Outpatient Prospective Payment System

Mississippi Medicaid Webinar Provider Training

June 11, 2019

June 13, 2019

Payment Method Development
Government Healthcare Solutions
MSO19022

Topics

1. Overview and background
2. Current policies
3. SFY 20 updates
4. Claim examples
5. Additional resources

Overview and background

OPPS history 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 Division of Medicaid (DOM) to implement
- Phase 1 implementation: September 1, 2012
- Phase 1A implementation: January 1, 2013
- Phase 2 implementation: July 1, 2015
- Fee schedule, revenue code list, and physician-administered drugs (revenue code 0636) list are updated and published July 1 annually

OPPS phases

Phase 1:

- 9/1/2012
- Implemented APC-based payment method
- NCCI edits
- Unit edits
- Date bundling

Phase 1A:

- 1/1/2013
- Brought payment for codes price using APC weights or Medicare payment rates on Addendum B up to 100% of Medicare rates

Phase 2:

- 7/1/2015
- Span billing rules
- Multiple procedure discounting
- Multiple medical visits
- Dental policy
- Revenue code changes
  - Trauma response
  - Revenue code 0636

Outpatient payment for Mississippi Medicaid

- Implemented September 1, 2012, with two major updates to policy in addition to annual fee schedule updates
- Mississippi Medicaid's Outpatient Prospective Payment System (OPPS) covered approximately 1.2 million outpatient claims in SFY 18 across fee-for-service (FFS) and two coordinated care organizations (CCOs) (Magnolia Health and United Healthcare)*
- Total allowed amount across FFS, Magnolia, and United was about $446 million in SFY 18
- Outpatient services are paid using a fee schedule that provides fees and other values associated with Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes

Scope of the MS OPPS Payment Method	
Item	**MS OPPS**
Included hospitals	Acute care hospitals
	Critical access hospitals (CAHs)
	Out-of-state hospitals
	Freestanding rehabilitation hospitals
Excluded hospitals	Indian Health Services
	Freestanding psych hospitals or community mental health centers
	Ambulatory surgical centers
	Hospital-based dialysis services
	Independent lab and x-ray providers
Claim type	ASC X12N 837I and UB-04
Included type of bill	013X Hospital outpatient
	014X Hospital laboratory services provided to non-patients
	085X Critical access hospital
Excluded type of bill	083X Ambulatory surgery center
	084X Freestanding birthing center

*Molina Healthcare began participating in MS Coordinated Access Network (MSCAN) on 10/1/18

OPPS payment method design

Modeled after Medicare's payment system:

- 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 (Mississippi Medicaid uses Medicare's weights)
- These weights are multiplied by a conversion factor to calculate a per unit payment
- 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; many have a "N" status indicator and the payment is packaged with the primary service
- Allowed amounts are calculated on a per line basis as fee * units, although some adjustments may apply

Example: 99281 (Emergency dept. visit), APC 5021 (Level 1 Type A ED Visit)

*APC weight 0.8772 * conversion factor $64.714 = Mississippi Medicaid fee $56.77*

Mississippi Medicaid OPPS Conversion Factors		
Year	Conversion Factor	Change from Previous Year
SFY 13	$62.261	-
SFY 14	$62.935	1%
SFY 15	$64.008	2%
SFY 16	$64.130	0%
SFY 17	$63.790	-1%
SFY 18	$64.714	1%

Notes:

1. Conversion factors are from Medicare for the Jackson area.
2. Mississippi Medicaid maintained the conversion factor for SFYs 19 and 20 at the same level as SFY 18.

OPPS and Chemo Fee schedules

- OPPS payment is driven by the fee schedule
  - CPT/HCPCS code, minimum/maximum age, maximum units, fee, status indicator
- Fee schedule updated annually each July 1, largely based on Medicare Addendum B, which also provides relative weights for APCs attached to certain CPT/HCPCS codes
  - Starting with the July 1, 2019, update, the January version of Addendum B is used as the basis for the update; previously, the April version was used
- Mississippi Medicaid uses two fee schedules:
  - OPPS: All CPT/HCPCS codes billable under Mississippi Medicaid's OPPS
  - Chemo: Provides the Average Sale Price (ASP) for chemotherapy codes when billed on a claim where revenue code 0330-0339 is present on a paid line
  - Posted on the Division's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#

Key terms to understand

- Outpatient claims are subject to Medicaid National Correct Coding Initiative (NCCI) edits (includes Procedure-to-Procedure (PTP) and Medically Unlikely Edits (MUEs)
- Unit Edits – For all procedure codes for which a fee is paid, the payment will equal the fee multiplied by the number of units
  - Submitted units must not exceed maximum allowed units
- Outpatient Status Indicators (SI) show how a claim is priced, whether it is covered, non-covered, discounted, or packaged
  - SIs also indicate where a fee comes from, such as APC, Medicare Fee Schedule, or Medicaid
  - A list of Mississippi Medicaid's SIs is available in the fee schedule on DOM's website

Key points to consider

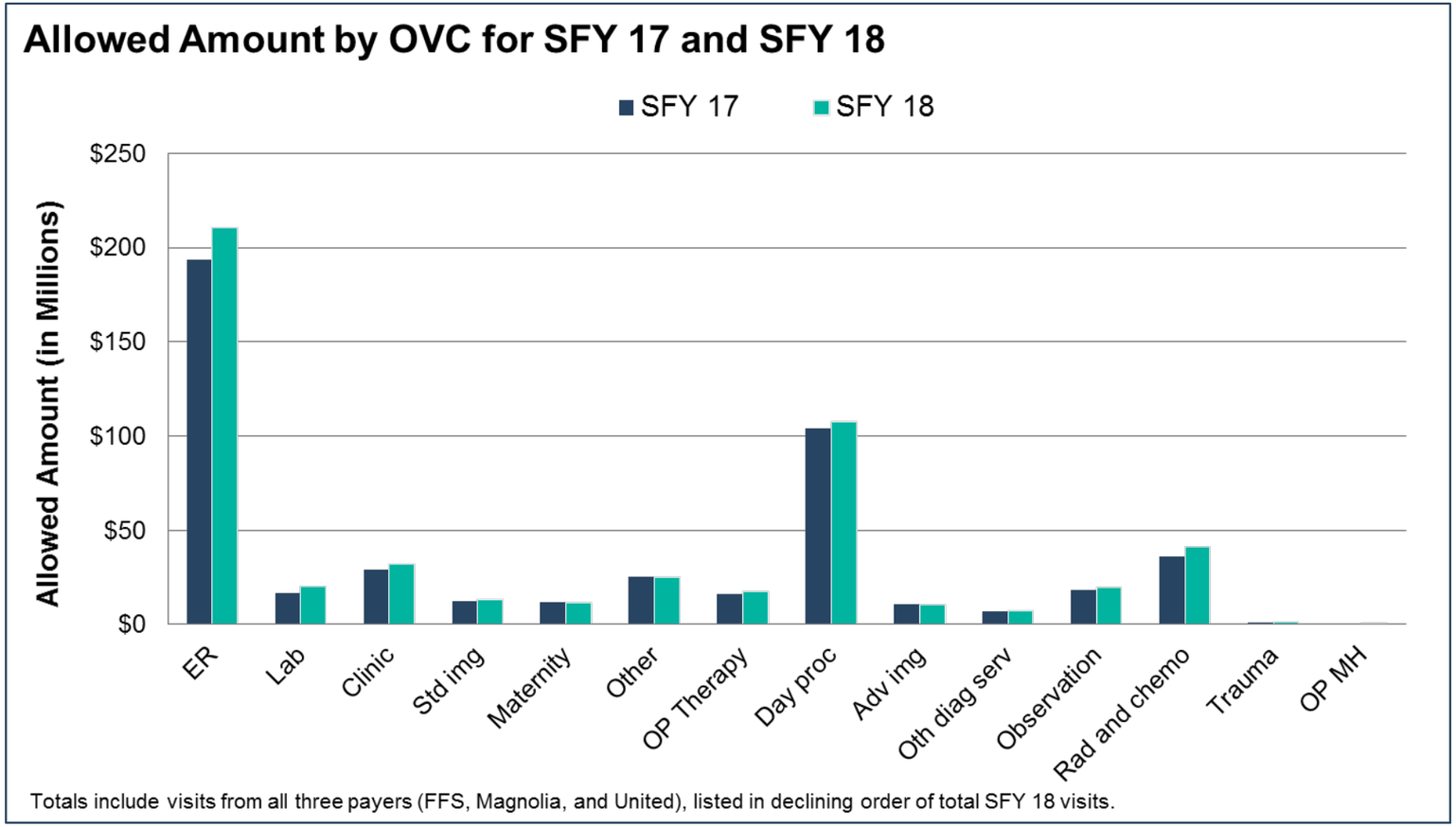
- Appropriate and accurate coding is the key to proper pricing
- Look at MS OPPS Fee Schedule for code coverage
  - A non-covered code may have a different code that is appropriate for outpatient hospital billing – refer to CPT/HCPCS books
  - Always use a procedure code when possible, even when the revenue code does not require one
  - No procedure code means no payment
  - Some procedure codes bundle and do not receive separate payment, but should still be included on the claim
- Providers must adhere to all billing policies as applicable

Outpatient Visit Categories

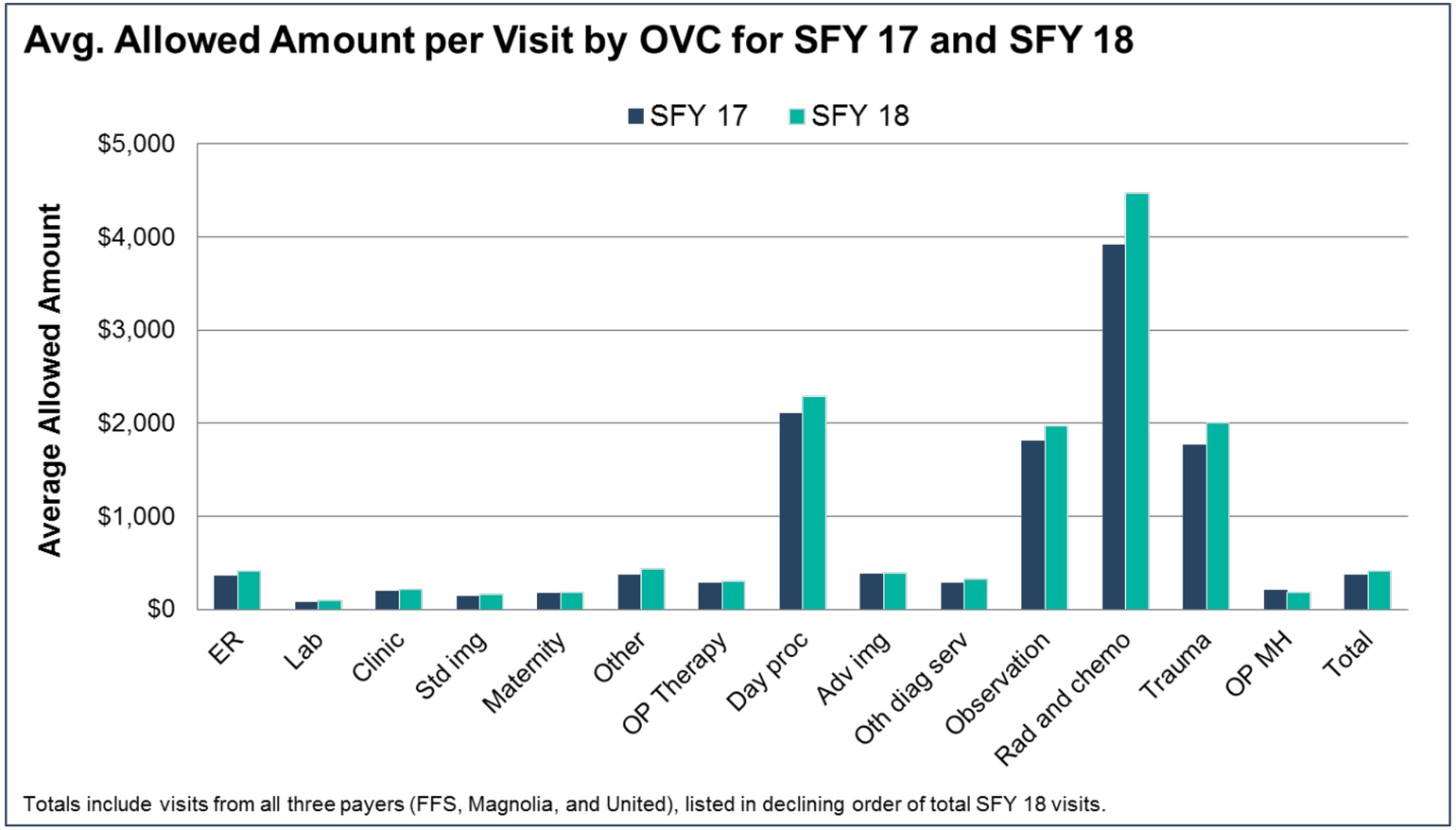
- Outpatient Visit Categories (OVCs) are a hierarchical categorization algorithm developed by Conduent that assigns each claim (visit) to one and only one visit reason depending on the first criteria met
- Allows for utilization analysis of types of outpatient hospital care that aids DOM in setting policies

Outpatient Visit Categories			
Rank	**Outpatient Visit Category**	**Criteria**	**Services**
1	Trauma care	Rev codes 0681-0689 (Should not see 0680)	Trauma response
2	ER	Rev codes 0450-0459 or proc code 99281-99285	Emergency room
3	Observation	Rev code 0762 or proc code G0378 & G0379	3 days, G0378 billable, G0379 is 0
4	Maternity care/delivery	Rev code 0722, proc code 59000-59899, or any of 2,371 diag codes	Pregnancy-related care
5	Clinic	Rev codes 0510-0519, 0770, 0771 or proc codes G0463, 99201-99215	General and specialty physician clinics
6	Outpatient mental health	Rev codes 0900-0919	Outpatient mental health services
7	Day procedures	Rev codes 0360-0369, 0481, 0490, 0499, 0750	Outpatient surgery, cardiac catheterization, gastrointestinal procedures
8	Outpatient therapy	Rev codes 0410-0449, 0470, 0479, 0943	Occupational therapy, physical therapy, speech therapy, respiratory therapy, cardiac rehabilitation
9	Radiation and Chemotherapy	Rev codes 0330-0339 or proc code J8500-J9999	Chemotherapy, radiation therapy
10	Advanced imaging	Rev codes 0340-0349, 0350-0359, 0404, 0610-0619	CT scans, PET scans, magnetic resonance imaging, nuclear medicine
11	Standard imaging	Rev codes 0320-0329, 0400-0409	X-rays, ultrasound, other imaging
12	Other diagnostic services	Rev codes 0460, 0469, 0730-0740, 0920-0925	EKG, EEG, pulmonary function tests, etc.
13	Lab	Rev codes 0300-0319	Lab, pathology
14	Other	All other visits	

Allowed amount by Outpatient Visit Categories

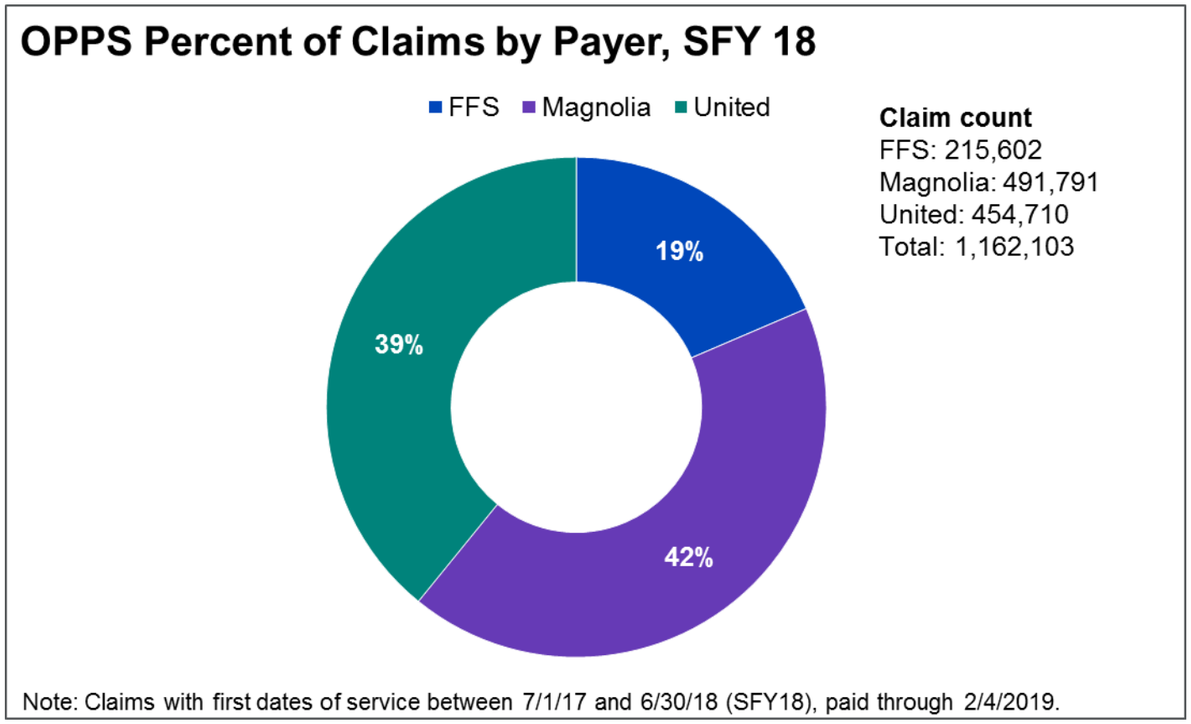


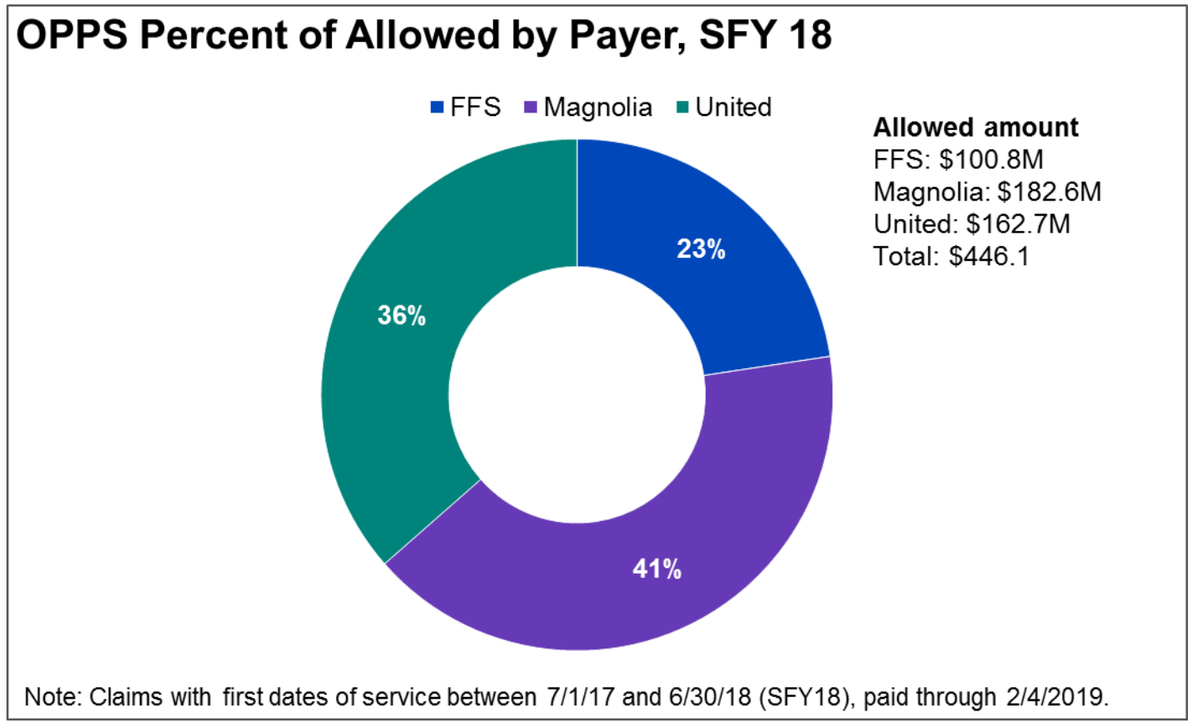
Average allowed by Outpatient Visit Categories



Payer types

- Mississippi Medicaid's OPPS applies to FFS claims, as well as those of three CCOs (Magnolia, United, and Molina)
- FFS comprises 19% of OPPS claims, but 23% of the total allowed amount, indicating that these patients are more complex on average than CCO patients
- Molina began participating in MSCAN on 10/1/18 and will be considered in future analyses





Current policies

Current policies

Status indicators

- Status indicators describe the source of fees associated with CPT/HCPCS codes (if any), as well as any potential pricing adjustments

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

Observation

- The first 7 units of Observation (G0378) are considered bundled and reimburse at $0
  - Units 8-23 are reimbursed using the applicable OPPS fee; all other units over 23 are bundled and reimburse at $0
- Up to 72 units are allowed but only units 8-23 are reimbursed using the applicable MS Medicaid fee; all other units are bundled and reimburse at $0
- Provider must bill only one line of G0378 per claim (subsequent lines will be denied)
- G0379 (Direct admission of patient for hospital observation care) has a MS Medicaid fee of $0 on the OPPS fee schedule
- Services on claims billed with G0378 may span over 3 days, but all units of G0378 must be billed on one line of service

MS OPPS Observation Pricing Policy (G0378)			
Submitted Units	Allowed Units	SFY 20 Fee	Allowed Amount
1-7	0	$84.48	$0.00
8	1	$84.48	$84.48
9	2	$84.48	$168.96
10	3	$84.48	$253.44
11	4	$84.48	$337.92
12	5	$84.48	$422.40
13	6	$84.48	$506.88
14	7	$84.48	$591.36
15	8	$84.48	$675.84
16	9	$84.48	$760.32
17	10	$84.48	$844.80
18	11	$84.48	$929.28
19	12	$84.48	$1,013.76
20	13	$84.48	$1,098.24
21	14	$84.48	$1,182.72
22	15	$84.48	$1,267.20
23 or more	16	$84.48	$1,351.68

Current policies

Bilateral/Multiple procedure pricing

- Pricing adjustments apply to CPT/HCPCS codes that are inherently bilateral, have status indicator T or MT, or are billed with Modifier 50, on the same date of service
- Pricing adjustments include paying 150% of the allowed (fee * units), 100%, 50%, or 0%, depending on criteria for those lines and other lines on the claim

MS OPPS Multiple Procedure Pricing Adjustments					
Line	Bilateral Code	Mod 50	SI "T" or Status Code "T or MT"	Pay %	Per Line
Pass 1 - to determine the line highest allowed amount on the claim					
Highest or only line	✓	✓		150%	Each line (will deny line if more than 1 unit)
Highest or only line	✓	✓	✓	150%	Each line (will deny line if more than 1 unit)
Highest or only line	✓			100%	Each line (will deny line if more than 1 unit)
Highest or only line	✓		✓	100%	Each line (will deny line if more than 1 unit)
Highest or only line			✓	100%	Each line
Highest or only line		✓	✓	Deny-0%	Not bilateral-No Mod 50
Highest or only line		✓		Deny-0%	Not bilateral-No Mod 50
Pass 2 - to determine line allowed amount after highest is determined					
Subsequent line(s)	✓	✓		100%	Each line (will deny line if more than 1 unit)
Subsequent line(s)	✓	✓	✓	100%	Each line (will deny line if more than 1 unit)
Subsequent line(s)	✓			50%	Each line (will deny line if more than 1 unit)
Subsequent line(s)	✓		✓	50%	Each line (will deny line if more than 1 unit)
Subsequent line(s)			✓	50%	Each line
Subsequent line(s)		✓		Deny-0%	Not bilateral-No Mod 50
Subsequent line(s)		✓	✓	Deny-0%	Not bilateral-No Mod 50
Subsequent line(s)				100%	Each line

Notes:

1. Procedure codes that are neither bilateral nor assigned to status indicators T or MT are always considered subsequent lines.
2. Status indicator T is from Medicare OPPS Addendum B; status code T or MT are in OPPS Fee Schedule.
3. MS State Plan Attachment 4.19-B (TN# 15-011).

Current policies

Span billing rules

- Outpatient hospital claims that span over multiple dates of service are denied unless they meet certain criteria and the date span is less than or equal to the threshold for that type of service

Span Billing Exception Thresholds		
Service	**Coding**	**Limitations**
Physical therapy	Revenue codes 0420-0429	31 days
Occupational therapy	Revenue codes 0430-0439	31 days
Speech-language pathology	Revenue codes 0440-0449	31 days
Chemotherapy services	Revenue codes 0330-0339	31 days
Observation services	Procedure code G0378	3 days
Emergency room	· Revenue code 0450 and · Any procedure code 99281-99285	2 days
Recovery room	Revenue code 0710	2 days

Dental policies and requirements

- Effective March 1, 2019, DOM implemented a revised billing policy for medically necessary dental services performed in an outpatient hospital setting*
- The revised billing policy:
  - Requires the **dentist** to obtain prior authorization for any dental procedures performed in the outpatient hospital setting
  - Allow for the coverage of more than one (1) unit per beneficiary per day with prior authorization
  - Require each approved unit billed as a separate line item
  - Apply multiple discounting
- The hospital is responsible for obtaining the approved prior authorization from the dentist

*MS Medicaid Provider Bulletin 25:1 (March 2019)
https://www.ms-medicaid.com/msenvision/servlet/DocumentViewerServlet?docType=ProviderBulletins&fileName=201903.pdf

Current policies

Three-day window rule

- Refers to outpatient services provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital*
  - Provided within 3 days prior to/including the admit date
  - Related to the inpatient stay
  - Includes diagnostic services and related therapeutic (non-diagnostic) services
  - Billed with inpatient claim and paid under APR-DRG
- If outpatient services are provided outside of the three-day window, the hospital must split bill for outpatient services provided on a claim separate from the inpatient claim
- Therapeutic services may be billed separately if unrelated to the inpatient stay using condition code 51 on the outpatient claim

*Mississippi Medicaid Administrative Code Title 23 Part 202 Hospital Services, Rule 1.1.C
https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-202.pdf

SFY 20 updates

SFY 20 updates

Policy decisions

- Maintain current policy rules
- APC conversion factor is maintained at $64.714
- Fee schedule updated using January 2019 Addendum B
  - 29 new CPT/HCPCS codes
  - Updated fees, max units, status indicators
  - Fee and max unit updates on Chemo fee schedule (no new or deleted codes)
- Dental policy updated
  - Prior approval required for dental services performed in an outpatient hospital setting
  - Multiple discounting (payment reduction) applies effective July 1, 2019, the dental procedure code line item with the highest allowed amount on the claim assigned a MS Medicaid OPPS status indicator “T” or “MT” is reimbursed at 100%;all other lines with significant dental procedures identified on the MS OPPS fee schedule assigned a MS Medicaid OPPS status indicator of “T” or “MT” is reimbursed at 25%

Datasets used in simulation

SFY 18 Analytical Dataset:

- Claims with first dates of service between 7/1/2017 and 6/30/2018 (SFY 18), paid through 2/4/2019
- 1,162,103 outpatient visits
- Allowed amount of $446.1 million
- Dataset estimated to be 95% complete (no completion factor applied)

SFY 19 Baseline:

- SFY 19 weights and fees applied to SFY 18 Analytical Dataset
- Maintained conversion factor ($64.714)
- Allowed amount of $447.6 million

SFY 20 Simulation

- SFY 20 weights and fees applied to SFY 18 Analytical Dataset
- Maintained conversion factor ($64.714)
- Allowed amount of $445.4 million (0.5% decrease)

SFY 20 updates

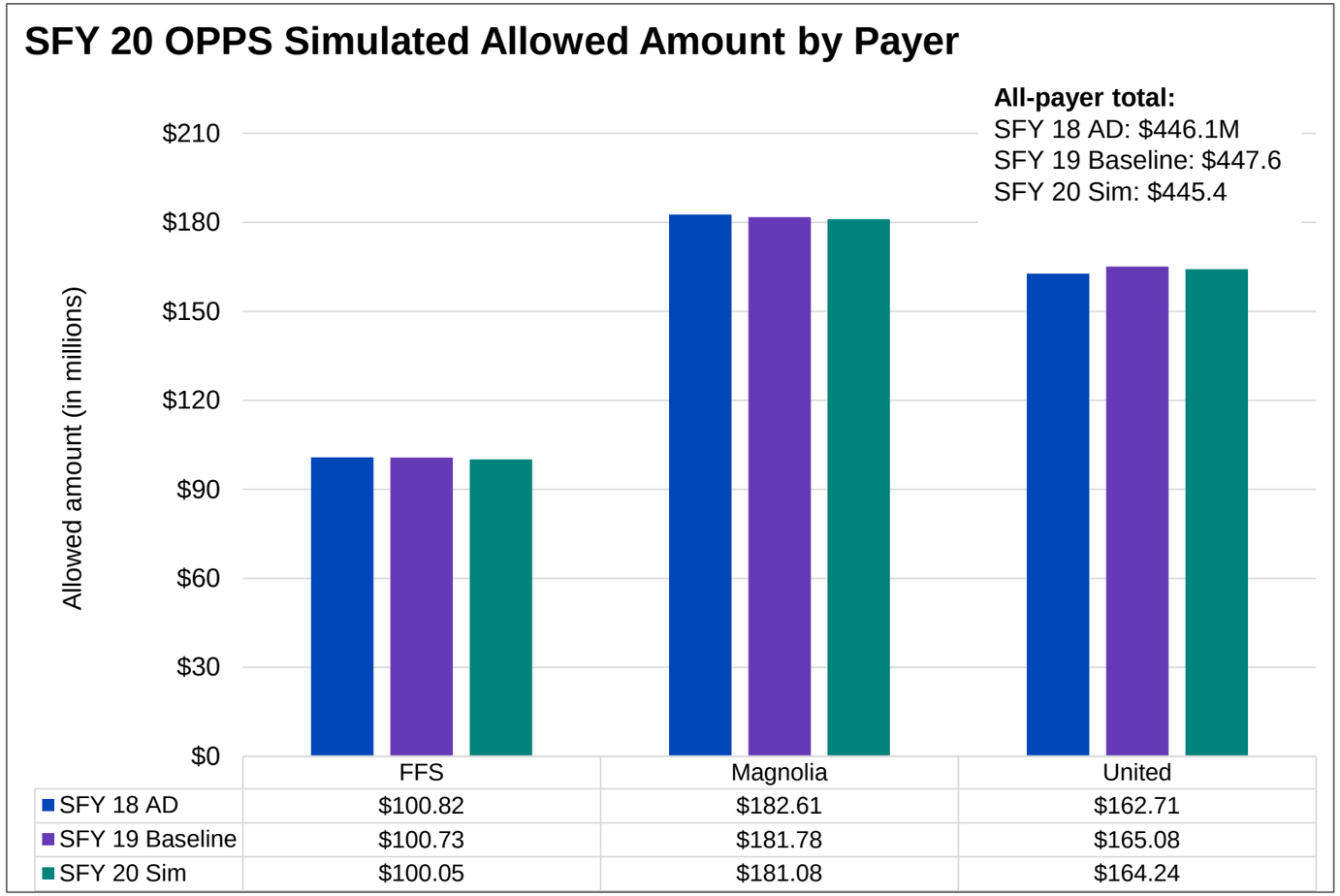
Overall simulation results

- Fee schedule update results in estimated $2.2 million decrease (0.5%) across all hospitals for SFY 20
- Simulation is not a forecast, since it does not reflect forecasts of eligibility and utilization
- Payment excludes supplemental payments to hospitals

SFY 20 OPPS Ratesetting Simulation Summary			
Ratesetting Simulation Results	**Analytical Dataset**	**Baseline Dataset**	**Simulation Dataset**
Metric	**SFY 18 Policy and Fees Applied**	**SFY 19 Policy and Fees Applied**	**SFY 20 Policy and Fees Applied**
First dates of service	7/1/2017-6/30/2018	7/1/2017-6/30/2018	7/1/2017-6/30/2018
Paid through	2/4/2019	2/4/2019	2/4/2019
Claims	1,162,103	1,162,103	1,162,103
Lines	5,258,484	5,258,484	5,258,484
Total allowed	$446,128,685	$447,583,340	$445,369,200
Avg allowed per claim	$383.90	$385.15	$383.24
Avg lines per claim	4.5	4.5	4.5
Conversion factor	64.714	64.714	64.714
Fee schedule applied	SFY 18	SFY 19	SFY 20 (approved)
Difference from Analytical Dataset		$1,454,655	-$759,485
Difference from Baseline (SFY 19)			-$2,214,139

Impact by payer

- Allowed amount levels are mostly flat across all three payers (FFS, Magnolia, and United)
- Analytical dataset predates Molina claims



Claim examples

Claim examples

Straight pricing

- Straight pricing means that no pricing adjustments or discounts are applied
- The allowed amount for every line on the claim is calculated as fees times submitted units (max unit edits still apply)

Example of Straight OPPS Claim Pricing										
Line	Service Date	Revenue Code	Revenue Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee	Allowed Amount
1	7/1/2019	0271	Non-Sterile Supply			1	$23.75		-	$0.00
2	7/1/2019	0450	Emergency Room - General	99284		1	$1,599.85	V	$293.38	$293.38
3	7/1/2019	0307	Laboratory - Urology	81001		1	$160.00	A	$3.17	$3.17
4	7/1/2019	0301	Laboratory - Chemistry	84703		2	$350.00	A	$7.52	$15.04
Total							**$2,133.60**			**$311.59**

Note:

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

Claim examples

Span billing - Therapy

- Therapy claims (defined by revenue codes 0420-0449) may include dates of service that span up to 31 days

Example of Span Billing a Therapy Claim										
Line	Service Date	Revenue Code	Revenue Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee	Allowed Amount
1	7/1/2019	0420	Physical Therapy - General	97110	GP	1	$460.00	A	$26.13	$26.13
2	7/7/2019	0420	Physical Therapy - General	97110	GP	1	$460.00	A	$26.13	$26.13
3	7/14/2019	0420	Physical Therapy - General	97110	GP	1	$460.00	A	$26.13	$26.13
4	7/21/2019	0420	Physical Therapy - General	97110	GP	1	$460.00	A	$26.13	$26.13
5	7/28/2019	0420	Physical Therapy - General	97110	GP	1	$460.00	A	$26.13	$26.13
6	7/31/2019	0420	Physical Therapy - General	97110	GP	1	$460.00	A	$26.13	$26.13
Total							**$2,760.00**			**$156.78**

Note:

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

Claim examples

Span billing - ER

- ET modifier allows ER claims to span past midnight

Example of Span Billing for an ER Claim										
Line	Service Date	Revenue Code	Revenue Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee	Allowed Amount
1	7/1/2019	0271	Non-Sterile Supply			1	$23.75		-	$0.00
2	7/1/2019	0450	Emergency Room - General	99284		1	$1,599.85	V	$293.38	$293.38
3	**7/2/2019**	0307	Laboratory - Urology	81001	**ET**	1	$160.00	A	$3.53	$3.53
4	**7/2/2019**	0301	Laboratory - Chemistry	84703	**ET**	2	$350.00	A	$7.52	$15.04
Total							**$2,133.60**			**$311.95**

Note:

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

Claim examples

Observation (incorrect)

- Only the first billed G0378 line is paid, in this case $0
- Subsequent G0378 lines are denied

Example of an Observation Claim (Incorrect)											
Line	Service Date	Revenue Code	Revenue Code Description	Procedure Code	Modifier	Submitted Units	Allowed Units	Submitted Charges	Status Indicator	Fee	Allowed Amount
1	7/1/2019	0300	Laboratory - General	85730		1	1	$65.00	A	$6.00	$6.00
2	7/1/2019	0300	Laboratory - General	80048		1	1	$86.00	A	$8.46	$8.46
3	7/1/2019	0300	Laboratory - General	36415		1	1	$8.35	A	$2.70	$2.70
4	7/1/2019	0450	Emergency Room - General	99285	25	1	1	$975.00	V	$427.66	$427.66
5	**7/1/2019**	**0762**	**Observation Room**	**G0378**		**7**	**0**	**$700.00**	**M1**	**$84.48**	**$0.00**
6	7/2/2019	0352	CT - Body Scan	74177		1	1	$2,656.00	S	$314.15	$314.15
7	7/2/2019	0730	EKG/ECG - General	93005		1	1	$114.00	S	$45.51	$45.51
8	**7/2/2019**	**0762**	**Observation Room**	**G0378**		**24**	**-**	**$2,400.00**	**M1**	**$84.48**	**-**
9	**7/3/2019**	**0762**	**Observation Room**	**G0378**		**10**	**-**	**$1,000.00**	**M1**	**$84.48**	**-**
Total								**$8,004.35**			**$804.48**

Note:

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

Observation (correct)

- All G0378 units should be reported on one line

Example of an Observation Claim (Incorrect)											
Line	Service Date	Revenue Code	Revenue Code Description	Procedure Code	Modifier	Submitted Units	Allowed Units	Submitted Charges	Status Indicator	Fee	Allowed Amount
1	7/1/2019	0300	Laboratory - General	85730		1	1	$65.00	A	$6.00	$6.00
2	7/1/2019	0300	Laboratory - General	80048		1	1	$86.00	A	$8.46	$8.46
3	7/1/2019	0300	Laboratory - General	36415		1	1	$8.35	A	$2.70	$2.70
4	7/1/2019	0352	CT - Body Scan	74177		1	1	$2,656.00	S	$314.15	$314.15
5	7/1/2019	0450	Emergency Room - General	99285	25	1	1	$975.00	V	$427.66	$427.66
6	7/1/2019	0730	EKG/ECG - General	93005		1	1	$114.00	S	$45.51	$45.51
7	**7/1/2019**	**0762**	**Observation Room**	**G0378**		**41**	**16**	**$4,100.00**	**M1**	**$84.48**	**$1,351.68**
Total								**$8,004.35**			**$2,156.16**

Note:

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

Claim examples

Bilateral/multiple procedures

- The highest-paying T status line with Modifier 50 pays 150% of fee * units
- Subsequent T status with Modifier 50 pays at 100%
- Other T status without Modifier 50 pays at 50%

Example of Multiple Procedure Pricing Adjustments											
Line	Service Date	Revenue Code	Revenue Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee	Pricing Adjustment	Allowed Amount
1	7/1/2019	0259	Pharmacy - Other	J3010		1	$183.99	N	$0.00		$0.00
2	7/1/2019	0272	Sterile Supply			1	$798.80		-		$0.00
3	**7/1/2019**	**0360**	**Operating Room - General**	**36820**	**50**	**1**	**$2,837.50**	**T**	**$3,562.99**	**100%**	**$3,562.99**
4	7/1/2019	0730	EKG/ECG General	93005		1	$232.00	S	$45.51		$45.51
5	**7/1/2019**	**0761**	**Treatment Room**	**37248**	**50**	**1**	**$4,600.00**	**T**	**$3,808.86**	**150%**	**$5,713.29**
6	**7/1/2019**	**0761**	**Treatment Room**	**36901**		**1**	**$2,500.00**	**T**	**$890.34**	**50%**	**$445.17**
Total							**$11,152.29**				**$9,766.96**

Note:

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

Claim examples

Dental procedures

- The highest-paying dental procedure pays 100% of fee * units
- Subsequent dental procedures pay at 25%

Example of Multiple Procedure Pricing Adjustments											
Line	Service Date	Revenue Code	Revenue Code Description	Procedure Code	Modifier	Submitted Units	Submitted Charges	Status Indicator	Fee	Pricing Adjustment	Allowed Amount
1	7/1/2019	0250	Pharmacy - General			1	$517.23		-	-	$0.00
2	7/1/2019	0259	Pharmacy - Other	J2270		2	$580.53	N	$0.00	-	$0.00
3	7/1/2019	0272	Sterile Supply			1	$3,617.49		-	-	$0.00
4	**7/1/2019**	**0360**	**Operating Room - General**	**D2930**		**1**	**$4,473.90**	**MT**	**$134.79**	**25%**	**$33.70**
5	**7/1/2019**	**0360**	**Operating Room - General**	**D7140**		**1**	**$2,684.39**	**T**	**$732.04**	**100%**	**$732.04**
6	**7/1/2019**	**0360**	**Operating Room - General**	**D1120**		**1**	**$447.39**	**MT**	**$30.11**	**25%**	**$7.53**
7	**7/1/2019**	**0360**	**Operating Room - General**	**D1206**		**1**	**$447.39**	**MT**	**$22.42**	**25%**	**$5.61**
Total							**$12,768.32**				**$778.88**

Note:

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

Additional resources

Key resources

Division of Medicaid's website:

- https://medicaid.ms.gov/providers/reimbursement/
  - FAQ
  - Quick tips
  - Training presentation
- https://medicaid.ms.gov/providers/fee-schedules-and-rates/
  - OPPS fee schedule (PDF and Excel)
  - Interactive Envision fee schedule
  - Provider Billing Handbook
- https://medicaid.ms.gov/about/state-plan/
  - State Plan Amendments approved
  - State Plan Amendments proposed
  - Withdrawn or terminated State Plan Amendments

For further information

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