

State of Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF
MEDICAL CARE AND SERVICES PROVIDED

2a. Outpatient Hospital Services

Visits for medically necessary outpatient hospital services are allowed for all beneficiaries.

Prior authorization is required for outpatient hospital physical therapy, occupational therapy, speech therapy and mental health services. Prior authorization is performed by the Utilization Management and Quality Improvement Organization (UM/QIO) contractor for the Division of Medicaid.

Emergency room services are allowed for all beneficiaries without limitations.

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

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AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

- Provided: No limitations With limitations*
 Not provided.

b. Services of Christian Science nurses.

- Provided: No limitations With limitations*
 Not provided.

c. Care and services provided in Christian Science sanatoria.

- Provided: No limitations With limitations*
 Not provided.

d. Nursing facility services for patients under 21 years of age.

- Provided: No limitations With limitations*
 Not provided.

e. Emergency hospital services.

- Provided: No limitations With limitations*
 Not provided.

f. Personal care services in recipient's home prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

- Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

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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), will be used by the Division of Medicaid (DOM) in calculating these predetermined rates and will be updated July 1 of each year.

- a. On July 1st of each year, the DOM publishes and makes effective the Medicaid outpatient fee schedule used for services paid under the Medicaid Outpatient Prospective Payment System. The most recent final Medicare outpatient Addendum B and Addendum C published by the Centers for Medicare and Medicaid Services (CMS) as of April 1 each year will be used to calculate the APC and the Medicare Fees used on the Medicaid outpatient fee schedule effective July 1 with no retroactive adjustments. 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 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 weight times the Medicaid conversion factor.

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- c. The total claim allowed amount will be the lower of the provider's allowed billed charges before comparison or the allowed amount as calculated using Medicaid OPPS.
 - d. Subject to documentation of medical necessity, a separate payment will be made for observation care. Observation care will be paid regardless of patient diagnosis. For hospital observation services exceeding seven hours, Medicaid will pay an hourly fee for each hour up to a maximum of 23 hours (i.e., the maximum payment will be 16 hours times the hourly fee). Payment for the first seven hours of hospital observation services will be considered packaged within payment for other services.
 - e. 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 90% of the Ambulatory Payment Classification (APC) rate times the units (when applicable).
 - b. Where no APC fee has been assigned, outpatient services will be paid at 90% of any applicable Medicare fee times the units.
 - c. If there is no Medicare fee established for the service, payment will be made using the applicable Medicaid fee times the units (when applicable).

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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 APC 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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Emergency Hospital Services

Emergent Visits

Medically necessary emergency services provided by hospitals, except Indian Health Services, will be reimbursed through APCs for the three (3) highest level emergent Evaluation and Management codes as follows:

- a. For each emergent service or procedure, the fee is 90% of the Ambulatory Payment Classification (APC) rate times the units (when applicable).
- b. Where no APC fee has been assigned, emergent services will be paid at 90% of any applicable Medicare fee times the units.
- c. If there is no Medicare fee established for the emergent service, payment will be made using the applicable Medicaid fee times the units (when applicable).
- d. Emergent visits are subject to post-payment review.

Non-Emergent Visits

Division of Medicaid uses the two (2) lowest emergency department Evaluation and Management code descriptions to determine non-emergent emergency department visits. The level of the APC rate for the provider is determined by the level of the Evaluation and Management code billed for the service.

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 APC fee does not include the five percent (5%) reduction. This provision is not applicable to Indian Health Services.

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