

Bulletin Number: MSA 06-47

Distribution: Hospitals, Comprehensive Outpatient Rehabilitation Facilities, Rehab Agencies, and Freestanding Dialysis Centers (Provider Type 40)

Issued: July 1, 2006

Subject: Outpatient Prospective Payment System

Effective: April 1, 2007

Programs Affected: Medicaid, Children's Special Health Care Services, MOMS, Adult Benefits Waiver

The purpose of this bulletin is to describe changes being made to the Michigan Department of Community Health's (MDCH) reimbursement methodology for outpatient hospitals, hospital-owned ambulance services, freestanding dialysis centers, comprehensive outpatient rehabilitation facilities (CORFs), and rehabilitation agencies (Provider Type 40s) for services provided on and after April 1, 2007.

This bulletin, the first of multiple bulletins, provides final policies necessary for providers and health plans to develop and test their claims submission and/or claims processing systems for April 1 implementation.

OVERVIEW

Background

The MDCH currently uses a proprietary reimbursement methodology that does not align with any other payer, creating administrative burdens for facilities submitting claims and MDCH in coordinating benefits.

Purpose and Objectives

The purpose of implementing an OPSS is to have a Medicaid reimbursement methodology that promotes predictability of payments, equity and consistency of those payments among providers while maintaining access to quality care.

The objectives of this change are to facilitate coordination of benefits and relieve administrative burden on Medicaid-enrolled outpatient providers.

Affected Providers

All Medicaid-enrolled Provider Type 40s (outpatient hospitals, comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and freestanding dialysis centers), as well as hospital-owned ambulance services (currently enrolled as Provider Type 18s), will be reimbursed utilizing an Outpatient Prospective Payment System (OPSS) methodology. Hospitals currently excluded from Medicare Ambulatory Payment Classification (APC) reimbursement (e.g., children's hospitals, critical access hospitals, etc.) will **not** be excluded by MDCH.

Out-of-State Hospitals

The OPSS payment methodology applies to all out-of-state (including borderland) hospitals.

Covered Services

Changes in current coverage policies being implemented as part of the OPSS are described in this bulletin. To facilitate coordination of benefits, the MDCH OPSS will follow, as closely as possible and appropriate, Medicare's current OPSS coverage policies, and claim submission requirements.

MDCH Medicaid Policy Prevails

MDCH policy prevails in cases of disagreement between Medicare and Medicaid; however, for Medicaid beneficiaries with Medicare or commercial healthcare coverage, the rules of the primary payer must be followed. See the Coordination of Benefits Chapter of the Medicaid Provider Manual for additional information.

PAYMENT CALCULATIONS AND BUDGET IMPACT

Budget

It is the intent of the MDCH to implement its OPSS in a budget-neutral manner for its fee-for-service, non-dually eligible, Medicaid population. The initial MDCH reduction factor will be established based on this intent. MDCH will then monitor payments made under its OPSS and adjust the reduction factor as necessary to assure payments do not exceed appropriated funding.

Final policy related to the initial reduction factor, as well as how the reduction factor will be monitored and adjusted will be released in a separate policy bulletin a minimum of 45 days prior to the April 1, 2007 OPSS implementation. For the purposes of OPSS development and testing, a temporary reduction factor of 58% will be used.

Payment Calculation

MDCH will **not** utilize Medicare wage indices. A factor of 1.0 will be applied for all providers.

MDCH **will** utilize Medicare APC weights.

Payments made under the OPSS methodology will be calculated utilizing the current Medicare conversion factors/rates with an MDCH reduction factor (RF) applied to the calculated payment (Medicare fee x RF = Medicaid fee).

The MDCH payment will be the lesser of the:

- Medicaid fee screen/allowable amount minus any Medicare or other insurance payments, and any applicable Medicaid co-payment, patient-pay, and/or deductible; or
- For fee schedule items, provider's charge reduced by any contractual adjustments, minus any Medicare or other insurance payments, and any applicable Medicaid co-payment, patient-pay, or deductible amount; or
- beneficiary's liability for co-insurance, co-payments, and/or deductibles.

Transitional Payments

No transitional payments will be made.

AMBULATORY PAYMENT CLASSIFICATION (APC)

APC Method

The main payment methodology for the OPSS is the APC which is used by Medicare. MDCH will utilize the Outpatient Code Editor (OCE) with Correct Coding Initiative (CCI) editing as part of its OPSS.

Packaged/Bundled Services

MDCH will follow Medicare guidelines for packaged/bundled service costs. Services having a status indicator of "N" are considered packaged or bundled into other services. The costs of these services are allocated to the APC but are not paid separately. Medicare developed the relative weights for surgical, medical and other types of visits to reflect the packaged services in the APC assignment.

Discounted Procedures

MDCH will follow Medicare rules for discounting payment for multiple, bilateral or discontinued procedures (OPSS status indicator "T").

Outlier Payments

MDCH will implement Medicare's APC outlier payment policy. The MDCH reduction factor will not be applied to outlier payments.

Services Paid a Percentage of Charges

Services that are paid a percentage of charges are paid at a percentage of the hospital's charges for that service (e.g., pass-through payments). Each hospital's current Medicaid outpatient cost-to-charge ratio will be used for the initial OPSS implementation. Updates of the outpatient cost-to-charge ratios will be done in step with updates of the inpatient operating ratios. For out-of-state hospitals, the default cost-to-charge ratio is the average statewide outpatient cost-to-charge ratio. The MDCH reduction factor will not be applied to services paid a percentage of charge.

Pass-Through Payments

Pass-through payments are generally for new drugs, biologicals, radiopharmaceutical agents, and medical devices. Drugs and devices having a status indicator of "G" or "H" receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. The MDCH reduction factor will not be applied to drugs or devices with a status indicator of "H".

Fee Schedules

MDCH will utilize Medicare fee schedules, with the MDCH reduction factor applied, except as described in this bulletin.

CODING, BILLING AND EDITS

Billing Requirements

Medicare's billing requirements are being adopted, as closely as possible, for the MDCH OPSS. Differences to those requirements are noted in this bulletin, as well as clarification of changes to current MDCH requirements.

All services for a single outpatient encounter must be reported on one claim, except for Medicare's allowable repetitively billed services and hospital-owned ambulance services. MDCH will follow Medicare's guidelines for monthly repetitive/series billing; however, the current 50 service line limit will continue until the MDCH claims processing system replacement is completed.

Reporting CPT/HCPCS Codes

The OPSS payment calculations are dependent on CPT/HCPCS procedure codes and modifiers reported at the claim line level. Providers are advised to ensure the accuracy of procedure codes, modifiers, and the appropriateness of the revenue codes.

Date of Service

OPSS requires a claim line date of service for each service billed. If a claim line date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the "statement covers" period (from and through dates), the claim will be returned to the provider.

If the claim spans more than one calendar day, OCE will subdivide the claim into separate days for the purpose of determining discounting and multiple visits on the same calendar day.

Type of Bill

The following Type of Bill (TOB) will be accepted for outpatient claims under the MDCH OPSS: 13x, 14x, 34x, 72x, 74x, 75x or 85x.

Outpatient Code Editor with Ambulatory Payment Classification

The OCE software was developed for the implementation of the Medicare OPSS. The two main functions of the OCE are to identify errors and assign APCs. In addition, the software performs the following functions when processing a claim:

- Edits a claim for accuracy of the submitted date;
- Assigns payment indicators;
- Determines if packaging is applicable;
- Determines the disposition of a claim based on generated edits;
- Computes discounts and outliers, if applicable;
- Determines payment adjustment, if applicable.

MDCH will utilize Medicare's Outpatient Code Editor (OCE), including Correct Coding Initiative (CCI) editing. The OCE is updated quarterly.

Additional Editing

MDCH OPSS will utilize many of the MDCH proprietary edits that are not duplicated by the OCE edits. These edits review beneficiary and provider eligibility, third party liability, quantity/frequency of services, diagnosis, and other information normally reviewed by the fiscal intermediary under the Medicare OPSS. MDCH will maintain these proprietary edits for the initial implementation of OPSS and will continue to monitor the appropriateness post implementation.

Status Indicators

Under OPSS, Centers for Medicare and Medicaid Services (CMS) assigns a single character status indicator to each individual CPT or HCPCS code to identify if a code will be paid and how it will be paid. For certain categories of codes that MDCH intends to cover differently than Medicare under its OPSS, MDCH has created the following alpha/numeric status indicators:

MDCH Specific Status Indicators

Status Indicator	Description	Comments
A1	MDCH covered lab service	Paid based on associated MDCH fee schedule
A2	Series-billed dialysis service (revenue codes 82x, 83x, 84x, 85x)	Paid based on associated MDCH fee schedule
A3	Hospital-owned ambulance services	Paid based on associated MDCH fee schedule
A4	Non-Medicare covered services (e.g., family planning, dental, sterilization, abortion, etc.)	Paid based on associated MDCH fee schedule
A5	Non-Medicare covered adult vaccines	Paid based on associated MDCH fee schedule
A6	Vaccines For Children	Zero payment; Vaccines For Children (VFC) program
R1	MDCH non-allowed item or service (e.g., aquatic therapy, infertility services, etc.)	Items, codes, and services that are not covered by MDCH

SERVICE COVERAGE POLICIES

Inpatient Only Services

MDCH will adopt Medicare's inpatient only services list without modification.

Excluded Services

Mental health and substance abuse services provided through the Prepaid Inpatient Health Plans (PIHPs) will be excluded from MDCH OPPS.

Other OPPS/Non-APC Services

- **Ambulance:** Ambulance services provided by a hospital-owned ambulance must be billed through the outpatient hospital, unless associated with an inpatient transport.

Hospitals will no longer be able to submit ambulance claims utilizing the professional claim formats. Information regarding the change of hospital owned ambulance services enrollment from provider type 18 to provider type 40 will be provided in a separate bulletin.
- **Dialysis:** MDCH will retain its current coverage/reimbursement policies and fee schedule for chronic (series-billed) dialysis services, however, Medicare billing requirements will apply (i.e., claims must include appropriate diagnosis code, patient height/weight, etc.). The additional information being provided on the claim will be used for consideration of future reimbursement changes.
- **Lab:** Differences in coverage of lab services between Medicare and MDCH have been identified and, where appropriate, MDCH has extended coverage to include the additional procedure codes. In those limited instances where program differences require coverage disparity (e.g., MDCH coverage of the obstetric panel [procedure code 80055], Medicare coverage of sperm evaluation test [procedure code 89329], etc.), the differences will be reflected through the application of MDCH-specific status indicators.
- **Therapies:** MDCH will retain its current coverage policies related to therapy services, including prior authorization requirements.

Observation Room Services

MDCH will promulgate and implement observation room coverage and reimbursement policy separate from the OPSS implementation.

Medicare/Medicaid Coverage Differences

Due to differences in the populations served, there are some coverage differences between Medicare and Medicaid.

- **Dental Services:** MDCH will continue its current policies related to dental care provided in the outpatient hospital setting as described in the Dental Chapter of the Medicaid Provider Manual.
- **Sterilizations and Abortions:** Sterilizations and abortions will be covered per current MDCH policy.
- **Well Visits:** Well visits will be covered per current MDCH policy.
- **Injectables & Biological (Vaccines):** MDCH will continue its current coverage policies related to injectables and biologicals as described in of the Medicaid Provider Manual.
- **Family Planning:** Family planning services currently covered by MDCH will continue to be covered under the MDCH OPSS

These services will generally be reimbursed from the MDCH fee screens. However, if Medicare covers the appropriate procedure code for another reason/condition, the Medicare fee screen (with the reduction factor applied), will be used. Procedures paid from MDCH fee screens will be included in the MDCH wrap around procedure code list that will be maintained on the MDCH website. During the OPSS testing and implementation period, the list will be posted under the OPSS Project webpage at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers>>Outpatient Prospective Payment System (OPSS) Project. Effective April 1, 2007, the list will be added to the other databases available under Provider Specific Information.

OPSS Updates

MDCH will implement applicable Medicare OPSS edit/code and reimbursement/rate changes in step with Medicare. MDCH may adjust its reduction factor to maintain expenditures with appropriated levels if Medicare implements general rate increases.

APC Implementation Plan

Providers (or their billing agents) enrolled with Michigan Medicaid are encouraged to participate in the business-to-business (B2B) testing process established for OPSS implementation to assure their outpatient claims will process correctly through the MDCH claims processing system. The process will allow providers to submit electronic test claims in the 837I v.4010A1 format to MDCH for processing and have test results reported back in the 835 format. B2B testing is targeted for August 1, 2006, and continue through implementation. B2B testing instructions and updates are available on the MDCH website at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers>>Electronic Billing>>837 B2B Testing Instructions.

Providers are also encouraged to test with any Medicaid Health Plan for which they provide services and are reimbursed based on Medicaid fee-for-service methodology.

MDCH will also select a representative group of hospitals that have successfully completed B2B testing to participate in a three-six month OPSS pilot/parallel process scheduled to begin October 1, 2006. Participation in the B2B testing and the pilot period are essential to the successful implementation of OPSS.

Additional information about this project, including a Frequently Asked Questions (FAQ) document, is available on the MDCH website at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers>>Outpatient Prospective Payment System (OPSS) Project. Providers are encouraged to monitor the website as MDCH will continue to post new information.

Providers are also encouraged to submit questions related to this implementation to APCProject@michigan.gov at any time. Timely responses will be issued to questions received which may assist providers.

Manual Maintenance

Retain this bulletin for future reference.

Questions

If you have questions about the manual, or problems locating information, you may contact Provider Inquiry at 1-800-292-2550 or providersupport@michigan.gov. If you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary.

Approved

A handwritten signature in black ink, appearing to read "Susan Moran". The signature is fluid and cursive, with a long horizontal stroke at the end.

Susan Moran, Acting Deputy Director
Medical Services Administration