Outpatient Hospital Overview

"Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time."

-Provider Relations

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Acronyms

Acronym	Definition
APC	Ambulatory Payment Classification
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System
MDHHS	The Michigan Department of Health and Human Services
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
NDC	National Drug Code
NUBC	National Uniform Billing Committee
OCE	Outpatient Code Editor
OPH	Outpatient Hospital
OPPS	Outpatient Prospective Payment System
OT	Occupational Therapy
PT	Physical Therapy
SI	Status Indicator
ST	Speech Language Therapy
TOB	Type of Bill

Background

The Michigan Department of Health and Human Services (MDHHS) defines an outpatient hospital (OPH) as a portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization.

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Background

- Resources
  - Provider Enrollment Instructions
  - Medicaid Provider Manual
    - Billing & Reimbursement for Institutional Providers Chapter, Section 7 Hospital Claim Completion-Outpatient
    - Hospital Chapter, Section 1.2 Outpatient Hospital
  - Wrap Around Codes list
  - Reduction Factor History
  - Pricing Outpatient Hospital Claims

Outpatient Hospital (OPH) services are furnished under the direction of a physician (MD or DO) or dentist or in a facility that is certified as a provider, or as having provider-based status, by Medicare.

MDHHS uses the Medicare Outpatient Code Editor (OCE) and the Medicaid National Correct Coding Initiative (NCCI) when processing OPH claims. The main functions of the OCE are to identify errors and to assign the Ambulatory Payment Classification (APC).

MDHHS uses proprietary edits that are not duplicated by the OCE to 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 Outpatient Prospective Payment System (OPPS).

Claim Completion

MSA policy should be used in conjunction with the National Uniform Billing Committee (NUBC) Manual when preparing Outpatient Hospital claims.

- NUBC Manual
- Medicaid Provider Manual
  - Billing & Reimbursement for Institutional Providers Chapter, Section 7 Hospital Claim Completion-Outpatient

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OPPS/Ambulatory Payment Classification

- Resources
  - Addendum A – APC pricing information
  - Addendum B – lists the status indicator for each HCPCS code
  - Addendum D1 – status indicator definitions
  - Identifying APC Code and Status – CHAMPS instructions to identify the APC Code and Status which set on a claim service line.

Medicare assigns a payment Status Indicator (SI) to every HCPCS code and identifies whether the service is paid under OPPS, and whether payment is made separately or packaged. The SI may also provide additional information about how the code is paid under OPPS, another payment system, or the MDHHS fee schedule.

MDHHS follows Medicare guidelines for packaged/bundled service costs. Services having a Status Indicator (SI) of "N" are considered packaged/bundled into other services. The costs of these services are allocated to the APC but are not paid separately.

Providers must report all HCPCS/CPT codes and charges for all services provided on a claim whether payment for the service(s) is made separately or is packaged for the claim to pay correctly.

Charges related to the packaged services are used for the outlier calculation. Packaged services revenue codes, when billed under OPPS, do not require a HCPCS code. Any other revenue codes billable on an outpatient hospital claim must contain the HCPCS code to assure payment under OPPS.

- If a claim is billed with codes that have only SI "N" the claim will be denied.

Type of Bill

The following Types of Bill (TOB) are accepted for outpatient claims under the MDHHS OPPS:

- 013X - Hospital Outpatient
- 014X – Hospital Lab Services
- 034X – Home Health
- 072X – Clinic Hospital Based or Independent RDC
- 074X – Outpatient Rehab Facility
- 075X – CORF- Comprehensive Outpatient Rehab Facility
- 085X – Critical Access Hospital

Reporting CPT/HCPCS Codes

- Certain revenue codes require the reporting of a HCPCS/CPT code on a claim.
  - Refer to the Revenue Code Requirement table for additional information.
- Reimbursement is based on HCPCS/CPT and modifiers reported at the claim service line level.
  - Medicare rates are applied during claim reimbursement along with the MDHHS reduction factor.
  - If the code is on the MDHHS OPPS wrap around codes list that established rate is paid (no reduction factor is applied).

Date of Service

- OPPS requires a claim line date of service for each service billed. If the dates are not reported or are not within the from and through dates on the header, the claim will be denied.
- If the claim spans more than one calendar day the OCE will divide the claim into separate days for the purpose of determining discount and multiple visits on the same day.
- All services for a single encounter must be reported on one claim except for Medicare's allowable repetitively billed services.
  - Providers can attest that the services be billed separately by reporting the appropriate condition code.
- Late charges do not apply for outpatient hospital claims (type of bill 135). A claim adjustment/replacement would be submitted to report correct charges.
  - CHAMPS claim adjust/void quick reference guide

Covered Services

Injections • Dialysis • Therapies • Telemedicine

For outpatient hospital services, MDHHS follows Medicare's coverage policies as closely as is possible and appropriate.

Services MDHHS covers differently are described in this section.

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Injections

- Resources
  - Medicaid Provider Manual, Billing & Reimbursement for Institutional Providers, Section 7.18 Injections
  - Drug Carveout Tip
  - 340B policy MSA 17-07
  - Compound billing tip

- Outpatient hospital providers who bill physician administered drugs (injectable and non-injectable) separately to Medicaid must report the National Drug Code (NDC) and its supplemental information in addition to the corresponding procedure code (CPT or HCPCS) to assist Medicaid in collecting rebates.
- Invalid or missing NDC information or an NDC by a manufacturer who does not have a signed rebate agreement with CMS will reject at the claim service line level.
- To bill a procedure code (HCPCS or CPT) with multiple NDCs:
  - Electronic Claims
    - Report the HCPCS on multiple service lines
    - Report the 2-digit qualifier along with the NDC
    - The Qualifier or the Prescription/Link Number must be the same on each service line.

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Dialysis

- Resources
  - Medicaid Provider Manual, Billing & Reimbursement for Institutional Providers Chapter, Section 7.12 Dialysis (Hemodialysis and Peritoneal)
  - OPPS wrap around codes list
    - Dialysis services are identified by SI A2

- MDHHS follows Medicare's billing requirements for chronic dialysis services (e.g., the appropriate diagnosis code, patient weight, height, etc.); however, coverage and reimbursement policies differ.

MDHHS Outpatient Prospective Payment System
Wrap Around Codes
April 2021

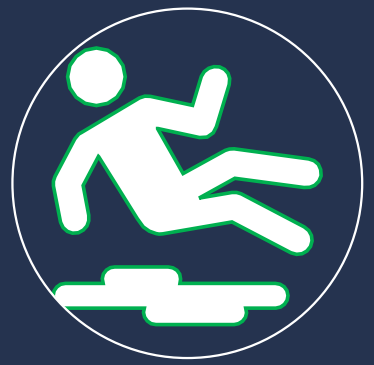
MDHHS Status Indicators Key

A1 = Reserved
A2 = Dialysis Services
A3 = Hospital Owned Ambulance Service
A4 = MDHHS Covered Services (Non-Medicare)
A5 = Medicaid Covered Vaccines
A6 = Vaccines for Children
A7 = State Plan Reimbursement
R1 = MDHHS Non-Covered Items

Code	Description	MDHHS Status Indicator	MDHHS Rate or CMS SI
90935	Hemodialysis One Evaluation	A2	$145.34
90937	Hemodialysis Repeated Eval	A2	$39.33
90945	Dialysis One Evaluation	A2	$61.07
90947	Dialysis Repeated Eval	A2	$40.21
90963	Esrd Home Pt Serv P Mo <2yrs	A2	$1,866.60
90964	Esrd Home Pt Serv P Mo 2-11	A2	$1,866.60
90965	Esrd Home Pt Serv P Mo 12-19	A2	$1,866.60
90966	Esrd Home Pt Serv P Mo 20+	A2	$1,866.60
90967	Esrd Svc Pr Day Pt <2	A2	$61.07
90968	Esrd Svc Pr Day Pt 2-11	A2	$61.07
90969	Esrd Svc Pr Day Pt 12-19	A2	$61.07
90970	Esrd Svc Pr Day Pt 20+	A2	$61.07
90989	Dialysis Training Complete	A2	$331.14
90993	Dialysis Training Incompl	A2	$22.07
90999	Unlisted Dialysis Procedure (Per Medicare, Hemodialysis Claims Must Include Hcpcs 90999 On The Line Reporting Revenue Code 082x)	A2	$145.34

Therapies

- Reimbursement is based on the Multiple Procedure Payment Reduction (MPPR) rate file: https://www.cms.gov/Medicare/Billing/TherapyServices
  - Michigan uses Locality 99 and Carrier 08202



Occupational Therapy (OT)

- Maximum of 144 units within a calendar year
- The fee for OT includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy, unless the visit is unrelated to OT.

Physical Therapy (PT)

- Maximum of 144 units within a calendar year
- Evaluation or re-evaluation may be billed with other PT services on the same day. Therapy must be provided by the evaluating discipline.

Speech Language (ST)

- Maximum of 36 visits within the first 12 consecutive calendar months of therapy
- Hospitals cannot bill a clinic room charge in addition to the therapy unless the visit is unrelated to speech therapy.

Prior Authorization is required for continuing therapy beyond the initial 12 consecutive calendar months of therapy.

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Telemedicine

- Telemedicine Database
- Medicaid Provider Manual, Practitioner Chapter, Section 17 Telemedicine
- MSA 20-09 : General Telemedicine Policy Changes

- Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location.
- MDHHS requires a real time interactive system at both the originating and distant site, allowing instantaneous interaction between the patient and health care professional via the telecommunication system.
- To be reimbursed for the originating site facility fee, the hospital must bill the appropriate telemedicine CPT/HCPCS procedure code and modifier.
- For services submitted on the institutional invoice, the appropriate National Uniform Billing Committee (NUBC) revenue code, along with the appropriate CPT/HCPCS procedure code and modifier must be submitted. Telemedicine claims without these indicators may be denied.

Top Denials

CHAMPS will deny claims either entirely at the header level or at the individual service line(s) level.

Only paid status claims can be adjusted or replaced.

Header Denials

- Reason and Remark code definitions: https://x12.org/reference
- Additional Resource: Common Hospital Claim Denials

Reason Code (CARC)	Remark Code (RARC)	Resolution/Resource
22 - This care may be covered by another payer per coordination of benefits.	N598 - Health care policy coverage is primary.	• How to Locate Payer ID and Other Health Insurance Information • Other insurance reporting requirements
A8 - Ungroupable DRG.	N657 - This should be billed with the appropriate code for these services.	A8 Claim Denials
97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	Medicare's allowable repetitively billed services
146 - Diagnosis was invalid for the date(s) of service reported.	M76- Missing/incomplete/invalid diagnosis or condition.	Review the date of service being reported on the claim. Ensure Diagnosis code is active on the date of service.
23 - The impact of prior payer(s) adjudication including payments and/or adjustments.		Provider Alert October 8, 2019: Attention Outpatient Hospital Providers

Service Line Denials

- Reason and Remark code definitions: https://x12.org/reference

Reason Code (CARC)	Remark Code (RARC)	Resolution/Resource
24-Charges are covered under a capitation agreement/managed care plan.		Verify eligibility and submit charges to correct benefit plan. • CHAMPS Eligibility and Enrollment Tab Instructions • Drug Carveout Tip
204 - This service/equipment/drug is not covered under the patient's current benefit plan.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	Verify eligibility • CHAMPS Eligibility and Enrollment Tab Instructions
18 - Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO).	N522 - Duplicate of a claim processed, or to be processed, as a crossover claim.	Claim Limit List Function
16 - Claim/service lacks information or has submission/billing error(s).	N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.	Review addendum B and wrap list • Addendum A and Addendum B Updates • OPPS Wrap Around Codes List
16 - Claim/service lacks information or has submission/billing error(s).	M119 - Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	Procedure code reported requires a valid NDC code.

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Coronavirus (COVID-19) Resources

Visit Michigan.gov/COVIDVaccine for the most recent information on the vaccine in Michigan

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Coronavirus (COVID-19) Resources

MDHHS resources to keep providers informed about the Coronavirus (COVID-19) pandemic and the State of Michigan's response.

- Learn about our responses to Coronavirus (COVID-19) and find the latest program guidance. www.michigan.gov/coronavirus >> Resources >> For Health Professionals

- Additional Information:
  - COVID-19 Response Database
  - Telemedicine Database
  - Actions for Caregivers of Older Adults During COVID-19 and supporting Frequently Asked Questions (FAQ) document
  - COVID-19 Response MSA Policy Bulletins

- Questions About COVID-19?
  - Visit our Frequently Asked Questions page
    - Our most commonly answered questions can be found there and are updated often.
  - Call the COVID-19 Hotline at 1-888-535-6136
  - Email COVID19@michigan.gov

Learn about each phase of the MI Safe Start Plan

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Provider Resources

MDHHS website:
www.michigan.gov/medicaidproviders

We continue to update our Provider Resources:

- CHAMPS Resources
- Listserv Instructions
- Medicaid Provider Training Sessions
- Provider Alerts
- Provider Enrollment Website

Provider Support:

ProviderSupport@Michigan.gov
1-800-292-2550

Thank you for participating in the Michigan Medicaid Program