorial Hospital
8. East Carroll Parish Hospital
9. East Jefferson General Hospital
10. Franklin Foundation Hospital
11. Franklin Medical Center
12. Hardtner Medical Cent
13. Hood Memorial Hospital
14. Iberia Parish Hospital
15. Jackson Parish Hospital
16. Lady of the Sea Hospital
17. Lane Regional Medical Center
18. LaSalle General Hospital
19. Leonard J. Chabert Medical Center
20. Madison Parish Hospital
21. Morehouse General Hospital
22. Natchitoches Parish Hospital
23. New Orleans East Hospital
24. North Caddo Memorial Hospital
25. North Oaks Medical Center
26. North Oaks Rehab Hospital
27. Opelousas General Hospital
28. Pointe Coupee General Hospital
29. Prevost Memorial Hospital
30. Reeves Memorial Medical Center
31. Richardson Medical Center
32. Richland Parish Hospital
33. Riverland Medical Center
34. Riverside Medical Center
35. Savoy Medical Center
36. Slidell Memorial Hospital
37. St. Bernard Parish Hospital
38. St. Charles Parish Hospital
39. St. Helena Parish Hospital
40. St. James Parish Hospital
41. St. Tammany Parish Hospital
42. Terrebonne General Medical Center
43. Thibodaux General Medical Center
44. West Calcasieu-Cameron Hospital
45. West Feliciana Parish Hospital

Flowchart of arrangements and selection of UPL Type:

(Note: determination assumes licensing and Medicaid enrollment criteria have been met)



1. Billing Ownership Public/Private: Refers to the Public Private Indicator (PPI) in the LDH MMIS Database.
   - PPI-1 Private
   - PPI-4 Public
   - PPI-5 LSU
2. Eligible Services: Refers to the volume of Physician UPL eligible services billed to the submitted Medicaid Billing ID.

Summary of Arrangements and Questions and Answers

Qualifying Entity	Billing ID Ownership (Public Private Indicator - PPI)	Eligible Services Limited to Qualifying Entity	Type
Non-State Gov't	Public	No	A/B
Non-State Gov't	Private	No	D
Non-State Gov't	Private	Yes	C or G
State Owned	LSU	No	E
State Owned	Private	No	F

Questions and Answers – Eligible Practitioners:

1) Question – Are the services of provider-based rural health clinic (RHC) physicians' eligible for physician UPL supplemental payment?
    a. Answer – Any covered RHC or FQHC services would not be eligible for the supplemental payment. These services are paid by Medicaid under a prospective all-inclusive (global) rate (see Section V- Q&A-#1). Professional services performed by the provider-based RHC physicians in the hospital (or elsewhere if employment type A, B or D) would be eligible for supplemental payment.

2) Question-Are physicians that provide services at the Governmental without a written contract (verbal arrangement only) eligible for supplemental payment.
    a. Answer-A written contract must be in place in order to be eligible for supplemental payments. A retroactive written agreement will be accepted as long as it pertains to actual services performed at the hospital site during the applicable supplemental payment dates of service.

Section II

Complete the La Commercial Data Request Form – Practitioner Information Tab

Section II - Complete the La Commercial Data Request Form – Practitioner Information Tabs

Submission of Practitioner Information forms to LDH – participation dates of service as identified on forms available on contractor website: www.lrcaudit.com/#physician. Ensure that your form matches the form on the website noted above if obtaining your LA Commercial Data Request form from a different source. Failure to use the current forms will cause delays in completing your submission. If your data includes information for the incorrect dates of service period, you may be required to resubmit using the correct period data.

Note: To update an expired conversion factor ("Rebase submission") Please contact LRCA directly to obtain the correct form to ensure continued eligibility.

Complete the Practitioner Information form tabs applicable to the contract arrangement to include all eligible practitioners identified in Section I of this document.
Note: The UPL program data is obtained using the seven digit Medicaid Provider Billing ID. We are unable to obtain system claim data using the NPI. The forms must be completed using the seven digit assigned Medicaid Provider Billing ID so that the appropriate claim data may be ordered.

Example for completing Billing ID columns 1 and 2:

Example 1: A hospital employs a physician to work primarily in the hospital-based RHC clinic. The physician also periodically covers the hospital's Emergency Room department. The Emergency Dept services are billed to the Medicaid program using the physicians servicing Medicaid Provider ID. In this case, both column 1 and 2 of the Practitioner Information tab should include the physicians servicing provider Id.

Example 2: A hospital contracts a Radiology group to perform services in the Hospital's Radiology department. Three radiologists perform services at the hospital. All Medicaid claims are billed using one Group Radiology Medicaid Provider ID. Column 1 of the Practitioner Information tab should contain the Group Radiology Medicaid Provider ID. Column 2 should contain the individual Practitioners Medicaid Servicing number next to each of the three Practitioners names.

Sample Completed form – following page

Full Medicaid Pricing (FMP) Practitioner Information

Supplemental Payment to Qualifying Non-State Governmental Facility (Type A ,B, C)

Qualifying Governmental Facility Name:					
Designated Governmental-Owned Group PHYSICIAN Type Medicaid Number:	1234567 +				
The facility must choose one designated Group ID to receive Supplemental Payment for all Type A, B, and C physician groups included in the submission.					
Activity Period for Review	From	**7/1/2022**	Through	**6/30/2023**	
Contact Name	**Governmental Facility Representative**				
Contact Phone #	**xxx-xxx-xxxx**	**Contact Email:**	Example@Hospital .com		

Practitioner Information

							For Type C Only			
	Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8		
	Practitioner (or Group) Medicaid Provider Billing ID (Billing Provider Number)	**Practitioner Medicaid Provider Billing ID (Servicing Provider Number)**	**Practitioner Name**	**Practitioner Specialty (Pathologist, Cardiologist)**	**Contract Arrangement: A: Govt Employed W2 B: Contracted-Govt Bills C: Contracted-Pract Bills, Govt SP**	**Does this Practitioner Assign his/her Medicaid payments (Non Supplemental) to the Gov't Facility? (Yes/ No)**	**Partial Period Arrangements: Provide hire/contract effective date for arrangements beginning during the review period**	**Partial Period Arrangements: Provide termination date for arrangements ending during the review period**		
*	XXXXX1	XXXXX1	Dr RHC Hospital Serv	Internal Med	A	Yes				
*	1234567	XXXXX2	NP Hospital Bills	Internal Med	B	Yes				
*	1234567	XXXXX3	Dr. Hospital Bills	Hospitalist	A	Yes				
	8888888	XXXXX4	Dr My Group Bills	Radiology	C	No	4/1/2017			
	8888888	XXXXX5	PA My Group Bills	Radiology	C	No				

Notes by Column:

1 Provide the Medicaid Provider Billing ID. The NPI reported in CMS Form 1500-Box 33b is assigned to this Medicaid Provider Billing ID.

2 Provide the Medicaid Provider Servicing ID number of the practitioner who performed the service. The NPI reported in CMS Form 1500-Box 24J is assigned to this Medicaid Provider Servicing ID.

5 Provide Contract Arrangement as indicated:

Type A: Governmental Facility Employed Practitioner (Form W-2 employee). Governmental Facility bills and is payee of Medicaid claim.

Type B: On Contract - Practitioner assigns Medicaid claim to Governmental Facility. Governmental Facility bills and is payee of Medicaid claim.

Type C: On Contract - Practitioner is owner of billing id. Practitioner bills/retains their own claims. Services limited to Gov't location. (match performed)

6 Please indicate whether or not this practitioner has assigned his/her Medicaid nonsupplemental claims payments to the NS Governmental facility.

Catergory C Type Arrangements only:

7 Partial Period Arrangements only: Please provide the date the initial affiliation arrangement between the practitioner and the hospital if this occurred after the first date of the review period.

8 Partial Period Arrangments only: If this practitioner is no longer under contract during the review period, please provide the effective date of the

\+ Governmental-Owned Medicaid Physician-Type Provider Billing ID that will be used for UPL payment for ALL Type A,B,C contract arrangements. A hospital-type ID is not eligible to receive payments.

The facility must designate a single wholly owned ID to receive supplemental payment for all Type A, B, and C group IDs included in the submission.

* Governmental is owner "payee" of the Medicaid Provider Billing ID.

Full Medicaid Pricing (FMP Practitioner Information)

Type D,E,F,G

Qualifying Governmental Facility Name:					
Group Name/Location Reference (optional):					
Activity Period for Review:		From	7/1/2022	Through	6/30/2023
Contact Name	**Governmental Facility Representative**				
Contact Phone #	**xxx-xxx-xxxx**	**Contact Email:**	Example@Hospital.com		

						Type D, F and G only	
Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8
Practitioner (or Group) Medicaid Provider Billing ID (Billing Provider Number)	**Practitioner Medicaid Provider Billing ID (Servicing Provider Number)**	**Practitioner Name**	**Practitioner Specialty (Pathologist, Cardiologist)**	**Practitioner Type: 1: Physician 2:Physician Assistant 3: CRNP 4: CRNA 5: Dentist**	**Contract Arrangement: D: Under Contract with NSGov't-Govt E: LSU Owned Billing Number F: Under contract with LSU. LSU identifies Non-Govt Pract Group as eligible for SP G: Under contract with NSGov't-Services limited to NSGov't site**	**"Payee" of Billing ID referenced in Col 1 is a Non-Governmental Facility (Yes/No)**	**Practitioner is under contract to perform services at or in affiliation with a Gov't Facility (Yes/No)**
Group Z#	XXXXX1	Dr RHC Hospital Serv	Internal Med	1	D	Yes	Yes
Group Z#	XXXXX2	NP Group Billing	Internal Med	3	D	Yes	Yes
9876544	XXXXX3	Dr. Hospitalist	Hospitalist	1	D	Yes	Yes
XXXXX4	XXXXX4	Dr My Group Bills	Radiology	1	D	Yes	Yes
XXXXX5	XXXXX5	PA My Group Bills	Radiology	2	D	Yes	Yes
XXXXX6	XXXXX6	Dr. Anesthesia	Anesthesiology	1	D	Yes	Yes
XXXXX7	XXXXX7	Larry Z CRNA	Anesthesiology	4	D	Yes	Yes
5678910	XXXXX8	Dr LSU Owned Group	Internal Med	1	E		
7895412	XXXXX9	Dr Under Contract with LSU	Internal Med	1	F	Yes	Yes

Notes by Column:

1	Provide the Medicaid Provider Billing ID. The NPI reported in CMS Form 1500-Box 33b is assigned to this Medicaid Provider Billing ID.
2	Provide the Medicaid Provider Servicing ID number of the practitioner who performed the service. The NPI reported in CMS Form 1500-Box 24J is assigned to this Medicaid Provider Servicing ID.
6	Provide Contract Arrangement as indicated:
	Type D: Under Contract with Non-State Owned Governmental Facility. NSGov't identifies Non-Governmental Practitioner Billing ID as eligible for supplemental payment.
	Type E: LSU Essential Provider State Owned Billing IDs.
	Type F: Under Contract or Affiliated with LSU Essential Provider. LSU identifies Non-Governmental Practitioner Billing ID as eligible for supplemental payment.
	Type G: Under Contract or Affiliated with Non State Gov't. Non State Gov't identifies Non-Governmental Practitioner Billing ID as eligible to receive supplemental payment only for services performed at the Non State Governmental location. Services limited to Qualifying Non-State Governmental location.
8	Please confirm that a contract arrangement is effective and signed by both the Governmental and the Owner of the Billing ID [referenced in Column 1] PRIOR to submission of form for review.

Section III

Identify the Top 3 commercial payers

Section III - For each Medicaid Billing number identified in Section II, identify the Top 3 commercial payers for the Group or Practitioner ID.

An overall commercial to Medicare conversion factor will be established for each qualifying practitioner (or group of qualifying practitioners utilizing the same Medicaid billing number) identified in section 2 above. To determine the top three payers by volume, analyze total payment activity (not by CPT) for the professional primary commercial payer claims to include the applicable review period (see review period on Practitioner Information Form).

Commercial payer information should not include data for the following payers:

- Medicare (including managed Medicare paid through commercial payers)
- Medicaid (including managed Medicaid paid through commercial payers)
- Workers Comp
- Tricare
- Managed Care not paid on a fee for service arrangement

Only CPT codes for which there was Medicaid volume during the prior state fiscal year will be used in the calculation of the average commercial to Medicare payment conversion factor.

Ensure the population of data is equivalent to the arrangement filed. If Type A, B, D, E, or F, ensure all services are included in the analysis regardless of location. If Type C or G, limit services to those performed at the qualifying entity.

An Accounts Receivable or similar accounting report should be run identifying total payments received, by primary insurance plan, (in total not by CPT) for the review period. If your system identifies several plans for the same insurance carrier, (example – Blue Cross – PPO, Blue Cross HMO, Blue Cross OGB, Blue Cross Medicare Advantage) payments should be grouped based on same Network Fee Schedules (group PPO network, HMO network).

Note: If any out of network payors are claimed as one of the top 3 commercial payors, the support for the determination of the top payors must be included with the filing.

Example for identifying top 3:

Billing#1 - AR Report – Billing Number #1234567 - Professional payments received covering review period:

Aetna Better Health - $40,000 (omit – Medicaid – not commercial)
Benefit Management – $10,000 (BC-PPO Network of Physicians) A
Blue Cross PPO - $100,000 (BC-PPO Network of Physicians) A
Blue Cross HMO - $20,000 (BC-HMO Network of Physicians)
Blue Cross Medicare Advantage - $50,000 (omit – Medicare- not commercial)
Blue Cross OGB - $30,000 (BC-PPO Network of Physicians) A
Cigna – PPO - $75,000 (Cigna-PPO Network of Physicians)
Louisiana Healthcare Connections - $500,000 (omit – Medicaid – not commercial)
Medicare - $1,000,000 (omit – Medicare – not commercial)
OGB (non-Blue Cross) - $30,000 (OGB-PPO Network of Physicians)
United Traditional PPO - $30,000 (United-PPO Network of Physicians)

United ChoicePlus - $200,000 (United-Choice Network of Physicians) B
United Choice - $30,000 (United-Choice Network of Physicians) B

Step 1 – Group by Payer/Network Fee Schedule
Blue Cross – PPO Network - $140,000 (Sum of A)
Blue Cross – HMO Network - $20,000
United PPO Network - $30,000
United Choice Network - $230,000 (Sum of B)
Cigna – PPO Network - $75,000
OGB – PPO Network of Physicians - $30,000

Step 2 – Select the top 3 payers:
United Choice Network - $230,000
Blue Cross PPO Network - $140,000
Cigna PPO Network - $75,000

Billing#2 - AR Report – Billing Number #678910 - Professional payments received covering review period:
Blue Cross PPO - $75,000
Blue Cross HMO - $5,000
Cigna PPO - $10,000
Aetna PPO - $25,000

Group by Payer/Network and Select the top 3 payers:
Blue Cross PPO - $75,000
Aetna PPO - $25,000
Cigna PPO - $10,000

III. Questions and Answers – Selection of Top 3 commercial payers:

1) Question – How is "volume" defined in determining which commercial payers are the top 3 commercial payers by volume? Should the analysis be performed on a hospital, practice or practitioner level basis?
    a. Answer- The preferred method to determine volume should be based on the total professional payments received, by insurance plan, from commercial payers for the participation period generally to include one year (in total, not by CPT). If identifying total payments by payer is not readily available through the accounting system, an alternative method of using billed charges for the period (in total, not by CPT) will be accepted. Documentation of the basis used to determine the top commercial payors must be available for review and clearly demonstrate that the activity of all insurance payers for the applicable billing number were included in the population.

       A separate analysis should be performed for each Medicaid billing provider number. For example, if several practitioners submit claims to Medicaid using a single group practice billing provider number, the combined total of all payments received from commercial

payers for the group should be reviewed to identify the top 3 commercial payers.

For C or G Type groups, limit the payment activity to the submitting Qualifying Non-State Governmental Entity only. If unable to obtain location specific data, the hospital's patient activity will be used in lieu of the practitioner group's patient activity.

2) Question – What should be included in column three of the Average Commercial Rate tab if after reviewing a year of activity I have only identified 2 commercial payers?

    a. Answer – If there is no payment activity (in total not by CPT) for the commercial payer, Column 3 of the Average Commercial Rate tab should be left blank. The average commercial rate by CPT will be computed using rate information from payers 1 and 2. The provider must submit the documentation to support the absence of a 3rd commercial payor.

3) Question – Should the commercial carrier used to administer my Hospital self-insurance employee claims be considered in selecting the top 3 commercial payers?

    a. Answer – No. Payments made on behalf of the Hospital's self-insurance fund should be excluded in selecting the top 3 commercial payers. However, if the commercial payer applies a consistent physician fee structure to both employee and non-employee patients (ex. all use Blue Cross PPO network fees, all use % of Medicare fees, etc) , then the total commercial payer payments may be included in the selection of the top 3 commercial payers.

4) Question – Can third party administrator or partnership claims be included in a commercial payor's population?

    a. Third Party Administrator (TPA)/Partnership claims included within a top 3 payor's population can only be included if the TPA is paying at the commercial payor's in-network rate. (Ex. Gilsbar is a TPA in partnership with Cigna. If the group is in-network with Cigna, and Gilsbar is paying the Cigna network rate, they can be included. If Cigna is out of network, Gilsbar cannot be included in the Cigna population.)
    b. If the commercial payor is out of network, TPA or partnership claims cannot be included within the population. Examples:

        i. United Health Care and United Medical Resources (UMR) must be classified separately.

        ii. Cigna partnerships (NALC, Lucent Health, The Health Plan, Gilsbar, etc) must be classified separately.

5) Question – We have several low volume insurance payers that are grouped into a Miscellaneous Payer category on our AR Reports. Is it necessary to separately identify the individual plans in this group?

    a. Answer – If the balance of the Miscellaneous Payer group could impact the selection of the Top 3 payers, it is necessary to separately identify the individual payers within the Miscellaneous group. If the inclusion could not impact the selection of the Top 3 in any way, it is not necessary to separate the category.

Example - AR Report :
Blue Cross - $1,000,000
United Healthcare- $800,000
Aetna PPO - $100,000
Cigna PPO - $90,000
Miscellaneous - $15,000

For the above example, it would be necessary to identify the individual payers within the Miscellaneous group because if there are Cigna networks within the Miscellaneous group totaling greater than $10,000, the Top 3 will be affected

Section IV

Identify the CPT codes with Medicaid activity for the volume period used to calculate the Average Commercial to Medicare conversion factor

Section IV - Identify the CPT codes with Medicaid activity for the volume period used to calculate the Average Commercial to Medicare conversion factor

In accordance with the State Plan Amendment, the average commercial to Medicare payment conversion factor will be established by aligning Medicaid claims data for the prior State fiscal year with the current commercial CPT rate information In order to determine which CPT codes are needed to gather commercial rate information, you should determine the Medicaid covered CPT activity for the preceding state fiscal year period July 1 through June 30th (review period identified on the current Practitioner form).

IV. Questions and Answers – Identification of applicable CPT codes to establish conversion factor:

1) Question – Is it acceptable to submit commercial payer information only on the top 10 or top 20 Medicaid CPT codes in order to determine the average commercial to Medicare payment conversion factor?
    a. Answer – Yes. As long as the CPT code volume submitted represents at least 80% of the total volume for the period.

Section V

Complete the LA Commercial Data Request Form – Average Commercial Rate Tab

Section V – Completion of the LA Commercial Data Request Form – Average Commercial Rate Tab

For each Medicaid Billing number identified in Section II, complete the LA Commercial Data Request Form – Average Commercial Rate Tab (tab 3) to include the CPT code fee schedule/ allowed amounts for the applicable payers identified in Sections III. The average is calculated using a straight average of commercial rate amounts. (100+75+50/3= $75).

Note: CPT fee schedule/allowed amounts may be submitted for all codes. However, only those codes identified in Section IV (the prior State fiscal year volume period) will be used in calculating the average commercial to Medicare payment conversion factor.

V. Questions and Answers – Completion of Average Commercial Rate Tab

1) Question – Should commercial payer rate information be submitted for CPT codes that include both a technical and professional component payment amount (i.e. CPT codes having modifier 26, all-inclusive prospective payment codes)?
   a. Answer – CPT codes that include both technical and professional component payment amounts will be excluded from the supplemental payment calculation. It is not necessary to submit commercial payer information related to these codes. If the top 3 commercial payers identify a separate payment amount for mod 26-Professional component, ensure that rate is filed.

2) Question – On the LA Commercial Data Request form, Average Commercial Rate sheet, the column description says Top 3 commercial fee schedule payment amounts in effect for the review period. Is this for amounts actually paid during that time frame or do we need to pull from dates of service during the time frame?
   a. Answer – Commercial rate information should reflect the latest (most current) rate agreements in effect during the review period. Therefore, include commercial payment rate information on dates of service during this period rather than those paid related to claims from an earlier agreement. Note: If a new commercial payer rate agreement was negotiated within the requested timeframe, it is not necessary to weight rate information per CPT code. Use the payment rate amounts from the latest agreement. It is only necessary to weight rate information if there are multiple payment rates for the same CPT code on the latest agreement in effect.

Example:	Allowed Amt Jan. 1	Allowed Amt effective Mar. 1
CPT XXXX1	100.00	110.00
CPT XXXX2	105.00	115.00
CPT XXXX3-hospital	115.00	125.00
CPT XXXX3-clinic	150.00	160.00

Rates to include (XXXX1-$110, XXXX2-$115, XXXX3- weighted avg of $125 and $160 based on actual activity during the period)

3) Question-Are commercial payer arrangements in which the contract rate is based on a percentage of billed charges acceptable to include in the Average Commercial Rate tab?
   a. Answer – Yes. Include the computed allowed amount for each applicable CPT code in the schedule.

4) Question – If multiple physician practices (separate Medicaid billing numbers) negotiate the same physician fee amounts with commercial payers, is it necessary to repeat the commercial payer information on the LA Commercial Data Request form for each Medicaid billing number?
   a. Answer – No. For practice billing numbers that have the same top 3 commercial payers by volume and share the same payment rate agreements, the commercial payer information may be included once on the LA Commercial Data Request form, average commercial rate tab. A cover statement should be attached listing each Medicaid billing number for which the commercial payer information applies.

5) Question – Should a separate LA Commercial Data Request form or separate average commercial payer tab be submitted for each separate Medicaid billing number or should the commercial payer information be listed continuously on the provided average commercial rate tab?
   a. Answer – Any of the listed methods is acceptable. A separate file, separate tabs within one file or continuous reporting on the same tab will be accepted.

6) Question-If our practice bills under one group number to Medicaid, is it necessary to include the individual servicing practitioner numbers on the LA Commercial Data Request, Average Commercial Rate tab?
   a. Answer – No. Only include commercial payer information for the group number used to bill Medicaid claims. The applicable Servicing Practitioner Provider ID# should be listed on the applicable “Practitioner Information” tab.

7) Question – My third payer is out of network and I do not have a standard fee schedule. What do I include in the third column on the Average Commercial Rate tab?
   a. Answer – Using the activity for the review period, it will be necessary to calculate the average allowed amount by CPT.
   b. The support for the selection of the top 3 commercial payors must be filed with the submission.
   c. Complete LA Commercial Data Request Form – Tab 5: Out of Network Detail with the full claims population by CPT code for all out of network payors. This data must support an average allowed amount per CPT code. If allowed amounts are not available, insurance payment by CPT may be used instead.
   d. The Average Commercial Rate Form must still be completed using applicable contractual/fee schedule/expected rates for in-network payors.

8) Question – My payor has both Facility and Non-Facility rates for some of the CPT Codes. Which rate should I include on the Rate Tab?
   a. When a payer pays more than one amount per CPT, the provider can approach this in one of two methods. The UPL program aims to collect rates for Physician services at the qualifying governmental facility. Therefore, the program default is to process the facility rates. However, if the provider has significant non-facility activity,

weighted rates based on actual place of service volume may be provided.

i. Option A) Submit Facility rates.
ii. Option B) Weight commercial rates by Place of Service
    1. The provider should determine Medicaid volume by place of service for each CPT code, and weight the fee schedules' facility and non-facility rates based on the ratio determined. Please ensure that the support for this calculation is provided with your submission.
    2. Please contact us for further guidance if needed.

Sample Completed form – following page

Qualifying Governmental Fa		U		
Activity Period for Review:	From	**7/1/2022**	Through	**6/30/2023**

Identification of Commercial Rates

		1	2	3
		Payor 1	**Payor 2**	**Payor 3**
Identify Payor Name		Payor Name	Payor Name	Payor Name
Select In/Out of Network		Select Answer	Select Answer	Select Answer
Select Place of Service		Select Answer	Select Answer	Select Answer
Medicaid Provider Billing ID	**CPT Code**	**Payor 1**	**Payor 2**	**Payor 3**
1234567	10001	10.00	15.00	20.00
1234567	10002	12.00	13.00	14.00

Place of Service (Other):
Please identify the method used to determine the commercial rate.

Commercial Rate Guidance

1A **Determine Top Commercial Payors.** For each Medicaid Provider Billing ID, determine your top 3 commercial payers using the total professional insurance payments by commercial insurance plan received for the period noted above. Support should be summary level of total insurance payments received by all insurance payors (in total by payor, not by CPT). In order to support the proper payor determination, this report should not filter payors or financial classes (support must include governmental payors). Detailed instructions on how to properly select your top payors is available on our website at:

http://www.lrcaudit.com/#physician

1B **Third Party Administrator (TPA)/Partnership** claims included within a top 3 payor's population can only be included if the TPA is paying at the commercial payor's in-network rate. (Ex. Gilsbar is a TPA in partnership with Cigna. If the group is in-network with Cigna, and Gilsbar is paying the Cigna network rate, they can be included. If Cigna is out of network, Gilsbar cannot be

1C Please identify if your commercial payers are **in-network** or **out-of-network** on the first line of the rate schedule using the drop down menu. (Indicate payor status on row 10)

1D **Out of Network Payers**: Complete the schedule using average allowed amounts by CPT code. If filing an out-of-network payor, Sections 1 and 2 on Tab 5. Out of Network Detail must be completed and included in the submission. This includes providing support for the top 3 insurance payor determination and a download at patient level detail for each out of network payer containing all activity supporting the average allowed amounts.
Completion of Sections 1 and 2 on Tab 5, Out of Network Detail is required to begin this review.

2A **Determine Commercial Rates by CPT.** Once the Top 3 payers are determined, identify the allowed rate by CPT received (or expected rate per the payer fee schedule). For cases where there is a rate difference due to differing Place of Service (facility/non-facility), either provide the facility fees or weight the commercial rate based on servicing location (refer to FAQ for weighting instruction/examples Section V, #8). (Indicate method used on row 11)

2B **For Global Codes** (Global, TC, 26 modifiers), ensure that only the "26" (professional) modified rate is included on the schedule.

Note 1: A sample of the information provided may be requested. Support requested would need to be validated to the Accounts Receivable system.

Note 2: It is not necessary to include formula based Anesthesiology codes (generally ASA codes 00100-01999) here. Please provide conversion factor and medical direction percentages on separate tab for Anesthesiology services. Anesthesiology codes that are not paid on a formula based reimbursement (flat fee/code) should continue to be reported on this schedule.

Section VI

Other General Questions and Sample Supplemental Payment Calculation

Questions and Answers – General Questions and Sample Supplemental Payment Calculation

1) Question- Can the LA Commercial Data Request form be submitted directly by the physician practice to LDH separately from the LA Physician Certification Form?
    a. Answer – An authorized agent of the facility must sign the certification form. The certification form can be found on the contractor website: www.lrcaudit.com/#physician. The LA Physician Certification form and the LA Commercial Data Request form must be submitted together to LDH (or LRCA) by the non-state owned or operated governmental authorized agent.

2) Question – Which fee payment column (Facility or Non-Facility) of the Medicare fee schedule will be used in calculating the physician UPL supplemental payment?
    a. Answer – The non-Facility column of the Medicare fee schedule will be used in calculating both the average commercial to Medicare payment conversion factor and the supplemental payment amount.

Example – Supplemental Payment Calculation – Following Page

Qualifying Entity	
Physician or Group Name	
Medicaid Billing Provider Number	

	Calculation of Average Commercial Rate									Calculation of 1st Supplemental Payment					
Column Reference	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	**N**	**O**
CPT	**Payer 1**	**Payer 2**	**Payer 3**	**Average Commercial Rate per CPT**	**Medicaid Volume**	**Medicaid Volume X Avg. Commercial Rate (D * E)**	**Medicare Rate per CPT (Non-Fac)**	**Medicare Rate per CPT X Medicaid Volume (G * E)**	**Avg. Commercial Rate as Percentage of the Medicare Rate (F ÷ H)**	**Medicaid Volume**	**Medicare Rate per CPT (Non-Fac)**	**Medicare Rate per CPT X Medicaid Volume (J *K)**	**Payment Ceiling = Medicare Rate x Medicaid Volume x ACR (Total L * Total I)**	**Medicaid Payment**	**Supplemental Payment**
XXXX1	$100	$75	$50	75.00	100	$ 7,500.00	$ 55.00	$ 5,500.00	136.36%	95	60	$ 5,700.00			
XXXX2	$105	$50	$94	83.00	200	$ 16,600.00	$ 60.00	$ 12,000.00	138.33%	175	65	$ 11,375.00			
Total						$ 24,100.00		$ 17,500.00	**137.71%**			$ 17,075.00	$ 23,513.98	$ 12,000.00	$ 11,513.98

Notes by Column:

A -C Top 3 (by volume) commercial fee schedule allowed amounts in effect for the period prior to the review period.
Contains the payment (allowed amount) by third party payers per CPT up to the allowed amount including co-pays and deductibles.
When a payer pays more than one amount per CPT, determine the average payment weighted by volume.
Exclude data from Medicaid, Medicare, Medicare Crossover, Workers Comp, Tricare, and other non-commercial payers and codes not reimbursed by Medicaid.

E Report the Medicaid claims volume for dates of service prior to the review period

G Most currently available national non-Facility Medicare fee schedule amount.

I To derive the overall ratio of commercial payment to Medicare payment, use the total of column F divided by column H. See the highlighted cell.

Sample Calculation of 1st Supplemental Payment to be made for claims paid during the period submitted for review.

J Report the Medicaid claims volume for dates of service for the review period.

K Most currently available national non-Facility Medicare fee schedule amount.

M Payment Ceiling is total of Col L x Total Commercial to Medicare Conversion factor computed in Column I. Note: Ceiling reduced to 80% for non-physician practitioners.

N Medicaid payment in total for dates of service for review period.

O Column M-Column N

Note 1: The average commercial to Medicare conversion factor used to calculate supplemental payments will be updated at least every three years.