Mississippi Medicaid Outpatient Prospective Payment System (OPPS) Payment Method

Frequently Asked Questions for SFY 20

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This Frequently Asked Questions (FAQs) document provides questions and answers about the Mississippi Medicaid Outpatient Hospital payment method, as of July 1, 2019.

Please note that this FAQ document does not supersede applicable laws, regulations, and policies.

THE OUTPATIENT HOSPITAL PAYMENT METHOD

The Division of Medicaid ("Division" or "DOM") implementation of the Outpatient Prospective Payment System (OPPS) payment method occurred on September 1, 2012. The payment method was implemented in two phases: Phase I, based on a fee schedule, was effective for claims with dates of service on or after September 1, 2012. Phase II, which included span billing rules and multiple procedure discounting, became effective for claims with dates of service on or after July 1, 2015.

1. Are there changes to the OPPS payment method effective July 1, 2019?

Yes. The Division will implement the following changes effective for the payment of hospital outpatient claims with dates of service on and after July 1, 2019:

- Annual update to the OPPS fee schedule, using the Medicare OPPS Addendum B effective January 1, 2019.
- Apply discounting policy to dental procedures billed on hospital outpatient claims where the highest allowed dental procedure is priced at 100% of the allowed amount or published fee and all subsequent dental procedures are priced at 25% of the allowed amount or published fee.

2. Which providers and services are affected?

The OPPS method applies to fee-for-service (FFS) outpatient facility services in all acute care hospitals including general hospitals, freestanding rehabilitation hospitals and long-term care hospitals; it is not applicable to services rendered by Indian Health Services. Unlike Medicare, Medicaid uses the OPPS method for critical access hospitals. Outpatient care in freestanding psychiatric hospitals is not covered under OPPS.

Payments to physicians **are not** affected.

3. What are the Division's reasons for using the OPPS payment method?

The Division 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 OPPS method, hospitals 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 OPPS method, when a claim is processed, the payment is final.
- ***Reduce reliance on Medicare cost reports.*** Under the previous method, the 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 OPPS method allows the Division clearer insight into the services being purchased. Because payment is based on procedure codes, the Division is 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 OPPS method, all hospitals are paid the same for the same service as the payment is based on the procedure code being billed.

COMPONENTS OF THE PAYMENT METHOD

4. What is the basic approach to the payment method?

The Medicaid OPPS method is similar to the Ambulatory Payment Classification (APC) based method currently in use by Medicare. In general, payment is made using the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes listed on the line level of an outpatient hospital claim. Payments for certain services may pay zero ($0.00), because payment for these services is considered "bundled" into payment with other services.

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

5. How does the outpatient payment methodology work?

- If there is a Medicare APC relative weight assigned to the code, the fee will be the Mississippi Medicaid conversion factor times the national APC relative weight times the units (when applicable).
- If there is no APC relative weight assigned and a Medicare payment rate is available, the payment will be 100% of the Medicare payment rate times the units (when applicable).
- If there is no APC relative weight or a Medicare payment rate, the fee will be the Mississippi Medicaid fee times the units (when applicable).
- If there is (1) no APC relative weight, Medicare payment rate, or a MS Medicaid fee for a procedure or service, or a device, drug, biological or imaging agent, or (2) when it is determined, based on documentation, that a procedure or service, or device, drug, biological or imaging agent reimbursement is insufficient for the Mississippi Medicaid population or results in an access issue, a manual review of the claim will be made to determine an appropriate payment based on the resources used, cost of related equipment and supplies, complexity of the service and physician and staff time. The rate of reimbursement will be limited to:

  (1) a MS Medicaid fee calculated as 90% of the Medicare rate of a comparable procedure or service or

  (2) the provider submitted invoice for a device, drug, biological or imaging agent.

6. How are the APC-based fees calculated?

APC-based fees are computed using the Mississippi Medicaid conversion factor times the specific APC relative weight found on the Medicare Addendum B. Beginning with the July 1, 2019 update, the Division uses the January 1 Addendum B as the basis for the annual fee schedule update. In prior years, the April 1 version was used.

Addendum B is located on the Medicare website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

7. What is the Mississippi Medicaid conversion factor?

The Division uses the SFY 18 Jackson, MS, Medicare conversion factor of $64.714. This conversion factor is used for all APC groups and for all hospitals.

8. What are the main similarities between Medicare and Medicaid payment methods?

- ***Payment by APC.*** For some services, CPT/HCPCS codes are 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 uses the same relative weights as Medicare, adjusted annually based on the January 1 Addendum B.
- ***Multiple procedure discounting.*** Claims including more than one (1) significant procedure with a MS Medicaid OPPS status indicator "T" (Significant procedure paid by APC for which the multiple procedure discounts DOES apply) or "MT" (Codes MS Medicaid discounts differently than Medicare) are discounted. The line item with the highest allowed amount with a MS Medicaid status indicator of "T" or "MT" will pay at one hundred percent (100%) of the fee. All other significant procedures identified with MS OPPS status "T" or "MT" will pay at (50%) of the 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.
- Effective July 1, 2019, claims with more than one (1) significant dental procedure code, assigned a MS Medicaid OPPS status indicator "T" or "MT" are discounted. 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 priced at one hundred percent (100%) of the allowed amount or published fee. 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" are priced at twenty-five percent (25%) of the allowed amount or published fee.
- Bilateral Pricing Policy. Claims with CPT/HCPCS codes that are inherently bilateral, have status indicator "T" or "MT," or are billed with modifier 50, are also subject to discounting.
- ***Lab and imaging services.*** The Division uses the Outpatient Payment Methodology to pay for these services under Medicaid OPPS.
- ***Status Indicators.*** The Division assigns and defines status indicators as outlined in policy. Mississippi Medicaid OPPS status indicators and definitions can be found in the fee schedule on the DOM website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

9. What are the main differences between Medicare and Medicaid OPPS?

- ***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.
- ***Medicare Integrated Outpatient Code Editor (I/OCE).*** The Medicare I/OCE is designed to implement Medicare coverage and payment policy, which can differ from Medicaid. Medicaid does not use the I/OCE. Medicaid will adjudicate hospital outpatient claims using its own edits related to covered diagnoses, revenue codes and procedures, maximum units, payment policies, and the National Correct Coding Initiative (NCCI).

- ***Composite APCs.*** Medicare assigns APC status indicators Q1-Q4 to codes that are sometimes packaged. Medicaid does not package these codes.
- ***Comprehensive APCs (C-APCs).*** Medicare assigns APC status indicators J1-J2 to codes and package the majority of billed items on a claim into a single APC payment. Medicaid does not apply C-APC logic.
- ***Modifiers.*** Medicare makes extensive use of modifiers that affect pricing (e.g., 25, 50, 52, 59, 73, 74, 76, 77, 78, 79, CA, FB, FC, PO, PN, and anatomical). Modifiers that affect payment under Medicaid are more limited (e.g., 50, ET, QX, QZ, and UD). Note that modifiers may also affect payment when NCCI edits apply.
- ***Outlier payments.*** Medicaid does not make outpatient outlier payments.
- ***Charge cap.*** To calculate the cap, the providers' covered billed amount is compared to the allowed amount at the claim level for all paid lines of service (denied lines are excluded). If the claim level covered billed amount is less, the claim level covered billed amount becomes the allowed amount.

COVERAGE AND PAYMENT FOR SPECIFIC SERVICES

10. Are there any changes to prior authorization?

Current prior authorization requirements for outpatient hospital services continue to apply. This includes:

- Advanced imaging, except during an ED visit or 23-hour observation period
- Physical, occupational and speech therapies
- Mental health services, and
- Dental services

11. How does 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.

12. Does Medicaid pay for trauma team activation?

Yes. The OPPS payment method does not affect the coverage policy for trauma team activation, which can be found in the Mississippi Administrative Code Title 23, Medicaid, Part 202, Rule 5.5. The CPT code for trauma team activation may only be billed with revenue codes 0681, 0682, 0683, or 0684.

13. How are dental services provided in the outpatient hospital setting paid?

The Division uses the Outpatient Payment Methodology to pay for dental services under Medicaid OPPS. Dental codes are priced based on the Medicare APC or the Mississippi Medicaid fee. Dental services performed in the outpatient hospital setting require prior authorization.

Dental procedures identified with status indicators "T" or "MT" are subject to discounting. Discount pricing is applied at the line level (one unit per line limit). The highest allowed dental code prices at 100% of the allowed amount or published fee, all other dental codes price at 25% of the allowed amount or published fee.

CODING, BILLING AND EDITING

14. What billing and coding practices are important for hospitals to follow?

There are several billing requirements that are important under Medicaid OPPS.

- ***Single claim for a single visit***. Hospitals must bill all services for the same patient on the same day on the same claim. Incoming claims are 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 one (1) date of service will be denied (see FAQ #15 for exceptions).
- ***Distinct medical visits.*** Claims with separate and distinct medical visits for the same beneficiary on the same day and by the same provider will be allowed and require condition code G0 (G zero). Distinct medical visits subsequent claims will deny without this code.
- ***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 (zero). The list of revenue codes can be found in the fee schedule located on the Division's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#. Certain HCPCS codes may only be billed with revenue code 0636 (Drugs Requiring Detailed Coding), as indicated below.
- ***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. The Division defines drug units according to the current HCPCS description of a drug (e.g., Baclofen injection 10 mg equals 1 unit).
- ***National Correct Coding Initiative (NCCI).*** 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 associated with procedures and modifiers apply under Medicaid OPPS.

15. Does Medicaid allow span date billing?

Yes, with some limitations. Span date billing is defined as services furnished by a single provider, to a single beneficiary over a span of multiple dates. 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:

- Therapies (speech, physical, and occupational), limited to 31 days. These services cannot span calendar months.
- Chemotherapy (claims with revenue codes 0330-0339), limited to 31 days. These services cannot span calendar months.
- Observation (claims with procedure code G0378), limited to 3 days.
- Emergency department visits (claims with revenue code 0450 and procedure codes 99281-99285) that extend past midnight must include "ET" modifier, limited to 2 days.
- Recovery room (claims with revenue code 0710), limited to 2 days.

16. How does the National Correct Coding Initiative (NCCI) apply under the Medicaid payment method?

The NCCI is a federal requirement for all Medicaid programs. Mississippi Medicaid specific NCCI policies can be found at http://www.medicaid.ms.gov/providers/national-correct-coding-initiative/. NCCI contains two types of edits:

- ***NCCI procedure-to-procedure (PTP) edits.*** These edits define pairs of CPT/HCPCS 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.

- ***Medically Unlikely Edits (MUEs).*** These edits define for each CPT/HCPCS 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.

The CMS National Correct Coding Initiative in Medicaid webpage can be found at https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html.

17. Are National Drug Codes (NDC) 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 results in increased rebates from pharmaceutical manufacturers to state Medicaid programs.

Outpatient claim lines 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 Measurement Qualifier * ↑ Unit Quantity

* 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://www.ms-medicaid.com/msenvision/index.do

18. How is payment affected if there is a provider-preventable condition on the claim?

Federal law prohibits Medicaid payment for Other Provider-Preventable Conditions, defined as the three never events under the National Coverage Determinations: (1) wrong surgical or other invasive procedure performed on a patient, (2) surgical or other invasive procedure performed on the wrong body part, and (3) surgical or other invasive procedure performed on the wrong patient.

19. Do hospitals have to buy software to submit claims under the OPPS payment method?

No. Providers do not have to buy software to submit claims under OPPS.

20. Would 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 Mississippi Medicaid payment method.

21. For a claim to be considered in Outpatient Visit Category (OVC) Trauma, will the claim need critical care codes on the claim?

For a claim to be considered in the OVC of Trauma, the claim must have lines billed with the revenue codes of 0681-0689 present on the claim.

22. Why does Medicaid not follow Medicare and cover G0463-Hospitals outpatient clinic visit? This causes problems with secondary claims.

G0463 does not provide severity levels. DOM wants to understand and provide appropriate reimbursement for the acuity of service provided and procedure code G0463 prohibits DOM the option to capture severity levels.

23. Does Medicaid have any intention of following CMS for 340B drugs billing and using modifier JG instead of UD?

When Medicare is either the primary or secondary payer, the appropriate 340B modifier is required in accordance with the Medicare OPPS 340B payment policy.

Medicare left the discretion for 340B modifier requirements to state Medicaid. Effective November 1, 2018, the Division requires the UD modifier for 340B drugs and does not plan on changing this policy at this time. For more information regarding the Division's 340B Program please visit https://medicaid.ms.gov/providers/pharmacy/pharmacy-reimbursement/.

CONSULTATION AND EDUCATION

24. What assistance is available to educate and keep hospitals informed about the OPPS payment method?

Training materials include this FAQ document, a Quick Tips sheet, and provider training presentations. These materials are periodically updated and may be accessed at the Division of Medicaid website and via a link from the Conduent Mississippi Envision website:

- Division of Medicaid: https://medicaid.ms.gov/providers/reimbursement/
- Conduent Mississippi Envision: https://www.ms-medicaid.com/msenvision/index.do, select the **heading "Visit-Division of Medicaid" and "Providers-Finance-Reimbursement."**

25. Who can I contact for more information?

- ***General questions.*** The Medicaid field representative assigned to your hospital. If you don't know the field representative's name, Conduent Provider and Beneficiary Services at 1-800-884-3222.
- ***Division OPPS policy.*** Zeddie R. Parker, Office Director, Hospital Programs and Services, Division of Medicaid, Zeddie.Parker@Medicaid.ms.gov, 1-601-359-2562.

Shatara M. Bogan, Accounting Administrator, Hospital Program, Office of Reimbursement, Division of Medicaid, Shatara.Bogan@Medicaid.ms.gov, 1-601-359-6099.

- ***Technical questions.*** Debra Stipcich, Director of Client Services, Payment Method Development, Conduent State Healthcare LLC, Debra.Stipcich@conduent.com, 1-406-437-1886.