

# *A New Outpatient Hospital Payment Method for Mississippi Medicaid*

**Version Date: March 8, 2013**

**Please note that changes remain possible before the implementation date.**

*Mississippi Division of Medicaid (DOM) has moved to a new method of paying for hospital outpatient services. Our goals are to reward efficiency, reduce administrative burden for both hospitals and DOM, reduce reliance on Medicare cost reports, improve purchasing clarity, and increase fairness to hospitals.*

*This document provides questions and answers about the new method. We invite additional questions and welcome suggestions.*

## **The New Outpatient Hospital Payment Method**

### **1. When will the new method be implemented?**

Implementation of the new payment method occurs in two phases. In Phase I, payment is based on a fee schedule and effective for claims with dates of service on or after September 1, 2012. The implementation of Phase II, which includes bundling and discounting, will be determined at a later date.

### **2. What change is being made?**

DOM changed the method it uses to pay hospitals for outpatient care. Under the new method, hospitals are paid using an Outpatient Prospective Payment System (OPPS) similar, but not identical, to the Medicare OPPS.

### **3. What providers and services will be affected?**

The new method applies to outpatient facility services in all acute care hospitals, including general hospitals, freestanding rehabilitation hospitals and long-term care hospitals; it is not applicable to Indian Health Services. Unlike Medicare, Medicaid will use the method for critical access hospitals. Outpatient care in freestanding psychiatric hospitals is not covered.

Payments to physicians **will not** be affected.

### **4. How much money is affected?**

In the fiscal year that ended June 30, 2011, DOM paid hospitals \$264 million for outpatient care. This excludes “DSH” payments to hospitals, payments on Medicare crossover claims, and the net impact of the cost settlement process.

## 5. How did the previous payment method work?

Three-quarters of payments historically were made using a cost reimbursement approach. Initially, claims were paid based on a cost-to-charge ratio (CCR), that is, the lesser of the hospital-specific Medicare cost-to-charge ratio using the original cost report, or 75%. For example, if the CCR was 30% and the hospital charged \$1,000 for an emergency room visit, then the interim payment was \$300. After the final cost report was received from the Medicare contractor, the cost-to-charge ratio was recalculated and claims history was adjusted. If the CCR was changed to 25% based on the final cost report, the new payment would be \$250. The provider would repay \$50 to DOM. If the CCR increased based on the final cost report, DOM would owe the hospital additional payment. The process, including hospital cost report submission, review by a federal contractor, and final rate and claims adjustments by DOM, took about two to three years after the date of service. The cost-based payment was applied to all outpatient hospital services except lab and imaging services.

For the other one-quarter of payments, lab and imaging services, payments were made on a fee-for-service basis with no cost settlement.

DOM is required by State law to reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service.

DOM's overall approach dates from 1981 and was similar to the methods that were used by Medicare and many other Medicaid programs throughout the 1980s and 1990s.

## 6. Why change to the new payment method?

DOM has five reasons:

- **Reward efficiency.** Under the previous method, hospitals that became more efficient and decreased their cost were penalized with lower payments. Under the new method, hospitals will receive a designated fee for each service. If they improve efficiency, they will keep the savings.
- **Reduce administrative burden.** Under the previous method, delays and adjustments to cost reports and payment rates negatively impacted financial planning for both the hospitals and the Division. Financial managers had to wait several years before outpatient payments were finalized. Under the new method, when a claim is processed the payment is final.
- **Reduce reliance on Medicare cost reports.** Under the previous method, lengthy cost report settlement process was burdensome for everyone. The previous method depended on the Division receiving settled hospital cost reports from Medicare contractors. Federal contractors audit only 15% of reports, focusing on those areas that are important to Medicare payment. These areas may or may not include the cost centers that are important for Medicaid payments.
- **Improve purchasing clarity.** The new method will allow the Division clearer insight into the services being purchased. Because payment will be based on procedure codes, the Division will be better able to ensure that payment is being made for appropriate and covered services.
- **Increase fairness to hospitals.** Under the previous method, two hospitals were often paid very different amounts for very similar care, as it was based on the charges submitted. Under the new method, all hospitals will be paid the same for the same service as the payment is based on the procedure code being billed.

## **Components of the New Payment Method**

### **7. Overall, how will the new payment method work?**

The new method is similar to the Ambulatory Payment Classification (APC) based method currently in use by Medicare. In general, payment is made using the CPT or HCPCS codes listed on the line level of an outpatient hospital claim. Payments for certain items may pay zero (\$0.00), because payment for these items is considered “bundled” into payment for the other services.

The Medicaid OPPS method is not identical to Medicare. The differences reflect both the fact that Medicare payment policy isn’t always appropriate for Medicaid and the desire to avoid some of the complexities of the Medicare method.

### **Outpatient Payment Methodology Paid Under Medicaid OPPS**

- If there is a Medicare APC assigned to the code, the fee will be the Mississippi Medicaid conversion factor times the national APC weight times the units (when applicable).
- If there is not an APC assigned and a Medicare fee is available, the payment will be the Medicare fee times the units.
- If there is not an APC or a Medicare fee, the fee will be the Mississippi Medicaid fee times the units (when applicable). If a technical component or site-of-service differential are appropriate that fee will apply, otherwise the general Mississippi Medicaid fee will apply.
- If there is no APC fee, Medicare fee, or Medicaid fee for a service, payment is made as follows: Drugs are paid at 100% of the provider’s invoice cost and procedures are paid a comparable procedure fee based on time, resources and complexity.

APC rates are computed using the conversion factor times the specific APC weight found on the April 1 Medicare Addendum B. The Medicare Addendum B is located on CMS website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>.

DOM is required by State law to reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service.

Federal law prohibits payment for Other Provider Preventable-Conditions and for the three Never Events as defined by the National Coverage Determination: Wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, and surgical or other invasive procedure performed on the wrong patient.

### **8. What will be the main similarities between Medicare and Medicaid?**

- **Payment by APC.** For some services, CPT/HCPCS codes will be assigned to an APC status indicator and an APC. The fee will equal the relative weight for that APC times the Mississippi Medicaid conversion factor times the units (when applicable). Medicaid will use the same relative weights as Medicare adjusted annually per Medicaid administrative code.

- **Discounting of multiple procedures.** If a claim includes more than one significant procedure with APC status “T” (Significant procedure paid by APC that the multiple procedure discount DOES apply) or “MT” (a MS specific status indicator will be used for codes that DOM has elected to discount differently than Medicare), the highest allowed line will be paid at 100% of the APC fee and the other status “T” or “MT” procedures will be paid at 50% of the APC fee or Mississippi Medicaid fee. Line order **does not** matter. Discounting is intended to reflect the economies realized by a hospital when multiple procedures are performed on the same patient.
- **Therapy services.** Hospitals will be paid using the same set of fees that Mississippi Medicaid currently uses to pay community-based therapists.
- **Lab and imaging services.** DOM will use the Outpatient Payment Methodology paid under Medicaid OPSS as outlined in item 7 above.
- **Status Indicators.** DOM will use the same status indicators as Medicare with two additional Mississippi Medicaid specific status indicators. These can be found at <http://www.medicaid.ms.gov/>.

## 9. What will be the main differences between Medicare and Medicaid?

- **Coverage policy.** Both Medicare and Medicaid cover a very wide range of hospital outpatient services. However, there are a few instances where coverage policy differs between the two payers.
- **Conditional packaging.** Medicare assigns APC status indicator Q (Medicare composite rates) to codes that are sometimes packaged and sometimes not. Medicaid will not package these codes.
- **Modifiers.** Emergency room services, which span midnight, may be span billed. Medicaid requires modifier “ET” on all line items with the next date of service for emergency room encounters (E&M emergency CPTs), which are performed after midnight.
- **Outlier payments.** Medicaid will not make outpatient outlier payments.
- **Rate levels.** The Mississippi Medicaid conversion factor and Medicaid fees for individual services will not necessarily be the same as Medicare for all procedure codes.
- **Charge cap.** To calculate the cap, the providers covered billed amount is compared to the covered allowed amount at the claim level. If the claim level covered billed amount is less, the claim level covered billed amount becomes the allowed amount.
- **Emergency room.** DOM no longer has a limit for emergency visits for adults. Additional emergency services for beneficiaries over the age of twenty (20), for the two lowest-level Evaluation and Management codes (99281 & 99282), will unbundle and pay.

## 10. How will Medicaid pay for observation care?

Subject to documentation of medical necessity, Medicaid will pay an hourly fee for each hour of outpatient observation exceeding seven hours, to a maximum of 23 hours (i.e., the maximum payment will be 16 hours times the hourly fee). Observation care will be paid regardless of patient diagnosis. Payment for the first seven hours of observation will be considered bundled within payment for other services and pay \$0.00. Direct admits to outpatient observation always bundle and pay \$0.00. Phase 2 will allow observation billed with procedure codes 99284, 99285, or 99291 to pay at a higher Medicaid rate.

### Coding, Billing and Editing

## 11. What billing and coding practices will be important for hospitals to follow?

There are several billing requirements that will become increasingly more important under the new payment method.

- **Single claim for a single visit.** Hospitals will bill all services for the beneficiary on the same day on the same claim. Incoming claims will be checked against claims history and will be denied if a claim has already been submitted for that date of service, even if the procedures are different.
- **Date Bundling/Span Billing.** Date bundling refers to multiple services (different departments) on the same date of service. Span billing is where a repeated service is billed over a period of different days. Any claim with more than 1 date of service will be denied with the exception of the following:
  - Therapy services (Physical, Speech, and Occupational) may continue to be span bill up to 31 days.
  - Emergency room services that carryover midnight (into the next day) will be allowed to span bill over a 2-day period with the use of the “ET” modifier on all lines billed on the second day of service. The ET modifier will only be allowed for claims which 99281 - 99285 are present on the first date of service.
  - Observation services may be span bill for up to 3 days.

**Note: Based on provider feedback during OPPS training, DOM is currently reviewing other span billing issues.**

- Complete procedure coding.** There are certain revenue codes that are required to be billed with a procedure code. If a procedure code is not present, the line will deny. If the revenue code does not require a procedure code and one is not present, the line will bundle and payment will be \$0.00. The list of revenue codes can be found on the Division's website at <http://www.medicaid.ms.gov/>. Certain HCPCS codes may only be billed with revenue code 0636 (Drugs Requiring Detailed Coding) as listed below. **Please note this list is subject to the updates found in the Uniform Billing Editor.**

## J & Q HCPCS that are exclusively associated with Revenue Code 0636

J0129-J0132	J1570	J2820-J2850	Q0166
J0135	J1571-J1573	J2941	Q0180
J0152	J1595	J2993-J2997	Q0181
J0180	J1610	J3101	Q0515
J0205-J0257	J1640	J3240-J3246	Q2017
J0287-J0289	J1670	J3262	Q2035-Q2039
J0348	J1725-J1786	J3285-J3300	Q2043
J0475-J0490	J1810	J3310-J3315	Q3025
J0583-J0588	J1830	J3350-J3357	Q4101-Q4116
J0594	J1930-J1931	J3365	Q4118
J0597-J0598	J1945-J1950	J3385-J3400	Q4121
J0600	J1955	J3465	Q4122
J0637-J0638	J2020	J3487-J3488	Q4124
J0718	J2170	J7180	Q4130
J0735-J0740	J2248	J7183	Q9968
J0775	J2278	J7185-J7198	
J0795-J0885	J2315-J2320	J7199	
J0894	J2323-J2353	J7308-J7326	
J1162	J2355-J2358	J7335	
J1190	J2425-J2426	J7501	
J1205-J1212	J2469	J7504-J7505	
J1290-J1300	J2503-J2513	J7511-J7513	
J1327	J2562	J7525	
J1410-J1430	J2700	J8501-J8510	
J1438-J1441	J2724	J8520-J8521	
J1451	J2730	J8560-J8562	
J1453	J2770-J2778	J8700-J8705	
J1455	J2783-J2794	J9000-J9999	
J1457-J1460	J2796	Q0138	
J1559-J1569	J2805	Q0144	

- **Attention to units.** Procedure codes will pay the fee times the number of units billed, unless the billed units exceed the allowed units. If billed units exceed the maximum allowed, the claim line will deny. DOM defines drug units according to the current HCPCS description of a drug (e.g. Injection Baclofen 10 mg equals 1 unit).
- **National Correct Coding Initiative.** NCCI is an initiative of the Centers for Medicare and Medicaid Services to ensure that CPT and HCPCS codes are billed in appropriate combinations. NCCI edits refer to code pairs, of which there are two types. Medicaid expects hospitals to follow the same NCCI hospital outpatient coding practices that Medicare expects. These edits are published at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>

There are two types of edits for NCCI, not just code pairs. The National Correct Coding Initiative contains two types of edits.

1. NCCI procedure-to-procedure (PTP) 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. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.
  2. Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.
- **Distinct medical visits.** Separate and distinct visits on the same day will be allowed with condition code G0 (G zero).

## 12. Will Medicaid use the Medicare Outpatient Code Editor (OCE)?

No. The OCE is designed to implement Medicare coverage and payment policy, which can differ from Medicaid. Medicaid will adjudicate hospital outpatient claims using existing and new edits related to covered diagnoses, revenue codes and procedures, maximum units, payment policies, and the National Correct Coding Initiative.

## 13. Any changes to prior authorization?

No changes to prior authorization requirements are being made as part of this project. Current prior authorization requirements will continue to apply.

## 14. Will Medicaid pay for trauma team activation?

Yes. The new payment method does not affect the coverage policy for trauma team activation, which can be found in the Administrative Code Title 23, Medicaid, Part 202, Rule 1.10. The CPT code for trauma team activation may only be billed with revenue codes 0681, 0682, 0683, or 0684.

**15. Will National Drug Codes (NDC) be required?**

Yes. Under a federal mandate, Mississippi and other states require hospitals to list National Drug Codes (NDCs) on hospital outpatient claim lines for pharmacy services. The requirement will result in increased rebates from pharmaceutical manufacturers to state Medicaid programs. Outpatient claim lines will require NDCs for pharmacy services. NDCs must be present for all drug codes and must be rebateable to receive payment. NDCs are placed in Form Locator (FL) 43 on paper submitted claims.

**Requirement on UB 04 form:**

FL 42: Revenue Code

FL 43: NDC 11 digit number, Unit of Measurement Qualifier, and Unit Quantity

FL 44: HCPCS Code

42. Rev. CD	43. Description	44.HCPCS/Rate	45. Serv. Date	46. Serv. Units
636	[60126598741][UN][1111.234]	HCPC code	07/01/2008	HCPCS unit

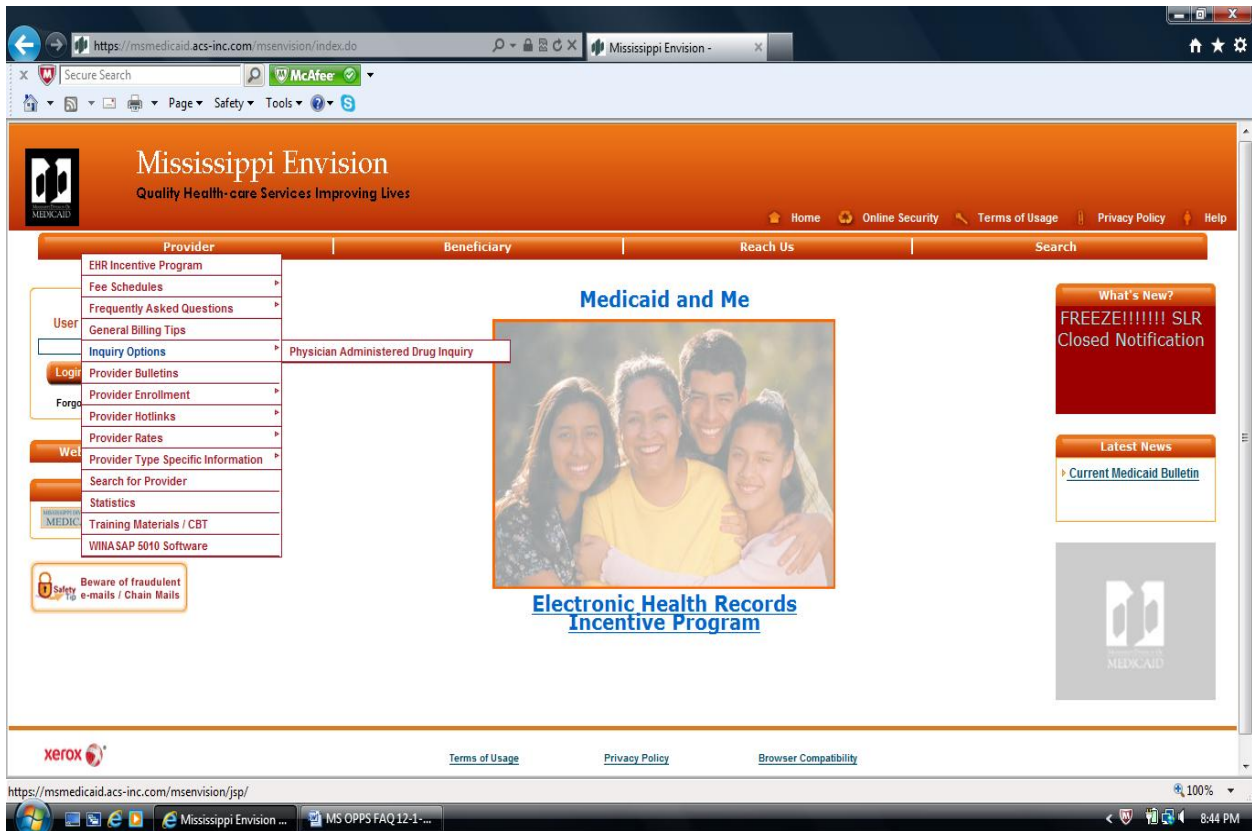
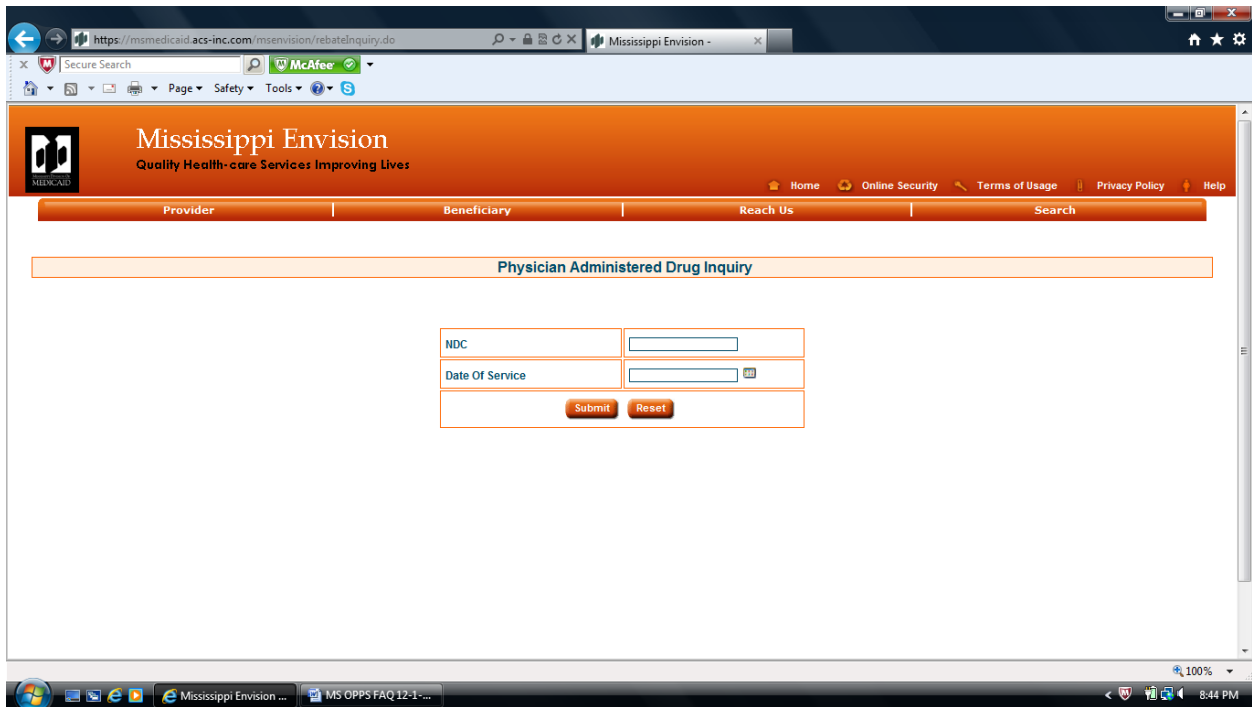
↑            ↑            ↑  
 11 digit NDC    Unit of    Unit Quantity  
                           Measurement  
                           Qualifier \*

* Unit of Measurement Qualifier
F2-International Unit
GR-gram
ML-Milliliter
UN-Unit



To determine if a drug is eligible for a rebate, follow the link below.

<https://msmedicaid.acs-inc.com/msenvision/>



## **Consultation and Education**

### **16. What assistance will be available to help hospitals plan for the new payment method?**

DOM and its fiscal agent, Xerox State Healthcare, will provide updates to these questions and answers on the DOM and Xerox websites, along with the training presentation and fee schedule(s). Additional provider training sessions will also be scheduled.

### **17. Do hospitals have to buy software to submit claims under the new payment method?**

No.

### **18. Will commercial APC software be applicable to the Medicaid payment method?**

Commercially available APC software is intended for use in submitting and analyzing Medicare claims. Because of the differences between Medicare and Medicaid, the software will not be completely accurate in emulating the Medicaid payment method.

### **19. Who can I contact for more information?**

- For general questions, the Medicaid field representative assigned to your hospital. If you don't know the field representative's name, contact Tiffany Hollis-Johnson, Provider Field Services Supervisor and Publications Coordinator, Xerox State Healthcare Solutions, LLC (tiffany.hollis@xerox.com, 601-206-2986).
- For technical questions about the payment method: Debra Stipcich, Project Director, Payment Method Development, Xerox State Healthcare Solutions, LLC (debra.stipcich@xerox.com, 406-457-9587).
- For questions about outpatient Medicaid policy: Zeddie R. Parker, Accountant/Auditor IV, Professional, Division of Medicaid (zeddie.parker@medicaid.ms.gov, 601-359-6021).