

DIVISION OF MEDICAID
APC (OUTPATIENT) Quick Tips
Effective September 1, 2012

KEY CONTACTS:

- Medicaid website: www.medicaid.ms.gov.
- For Provider Relations assistance call 1-800-884-3222
- To check the rebate status for Physician Administered Drugs visit <https://msmedicaid.acs-inc.com/msenvision/index.do>.

KEY POINTS to CONSIDER:

1. Use single claim for single visit – All services provided by the same hospital to the same patient on the same day must be billed on the same claim (except therapy services).
2. Charge Cap in place – claims will be paid the lower of the calculated allowed amount and the billed charges, with the comparison done at the claim level, not the line level.
3. Outpatient claims are subject to NCCI edits (includes Unit Edits).
4. Unit Edits – For all procedure codes where a fee is paid, the payment will equal the fee times the number of units. Units billed must be consistent with the CPT and HCPCS code book definitions. If a claim line fails the Medicaid maximum units edit, the line will be denied. The provider may re-submit the claim with correct units or, if appropriate, document the medical necessity of the units billed.
5. APC Status Indicators (SI) show how a claim is priced, whether it is covered, non-covered, covered but discounted, or bundled. They also show where a fee comes from, such as APC, Medicare, or Medicaid. A list of APC SI is available via the Medicaid website.
6. Service Limit Changes:
 - Outpatient blood unit limits no longer apply.
 - Outpatient hospital emergency department visit limits no longer apply.
7. Injectable administered drugs, known as “Drugs Requiring Specific Information”, must be billed with revenue code 636, require NDC, and are only reimbursed if the drug is subject to rebates.
8. Observation Care:
 - Must be included on a single line – even the hours that take place after midnight.
 - Observation Care will be paid a per hour rate for minimum of 8 and maximum of 23 hours.
 - Only the hours between 8 and 23 will pay. The first 7 hours are bundled and hours over 23 will be denied.
 - G0379 will be set at status indicator N, for bundled, and pay at \$0.00.
 - Physician observation codes will not be paid if billed on the hospital claim.
9. Revenue Codes:
 - Revenue codes not requiring CPT/HCPCS codes are listed on the Medicaid website.
 - Claims will price at \$0.00 if a procedure code is absent.

KEY POINTS NOT CHANGING:

- 5% assessment
- Prior authorization policies, medical necessity reviews, unit limits and other service limits (i.e. age and sex)
- Outpatient Physician services, Therapy services, Lab services,
- Services provided in Community Mental Health Centers and Free-Standing Psychiatric Hospitals
- Hospital-based Dialysis services are to be billed using the dialysis provider number NOT the hospital provider number