APA-2

ALABAMA MEDICAID AGENCY

NOTICE OF INTENDED ACTION

RULE NO. & TITLE: 560-X-7-.17 Outpatient Hospital Services

INTENDED ACTION: Amend 560-X-7-.17

SUBSTANCE OF PROPOSED ACTION: The above referenced rule is being amended to allow a licensed nurse practitioner or physician assistant to certify medically necessary services in the hospital emergency room that are within their scope of practice.

TIME, PLACE, MANNER OF PRESENTING VIEWS: Written or oral comments may be submitted to the Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624. Agency business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:. Written/Oral comments concerning this change must be received by the Alabama Medicaid Agency no later than February 4, 2016.

CONTACT PERSON AT AGENCY: Stephanie Lindsay, Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624. Phone: (334) 242-5833.

Stephanie McGee Azar
Commissioner

Rule No. 560-X-7-.17 Outpatient Hospital Services

(1) "Outpatient hospital services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician/dentist at a licensed hospital.

(2) Medical services provided in the outpatient department must be identified and the specific treatment documented in the medical record.

(3) Outpatient surgical services are those covered procedures commonly performed on an inpatient basis that may be safely performed on an outpatient basis. Only those surgeries included on the Medicaid outpatient hospital fee schedule will be covered on an outpatient basis. Surgeries included on the Medicaid outpatient surgical list are reimbursable when provided on an inpatient basis if utilization review criteria are met.

(a) Surgical procedures that are not listed on Medicaid's outpatient fee schedule may be sent to the Institutional Services Unit to be considered for coverage in the outpatient setting if medically necessary and the procedure is approved by the Medical Director.

(b) Refer to the Outpatient Hospital Fee Schedule on the Medicaid website for a list of covered surgical codes.

(4) Reimbursement of outpatient hospital visits includes the use of the facility and no additional facility fee may be billed.

(a) All outpatient hospital services provided by the hospital from admission to discharge of the outpatient will constitute a visit.

(b) Specimens and blood samples sent to the hospital for performance of tests are classified as non-patient hospital services since the patient does not directly receive services from the hospital; therefore, this does not constitute a visit and is not subject to program limitations.

(c) Providers who send specimens to independent laboratories for analysis may bill Medicaid for a collection fee. This fee shall not be paid to anyone who has not actually collected the specimen from the patient.

(d) Routine venipuncture for collection of laboratory specimens may be billed only when sending blood specimens to another site for analysis. The collection fee may not be billed if the lab work is done at the same site where the specimen was drawn.

(e) Hospital labs may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. Payment may be made to the referring laboratory but only if one of the following conditions is met:

1. the referring laboratory is located in, or is part of, a rural hospital;
2. the referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity; or
3. the referring laboratory does not refer more than 30 percent of the clinical laboratory tests for which it receives requests for testing during the year (not counting referrals made under the wholly-owned condition described above).

(f) . Radiology services are defined as CPT-4 procedure codes 70000 through 79999. Laboratory services are defined as procedure codes 80000 through 89999.

(g) Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure indicated on the Medicaid outpatient hospital fee schedule on the Medicaid website. This rate is established as a facility fee for the hospital and includes all nursing and technician services; diagnostic, therapeutic and pathology services; pre-op and post-op lab and x-ray services; materials for anesthesia; drugs and biologicals; dressings, splints, casts, appliances, and equipment directly related to the surgical procedure.

(h) Multiple surgical procedures on the claim will be reimbursed the lesser of charges or 100% of the fee on the pricing file for the initial procedure and the lesser of charges or 50% of the fee on the pricing file for subsequent procedures.

(5) "Emergency services" are services that are furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. A "certified emergency" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part."

(6) Emergency medical services provided in the hospital emergency room must be certified and signed by the attending licensed physician, nurse practitioner or physician assistant at the time the service is rendered, and documented in the medical record if the claim is filed as a "certified emergency."

(7) Certified emergency visits are unlimited if the medical necessity is properly documented and certified in the medical record by the attending licensed physician, nurse practitioner or physician assistant at the time services are rendered. Certified emergency visits do not require a PMP referral.

(8) UB 04 claims for emergency department services must be coded with the appropriate CPT code according to the criteria established by Medicaid to be considered for payment.

(9) Outpatient dialysis services are covered under the End-Stage Renal Disease Program and cannot be reimbursed as an outpatient hospital service. See Chapter 24 for details.

(10) Inpatient Admission after Outpatient Hospital Services-If the patient is admitted as an inpatient before midnight of the day outpatient services were rendered at the same hospital all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient will be considered as the first day of inpatient hospital services.

(11) Outpatient Observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

(a) Outpatient observation is defined as the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a

decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to no more than 23 hours.

(b) Outpatient observation is considered an outpatient visit.

(c) An observation unit is defined as an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires either additional observation before a decision is made about admission to the hospital or prolonged patient care is rendered. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient. The following guidelines apply:

1. A physician's order is required for admission and discharge from the observation unit.

2. A physician must have personal contact with the patient at least once during the observation stay.

3. Patients in the observation unit must be monitored by a registered nurse or an employee under his/her direct supervision.

4. Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as services provided.

5. A recipient must be in the observation unit a minimum of three hours but no more than 23 hours.

(d) Outpatient observation charges must be billed in conjunction with the appropriate emergency room facility fee.

(e) Observation coverage is billable in hourly increments only; therefore, a recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed.

(f) The first three hours of observation are included in the emergency room facility fee.

(g) Observation services should be billed according to the instructions in Chapter 19, (Hospital) of the Alabama Medicaid Provider Manual. The appropriate HCPCS or CPT code may be billed up to 20 units (unit=one hour) per day.

(h) Ancillary charges (lab work, x-ray, etc.) may be billed with the emergency room facility fee and observation charge.

(i) If the observation spans midnight and the recipient is discharged from the observation unit the following day, the provider should bill all observation charges using the date of admission to the observation unit on the outpatient claim form.

(j) If a recipient is admitted to the hospital from outpatient observation, all outpatient charges must be combined and billed with the inpatient charges. The provider should indicate the date of admission to the inpatient hospital as the admission date on the claim form for inpatient services.

(k) Outpatient observation charges cannot be billed in conjunction with outpatient surgery or critical care.

(l) Medical records will be reviewed retrospectively by Medicaid to ensure compliance with the above stated guidelines and criteria.

(12) Medicaid will cover two obstetrical ultrasounds per year for Medicaid recipients that are not participating in the maternity care program. Additional ultrasounds may be approved if a patient's documented medical condition meets the criteria established by Medicaid.

Providers should contact Medicaid's Prior Authorization Unit in writing to request approval for additional ultrasounds.

Author: Solomon Williams, Associate Director, Institutional Services.
Statutory Authority: State Plan, Attachment 4.19-B, page 8.1, Attachment 3.1-A, page 1.2; Title XIX, Social Security Act, Section 1833(h) (5) (A); 42C.F.R. Sections 440.20, 440.170, 440.255, 447.321.
History: Rule effective October 1, 1982. **Amended:** October 1, 1983; June 9, 1986; February 9, 1987; May 1, 1987; August 10, 1987; November 10, 1987; August 10, 1988; January 12, 1990; July 1, 1990; October 1, 1991; December 12, 1991; January 14, 1992; April 11, 1997; June 18, 1999; September 10, 1999; December 16, 1999; March 13, 2000; April 20, 2000; July 11, 2000. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed March 22, 2010; effective June 16, 2010. **Amended:** Emergency rule filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010. **Amended:** Emergency rule filed September 16, 2011 and effective October 1, 2011. **Amended:** Filed October 20, 2011; effective January 16, 2012. **Amended:** Filed June 11, 2015; effective July 16, 2015. **Amended:** Filed December 18, 2015.