Outpatient hospital services are preventative, diagnostic, therapeutic, rehabilitative, or palliative services provided by a licensed hospital to an outpatient by or under the direction of a physician or dentist.

The Division of Medicaid covers medically necessary outpatient hospital services. This includes outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five (35) mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009.

The outpatient services must be provided by hospital salaried or contracted employees. Contracted services means hospital services provided according to a written agreement between a hospital and the health care professional providing the hospital services. Hospitals may bill only for services provided in the hospital's outpatient department as defined above.

Off Site Services

If contracted or employed hospital employees provide services off site and outside of the outpatient hospital departments, the hospital may not bill a charge on the UB04 claim format as an outpatient hospital service. This includes, but is not limited to, sites such as the beneficiary's home, daycare centers, schools, skilled nursing facilities, physician clinics, or therapy clinics. Such places of service are not in the hospital's outpatient hospital departments and do not qualify as an outpatient hospital service.

Partial Hospitalization or Day Treatment Programs

Partial hospitalization programs or day treatment programs are not covered by the Division of Medicaid in an outpatient hospital setting. For DOM purposes, this will be defined as those programs that are clearly billed as partial hospitalization and those represented to the community as partial hospitalization programs or day treatment programs and billed to the Division of Medicaid through revenue and procedure codes in a pattern that would reflect multiple units or daily services.

Professional Fees

To bill professional fees for physician services performed in hospital owned physician clinics, hospitals must file services on the CMS 1500 claim form under a physician group provider number. If a hospital needs to apply for a physician group number, the hospital may apply online, obtain a provider enrollment form at www.medicaid.ms.gov or contact the fiscal agent for the form. The provider application must be returned to the fiscal agent for processing. This same policy applies to other hospital owned clinics or facilities for other types of health care professionals (nurse practitioners, therapists, etc.) that qualify as a Mississippi Medicaid provider.

Benefits/ Limitations/ Exclusions

Benefits are paid for covered facility and professional services in accordance with provisions of the Mississippi Medicaid Program. All services, limits, and exclusions are applicable.

Outpatient hospital services shall be reimbursed at a percentage of billed charges (unless specified differently). The percentage paid is the lower of 75% of charges or the cost-to-charge ratio, as computed by Medicaid using the hospital's cost report or by other means approved by the grantor agency. The cost-to-charge ratio shall be computed each year for use in the following year's payments. Adjustments to outpatient services claims may be made if the cost-to-charge ratio is adjusted as a result of an amended cost report, audit, or Medicare Final Settlement. The cost-to-charge ratio for outpatient services will be computed under Title XVIII (Medicare) methodology, excluding bad debts and other services paid by Medicaid under a different methodology (ex: Rural Health Clinic services and Federally Qualified Health Center services).

All outpatient laboratory and radiology services shall be reimbursed on a fee-for-service basis.

Hospital-based clinics may not bill facility fees on the UB-04 unless they are a teaching hospital with a resident-to-bed ratio of 0.25 or greater.

In cases of a change of ownership, the first cost report filed by the new owner will be used to set the outpatient percentage retroactive to the date of the change of ownership.

Refer to Provider Policy Manual Section 28.15 for transplant reimbursement policy.

Outpatient hospital services are preventative, diagnostic, therapeutic, rehabilitative, or palliative services provided by a licensed hospital to an outpatient by or under the direction of a physician or dentist.

~~Outpatient hospital services which are covered by Mississippi Medicaid must be provided within the main campus of the hospital.~~

~~For Mississippi Medicaid, campus means the physical area immediately adjacent to the hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are immediately adjacent structures owned or leased by the hospital.~~

The Division of Medicaid covers medically necessary outpatient hospital services. This includes outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five (35) mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009.

The outpatient services must be provided by hospital salaried or contracted employees. Contracted services means hospital services provided according to a written agreement between a hospital and the health care professional providing the hospital services. Hospitals may bill only for services provided in the hospital's outpatient department as defined above.

Off Site Services

If contracted or employed hospital employees provide services off site and outside of the outpatient hospital departments, the hospital may not bill a charge on the UB04 claim format as an outpatient hospital service. This includes, but is not limited to, sites such as the beneficiary's home, daycare centers, schools, skilled nursing facilities, physician clinics, or therapy clinics. Such places of service are not in the hospital's outpatient hospital departments and do not qualify as an outpatient hospital service.

Partial Hospitalization or Day Treatment Programs

Partial hospitalization programs or day treatment programs are not covered by the Division of Medicaid in an outpatient hospital setting. For ~~Mississippi Medicaid~~ DOM purposes, this will be defined as those programs that are clearly billed as partial hospitalization and those represented to the community as partial hospitalization programs or day treatment programs and billed to the Division of Medicaid through revenue and procedure codes in a pattern that would reflect multiple units or daily services.

Professional Fees

To bill professional fees for physician services performed in hospital owned physician clinics, hospitals must file services on the CMS 1500 claim form under a physician group provider number. If a hospital needs to apply for a physician group number, the hospital may apply online, obtain a provider enrollment form at ~~www.dom.state.ms.us,~~ www.medicaid.ms.gov or contact the fiscal agent for the form. The provider application must be returned to the fiscal agent for processing. This same policy applies to other hospital owned clinics or facilities for other types of health care professionals (nurse practitioners, therapists, etc.) that qualify as a Mississippi Medicaid provider.

Outpatient hospital services shall be reimbursed at a percentage of billed charges (unless specified differently). The percentage paid is the lower of 75% of charges or the cost-to-charge ratio, as computed by Medicaid using the hospital's cost report or by other means approved by the grantor agency. The cost-to-charge ratio shall be computed each year for use in the following year's payments. Adjustments to outpatient services claims may be made if the cost-to-charge ratio is adjusted as a result of an amended cost report, audit, or Medicare Final Settlement. The cost-to-charge ratio for outpatient services will be computed under Title XVIII (Medicare) methodology, excluding bad debts and other services paid by Medicaid under a different methodology (ex: Rural Health Clinic services and Federally Qualified Health Center services).

All outpatient laboratory and radiology services shall be reimbursed on a fee-for-service basis.

Hospital-based clinics may not bill facility fees on the ~~UB-92~~ UB-04 unless they are a teaching hospital with a resident-to-bed ratio of 0.25 or greater.

In cases of a change of ownership, the first cost report filed by the new owner will be used to set the outpatient percentage retroactive to the date of the change of ownership.

~~Providers should refer to Section 28.15 for information on transplant reimbursement.~~ Refer to Provider Policy Manual Section 28.15 for transplant reimbursement policy.