

Mississippi Medicaid Outpatient Prospective Payment System (OPPS) Payment Method

Billing Quick Tips Effective July 1, 2015

- Division of 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 hospital to the same beneficiary on the same day must be billed on the same claim (with some exceptions).
 - Therapies (speech, physical and occupational): Limit of thirty-one (31) days
 - Chemotherapy (claims billed with rev codes 0330-0339): Limit of thirty-one (31) days
 - Observation (claims billed with procedure code G0378): Limit of three (3) days
 - Emergency Department (claims billed with procedure codes 99281-99285): Limit of two (2) days, must include 'ET' modifier on line items of second day.
 - Claims for multiple distinct visits for the same beneficiary, same date of service, and same provider must denote condition code G0 (zero).
2. Charge Cap in place – Claims will be paid the lower of the calculated allowed amount or the billed charges, with the comparison done at the claim level, not the line level.
3. Outpatient claims are subject to Medicaid National Correct Coding Initiative (NCCI) edits (includes Procedure-to-Procedure (PTP) and Medically Unlikely Edits (MUEs)).
4. Unit Edits – For all procedure codes for which a fee is paid, the payment will equal the fee multiplied by the number of units. Units billed must be consistent with the CPT and HCPCS code book definitions. If a claim line exceeds the DOM maximum units, the line will be denied.
5. OPPS Status Indicators (SI) show how a claim is priced, whether it is covered, non-covered, covered but discounted, or bundled. SI also indicates where a fee comes from, such as APC, Medicare, or Medicaid. A list of OPPS SI is available via the DOM website.
6. Physician Administered Drugs (PAD), known as "Drugs Requiring Specific Information," must be billed with revenue code 0636, requires an NDC, and are only reimbursed if the drug is rebateable.
7. Observation Services:
 - Must be included on a single line – even the hours that take place after midnight.
 - Observation services will be paid a per hour rate for minimum of eight (8) hours and maximum of twenty-three (23) hours.
 - The first seven (7) hours are bundled and pays zero (\$0.00). Hours between eight (8) and twenty-three (23) will pay a fee.
 - Physician observation codes will not be paid if billed on the hospital claim.
8. Multiple Procedure Discounting - multiple procedure discounting applies when two (2) or more services with a status indicator "T" or "MT" are billed on the same date of service.

KEY POINTS NOT CHANGING:

- 5% assessment
- Prior authorization policies, medical necessity reviews, unit limits and other service limits (i.e. eligibility and gender)
- Outpatient physician services, therapy services, lab services
- Services provided in community mental health centers and freestanding psychiatric hospitals
- Hospital-based dialysis services are to be billed using the dialysis provider number, not the hospital provider number