

Frequently Asked Questions

1. With the implementation of this new payment system, will it eliminate the surgery rate payment system?
Yes, OPSS replaces the current Ambulatory Surgical Center (ASC) payment methodology for surgical procedures performed in an outpatient hospital setting.
2. Does this mean that there are not going to be Critical Access Hospitals (CAH) in the State of Wyoming anymore according to Medicaid?
No, CAH still exist, only the payment methodology is changing. Instead of being paid 70% of billed charges, CAHs will be paid according to Ambulatory Payment Classifications (APCs), which are, in essence, a line-level fee schedule by procedure code.
3. What steps did the Department of Health take to provide for public comment prior to implementation of any proposed changes?
The Department posted a public notice in the Casper Star Tribune and the Wyoming Tribune-Eagle papers on May 9, 2005. The notice allowed for public comment.
4. What prospective, predictive review and analysis took place to determine the “winners and losers” of the “budget neutral” proposed change?
The Department compared payments under the current system to payments under the proposed OPSS system on an individual provider level. For the three main provider groups (CAH, children’s hospitals, and general acute hospitals) the analysis indicated:
 1. *The general acute hospitals would experience, on average, estimated cost coverage equal to 57 percent under the new methodology. Under the previous methodology, estimated cost coverage was 51 percent;*
 2. *The majority of children’s hospitals would experience an increase in payments; and*
 3. *The majority of CAH would experience a decrease in payments due to decreasing overall payments to this group from 70% of charges to 90% of estimated costs.**The Department will perform on-going payment and provider billing monitoring under the new system, and make adjustments to the conversion factors if necessary.*
5. What are the results of Durable Medical Equipment (DME)?
Non-implantable DME (status indicator “Y”) is not covered under OPSS and should be billed using a DME provider number.
6. On ER claims, will there still only be 1 payment for the level of care or will payment be allowed separately for procedures performed in the ER?
If admitted to the hospital as an inpatient from the ER then the ER services would need to be included in the inpatient claim. OPSS does not affect inpatient billing.
7. When will the inpatient list be updated and will it keep up with Medicare’s updates?
The Department has adopted Medicare’s list of inpatient only codes. The list is available on the OPSS information page of the EqualityCare website (<http://wyequalitycare.acs-inc.com/opps.html>). The inpatient list is updated yearly for a January 1 effective date.

8. Is the implementation date of July 1, 2005 set in stone?

No, the implementation has been delayed until October 1, 2005.

9. Will the Department continue to follow the less than 24 hour rule on admission or go to the inpatient only list?

The Department will continue to follow the inpatient only list. The procedures on the list may only be performed in an inpatient setting. Inpatient stays less than 24 hours would be paid the per diem rate while stays greater than 24 hours would be paid the level of care rate.

10. Does the 24-hour rule (outpatient services within 24 hours of an inpatient admission need to be combined with the inpatient claim) still apply to CAH?

The policy will not change and still applies to all hospitals (CAH, children's hospitals and general acute hospitals).

11. With the RA, is there a total by claim as far as total amount billed, paid, write off, and copay? It does not appear to be in the example in the ACS Video Conference Presentation.

Yes, there is a total by claim. In the presentation example (slide 48), it is the first line below the client's name, ID and patient account number.

12. How did the Department determine the relative weight?

The Department adopted Medicare's relative weights. Medicare implemented OPPTS in August 2000. By adopting Medicare's relative weights, the Department is taking advantage of Medicare's groundwork as well as provider's familiarity with Medicare's system.

13. Are the presentations from the Video Conference on the website?

Yes, they are available on the OPPTS Information page of the EqualityCare website (<http://wyequalitycare.acs-inc.com/opps.html>).

14. What is an example of no more than one date of service per line item?

Incorrect:

Rev Code	Procedure	Service Date		Units
0259	J0128	060605	060705	2

This example shows more than one date of service per line. The provider billed for injections given on June 6th and 7th on the same line.

Correct:

Rev Code	Procedure	Service Date		Units
0259	J0128	060605	060605	1
0259	J0128	060705	060705	1

This example shows one date of service per line. The provider billed for injections given on June 6th and 7th on separate lines.

15. On the line item issue, the Department stated different dates of service must be billed on separate lines, like pharmacy or supplies. Are you including pre-OP?
Yes, even though the same service (pharmacy, supplies, etc.) can be provided on consecutive days, each date of service must be billed on a separate line.
16. Will the Department deny line items with the same revenue code on the same date of service?
Not necessarily. As long as the procedure codes are different, lines with the same revenue code and the same date of service will not deny as duplicates.
17. We are seeing that the Department is denying for duplicate revenue codes even with different procedure codes.
Yes, under the current reimbursement methodology, some revenue codes are denied as duplicates even when the procedure codes are different. However, under the new methodology, lines with the same revenue code and the same date of service will not deny as duplicates as long as the procedure codes are different.
18. Is the exception on slide 30 of the presentation correct that reference labs do not have to bill all services on the same day for a client on the same claim?
Yes, the exception is correct as long as the bill types are different. All services provided to an EqualityCare client by a hospital on the same day must be billed on a single claim unless a reference lab (bill type 14X) is billed in conjunction with a claim for an outpatient hospital (bill type 12X, 13X or 85X). Reference labs will still have to bill all of their services on the same claim. They just do not have to combine them with the outpatient hospital claim.
19. When the Department refers to same date of service billing, what if Medicaid is the secondary payer? Do those services still need to be billed together?
Yes, all services provided to an EqualityCare client by an outpatient hospital on the same day must be billed on a single claim. The only the exception is for reference labs. Reference lab services (bill type 14X) may be billed separately from outpatient hospital services (bill type 12X, 13X or 85X).
20. If we bill commercial insurance carriers on two separate claims, how do we get those claims reimbursed by EqualityCare? Do we send two separate claims with two separate EOBs or combine all together?
It will be necessary to combine the two separate claims into one and attach the two insurance EOBs.
21. Do modifiers print on the remittance advice (RA)? It does not appear to be in the example on slide 48 of the presentation.
Although that particular example did not include modifiers, up to four may be printed per line on the RA.
22. If billing reoccurring services for a 30 day period and those dates cross the implementation date, will we need to split the claim into two (bill those services prior to the implementation date on one claim and those services after the implementation date on another claim)?
No, you will not have to split the claim. The "From" date at the header level determines how the claim will be paid. If the "From" date is prior to October 1, 2005, then the claim will be reimbursed using the current methodology. If the "From" date is October 1, 2005 or thereafter, then the claim will be reimbursed using the OPPS methodology. Therefore, a claim that crosses the implementation date will be paid using the current methodology.