PROVIDER RELATIONS
Michigan Department of Health and Human Services

Pricing Outpatient Hospital Claims

Resources Billers Use To Price Claims

Policy: Medicaid Provider Manual (MPM) Chapter "Hospital" Hospital Reimbursement Appendix Section 1 Outpatient.

The Michigan Department of Health and Human Services (MDHHS) Provider Relations Section receives frequent inquiries regarding how specific outpatient hospital claims were priced and if certain procedure codes are covered and reimbursable to this provider type. This document was created to assist providers trying to price a claim to compare with what is on their remittance advice (RA) and to provide guidance as to what procedure codes are covered. No facilities (i.e. critical access or children's hospitals) are excluded from Medicaid's Ambulatory Payment Classification (APC) reimbursement methodology. Payment made under Medicaid's Outpatient Prospective Payment System (OPPS) is calculated utilizing current Medicare rates per their Addendum B, with a MDHHS reduction factor applied. Exceptions are posted to our website via the OPPS Wrap Around Codes List by the quarterly version date and includes the Medicaid specific Status Indicators. All Outpatient Hospital claims are processed through an Integrated Outpatient Code Editor to edit the data to identify billing errors and to assign the APC to price the claim. Status Indicators (Medicare SI or the MDHHS Specific SI) are applied which may be viewed at the service line level screens within CHAMPS claims inquiry function. This means that when trying to price a claim, each HCPT code will need to be looked up on Medicare's Addendum B for the status indicator and fee screen but then to also look at the MDHHS wrap around codes list for any exception (for example, Medicare may cover a code that MDHHS does not cover).

The software used to group and price Outpatient Hospitals is implemented quarterly into CHAMPS. Providers are to bill their claims using the policy and billing instructions in effect on the date of service. Major national coding updates made each year, typically in January, may result in providers noticing above normal amounts of Return To Provider (RTP) claim rejections during the first quarter of every year (CARC A8). This will be due to the use of new HCPT codes that are not recognized within the current software. Providers can normally expect to see our posting of a Biller Be Aware message announcing when all affected claims will be recycled. These claims will include a claim note to help providers identify these transactions.

Other helpful websites hospital billers may use:

1. Integrated OCE Specifications effective 01/01/2016

   This document includes the definitions all of the status indicators published on page 22 (of 66); also the OCE edit descriptions are on page 19-20:

2. New codes information from MLN Matters 2015
3. New codes information from MLN Matters 2016
4. Clinical Laboratory Fee Schedule per CMS
5. CMS billing guidelines to seek separate payments for lab 2014 (Bundling rules)

6. OPPS Carrier Priced Laboratory Codes
7. Physical Therapy modifiers requirements described as sometimes required or always required-need to also review the "definitions"
8. Physical Therapy rates for local carriers= (click on MPPR download) (click on date of service data base) (use reduction factor)
9. Medicare Zip code to Carrier Locality File
10. Repetitive versus recurring services
11. Medically unlikely edits (MUE) per CMS (gives billable quantity limit):
12. Rebate drug product data file from CMS
13. NCCI edits