Outpatient Prospective Payment System (OPPS) Phase 2

Mississippi Medicaid Webinar Provider Training

May 29, 2015 10:00 am
June 9, 2015 2:00 pm
June 11, 2015 10:00 am

Introductions

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Questions?

Please send questions using the Chat function to the user logged in as Elizabeth Gillette (Host) or you can email your questions to Elizabeth.Gillette@xerox.com.

Answers will be provided as soon as possible or at the end of this presentation.

Agenda

1. Background
2. What is OPPS
3. Implementation
4. Pricing Calculation
5. Phase 2 Policy
6. Keys to OPPS Pricing
7. Claim Examples
8. Additional Resources

Background

Development of an Outpatient Prospective Payment System (OPPS) in Mississippi

- September 2005: Evaluation report assessing options
- June 2008: Detailed design of an Ambulatory Payment Classification (APC) based payment method
- May 2012: Legislature directed DOM to implement

Two Phases Toward Implementation

- Phase 1 implementation was September 1, 2012
- Phase 1A implementation was January 1, 2013
- Phase 2 implementation schedule for July 1, 2015
- Fee schedule and revenue code lists are updated and published July 1 annually
- Provider education
  - Provider webinars
  - FAQ
  - Quick Tips

What is OPPS

Outpatient Prospective Payment System

Modeled after Medicare's payment system

- Ambulatory Payment Classifications (APCs) are groups made up of CPT/HCPCS codes that share common types of service or common types of delivery of service.
- Weights are assigned to the APC based on the degree of difficulty of the service and cost of the service.
  - Low-range weight = 0.1787 (APC 2636: Sodium Iodide)
  - Mid-range weight = 24 (APC 0233: Level II Intraocular Procedure)
  - High-range weight = 415.49 (APC 0108: Level II ICD or Pacemaker)
- Many APC weights also include a calculation for nursing services, supplies, and drugs that are commonly performed or used at the same time as the principal service. This is why many supplies, drugs and administration of injection codes have a "N" or bundled status indicator.

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Pricing Calculation

Key Points to Consider

1. Outpatient claims are subject to Medicaid National Correct Coding Initiative (NCCI) edits (includes Procedure-to-Procedure (PTP) and Medically Unlikely Edits (MUEs)).

2. 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.

3. Outpatient Status Indicators (SI) show how a claim is priced, whether it is covered, non-covered, covered but discounted, or bundled. SI also indicate where a fee comes from, such as APC, Medicare, or Medicaid. A list of MS Medicaid's SI is available via the DOM website.

Phase 2 Policy

Overview of Policy

Status indicators

- Mississippi Medicaid definition

Multiple procedure discounting

- “T” and “MT” status indicators

Date bundling

- ET modifier
  - Must use modifier ET on all lines for day two
- Observation
  - All hours for observation must be combined on one line
- Therapies (PT, ST, and OT)
- Chemotherapy

Multiple medical visits

- Condition code G0 (zero)

Revenue Code 0636

- Billing requirements

Trauma Response

- Revenue code limits

Phase 2 Policy

APC Status Indicators (SI)

Mississippi-specific

Status Indicator	MS Medicaid Definition
A, B, M	Miscellaneous codes priced by a MS Medicaid fee
C	Inpatient only services
D	Discontinued code
E	Non-covered code
G, K	Drugs & biologicals priced by a Medicare fee
M1	MS Medicaid Specific Fee
N	Service is bundled into an APC (If all codes are N on a claim, the claim pays zero)
R	Blood products priced by a Medicare fee
S	Significant procedure priced by APC that the multiple procedure discount DOES NOT apply
T	Significant procedure priced by APC that the multiple procedure discount DOES apply
MT	Codes MS Medicaid discounts differently than Medicare
U	Brachytherapy
V	Medical visits in the clinic, critical care or emergency department (includes codes for direct admits)
X	Ancillary services priced by APC

Phase 2 Policy

Multiple Procedure Discounting

Discounting will apply to codes with a “T” or “MT” status indicator

- Claims with more than one (1) significant procedure with a MS Medicaid OPPS status indicator “T” or “MT” are discounted.
  - Line with the status indicator of “T” or “MT” with the highest calculated allowed amount is considered the highest line in the discounting calculation (with the possible exception of bilateral codes).
  - This may not be the first line or the highest priced line on the claim

For further information on bilateral and other NCCI edits, please visit :

https://www.medicaid.ms.gov/providers/national-correct-coding-initiative

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Phase 2 Policy

Date Bundling

All services provided by the same hospital to the same beneficiary on the same day should be billed on the same claim.

Only the following may be span billed:

- Therapies (speech, physical and occupational): Threshold 31 days
- Observation (claims with G0378): Threshold 3 days
- Chemotherapy (claims with rev codes 0330-0339): Threshold 31 days
- ER (claims with 99281-99285): Threshold 2 days (when billed with modifier ET on all lines on second day)

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Phase 2 Policy

Multiple Medical Visits

- Claims for separate and distinct medical visits for the same beneficiary on the same date and by the same provider must have condition code G0 (zero).
- Without this code subsequent claims will deny.
- Denied lines will receive the edit “0110 – Date bundling not allowed” for subsequent claims that do not have condition code G0.

Phase 2 Policy

Revenue Code Changes

Revenue Code 0636

- HCPCS codes requiring further detail must be reported under this revenue code
- National drug codes (NDCs) must be present for rebateable drug codes
  - Please remember: non-rebateable drug codes cannot be reimbursed

Trauma Response

- Trauma team activation (G0390) may only be billed with revenue codes 0681, 0682, 0683, or 0684 for qualifying trauma centers/hospitals
- All additional billing policies are applicable

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Keys to OPPS Pricing

OPPS Claims Should Paint a Picture

Every service performed should be coded

- Where did the patient come into the facility?
  - ER, clinic, direct admit?
- What happened to the patient?
  - Surgery?
  - Clinic visit?
  - Treatment room?
- What resources were used by the facility?
  - Supplies?
  - Pharmaceuticals?
  - Blood products?

The claim should tell the story of what happened to the patient

Keys to OPPS Pricing

Important Points

Appropriate and accurate coding is the key to proper pricing

Look at MS OPPS Fee Schedule for code coverage

- Physician codes may not be allowed in an outpatient setting
- It may be that a non-covered code has a different code that is appropriate for outpatient – refer to CPT/HCPCS books
- Always use a code when possible, even when the revenue code does not require a procedure code
- No code means no payment
  - *Note: some codes bundle

Providers must adhere to all billing policies as applicable

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Keys to OPPS Pricing

Example – Discounting

"T" status discounting applies

Table 1.
Example of Claim Payment with Discounting Applied

Line	Service Date	Rev Code	Rev Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee Schedule Amount	Allowed Amount
2	7/1/2015	0250	Pharmacy	J3010		1	$183.99	N	$0.00	$0.00
3	7/1/2015	0272	Sterile Supply			1	$798.80	N	$0.00	$0.00
5	7/1/2015	0360	Operating Room	36831		1	$2,837.50	T	$2,784.76	100% $2,784.76
7	7/1/2015	0730	EKG/ECG General	93005		1	$232.00	S	$67.84	$67.84
8	7/1/2015	0761	Treatment Room	36147		1	$2,500.00	T	$715.47	50% $357.74
TOTAL							**$6,552.29**			**$3,210.34**

Note: This example is not an actual or complete claim, but simply a hypothetical claim scenario to reflect the payment concept.

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Example – Multiple Procedure Pricing Policy

Bilateral pricing policy applies

Bilateral pricing policy for subsequent line applies

"T" status discounting applies

Table 2.

Example of Claim Payment with Discounting and Bilateral Pricing Policy Applied

Line	Service Date	Rev Code	Rev Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee Schedule Amount	Allowed Amount
2	7/1/2015	0250	Pharmacy	J3010		1	$183.99	N	$0.00	$0.00
3	7/1/2015	0272	Sterile Supply			1	$798.80	N	$0.00	$0.00
5	7/1/2015	0360	Operating Room	36820	50	1	$2,837.50	T	$2,784.76	100% $2784.76
6	7/1/2015	0730	EKG/ECG General	93005		1	$232.00	S	$67.84	$67.84
7	7/1/2015	0761	Treatment Room	35476	50	1	$4,600.00	MT	$3,924.61	150% $5,886.92
8	7/1/2015	0761	Treatment Room	36147		1	$2,500.00	T	$715.47	50% $357.74
TOTAL							**$11,152.29**			**$9,097.26**

Note: This example is not an actual or complete claim, but simply a hypothetical claim scenario to reflect the payment concept.

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Example – Emergency Department

Table 3.
Example of Emergency Department Claim Pricing

Line	Service Date	Rev Code	Rev Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee Schedule Amount	Allowed Amount
1	8/1/2015	0271	Non Sterile Supply			1	$23.75		$0.00	$0.00
2	8/1/2015	0450	Emergency Room	99284		1	$1,599.85	V	$288.60	$288.60
3	8/2/2015	0307	Laboratory - Urology	81001	ET	1	$160.00	M1	$3.88	$3.88
4	8/2/2015	0301	Laboratory - Chemistry	84703	ET	1	$175.00	M1	$9.21	$9.21
Total							**$1,958.60**			**$301.69**

Note: This example is not an actual or complete claim, but simply a hypothetical claim scenario to reflect the payment concept.

Example – Therapy

Table 4.
Example of Therapy Claim Pricing

Line	Service Date	Rev Code	Rev Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee Schedule Amount	Allowed Amount
1	7/1/2015	0420	Physical Therapy	97110	GP	1	$460.00	A	$27.11	$27.11
2	7/7/2015	0420	Physical Therapy	97110	GP	1	$460.00	A	$27.11	$27.11
3	7/14/2015	0420	Physical Therapy	97110	GP	1	$460.00	A	$27.11	$27.11
4	7/21/2015	0420	Physical Therapy	97110	GP	1	$460.00	A	$27.11	$27.11
5	7/27/2015	0420	Physical Therapy	97110	GP	1	$460.00	A	$27.11	$27.11
6	7/31/2015	0420	Physical Therapy	97110	GP	1	$460.00	A	$27.11	$27.11
Total							**$2,760.00**			**$162.66**

Note: This example is not an actual or complete claim, but simply a hypothetical claim scenario to reflect the payment concept.

Keys to OPPS Pricing
Example – Observation

Use date admitted to observation
All hours billed on 1 line
Bundled for 7 hours, paid for hours 8-23

Table 5.
Example of Observation Claim Payment

Line	Service Date	Rev Code	Rev Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee Schedule Amount	Allowed Amount
1	8/11/2015	0300	Laboratory	85730		1	$65.00	M1	$7.35	$7.35
3	8/12/2015	0300	Laboratory	80048		1	$86.00	M1	$10.36	$10.36
4	8/12/2015	0300	Laboratory	36415		1	$8.35	N	$0.00	$0.00
6	8/13/2015	0352	CT-Body Scan	74177		1	$2,656.00	S	$425.98	$425.98
8	8/11/2015	0450	Emergency Room	99285	25	1	$975.00	V	$324.72	$324.72
9	8/13/2015	0730	EKG/ECG	93005		1	$114.00	S	$67.84	$67.89
11	8/11/2015	0762	Observation Room	G0378		41	$1,200.00	M1	$46.41	$742.56
Total							**$5,104.35**			**$1,578.86**

Note: This example is not an actual or complete claim, but simply a hypothetical claim scenario to reflect the payment concept.

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Keys to OPPS Pricing
Example – Observation

Under 8 hours, payment is bundled
Line pays $0
Subsequent lines deny, no payment

Table 6.
Example of Observation Claim Payment with Denied Lines

Line	Payment Status	Service Date	Rev Code	Rev Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee Schedule Amount	Allowed Amount
1	P	8/11/2015	0300	Laboratory - General	85730		1	$65.00	M1	$7.35	$7.35
3	P	8/12/2015	0300	Laboratory - General	80048		1	$86.00	M1	$10.36	$10.36
4	P	8/12/2015	0300	Laboratory - General	36415		1	$8.35	N	$0.00	$0.00
6	P	8/13/2015	0352	CT-Body Scan	74177		1	$2,656.00	S	$425.98	$425.98
8	P	8/11/2015	0450	Emergency Room	99285	25	1	$975.00	V	$324.72	$324.72
9	P	8/13/2015	0730	EKG/ECG General	93005		1	$114.00	S	$67.84	$67.89
11	P	8/11/2015	0762	Observation Room	G0378		7	$250.00	M1	$46.41	$0.00
12	D	8/12/2015	0762	Observation Room	G0378		24	$1,200.00	M1	$46.41	$ --
13	D	8/13/2015	0762	Observation Room	G0378		10	$750.00	M1	$46.41	$ --
Total								**$6,104.35**			**$836.30**

Note: This example is not an actual or complete claim, but simply a hypothetical claim scenario to reflect the payment concept.

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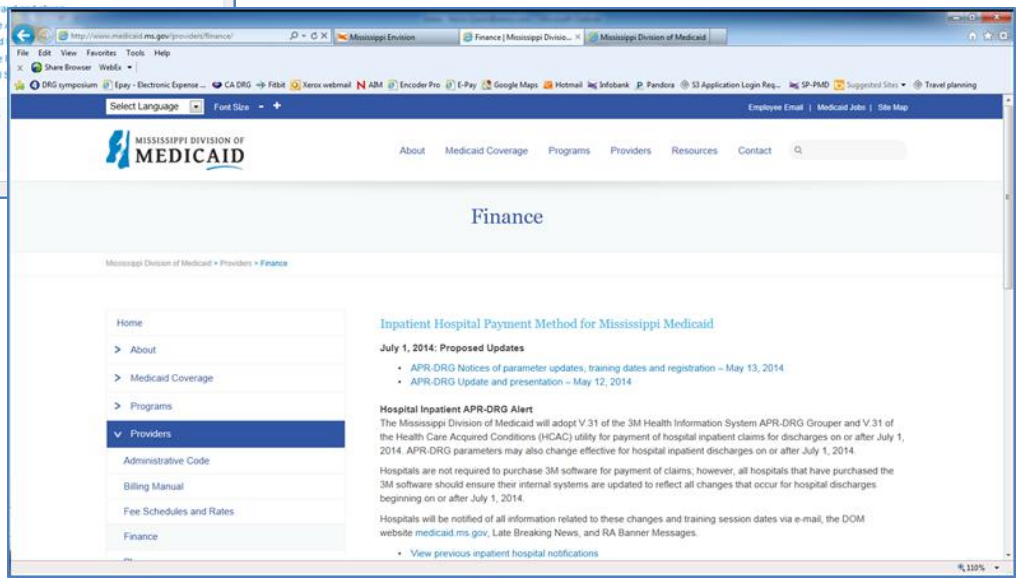
Additional Resources

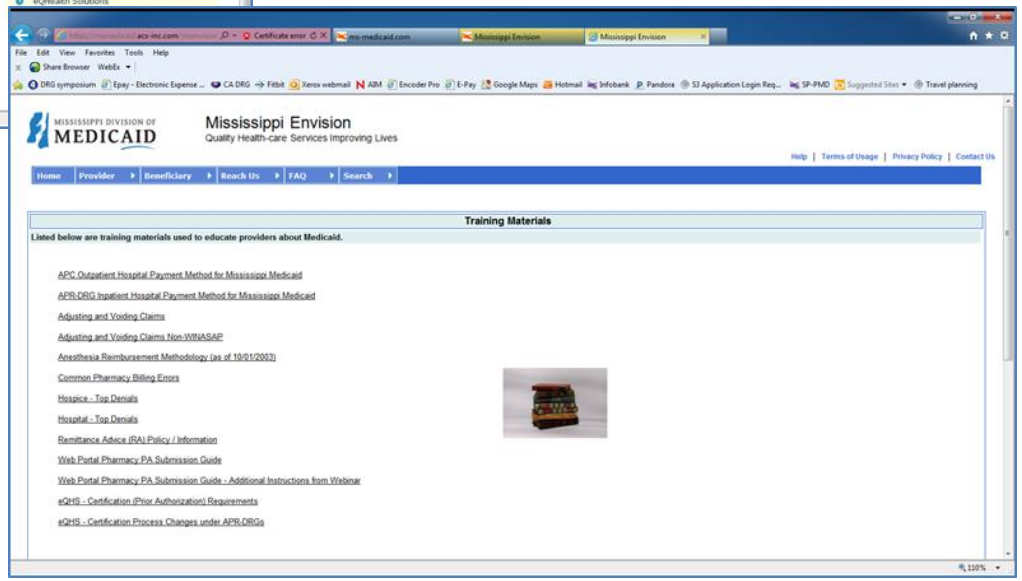
DOM website: www.medicaid.ms.gov



Additional Resources

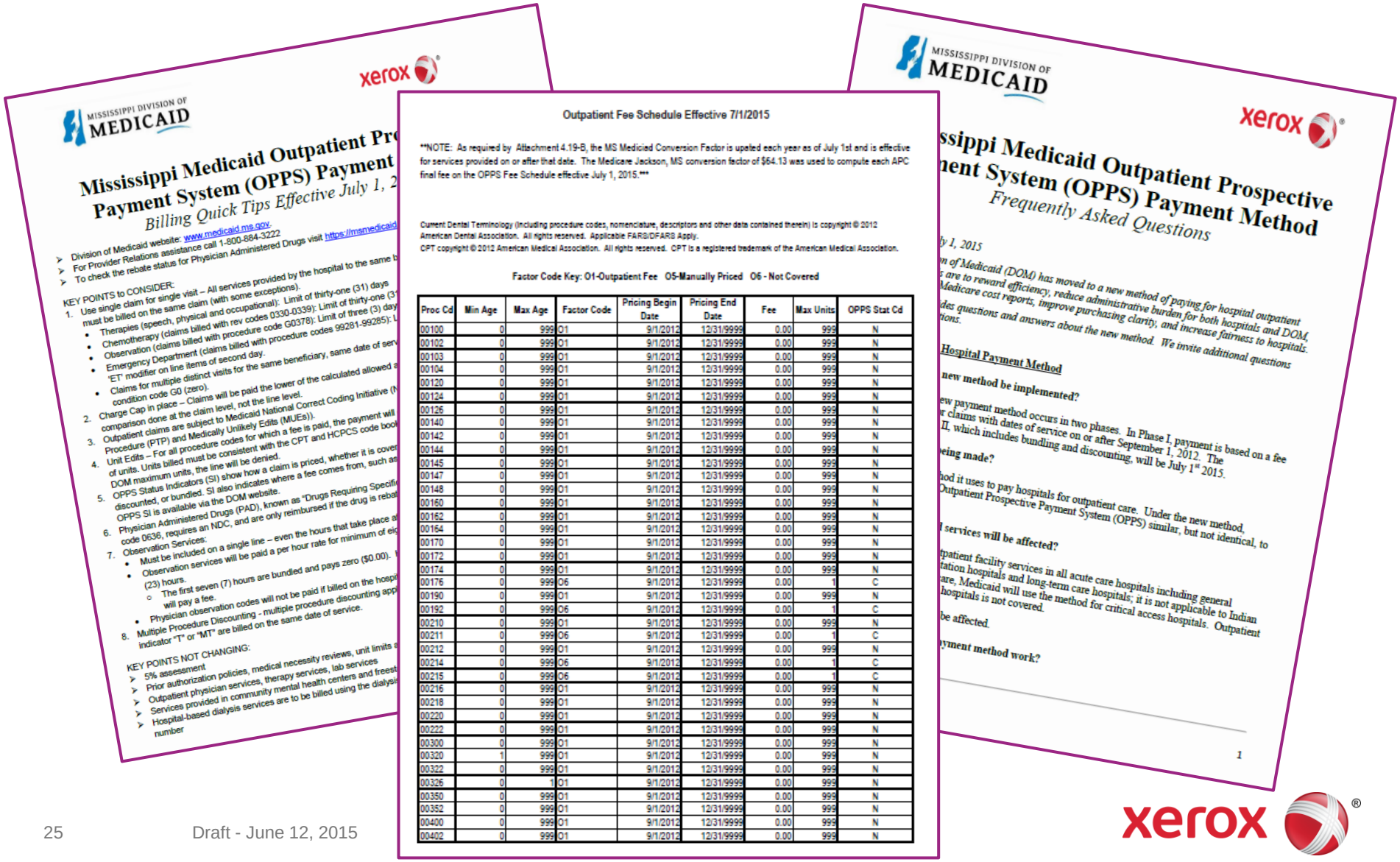
https://ms-medicaid.com/msenvision/index.do

Xerox Provider and Beneficiary Services: 800.884.3222



Additional Resources

Key Information Resources



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Mississippi Medicaid Outpatient Pro
Payment System (OPPS) Payment
Billing Quick Tips Effective July 1, 2

- 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

KEY POINTS to CONSIDER:

1. Use single claim for single visit – All services provided by the hospital to the same b 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
   - Observation (claims billed with procedure code G0378): Limit of three (3) day
   - Emergency Department (claims billed with procedure codes 99281-99285): L
   - 'ET' modifier on line items of second day.
   - Claims for multiple distinct visits for the same beneficiary, same date of serv
   - Claims for multiple distinct visits for the same beneficiary, same date of serv condition code G0 (zero).
2. Charge Cap in place – Claims will be paid the lower of the calculated allowed a comparison done at the claim level, not the line level.
3. Outpatient claims are subject to Medicaid National Correct Coding Initiative (N
4. Procedure (PTP) and Medically Unlikely Edits (MUEs)).
   Unit Edits – For all procedure codes for which a fee is paid, the payment will of units. Units billed must be consistent with the CPT and HCPCS code book
5. DOM maximum units, the line will be denied.
   OPPS Status Indicators (SI) show how a claim is priced, whether it is cover discounted, or bundled. SI also indicates where a fee comes from, such as
6. OPPS SI is available via the DOM website.
   Physician Administered Drugs (PAD), known as "Drugs Requiring Specific code 0636, requires an NDC, and are only reimbursed if the drug is rebat
7. Observation Services:
   - Must be included on a single line – even the hours that take place a
   - Observation services will be paid a per hour rate for minimum of eig (23) hours.
     - The first seven (7) hours are bundled and pays zero ($0.00).
     - will pay a fee.
   - Physician observation codes will not be paid if billed on the hospi
8. Multiple Procedure Discounting - multiple procedure discounting app 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
- Outpatient physician services, therapy services, lab services
- Services provided in community mental health centers and freest
- Hospital-based dialysis services are to be billed using the dialysi number

Outpatient Fee Schedule Effective 7/1/2015

NOTE: As required by Attachment 4.19-B, the MS Medicaid Conversion Factor is upated each year as of July 1st and is effective for services provided on or after that date. The Medicare Jackson, MS conversion factor of $64.13 was used to compute each APC final fee on the OPPS Fee Schedule effective July 1, 2015.*

Factor Code Key: O1-Outpatient Fee O5-Manually Priced O6 - Not Covered

Proc Cd	Min Age	Max Age	Factor Code	Pricing Begin Date	Pricing End Date	Fee	Max Units	OPPS Stat Cd
00100	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00102	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00103	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00104	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00120	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00124	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00126	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00140	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00142	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00144	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00145	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00147	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00148	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00160	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00162	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00164	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00170	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00172	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00174	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00176	0	999	O6	9/1/2012	12/31/9999	0.00	1	C
00190	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00192	0	999	O6	9/1/2012	12/31/9999	0.00	1	C
00210	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00211	0	999	O6	9/1/2012	12/31/9999	0.00	1	C
00212	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00214	0	999	O6	9/1/2012	12/31/9999	0.00	1	C
00215	0	999	O6	9/1/2012	12/31/9999	0.00	1	C
00216	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00218	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00220	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00222	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00300	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00320	1	999	O1	9/1/2012	12/31/9999	0.00	999	N
00322	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00326	0	1	O1	9/1/2012	12/31/9999	0.00	999	N
00350	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00352	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00400	0	999	O1	9/1/2012	12/31/9999	0.00	999	N
00402	0	999	O1	9/1/2012	12/31/9999	0.00	999	N

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ssippi Medicaid Outpatient Prospective
ent System (OPPS) Payment Method
Frequently Asked Questions

ly 1, 2015

n of Medicaid (DOM) has moved to a new method of paying for hospital outpatient s are to reward efficiency, reduce administrative burden for both hospitals and DOM, Medicare cost reports, improve purchasing clarity, and increase fairness to hospitals. des questions and answers about the new method. We invite additional questions tions.

Hospital Payment Method

new method be implemented?

ew payment method occurs in two phases. In Phase I, payment is based on a fee r claims with dates of service on or after September 1, 2012. The II, which includes bundling and discounting, will be July 1st 2015.

eing made?

hod it uses to pay hospitals for outpatient care. Under the new method, Outpatient Prospective Payment System (OPPS) similar, but not identical, to

l services will be affected?

tpatient facility services in all acute care hospitals including general tation hospitals and long-term care hospitals; it is not applicable to Indian are, Medicaid will use the method for critical access hospitals. Outpatient hospitals is not covered.

be affected.

yment method work?

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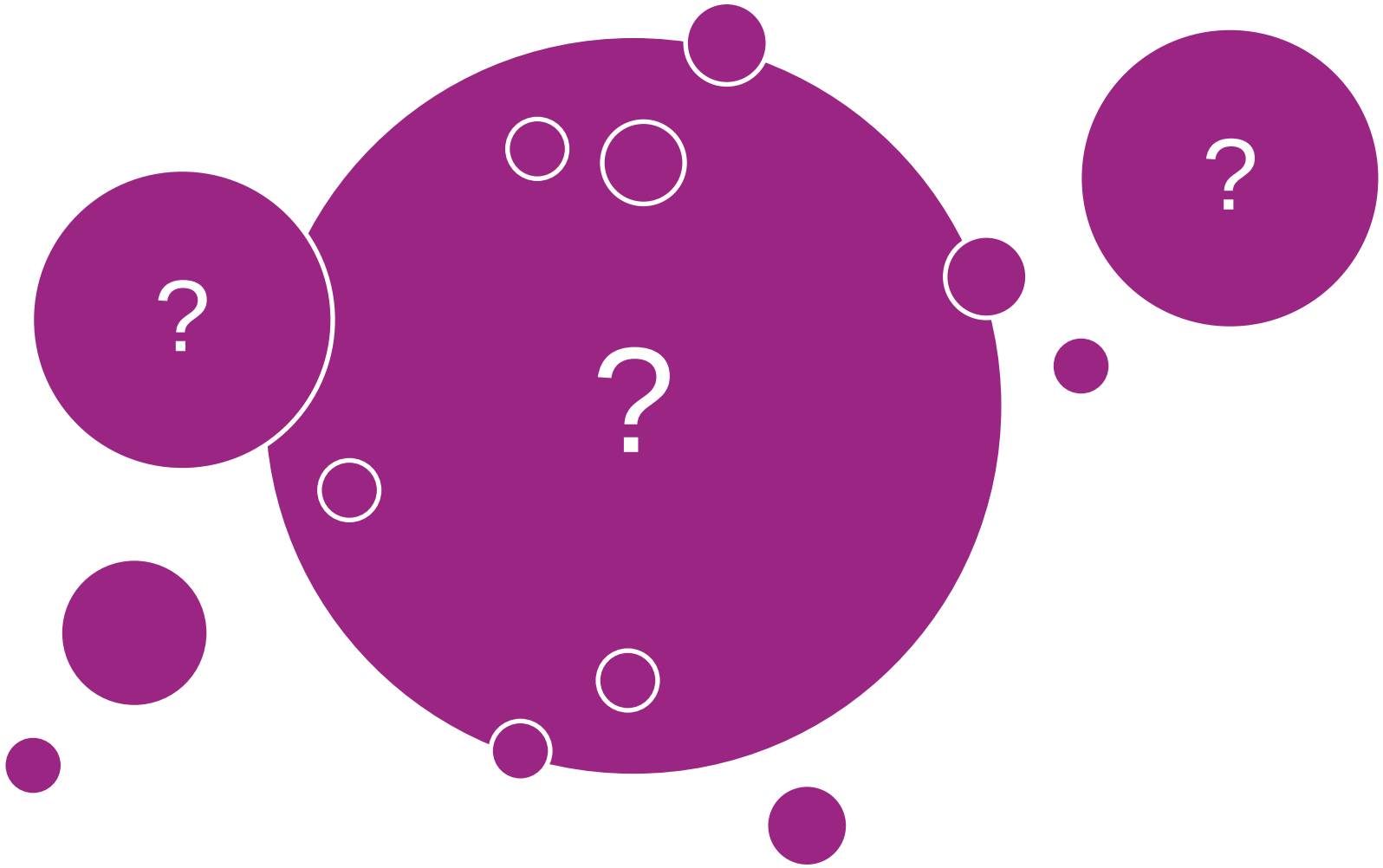
Additional Resources

For a list of revenue codes, please see the Uniform Billing Editor.

Questions



For Further Information

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