

State of Mississippi
Methods and Standards for Establishing Payment Rates – Other Types of Care

Hospital Outpatient Services

A. Except as otherwise specified, outpatient hospital services for all hospitals except Indian Health Services will be reimbursed under a prospective payment methodology as follows:

1. Medicaid Outpatient Prospective Payment System (OPPS), Ambulatory Payment Classification (APC) Groups

Outpatient hospital services will be reimbursed on a predetermined fee-for-service basis. The parameters published annually in the Code of Federal Regulations (CFR) (national APC weights, ~~status indicators~~, APC group assignments and Medicare fees) and MS Medicaid OPPS status indicators, will be used by the Division of Medicaid (DOM) in calculating these predetermined rates and will be updated July 1 of each year.

a. The Medicaid OPPS fees, including Clinical Diagnostic Laboratory OPPS fees, are calculated using 100% of the applicable APC relative weight or the payment rate for codes listed in the most current final Medicare outpatient Addendum B or C effective as of April 1st of each year as published by the Centers for Medicare and Medicaid Services (CMS). Codes with no applicable relative weight or payment rate in Addendum B or C are paid via a DOM published fee schedule based on 90% of the Medicare physician fee schedule or the Medicare Clinical Laboratory fee schedule of the current year. No retroactive adjustments will be made. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1st and is effective for services provided on or after that date. All fees are published on the agency's website at <http://www.medicaid.ms.gov/FeeScheduleLists.aspx>.

b. The Medicaid conversion factor used by DOM is the current Jackson, MS Medicare conversion factor. This conversion factor is used for all APC groups and for all hospitals. Each APC rate equals the Medicare Addendum B specific relative weight at 100% multiplied by the Medicaid conversion factor, with the exception of observation fee which is paid using a MS Medicaid fee. Except as otherwise noted in the plan, MS Medicaid

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OPPS fee schedule rates are the same for both governmental and private providers of hospital outpatient services. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1 and is effective for services provided on or after that date.

- c. Subject to documentation of medical necessity, in addition to any Medicaid covered service received during observation in an outpatient hospital setting, DOM will pay an hourly fee for each hour of observation exceeding seven (7) hours, up to a maximum of twenty-three (23) hours (i.e., the maximum payment will be sixteen (16) hours times the hourly fee). The hourly fee for observation is calculated based on the relative weight for APC 8009 multiplied by the current Jackson, MS Medicare conversion factor divided by the twenty-three (23) maximum payable hours. Documentation requirements for medical necessity regarding observation services can be found in the MS Administrative Code Title 23 Medicaid, Part 202 Hospital Services, Chapter 2 Outpatient Hospital, Rule 2.4: Outpatient (23-Hour) Observation Services as of April 1, 2012, located at www.medicaid.ms.gov/AdminCode.aspx. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1 and is effective for services provided on or after that date. All fees are published on the agency's website at <http://www.medicaid.ms.gov/FeeScheduleLists.aspx>.
- d. The total claim allowed amount will be the lower of the provider's allowed billed charges or the calculated Medicaid OPPS allowed amount.
- e. A MS Medicaid OPPS status indicator is assigned to each procedure code determining payment under Medicaid OPPS. The full list of MS Medicaid OPPS status indicators and definitions is found on Attachment 4.19-B, page 2a.6.
- f. Claims with more than one (1) significant procedure, assigned a MS Medicaid OPPS status indicator "T" or "MT", are discounted. The line item with the highest allowed amount on the claim for certain significant procedures identified on the MS OPPS fee schedule
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assigned a MS Medicaid OPPS status indicator “T” or “MT” is paid at one hundred percent (100%). All other lines with significant procedures identified on the MS OPPS fee schedule assigned a MS Medicaid OPPS status indicator of “T” or “MT” is paid at fifty percent (50%).

ge. Medicare has set guidelines for procedures it has determined should be performed in an inpatient setting only. The DOM follows Medicare guidelines for procedures defined as “inpatient only”.

2. Outpatient Payment Methodology Paid Under Medicaid OPPS

Except in cases where the service is non-covered by DOM, outpatient services will be reimbursed as follows:

- a. For each outpatient service or procedure, the fee is 100% of the current Ambulatory Payment Classification (APC) rate multiplied by the units (when applicable).
- b. Where no APC relative weight has been assigned, outpatient services will be paid at 100% of any applicable Medicare payment rate in the most current final Medicare outpatient Addendum B or C as of April 1st of each year as published by the CMS multiplied by the units (when applicable).
- c. If there is no APC relative weight or Medicare payment rate established in the most current final Medicare outpatient Addendum B or C as of April 1st of each year as published by the CMS, payment will be made using the current applicable MS Medicaid fee multiplied by the units (when applicable).
- d. If there is no APC relative weight, Medicare payment rate, or MS Medicaid fee for a procedure, service, or device, 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 payment rate of reimbursement will be limited to the MS Medicaid fee

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cost of a comparable service or the provider submitted invoice.

- e. When the Division of Medicaid identifies and determines, based on documentation, that an APC rate, including all its bundled services, is insufficient for the Mississippi Medicaid population or could result in a potential access issue, a MS Medicaid fee will be computed. Documentation must include, but not be limited to, cost information from providers, surveys of the Medicaid fees from other states, survey information from national fee analyzers, or other relevant fee-related information. The rate of reimbursement will be limited to a MS Medicaid fee of a comparable service.

3. Five Percent (5%) Reduction

Notwithstanding any other provision of this section, the Division of Medicaid, as required by State law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The published fee does not include the five percent (5%) reduction. This provision is not applicable to Indian Health Services.

B. Miscellaneous

The topics listed below from Attachment 4.19-A will apply to hospital outpatient services:

1. Principles and Procedures (~~except the reimbursement period for hospital outpatient services runs from July 1 through June 30~~).
2. Availability of Hospital Records
3. Records of Related Organizations
4. Appeals and Sanctions.

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MS MEDICAID OPPTS STATUS INDICATORS

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

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