19

19 Hospital

The Alabama Medicaid Program provides inpatient and outpatient hospital care. The policy provisions for hospitals can be found in the *Alabama Medicaid Agency Administrative Code,* chapter 7.

19.1 Enrollment

HP enrolls hospitals and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a hospital provider is added to the Medicaid system with the National Provider Identifier provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for hospital-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Hospitals are assigned a provider type of 01 (Hospital). Valid specialties for hospitals include the following:

- Post-extended care (PEC) hospital (540)
- General hospital (010)
- Inpatient psychiatric hospital under 21 (017)
- Inpatient psychiatric hospital over 65 (011)
- Lithotripsy (520)
- Mammography (292)
- Organ transplants (530)
- Long Term Care Hospital Unit (014)—for crossover claims only
- Psychiatric Unit (011)—for crossover claims only
- Rehabilitation Unit (012)—for crossover claims only

Enrollment Policy for Hospital Providers

In order to participate in the Alabama Medicaid Program and to receive Medicaid payment for inpatient and outpatient hospital services, a hospital provider must meet the following requirements:

- Receive certification for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital. Hospital types are identified on the “Hospital/CAH Medicare Database Worksheet” completed by the State Agency Surveyor.
- Possess a license as a hospital by the state of Alabama in accordance with current rules contained in the *Rules of Alabama State Board of Health Division of Licensure and Certification* Chapter 420-5-7.
- Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new facility.
- Submit a written description of an acceptable utilization review plan currently in effect.

The effective date of enrollment cannot be earlier than the Medicare certification dates.

Participating out-of-state (border) hospitals are subject to all program regulations and procedures that apply to participating Alabama hospitals and must submit copies of their annual certification from CMS, State licensing authority, and other changes regarding certification. "Border" is defined as within 30 miles of the Alabama state line.

Nonparticipating hospitals are those hospitals that have not executed an agreement with Alabama Medicaid covering their program participation, but that provide medically necessary covered out-of-state services. Application by nonparticipating hospitals is made to HP Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124-1685.

All Medicaid admissions to participating and nonparticipating facilities are subject to program benefits and limitations based on current Medicaid eligibility.

Enrollment Policy for Lithotripsy

The facility must submit an application to HP Provider Enrollment along with documentation that the lithotripsy machine is FDA approved.

19.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Refer to Appendix A, EPSDT for details on benefit limits for medically necessary services provided as a result of an EPSDT screening referral.

This section includes the following:

Section	Title	Topics Covered
19.2.1	Inpatient Benefits	• Routine Benefits • Extended Hospital Days for Delivery • Other Extended Benefits • Newborn Inpatient Benefits • Bed and Board and Semi-private Accommodations • Nursing and Other Services • Drugs and Biologicals • Supplies, Appliances, and Equipment • Hemodialysis • Organ Transplants • Blood • Sterilization and Hysterectomy • Abortions • Dental Services • Inpatient Noncovered Services • Payment of Inpatient Hospital Services • Utilization Review for Inpatient Hospital Admissions and Concurrent Stays • Adverse Events, Hospital-Acquired Conditions, and Present on Admission Indicators
19.2.2	Post-hospital Extended Care (PEC) Services	• General Information • PEC NPI • Admitting a Recipient to a PEC • Reimbursement for PEC Services
19.2.3	Swing Beds	• General Information • Level of Care for Swing Beds • Benefit Limitations for Swing Beds • Admission and Periodic Review
19.2.4	Billing Medicaid Recipients	Describes conditions under which Medicaid recipients may be billed for services rendered
19.2.5	Outpatient Services	• Outpatient Surgical Services • Injectable Drugs and Administration • Emergency Hospital Services • Outpatient Hemodialysis • Obstetrical Ultrasounds • Inpatient Admission after Outpatient Hospital Services • Outpatient Observation • Outpatient Hyperbaric Oxygen Therapy • Outpatient Lab and Radiology • Outpatient Chemotherapy and Radiation • Outpatient Physical Therapy • Outpatient Sleep Studies • Outpatient Cardiac Rehabilitation • Prior Authorization for Outpatient Service • Payment of Outpatient Hospital Services • Pulse Oximetry Services
19.2.6	Outpatient and Inpatient Tests	Describes program benefits and limitations for tests
19.2.7	Crossover Reimbursement	Provides crossover reimbursement benefit information for inpatient and outpatient services

19.2.1 Inpatient Benefits

This section describes benefits and policy provisions for the following:

Routine Benefits

An inpatient is a person admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he will remain overnight and occupy a bed (even if he is later discharged or is transferred to another hospital and does not use a bed overnight.)

Deleted: ~~Inpatient benefits for…per calendar year.~~

Added: Except for children…16 day payment.

Added: billed to Medicaid

Deleted: ~~charged to a recipient~~

Except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or additional inpatient days that have been authorized for deliveries or children who have been referred for treatment as a result of an EPSDT screening, the first 16 days in a calendar year will be reimbursed on an established per diem rate. Subsequent days will be factored into the establishment of cost as described in the *Alabama Medicaid Agency Administrative Code, Chapter 23, Hospital Reimbursement*. Since subsequent days are factored into the establishment of cost for inpatient hospital stays, the recipient **may not** be billed for services past the 16 day payment. The number of days of care billed to Medicaid for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is used to report days of care for Medicaid recipients even if the hospital uses a different definition of day for statistical or other purposes. When a claim is submitted to Medicaid for inpatient hospital services past the 16 day payment; Medicaid will zero pay the claim.

Added: When a claim…pay the claim.

Medicaid covers the day of admission but not the day of discharge. If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Extended Hospital Days for Delivery

Medicaid authorizes additional inpatient days for delivery for recipients who have exhausted their initial 16 covered days.

When medically necessary, additional days may be approved for deliveries, from onset of active labor to discharge. The number of extended days must meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria in order to be approved. Inpatient days prior to the onset of active labor will not be approved for extended benefits.

Requests for authorization should not be made prior to delivery. QA personnel issue a ten-digit authorization number for the approved stays.

Claims for extended benefit days should be filed separately from all other inpatient stays.

Other Extended Benefits

Medically necessary inpatient days are unlimited for recipients under the age of one in all hospitals.

Medically necessary inpatient days are unlimited for children under the age of six if the services are provided by a hospital that has been designated by Medicaid as a disproportionate share hospital.

Newborn Inpatient Benefits

Newborn well-baby nursery charges will be covered by an eligible mother's claim for up to ten days nursery care for each baby if the mother is in the hospital and is otherwise entitled to such coverage. For well-baby charges, revenue codes 170 and 171 are reflected on the mother's claim in conjunction with her inpatient stay for the delivery. The hospital per diem rate includes charges for the mother and newborn. Newborn well-baby care is not separately billable. Nursery charges for "boarder babies", infants with no identified problems or condition whose mothers have been discharged, were never admitted to the hospital, or are not otherwise eligible for Medicaid are not separately billable.

Criteria for Revenue Codes 170/171 - The infant is considered to have received "well baby" care if any of these criteria are met in the absence of more severe conditions:

1. Premature infants greater than 5.5 lbs. (2500) grams and/or greater than 35 weeks who are not sick;
2. Stable infants receiving phototherapy for less than 48 hours duration or while the mother is an inpatient receiving routine postpartum care, such as physiologic jaundice, breast milk jaundice, etc;
3. Infants on intake and output measurements;
4. Stable infants on intermittent alternative feeding methods, such as gavage, or frequent feedings;
5. Stabilized infants with malformation syndromes that do not require acute intervention;
6. Infants with suspected infection on prophylactic IV antibiotics while the mother is an inpatient;
7. Infants receiving close cardiorespiratory monitoring due to family history of SIDS;
8. Infants in stable condition in isolation;
9. Observation and evaluation of newborns for infectious conditions, neurological conditions, respiratory conditions, etc., and identifying those who require special attention;
10. Oliguria;
11. Stable infants with abnormal skin conditions;
12. Routine screenings, such as blood type, Coombs test, serologic test for syphilis, elevated serum phenylalanine, thyroid function tests, galactosemia, sickle cell, etc.;
13. Complete physical exam of the newborn, including vital signs, observation of skin, head, face, eyes, nose, ears, mouth, neck, vocalization, thorax, lungs, heart and vascular system, abdomen, genitalia, extremities, and back.

Newborns admitted to accommodations other than the well-baby nursery must be eligible for Medicaid benefits in their own right (claim must be billed under the baby's own name and Medicaid number). Example: If an infant is admitted to an intensive care or other specialty care nursery, the claim must be billed under the infant's number even if the mother is still an inpatient.

NOTE:

When billing for multiple births, list each baby's accommodation separately, noting "Baby A," "Baby B," and so on. Also, use the diagnosis codes that indicate multiple live births. For multiple births, nursery days equals the sum of the number of infants times the number of the mother's days.

Unless the newborn infant needs medically necessary, specialized care as defined below, no additional billings for inpatient services are allowed while the mother is an inpatient.

To bill Medicaid utilizing revenue codes 172 (Nursery/Continuing Care), 173 (Nursery/Intermediate Care), 174 (Nursery Intensive Care), and 179 (Nursery/Other), the infant must meet the following criteria established by Medicaid.

Criteria for Revenue Codes 172/173 - The infant must be 36 weeks gestation or less, or 5.5 lbs. (2500 grams) or less, AND have at least one of the following conditions which would cause the infant to be unstable as confirmed by abnormal vital signs or lab values:

1. Respiratory distress requiring significant intervention, including asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc;
2. Any nutritional disturbances, intestinal problems or known necrotizing entercolitis;
3. Cardiac disease requiring acute intervention;
4. Neonatal seizures;
5. Conditions which require IV intervention for reasons other than prophylaxis;
6. Apgar scores of less than six at five minutes of age;
7. Subdural and cerebral hemorrhage or other hemorrhage caused by prematurity or low birthweight;
8. Hyperbilirubinemia requiring exchange transfusion, phototherapy or other treatment for acute conditions present with hyperbilirubinemia, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
9. Pulmonary immaturity and/or without a pliable thorax, causing hypoventilation and hypoxia with respiratory and metabolic acidosis.

Criteria for Revenue Code 174 – Services must be provided in a neonatal intensive care unit due to the infant's unstable condition as confirmed by abnormal vital signs or lab values AND at least one of the following conditions:

1. Confirmed sepsis, pneumonia, meningitis;
2. Respiratory problems requiring significant intervention, such as asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc.;
3. Seizures;
4. Cardiac disease requiring acute intervention;

5. Infants of diabetic mothers that require IV glucose therapy;
6. Congenital abnormalities that require acute intervention;
7. Total parental nutrition (TPN) requirements;
8. Specified maternal conditions affecting fetus or newborn, such as noxious substances, alcohol, narcotics, etc., causing life threatening or unstable conditions which require treatment;
9. IV infusions which are not prophylactic, such as dopamine, isoproterenol, epinephrine, nitroglycerine, lidocaine, etc.;
10. Dialysis;
11. Umbilical or other arterial line or central venous line insertion;
12. Continuous monitoring due to an identified condition;
13. Cytomegalalovirus, hepatitis, herpes simplex, rubella, toxoplasmosis, syphilis, tuberculosis, or other congenital infections causing life threatening infections of the perinatal period;
14. Fetal or neonatal hemorrhage;
15. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
16. Necrotizing enterocolitis, diaphragmatic hernia, omphalocele.

Criteria for Revenue Code 179 – The infant must be unstable as confirmed by abnormal vital signs or lab values AND have one of the following conditions:

1. Close observation after operative procedures;
2. Total parenteral nutrition (TPN);
3. Umbilical or other arterial line or central venous line insertion;
4. Cardiac disease requiring acute intervention;
5. Neonatal seizures;
6. Neonatal sepsis, erythroblastosis, RH sensitization or other causes, or jaundice, requiring an exchange transfusion;
7. Respiratory distress, oxygen requirements for three or more continuous hours, apnea beds, chest tubes, etc.;
8. IV therapy for unstable conditions or known infection;
9. Any critically ill infant requiring 1:1 monitoring or greater may be maintained on a short term basis pending transfer to a Level III nursery;
10. Apgar scores of less than six at five minutes of age;
11. Congenital anomalies requiring special equipment, testing, or evaluation;
12. Bleeding disorders;
13. Hyperbilirubinemia of a level of 12 or greater requiring treatment.
14. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.

These charges are to be billed on a separate UB-04 claim form. ICD-9-CM diagnosis codes identifying the conditions that required the higher level of care must be on the claim. Medicaid will routinely monitor the coding of neonatal intensive care claims through post-payment review.

Bed and Board in Semi-Private Accommodations

Medicaid pays for semi-private accommodations (two-, three-, or four-bed accommodations). When accommodations more expensive than semi-private are furnished the patient because less expensive accommodations are not available at the time of admission or because the hospital has only private accommodations, Medicaid pays for the semi-private accommodations. In this case, the patient is not required to pay the difference.

When accommodations more expensive than semi-private are furnished the patient at his request, the hospital may charge the patient no more than the difference between the customary charge for semi-private accommodations and the more expensive accommodations at the time of admission. The hospital must have the patient sign a form requesting the more expensive accommodation and agreeing to pay the difference. This form must remain on file for review if questions arise regarding payment of private room charges.

Accommodations other than semi-private are governed by the following rules for private rooms.

Medically Necessary Private Rooms

Payment may be made for a private room or for other accommodations more expensive than semi-private only when such accommodations are medically necessary. Private rooms are considered medically necessary when the patient's condition requires him to be isolated for his own health or for that of others. Isolation may apply when treating a number of physical or mental conditions. Communicable diseases may require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatments are likely to alarm or disturb others in the same room. Medicaid pays for the use of intensive care facilities where medically necessary.

For the private room to be covered by Medicaid, the following conditions must be met:

- The physician must certify the specific medical condition requiring the need for a private room within 48 hours of admission.
- The physician’s written order must appear in the hospital records.
- When the physician certifies the need for continued hospitalization, the private room must also be re-certified as being medically necessary. Medicaid will not cover a private room on the basis of a retroactive statement of medical necessity by the physician.
- When medical necessity for a private room ceases, the patient should be placed in the semi-private accommodation.

Nursing and Other Services

Medicaid covers nursing and other related services, use of hospital facilities, and the medical social services ordinarily furnished by the hospital for the care and treatment of inpatients.

Drugs and Biologicals

Medicaid covers drugs and biologicals for use in the hospital that are ordinarily furnished by the hospital for the care and treatment of inpatients.

A patient may, on discharge from the hospital, take home remaining drugs that were supplied by prescription or doctor's order, if continued administration is necessary, since they have already been charged to his account by the hospital.

Medically necessary take-home drugs should be provided by written prescription either through the hospital pharmacy or any other Medicaid-approved pharmacy. Take-home drugs and medical supplies are not covered by Medicaid as inpatient hospital services.

Supplies, Appliances, and Equipment

Medicaid covers supplies, appliances, and equipment furnished by the hospital solely for the care and treatment of the Medicaid recipient during his inpatient stay in the hospital.

Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not generally covered as inpatient hospital services. A temporary or disposable item, however, that is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

The reasonable cost of oxygen furnished to hospital inpatients is covered under Medicaid as an inpatient hospital service.

Colostomy bags are provided for inpatients only for use while they are hospital patients. Hospitals cannot supply colostomy bags using Medicaid funds for home or nursing facility use.

Hemodialysis

Medicaid provides hemodialysis for chronic renal cases when the patient is not authorized this care under Medicare.

Organ Transplants

Medicaid-covered organ transplants require prior approval, which will be coordinated by the prime contractor. Medicaid's approved prime contractor is responsible for the coordination and reimbursement of all Medicaid-reimbursed organ transplants with the exception of cornea transplants. The Medicaid Professional Services staff has final approval. Contact the Medicaid Clinic Services Unit at (334) 242-5580 for contractor information.

Letters of approval or denial will be sent to the requesting provider by Medicaid’s coordinating entity upon completion of review by both the appropriate Medicaid Transplant Consultant and Medicaid’s Medical Director.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). Alabama Medicaid’s Transplant Program must receive the request for appeal within 30 calendar days from the date of the denial letter, or the decision will be final and no further review will be available.

Coordination services begin at initial evaluation and continue through a five-year post-operative period. Medicaid covers the following organ transplants for any age:

- Bone marrow transplants
- Kidney transplants
- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Liver/Small Bowel
- Small Bowel
- Pancreas
- Pancreas/Kidney

For Medicaid-eligible children through the age of 20, EPSDT-referred transplants not listed above will be considered for approval if the transplant is medically necessary, therapeutically proven effective, and considered non-experimental.

Reimbursement for all prior authorized transplants will be an all-inclusive global payment. This global payment includes pre-transplant evaluation; organ procurement; hospital room, board, and all ancillary costs both in and out of the hospital setting; inpatient postoperative care; and all professional fees. All services, room, board, pharmacy, laboratory, and other hospital costs are included under the global payment. All charges for services provided after the discharge, such as patient services, drugs, professional services, and other services will be reimbursed as fee-for-service.

The global payment represents payment in full. Any monies paid outside the global payment will be recouped. The recipient cannot be billed for the difference between the submitted amount and what the contractor pays.

For transplants performed at another in-state facility or at an out-of-state facility, the contractor negotiates the reimbursement rate with the facility and is responsible for global payment of the transplant from evaluation through hospital discharge. Medicaid reimburses the prime contractor for services provided.

The global payment for covered transplants performed out of state will be inclusive of all services provided out of state for the transplant, including all follow-up care, medications, transportation, food and lodging for caretaker/guardian of minor (if applicable), and home health. Once the patient has been discharged back to Alabama after transplant, services will be reimbursed fee for service and will count against applicable benefit limits.

Medicaid reimbursement is available only to the extent that other third party payers do not cover these services.

Blood

Charges for whole blood or equivalent quantities of packed red cells are not allowable since Red Cross provides blood to hospitals; however, blood processing and administration is a covered service.

Sterilization and Hysterectomy

Surgical procedures for male and female recipients as a method of birth control are covered services under the conditions set forth in Appendix C, Family Planning.

Any Medicaid service that relates to sterilization or hysterectomy must have documentation on file with Medicaid that shows consent or an acknowledgement of receipt of hysterectomy and sterilization information. This documentation must be submitted by the attending physician and is required to be on file at HP. This documentation must meet the criteria set forth under the sterilization and hysterectomy regulations. See Chapter 28, Physician and Appendix C, Family Planning, for further details.

NOTE:

Please refer to Section 5.7, Attachments, for information on billing electronic claims with attachments.

Abortions

Payment for abortions under Medicaid is subject to the conditions in the chapter pertaining to Physicians. Refer to Chapter 28, Physician, for further details.

Dental Services

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are covered for those recipients eligible for treatment under the EPSDT Program. See Chapter 13, Dentist, for details.

NOTE:

All inpatient hospital claims for dental services require prior authorization with the exception of children aged five and under.

Payment for Inpatient Hospital Services

Refer to the *Alabama Medicaid Administrative Code, Chapter 23, Hospital Reimbursement* for details on current hospital payment methodology.

Deleted: ~~Payment for all…DYS eligible recipients.~~

Added: Refer to the…hospital payment methodology.

Repeat Inpatient Admission

When a recipient is discharged and admitted to the same hospital on the same date of service, the hospital should completely discharge the recipient and then readmit on separate UB-04's (even if the readmission was for the same diagnosis).

Inpatient Services for Non-Citizens

- Sterilization codes are non-covered for non-citizens.
- Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid must be processed manually. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the Sobra worker, who determines eligibility; then forwards information to the Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.
- Delivery Services must be billed through HP for Non-Citizens.
- The Type of Admission restriction for type of admission “1” has been removed for UB-04 inpatient claims.
- For UB-04 inpatient claims, the following per diem is covered: Up to 2 days per diem for vaginal delivery and up to 4 days per diem for c-section delivery.
- Allowable diagnosis codes for UB-04 are: V270-V279, V300-V3921, 65100-65993, and 6571-6573.
- Allowable surgical codes for UB-04 are 740-7499.

Inpatient Non-covered Services

Medicaid does not cover the following items and services:

- Free items and services for which there is no legal obligation to pay are excluded from coverage, (for example, chest x-rays provided without charge by health organizations).
- Items and services that are required as a result of an act of war, occurring after the effective date of the patient's current coverage are not covered.
- Personal comfort items that do not contribute meaningfully to the treatment of an illness or injury or to functioning of a malformed body member are not covered. Charges for special items such as radio, telephone, television, and beauty and barber services are not covered.
- Routine physical check-ups required by third parties, such as insurance companies, business establishments or other government agencies are not covered.
- Braces, orthopedic shoes, corrective shoes, or other supportive devices for the feet are not covered.
- Custodial care and sitters are not covered.
- Cosmetic surgery or expenses in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the function of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic service, that coincidentally also serves some cosmetic purpose.

- Items and services to the extent that payment has been made, or can reasonably be expected to be made under a Workman's Compensation Law, a plan of the United States, or a state plan may not be paid for by Medicaid.
- Inpatient hospitalization for routine diagnostic evaluations that could be satisfactorily performed in the outpatient department of the hospital, in a physician's office, or in an appropriate clinic, are not covered.
- Medicaid does not cover psychological evaluations and testing, or psychiatric evaluations, unless actually performed by a psychiatrist in person.
- Medicaid does not cover speech therapy unless actually performed by a physician in person.
- There is no provision under Medicaid for payment of reserved inpatient hospital beds for patients on a pass for a day or more.
- Inpatient services provided specifically for a procedure that requires prior approval is not covered unless prior authorization from Medicaid for the procedure has been obtained by the recipient's attending physician. In the event that the recipient is receiving other services that require inpatient care at the time the procedure is performed, any charges directly related to the procedure will be noncovered and subject to recoupment. Additionally, all admissions must meet Alabama Medicaid Adult and Pediatric (SI/IS) Inpatient Care criteria.

Utilization Review for Inpatient Hospital Admissions and Concurrent Stays

Medicaid will utilize Alabama Medicaid Adult and Pediatric Inpatient Care Criteria (SI/IS) for utilization review, billing and reimbursement purposes.

- It is the hospital’s responsibility to utilize its own physician advisor.
- The attending physician and/or resident may change an order up to 30 days after discharge, as long as the patient met criteria for inpatient or observation services.

For admissions and continued stays on or after July 1, 2010, Medicaid will require in-state and border hospital providers to report dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

Dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy must be reported on the UB-04.

- Hospital Providers are required to use Occurrence Span Code 74 to identify days not meeting InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy, and
- Must enter the occurrence span dates for the dates that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

Inpatient psychiatric and rehabilitation services in an acute care facility will be exempt from reporting dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

The Alabama Medicaid Local Policy is available on the Alabama Medicaid website at www.medicaid.alabama.gov under *Programs/Hospital Services.* Hospital providers are to use the 2009 criteria until the 2010 criteria have been reviewed.

A percentage of admissions and concurrent stay charts will be reviewed by the Alabama Medicaid Agency and a Quality Improvement Organization contracted by the Agency.

All in-state and border hospitals must submit Medical Care Evaluation (MCE) Studies (i.e. Performance Improvement Studies) and Utilization Review (UR) Plans to the contracted Quality Improvement Organization every year upon request.

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services.

Adverse Events, Hospital-Acquired Conditions, and Present on Admission Indicators

Adverse Events are the events that must be reported to Medicaid by the hospital. To be reportable, these events must meet the following criteria:

- The event must be reasonably preventable as determined by a root cause analysis or some other means.
- The event must be within the control of the hospital.
- The event must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.
- The error or event must result in significant harm. The events for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 0 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from adverse events.

Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient hospital occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered POA.

Reporting Adverse Events

Adverse events must be reported to Medicaid by encrypted emailing required information to:

AdverseEvents@medicaid.alabama.gov. Each hospital will receive a password specifically for e-mail reporting. Reportable "Adverse Events" include:

- Surgery on a wrong body part
- Wrong surgery on a patient
- Surgery on a wrong patient

Reports will require the following information: Recipient first and last name, date of birth, Medicaid number, date event occurred and event type. A sample form is on the Alabama Medicaid Agency website at www.medicaid.alabama.gov under Programs/Hospital Services although hospitals may submit their own form as long as it contains all required information.

Reporting Hospital–Acquired Conditions (HAC) and Present on Admission (POA) on the UB-04 Claim Form

Hospitals should use the POA indicator on claims for these events. If no claim is submitted for the event or the event cannot be filed on a UB-04 claim form, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at AdverseEvents@medicaid.alabama.gov. The following information will be required: Recipient first and last name, date of birth, Medicaid number, date of event occurrence and event type. A sample form can be found on the Alabama Medicaid Agency website or a hospital may submit their own form as long as it contains all of the required information. Below are Hospital Acquired Conditions (HACs) with ICD-9 Codes that hospitals are required to report on the UB-04 claim form.

Selected HAC	CC/MCC (ICD-9-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) and 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829.1 830-839.9 850-854.1 925-929.9 949-949.5 991-994.9

Selected HAC	CC/MCC (ICD-9-CM Codes)
Catheter-Associated Urinary Tract Infection (UTI)	996.64—Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of poor glycemic control	250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10-249.11 (MCC), 249.20-249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) and one of the following procedure codes: 36.10-36.19.
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) OR 998.59 (CC) and one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85.
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis code-278.01 OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC), 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 81.51-81.52, 81.54.

The hospital may use documentation from the physician's qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the event be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

It is the responsibility of the hospital to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
- **1**-Unreported/Not used. Exempt from POA reporting.

If the value code '81' is indicated; then non-covered days must be present and the amount field must be greater than '0'.

It is the hospital's responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid's contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services.

19.2.2 Post Extended Care (PEC) Services

General Information

Inpatient hospital services rendered at a level of care lower than acute are considered post extended care services (PEC). The patient must have received a minimum of three consecutive days of acute care services in the hospital requesting PEC reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. Refer to Chapter 26, Nursing Facilities, for details.

Medically necessary services include, but are not limited to the following:

- Nursing care provided by or under the supervision of a registered nurse on a 24-hour basis
- Bed and board in a semi-private room; private accommodations may be used if the patient's condition requires isolation, if the facility has no ward or semi-private rooms, or if all ward or semi-private rooms are full at the time of admission and remain so during the recipient's stay
- Medically necessary over-the-counter (non-legend) drug products ordered by physician (Generic brands are required unless brand name is specified in writing by the attending physician)
- Personal services and supplies ordinarily furnished by a nursing facility for the comfort and cleanliness of the patient
- Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W, and normal saline)
- Services ordinarily furnished to an inpatient of a hospital

PEC National Provider Identifier

In order to receive reimbursement for PEC, the hospital must have a NPI. The NPI allows the hospital to designate up to ten beds for these services for hospitals with up to 100 beds, and an additional ten beds per each 100 beds thereafter. **All PEC services must be billed using a ‘PEC’ NPI.**

Determining the Availability of Nursing Facility Beds

Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available within a reasonable proximity and that the recipient requires two of the following medically necessary services on a regular basis:

- Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis
- Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis
- Nasopharyngeal aspiration required for the maintenance of a clear airway

- Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, or other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
- Administration of tube feedings by naso-gastric tube
- Care of extensive decubitus ulcers or other widespread skin disorders
- Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
- Use of oxygen on a regular or continuing basis
- Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post operative, or chronic conditions
- Routine medical treatment for a comatose patient

Admission and Periodic Review for PECs

To establish medical necessity, an application packet must be submitted to Medicaid within 60 days from the date Medicaid coverage is requested. The 60 days are calculated from the date the application is received and date stamped. All applications with a date over 60 days old will be assigned an effective date that is 60 days prior to the date stamp. No payment will be made for the days prior to the assigned effective date. The facility will be informed in writing of the assigned effective date.

The application packet consists of the following:

- A fully completed Medicaid Status Notification form XIX-LTC-4 including documentation certified by the applicant's attending physician to support the need for nursing home care
- Documentation certifying the patient has received inpatient acute care services for no less than three consecutive days during the current hospitalization in the requesting hospital prior to the commencement of post-extended care services. These days must have met the Medicaid Agency's approved acute care criteria
- Documentation certifying contact was made with each nursing facility within a reasonable proximity to determine bed non-availability prior to or on the date coverage is sought, and every 15 days thereafter

In order to continue PEC eligibility, re-certification must be made every 30 days. Nursing facility bed non-availability must be forwarded along with request for re-certification.

Reimbursement for PEC Services

Reimbursement for PEC services is made on a per diem basis at the average unweighted per diem rate paid by Medicaid to nursing facilities for routine nursing facility services furnished during the previous fiscal year. There shall be no separate year-end cost settlement. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, for details on rate computation.

A provider must accept the amount paid by Medicaid plus any patient liability amount to be paid by the recipient as payment in full, and further agrees to make no additional charge or charges for covered services.

Any day a patient receives such PEC services is considered an acute care inpatient hospital day. These beds are not considered nursing facility beds.

These services are not subject to the inpatient hospital benefit limitations. At this level of care, PEC days are unlimited if a nursing facility bed is not located.

All PEC services must be billed using the PEC NPI with the exception of outpatient services, pharmaceutical items to include over-the counter products, and prescription drugs.

- Outpatient services such as lab and x-ray services should be billed under the hospital National Provider Identifier number.
- Pharmaceutical items, to include over-the-counter products and prescription drugs should be billed separately under the hospital's pharmacy National Provider Identifier number.
- A Medicaid pharmacy provider outside of the hospital may fill the prescriptions if the hospital pharmacy is not a Medicaid provider.

19.2.3 Swing Beds

General Information

Swing beds are hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services.

Swing bed hospitals must meet all of the following criteria:

- Have fewer than 100 beds (excluding newborn and intensive care beds) and be located in a rural area as defined by the Census Bureau based on the most recent census
- Be Medicare certified as a swing bed provider
- Have a certificate of need for swing beds
- Be substantially in compliance with SNF conditions of participation for patient rights, specialized rehabilitation services, dental services, social services, patient activities, and discharge planning. (Most other SNF conditions would be met by virtue of the facilities compliance with comparable conditions of participation for hospitals.)
- Must not have in effect a 24 hour nursing waiver
- Must not have had a swing bed approval terminated within the two years previous to application for swing bed participation

Level of Care for Swing Beds

To receive swing bed services, recipients must require SNF level of care on a daily basis. The skilled services provided must be ones that, on a practical basis, can only be provided on an inpatient basis.

A condition that does not ordinarily require skilled care may require this care because of a special medical condition. Under such circumstances the service may be considered skilled because it must be performed by or supervised by skilled nursing or rehabilitation personnel.

The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. A patient may need skilled services to prevent further deterioration or preserve current capabilities.

Swing bed admissions not covered by Medicare because they do not meet medical criteria are also considered noncovered by Medicaid. These services cannot be reimbursed as a straight Medicaid service.

Benefit Limitations for Swing Beds

Swing bed services are unlimited as long as the recipient meets the SNF level of care medically and meets all other eligibility criteria, including financial criteria.

Admission and Periodic Review for Swing Beds

The Medicaid Long Term Care Admissions/Records (LTC ADMS/Records) Unit performs a pre-admission review of all Medicaid admissions to assure the necessity and appropriateness of the admission and that a physician has certified the need for swing bed care. Medicaid certifies the level of care required by the patient at the time of admission using the XIX-LTC-4 form. A control number is provided for each patient that is admitted.

The Medicaid staff physician(s) will review applications not initially approved by LTC ADMS/Records.

Recipients must meet SNF medical and financial requirements for swing bed admissions just as they are required for SNF admissions.

For recipients who receive retroactive Medicaid eligibility while using swing bed services, the hospital must furnish a form MED-54 to Medicaid. Attach all doctors' orders, progress and nurses' notes for the time in question.

LTC ADMS/Records issues medical approvals if the information provided to Medicaid documents the need for SNF care and the recipient meets criteria set forth in Rule 560-X-10-13 for SNF care.

The admission application packet must be sent to LTC ADMS/Records within 30 days from the date Medicaid coverage is sought and most contain a fully completed Medicaid status notification (form XIX-LTC-4), including documentation certified by the applicant’s attending physician to support the need for the nursing home care.

Once the LTC-4 is reviewed and approved, a prior control number is issued and entered into the Long Term Care Record file.

An LTC-2 form notifies the facility that the patient is medically eligible if the financial eligibility of the patient has been established and entered on the file. If financial eligibility has not been established and noted in the file, an XIX-LTC-2A is sent to the facility advising that medical eligibility is established but financial eligibility is not. If an LTC-2A is received, the facility should advise the patient or sponsor of the need to establish financial eligibility by applying at the District Office.

Continued stay reviews are required to assure the necessity and appropriateness of skilled care and effectiveness of discharge planning. Re-certification of SNF patients is required 30, 60, and 90 days after admission and then every 60 days thereafter. Physicians must state "I certify" and specify that the patient requires skilled care for continued stay in the facility. Facilities must have written policies and procedures for re-certification. The Inspection of Care team will monitor these during medical reviews to assure compliance.

19.2.4 Billing Medicaid Recipients

Providers may bill recipients for noncovered services, for example, days that do not meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria. private room accommodation charges incurred due to patient's request, or personal comfort items.

Added: days that do… Inpatient Care Criteria.

Deleted: ~~excessive days beyond benefit limitations,~~

Added: noncovered

The provider is responsible for informing the recipient of noncovered services. Medicaid recipients in hospitals may be billed for noncovered inpatient care occurring **after** they have received written notification of Medicaid non-coverage of hospital services. If the notice is issued prior to the recipient's admission, the recipient is liable for full payment if he enters the hospital. If the notice is issued at or after admission, the recipient is responsible for payment for all services provided **after** receipt of the notice.

19.2.5 Outpatient Hospital Services

Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician or dentist at a licensed hospital. Medical services provided in an outpatient setting must be identified and the specific treatment must be documented in the medical record. Outpatient visits (99281, 99282, 99283, 99284 and 99285) are limited to 3 per calendar year unless certified as an emergency. Providers must meet Medicare "provider based status determination" criteria in order to bill Medicaid for outpatient services provided in an 'off-campus' location. Refer to 42 CFR 413.65 for details on "provider based status determination".

Added: **Encounter Payment for Outpatient Hospital Services** section

Encounter Payment for Outpatient Hospital Services

Effective September 2, 2010 the following bullets describe an outpatient hospital encounter:

- Outpatient hospital encounters are generally face-to-face contacts between a patient and a health professional for medically necessary services.

- An encounter may also be classified as non-patient hospital services such as specimens and blood samples sent to the hospital for performance of tests. This may also include collection and processing of blood samples.

- Claims for ER and noncertified outpatient visits must be all inclusive. All inclusive means all charges associated with that visit such as lab and radiology services.

- Each hospital shall continue to bill for outpatient services as it did prior to the implementation of the encounter payment methodology. This means that Medicaid should not see a huge increase or decrease in the amount of claims with the implementation of the encounter payment methodology. If a hospital provider span billed for services such as chemotherapy, radiation services, or physical therapy services prior to implementation of the encounter payment methodology, then continue to span bill these services. Periodic post-payment reviews will be conducted by Medicaid.

- One encounter rate will be paid per ICN (internal control number)

Outpatient Surgical Services

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. Hospitals may bill other procedures (within the 90000 range) if they are listed on the Outpatient Fee Schedule located on the Medicaid website: www.medicaid.alabama.gov. Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

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

Patients who remain overnight after outpatient surgery, will be considered as an outpatient UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

Patients who remain overnight after outpatient surgery, will be considered as an outpatient UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

NOTE:

Claims for outpatient surgical procedures that are discontinued prior to completion must be submitted with modifier 73 or 74.

Lab and x-ray not directly related to the surgical procedure are not included in the fee and may be billed in addition to the surgical procedures that are reimbursed. Outpatient visits for surgical procedures do not count against the recipient's outpatient visit limit. Surgery procedure codes are billed with units of one.

Any lab and x-ray procedures considered 'directly related' to the surgical procedure are part of the reimbursement for the surgical fee if performed within 3 days (or 72 hours) prior to the surgery.

Any lab and x-ray procedures done as a pre-op for surgery will be covered by Medicaid in instances where the recipient is a 'no-show' for a scheduled surgical procedure.

In instances where a surgical procedure code has not been established or is an unlisted code the provider may bill the most descriptive procedure code with modifier 22 (unusual procedural services) until a covered procedure code is established.

Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure on the Medicaid outpatient surgical list. This rate is established as a facility fee for the hospital and includes the following:

- 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.

In order to bill for bilateral procedures (previously identified by modifier 50), the most appropriate procedure code must be billed on two separate lines and appended by the most appropriate anatomical modifier (i.e. RT, LT, etc).

Medicaid will automatically pay the surgical procedure code with the highest reimbursement rate at 100% of the allowed amount and the subsequent surgical procedures at 50%, minus TPL and copay.

Providers may visit the Medicaid website: www.medicaid.alabama.gov and click on the link for "Outpatient Fee Schedule", or continue to use the AVRS line at HP (1 (800) 727-7848) to verify coverage.

NOTE:

Procedures not listed in Appendix I or the Outpatient Fee Schedule may be covered for special circumstances. Approval must be obtained prior to the surgery. Refer to Chapter 4, Obtaining Prior Authorization. Providers should inform recipients prior to the provision of services as to their responsibilities for payment of services not covered by Medicaid.

Injectable Drugs and Administration

Injectable drugs from the Alabama Medicaid injectable drug list do not count against the yearly outpatient visit limitation. Medicaid has adopted Medicare's Drug Pricing Methodology utilizing the Average Sale Price (ASP) for HCPCS injectable drug codes. Hospitals are required to bill the current CPT codes for chemotherapy and non-chemotherapy administration. The crosswalk between the previous codes and the new codes is outlined in Appendix H, Injectable Drug Listing.

The following CPT drug administration code-ranges will remain as covered services:

- CPT code ranges 90760 through 90775, and CPT code ranges 96401 through 96542.

These guidelines should be followed by hospitals for billing administration codes:

- No administration fee (infusions, injections, or combinations) should be billed in conjunction with an ER visit (99281 – 99285).

- When administering multiple infusions, injections, or combinations, only one “initial” drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the services the patient is receiving and the additional codes are secondary to the initial one.

- “Subsequent” drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

- If the patient has to come back for a separately identifiable service on the same day, or has two IV lines per protocol, these services are considered separately billable with a modifier 76.

Emergency Hospital Services

Emergency medical services provided in the hospital emergency room must be certified and signed by the attending physician at the time the service is rendered and documented in the medical record if the claim is filed as a "certified emergency."

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

A certified emergency is an emergency 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 in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

The attending physician is the only one who can certify an emergency visit. In determining whether a claim should be submitted and documented as a certified emergency, consider the following guidelines:

- The case should be handled on a situational basis. Take into consideration the recipient, their background, extenuating circumstances, symptoms, time of day, and availability of primary care (if a weekend, night or holiday).
- Determine whether the presenting symptoms as reported would be expected to cause the patient to believe that a lack of medical care would result in an unfavorable outcome.
- Document why this case is a certified emergency. Documentation does not need to be extensive but should justify the certification.

- If it is not an emergency, do not certify the visit as one. Follow-up care (such as physical therapy, suture removal, or rechecks) should not be certified as an emergency.
- Children or adults brought to the emergency department for exam because of suspected abuse or neglect may be certified as an emergency by virtue of the extenuating circumstances.

Certified emergency visits are unlimited if the medical necessity is properly documented and certified in the medical record by the attending physician at the time services are rendered. The claim form for a certified emergency must have an “E” in field 73 on the UB-04 claim form.

UB-04 claims for emergency department services must be coded according to the criteria established by Medicaid to be considered for payment. Refer to Section 19.5.3, Procedure Codes, and Modifiers, for level of care codes for emergency department services.

These procedure codes (99281-99285) may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450.

Non-certified visits to the emergency room are considered outpatient visits and count against the three outpatient hospital visits allowed per calendar year.

Only one emergency room visit per day per provider will be reimbursed by Medicaid.

Outpatient Hemodialysis

Outpatient dialysis services are covered under the End-Stage Renal Disease Program and cannot be reimbursed as an outpatient hospital service. See Chapter 35, Renal Dialysis Facility, for details.

Obstetrical Ultrasounds

Medicaid covers two obstetrical ultrasounds per year for recipients under fee-for-service. Ultrasound payment is limited to one per day. Medicaid may approve additional ultrasounds if a patient’s documented medical condition meets the established criteria. Requests for additional obstetrical ultrasounds must include the required patient information as well as the following:

- Date of requested ultrasound
- Date of request
- A list of all dates of prior ultrasounds for the current pregnancy
- A diagnosis code for each ultrasound that has been done, starting with number one
- Recipient date of birth and Medicaid number
- HP-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

For patients covered under the Maternity Care Program, refer to Chapter 24, Maternity Care Program. Refer to Chapter 4, Obtaining Prior Authorization, for more information.

Inpatient Admission After Outpatient Hospital Services

If the patient is admitted as an inpatient before midnight of the day the 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 is considered to be the first day of inpatient hospital services.

Outpatient Observation

Outpatient observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

Outpatient observation is 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 23 hours or less.

Outpatient observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit unless documented as a certified emergency by the attending physician at the time of service.

An observation unit is 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 additional observation. 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:

- Patient must be admitted through the emergency room.
- A physician's order is required for admission and discharge from the observation unit.
- A physician must have personal contact with the patient at least once during the observation stay.
- A registered nurse or an employee under his/her direct supervision must monitor patients in the observation unit.
- Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as the services provided.
- A recipient must be in the observation unit at least three hours but less than 24 hours.

Outpatient observation charges must be billed in conjunction with the appropriate facility fee (99281 – 99285).

Observation coverage is billable in hourly increments only. A recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed. Observation charges are billed as follows:

- For the first three hours of observation the provider should bill a facility fee (99281 - 99285) with units of one.

- Procedure code 99218 should be used to bill the 4th through 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A detailed or comprehensive history

  - A detailed or comprehensive examination

  - Medical decision-making that is straightforward or of low complexity

The problem(s) requiring admission to “observation status” is usually of low severity.

- Procedure code 99219 should be used to bill the 4th through the 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A comprehensive history

  - A comprehensive examination

  - Medical decision-making of moderate complexity

  The problem(s) requiring admission to “observation status” is usually of moderate severity.

- Procedure code 99220 should be used to bill the 4th through the 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A comprehensive history

  - A comprehensive examination

  - Medical decision-making of high complexity

  The problem(s) requiring admission to “observation status” is of high severity.

Providers should bill the appropriate CPT code based on the severity of the patient’s condition. Providers may bill up to 20 units of each procedure code. Units are equal to the number of hours. These codes must be billed with a facility fee (99281-99285). The facility fee is billed with units of one and covers the first three hours. The applicable CPT code would then be billed for the 4th up to the 23rd hour.

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

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 claim form.

If a recipient is admitted to the hospital from outpatient observation before midnight of the day the services were rendered at the same hospital, all observation 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.

Outpatient observation charges cannot be billed in conjunction with outpatient surgery.

Medical records are reviewed retrospectively by Medicaid to ensure compliance with the above-stated guidelines and criteria.

Outpatient Hyperbaric Oxygen Therapy (HBO)

Hyperbaric oxygen therapy (HBO) is covered in an outpatient hospital setting under the guidelines listed below. HBO should not be a replacement for other standard successful therapeutic measures. Medical necessity for the use of HBO for more than two months duration must be prior approved. Prior approval (PA) requests for diagnoses not listed below or for treatment exceeding the limitations may be submitted for consideration to the Office of the Associate Medical Director. No approvals will be granted for conditions listed in the exclusion section. HBO should be billed on the UB-04 by the outpatient facility using revenue code 413 and procedure code 99183. Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Reimbursement for HBO is limited to that which is administered in a chamber for the following diagnoses:

Air or Gas Embolism

9580 9991

Limited to five treatments per year. PA required after five treatments.

Acute Carbon Monoxide Poisoning

986

Limited to five treatments per Incidence. Treatment should be discontinued when there is no further improvement in cognitive functioning. PA required after five treatments

Decompression Illness

9932 9933

Limited to ten treatments per year. Treatment should continue until Clinical exam reveals no further Improvements in response to therapy.

Gas Gangrene

0400

Limited to ten treatments per year. PA required after ten treatments.

Crush Injury

92700	92701	92702
92703	92709	92710
92711	92720	92721
9278	9279	92800
92801	92810	92811
92820	92821	9283
9288	9290	9299
99690	99691	99692
99693	99694	99695
99696	99699	

Limited to 15 treatments per year. Early application of HBO, preferably within four - six hours of injury, is essential for efficacy. The recommended treatment schedule is three 90 minute treatments per day over the first 48 hours after the injury; followed by two 90 minute treatments per day over the second period of 48 hours; and one 90 minute treatment over the third period of 48 hours.

Chronic Refractory Osteomyelitis

73010 - 73019

Limited to 40 treatments per year. To be utilized for infection that is persistent or recurring after appropriate interventions.

Diabetic wounds of lower extremities

70710 70711
70715 70719
70712 70714

Limited to 30 treatments per year. To be utilized only when wound fails to respond to established medical/surgical management. Requires an aggressive multidisciplinary approach to optimize the treatment of problem wounds. Diabetic wounds of the lower extremities are covered for patients who have type I or II diabetes and if the wound is classified as Wagner grade III or higher.

Radiation tissue damage

52689
990

Limited to 60 treatments per year. To be utilized as part of an overall treatment plan, including debridement or resection of viable tissues, specific antibiotic therapy, soft tissue flap reconstruction and bone grafting as may be indicated.

Skin grafts and flaps
99652
Limited to 40 treatments per year.
Twenty treatments to prepare graft site and 20 after graft or flap has been replaced.

Progressive necrotizing infection (necrotizing fasciitis)
72886
Limited to 10 treatments per year.

PA required after 10 treatments.

Acute peripheral arterial insufficiency
44421 44422 44481
Limited to five treatments per
year. PA required after five treatments.

Acute traumatic peripheral
Cyanide poisoning
Ischemia
90253 90301 9031
9040 90441
Limited to 15 treatments per year.

9877 9890
Limited to five treatments per incident. PA required after five treatments.

Actinomycosis
0390 - 0394
0398 - 0399
Limited to 10 treatments per year.
PA required after 10 treatments.

Exclusions
No reimbursement will be made for HBO provided in the treatment of the following conditions.

Cutaneous, decubitus, and stasis ulcer
Chronic peripheral vascular insufficiency
Anaerobic septicemia and infection other than clostridial
Skin burns
Senility
Myocardial Infarction
Cardiogenic Shock
Sickle Cell Crisis
Acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency)
Acute or chronic cerebral vascular insufficiency

Hepatic necrosis
Aerobic Septicemia
Nonvascular causes of common brain syndrome (i.e., Pick's disease, Alzheimer's disease, Korsakoff's disease)
Tetanus
Systemic aerobic infection
Organ transplantation
Organ storage
Pulmonary emphysema
Exceptional blood loss anemia
Multiple sclerosis
Arthritic diseases
Acute cerebral edema

Outpatient Lab and Radiology

Outpatient visits made solely for lab and radiology procedures do not count against a recipient's outpatient visit limits.

Claims containing only lab and radiology procedures may be span billed for one calendar month.

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.

Outpatient Chemotherapy and Radiation

Visits for these services do not count against the outpatient visit limitations and may be span billed for a calendar month. See Section 19.5.3, Procedure Codes, and Modifiers, for procedure codes to be used for these services. Diagnostic lab, diagnostic x-ray, and blood administration may be span billed in conjunction with outpatient chemotherapy and radiation.

Outpatient Physical Therapy

Physical therapy is a covered service based on medical necessity. Physical therapy is covered in a hospital outpatient setting for acute conditions. Recipients receiving therapy must be under the care of a physician or non-physician practitioner who certifies the recipient's need for therapy.

Added: For all physical…in this chapter.

For all physical therapy services performed as a result of an EPSDT screening refer to Chapter 37, Therapy, for policy only. Outpatient hospital physical therapy services will continue to be limited to those CPT codes listed in this chapter.

Added: documentation in the

Deleted: ~~evidence in the~~

Added: recertified

Deleted: ~~seen~~

If the therapy continues past the 60th day, there must be documentation in the patient's medical record that a physician or non-physician practitioner has recertified the patient within 60 days after the therapy began and every 30 days past the 60th day. Therapy services are not considered medically necessary if this requirement is not met. The 60-day period begins with the therapist's initial encounter with the patient (i.e., day the evaluation was performed). In the event an evaluation is not indicated, the 60-day period begins with the first treatment session. The therapist's first encounter with the patient should occur in a timely manner from the date of the physician's therapy referral.

Documentation in the patient's medical record must confirm that all patients receiving physical therapy services have been seen by the certifying physician as specifically indicated above. Having a physician signature on a certification or re-certification will not meet this requirement.

Therapy performed in an outpatient hospital setting does not count against the recipient's three non-emergency outpatient visit limits. Rehabilitative services are not covered. Rehabilitative services are the restoration of people with chronic physical or disabling conditions to useful activity.

Physical therapy services are limited to those CPT codes listed in this chapter. Maximum units for daily and annual limits are noted for each covered service.

Form 384 (Motorized/Power Wheelchair Assessment Form) may be obtained by contacting the Long Term Care Provider Services at 1-800-362-1504, option 1 for providers.

Records are subject to retrospective review. Physical therapy records must state the treatment plan and must meet the medical criteria below. If the medical criteria are not met or the treatment plan is not documented in the medical record, Medicaid may recoup payment.

Medical Criteria for Physical Therapy

Physical therapy is subject to the following criteria:

- Physical therapy is covered for acute conditions only. An acute condition is a new diagnosis that was made within three months of the beginning date of the physical therapy treatments.
- Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition that was diagnosed more than three months before the beginning date of the physical therapy treatments. An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition. For EPSDT recipients with chronic conditions refer to Chapter 37, Therapy, for policy only regarding physical therapy services. Physical therapy services are limited to those CPT codes listed in this chapter.

Added: For EPSDT recipients…in this chapter.

Plan of Treatment

In addition to the above stated medical criteria, the provider of service is responsible for developing a plan of treatment. This plan of treatment must be readily available at all times for review in the recipient's medical record. The plan of treatment should contain at least the following information:

- Recipient's name
- Recipient's current Medicaid number
- Diagnosis
- Date of onset or the date of the acute exacerbation, if applicable
- Type of surgery performed, if applicable
- Date of surgery, if applicable
- Functional status prior to and after therapy is completed

- Frequency and duration of treatment
- Modalities
- For ulcers, the location, size, and depth should be documented

The plan of treatment must be signed by the physician who ordered the physical therapy and the therapist who administered the treatments.

Physical Therapy (PT) Assistants

Physical therapy services provided in an outpatient hospital setting must be ordered by a physician and must be provided by or under the supervision of a qualified physical therapist.

Physical therapy assistants must work under the direction of a physical therapist with the following provisions:

- The PT must interpret the physician's referral.
- The PT must perform the initial evaluation.
- The PT must develop the treatment plan and program, including long and short-term goals.
- The PT must identify and document precautions, special problems, contraindications, goals, anticipated progress and plans for reevaluation.
- The PT must reevaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
- The PT must implement (perform the first treatment) and supervise the treatment program.
- The PT must co-sign each treatment note written by the physical therapy assistant.
- The PT must indicate he/she has directed the care of the patient and agrees with the documentation as written by the physical therapy assistant for each treatment note.

The PT must render the hands-on treatment, write and sign the treatment note every sixth visit.

Outpatient Sleep Studies

Sleep studies are covered services in an outpatient hospital. Medicaid does not enroll sleep study clinics. Indications for coverage are as follows:

Polysomnography includes sleep staging that is refined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). For a study to be reported as polysmnography, sleep must be recorded and staged for 6 hours and an attendant must be present throughout the course of the study.

The following are required measurements:

- Electrocardiogram (ECG)
- Airflow
- Ventilation and respiratory effort

- Gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis
- Extremity muscle activity, motor activity-movement
- Extended EEG monitoring
- Gastroesophageal reflux
- Continuous blood pressure monitoring
- Snoring
- Body positions, etc.

For a study to be reported as a polysomnogram:

- Studies must be performed for 6 hours
- Sleep must be recorded and staged
- An attendant must be present throughout the course of the study

Diagnostic testing is covered when a patient has the symptoms or complaints of one of the following conditions:

- Narcolepsy
- Sleep Apnea
- Parasomnias

(Refer to LMRP for further definition of conditions.)

Limitations

Diagnostic testing that is duplicative of previous sleep testing done by the attending physician to the extent the results are still pertinent is not covered because it is not medically necessary if there have been no significant clinical changes in medical history since the previous study.

Home sleep testing is not covered.

Polysomonography will not be covered in the following situations:

- For the diagnosis of patients with chronic insomnia
- To preoperatively evaluate a patient undergoing a laser assisted uvulopalatopharyngoplasty without clinical evidence that obstructive sleep apnea is suspected.
- To diagnose chronic lung disease (nocturnal hypoxemia in patients with chronic, obstructive, restrictive, or reactive lung disease is usually adequately evaluated by oximetry.)
- In cases where seizure disorders have not been ruled out
- In cases of typical, uncomplicated, and noninjurious parasomnias when the diagnosis is clearly delineated.
- For patients with epilepsy who have no specific complaints consistent with a sleep disorder.

- For patients with symptoms suggestive of the periodic limb movement disorder or restless leg syndrome unless symptoms are suspected to be related to a covered indication for the diagnosis of insomnia related to depression
- For the diagnosis of insomnia related to depression
- For the diagnosis of circadian rhythm sleep disorders (i.e., rapid time-zone change (jet lag), shift-work sleep disorder, delayed sleep phase syndrome, advanced sleep phase syndrome, and non 24-hour sleep wake disorder)

Revenue Codes associated with OP hospital billing:

074X	EEG-general classification
0920	Other diagnostic services-general classification

Refer to the LMRP for ICD-9 Codes that support medical necessity. These ICD-9 Codes are updated occasionally by Medicare.

Outpatient Cardiac Rehabilitation

The following conditions must be met in order for an outpatient hospital based cardiac rehabilitation clinic to provide services:

- Recipient must be referred by their attending physician
- Services must be medically necessary and include at least one of the following medical conditions:
  1. Have a documented diagnosis of acute myocardial infarction within the preceding 12 months.
  2. Began the program within 12 months of coronary bypass surgery.
  3. Have stable angina pectoris (evaluation of chest pain must be done to determine suitability to participate in the cardiac rehabilitation program).
  4. Had heart valve repair/replacement.
  5. Had a percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
  6. Had a heart or heart lung transplant.
- The frequency and duration of the program is usually two to three sessions per week for 12 to 18 weeks. Any services provided past 36 in a year will require prior authorization by Medicaid.
- Coverage may be extended with sufficient documentation that the patient has not reached the exit level, but will not exceed a maximum of 72 visits annually.
- Each exercise session must include at least one of the following: Continuous cardiac monitoring during exercise, and EKG rhythm strip with interpretation and physician's revision of treatment; or examination by the physician to adjust medications or for other treatment changes.

- No more than one EKG stress test with physician monitoring at the beginning of the exercise program with a repeat test in three months is reasonable and necessary. The medical necessity for stress tests in excess of the two allowed must be clearly established in the recipient's medical record.

- A physician must be immediately available in the exercise program area in case of emergency.

- Formal patient education services are not reasonable and necessary when provided as part of a cardiac rehabilitation exercise program; therefore, Medicaid will not pay for these services.

Prior Approval for Outpatient Services

Certain procedures require prior authorization. Please refer to Section 19.5.2, Revenue Codes, Procedure Codes, and Modifiers, and Appendix I, ASC Procedures List. Medicaid will not pay for these procedures unless authorized prior to the service being rendered. All requests for prior approval must document medical necessity and be signed by the physician. It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

For all MRI's, MRA's, CT scans, CTA's, and PET scans performed on or after March 2, 2009, providers will be required to request prior authorization from MedSolutions. Scans performed as an inpatient hospital service, as an emergency room service, or for Medicaid recipients who are also covered by Medicare are exempt from the PA requirement.

Prior authorization requests for outpatient diagnostic imaging procedures may be made to MedSolutions by phone at (888) 693-3211 or by fax at (888) 693-3210 during normal business hours 7:00 a.m. to 8:00 p.m. C.T. Requests can also be submitted through MedSolutions' secure website at www.MedSolutionsOnline.com . Please refer to Chapter 22, Independent Radiology, for procedure codes that require prior authorization.

Payment of Outpatient Hospital Services

Refer to the *Alabama Medicaid Administrative Code, Chapter 23, Hospital Reimbursement* for details on current hospital payment methodology.

Deleted: ~~Payment for all…established by Medicaid.~~

Added: Refer to the…hospital payment methodology.

Extracorporeal Shock Wave Lithotripsy (ESWL)

Extracoporeal Shock Wave Lithotripsy (ESWL) is a covered benefit for treatment of kidney stones in the renal pelvis, uretero-pelvic junction, and the upper one-third of the ureter. ESWL is **not** a covered service for urinary stones of the bladder and the lower two-thirds of the ureter.

Deleted: ~~Publicly owned hospitals… circumstances under Medicare~~.

For ESWL treatment to both kidneys during the same treatment period, Medicaid will pay the facility one-and-a-half time the regular reimbursement rate for this procedure. Repeat ESWL treatments on the same recipient within a ninety-day period will be reimbursed at half the regular reimbursement rate for this procedure.

ESWL treatments are not subject to outpatient benefit limitations.

The copayment amount for an ESWL treatment is $3.00 per encounter. This amount does not apply to services for recipients under 18 years of age, emergencies and nursing home recipients.

The ESWL reimbursement rate is an all-inclusive rate for each encounter and all services rendered in conjunction with the treatment (with the exception of the physician's and the anesthesiologist's) are included in the rate, such as lab, x-ray, and observation.

For repeat ESWL treatments on the same recipient within a ninety-day period, Medicaid will reimburse the surgeon at half the regular reimbursement rate for the surgical procedure.

Physician (surgeon) services for the ESWL procedure are not included in the facility's reimbursement rate and can be billed separately. No assistant surgeon services will be covered.

Anesthesiologist services are not included in the facility's or physician's reimbursement rate and can be billed separately.

Pulse Oximetry

Non-invasive ear or pulse oximetry services (94760-94762) are considered bundled services and, therefore, are not separately reimbursable. The only instances in which these services may be billed are when no other services are billed on the same day by the same provider. They must also be medically necessary and are subject to post-payment review and adjustment.

19.2.6 Outpatient and Inpatient Tests

Medicaid pays for medically necessary laboratory tests, x-rays, or other types of tests that have been ordered by the attending physician or other staff physician provided in inpatient or outpatient hospital facilities.

Hospital labs may bill 'routine venipuncture' only for collection of laboratory specimens when sending blood specimens to another site for analysis. 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:

- The referring laboratory is located in, or is part of, a rural hospital;
- 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
- 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).

19.2.7 Crossover Reimbursement

Part A

Medicaid inpatient hospital days run concurrently with Medicare days. Medicaid covers the Part A deductible, coinsurance, or lifetime reserve days, less any applicable copayment. Medicaid will not make such payments if the Medicaid covered days for the calendar year have been exhausted. This benefit limit does not apply for QMB recipients.

Medicaid covers Medicare coinsurance days for swing bed admissions for QMB recipients. Medicaid pays an amount equal to that applicable to

Medicare Part A coinsurance, but not greater than the Medicaid swing bed rate.

Part B

Medicaid pays the Medicare Part B deductible and coinsurance according to lesser of the following:

- Reimbursement under Medicare rules
- Total reimbursement allowed by Medicaid

Medicare-related claims for QMB recipients are reimbursed in accordance with the coverage determination made by Medicare. Medicare-related claims for recipients not categorized as QMB recipients are paid only if the services are covered under the Medicaid program.

Hospital outpatient claims are subject to Medicaid reimbursement methodology.

When a Medicaid recipient has third party health insurance of any kind, including Medicare, Medicaid is the payer of last resort. Thus, provider claims for Medicare/ Medicaid-eligible recipients and QMB-eligible recipients must be sent first to the Medicare carrier.

Providers complete the appropriate Medicare claim forms and ensure that the recipient's 13-digit Recipient Identification (RID) is on the form, then forward the completed claim to a Medicare carrier for payment.

QMB-only recipients are eligible for crossover services and are not eligible for Medicaid-only services.

Refer to Chapter 5, Filing Claims, for complete instructions on how to complete the claim form.

Providers in other states who render Medicare services to Medicare/Medicaid-eligible recipients and QMB-eligible recipients should file claims first with the Medicare carrier in the state in which the service was performed.

19.3 Prior Authorization and Referral Requirements

Some procedure codes for hospitalizations require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

Prior authorization is required for certain outpatient surgical procedures. Refer to Appendix I or the Outpatient Fee Schedule on the website: www.medicaid.alabama.gov . Prior authorization is not required for inpatient admissions.

Medicaid issues a 10-digit prior authorization number for those stays. This number must appear in form locator 91 on the hospital claim form.

NOTE:

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

19.4 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission. This includes bill types 111, 112, 121, and 122 only (with the exception of admit types 1-emergency and 5-trauma).

The copayment amount for an outpatient visit (99281– 99285) is $3.00 per visit or $3.00 per total bill for crossover outpatient hospital claims. The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost - sharing (copayment) amount imposed.

The copayment amount for an ESWL visit is $3.00 per visit.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, family planning, renal dialysis, chemotherapy, radiation therapy, physical therapy, and certified emergencies (excluding crossovers).

NOTE:

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-04.

19.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hospitals that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-04.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

All inpatient and outpatient claims must contain a valid physician's license number in field 76 of the UB-04 claim form.

Certified Emergency Outpatient Visits

Non-certified visits to the emergency room are limited to three per year. Section 19.2.5, Outpatient Hospital Services, states the visit must be certified as such in the medical record and signed by the attending physician at the time of the visit. Certified emergency claims are also exempt from requiring the Patient 1st referral. Only one emergency room visit per day per provider will be reimbursed by Medicaid. Refer to Chapter 5 (Filing Claims) for claim filing information.

Nonpatient Visits

Specimen and blood samples sent to the hospital for lab work are classified as “nonpatient” since the patient does not directly receive services. This service does not count against the outpatient visit limitations and should be billed as bill type 14X. Refer to Section 5.3, UB-04 Billing Instructions, for description of Type of Bill values.

Recipients with Medicare Part B (Medical Only)

If a Medicaid recipient is Medicare Part B/Medicaid eligible, lab and x-ray procedures are covered under Medicare Part B for eligible recipients. Charges that are covered by Medicare must be filed with Medicare, and Medicaid will process the claim as a crossover claim. The following revenue codes are normally covered for Part B reimbursement (bill type 121): 274, 300, 310, 320, 331, 340, 350, 400, 420, 430, 440, 460, 480, 540, 610, 636, 700, 730, 740, 770, 920, and 942.

Charges that are covered by Medicaid but not by Medicare should be filed directly to Medicaid for consideration. It is not necessary to indicate Medicare on the claim. Providers are not required to file claims with Medicare if the service is not a Medicare-covered service.

Split Billing for Inpatient Claims

Claims that span more than one calendar year must be split billed.

Claims that span a Medicaid per diem rate change must be split billed in order for the hospital to receive the correct reimbursement.

Deleted: ~~Claims that span…to PHP year-end.~~

Claims that span a recipient’s eligibility change must be split billed.

19.5.1 Time Limit for Filing Claims

Medicaid requires all claims for inpatient and outpatient services and psychiatric hospitals to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

19.5.2 Revenue Codes, Procedure Codes, and Modifiers

Revenue codes are used for both inpatient and outpatient services. Procedure codes must be used for outpatient services.

Refer to the Official UB-04 Data Specifications Manual for a complete listing of valid revenue codes.

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

This section covers revenue codes, procedure codes, and modifier information under the following topics:

- Emergency department
- Pharmacy
- Laboratory services
- Radiation therapy
- Respiratory services
- Occupational therapy
- Speech therapy
- Miscellaneous procedures
- Outpatient revenue codes
- Outpatient observation
- Esophagus
- Radiology
- Blood
- Physical therapy
- Orthotics
- ESWL

Outpatient Revenue Codes

Medicaid will accept all valid revenue and procedure codes on outpatient claims for dates of service 10/1/04 and after. Reimbursement methodology has not changed; therefore, detail lines with noncovered revenue and procedure codes will continue to deny.

Emergency Department

Emergency and/or outpatient hospital services performed on the day of admission (at the same hospital) must be included on the inpatient billing.

Hospital providers should use the following procedure codes when billing for emergency department services:

Hospitals are to utilize the definitions from the 'old Z codes' when billing for ER visits as described in the two tables below:

'Old Z Codes'	Description
Z5299	Brief – Emergency Department Includes use of facility, equipment, oral medications and incidental supplies, e.g., linens, tongue blades, and tissue.
Z5300	Limited – Emergency Department Includes use of facility, equipment, oral medications and additional supplies, e.g., IV solutions, splints, dressing, sterile trays, etc.

'Old Z Codes'	Description
Z5301	Critical Care – Emergency Department Includes use of facility, equipment, oral medication and additional supplies for the treatment of multiple injured, critically ill and/or comatose patients. This code should not be used unless critical care is rendered.

CPT Code	***Rev Code***	***Description***
99281 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A problem-focused history, • A problem-focused examination, and • Straightforward medical decision making
99282 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of low complexity
99283 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of moderate complexity
99284 (old code Z5300)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A detailed history, • A detailed examination, and • Medical decision making of moderate complexity
99285 (old code Z5301)	450	Emergency department visit for the evaluation and management of a patient that requires these three components within the constraints imposed by the urgency of the patient's clinical condition and mental status: • A comprehensive history, • A comprehensive examination, and • Medical decision making of high complexity

NOTE:

The above procedure codes may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450. Revenue code 450 should not be billed for surgical procedures provided in the emergency room. In these instances the appropriate ER facility fee (99281-85) must be used. Surgical procedures may be billed only when an operating room has been opened for the surgery. Surgical codes must be billed with revenue code 360.

Outpatient Observation

Outpatient Observation is medically necessary extended outpatient care provided to a patient who presents to the emergency department and whose condition warrants more than the three hours of care already included in the emergency department procedure codes 99281-99285 This service is covered only when certified by the attending physician at the time of the service.

Outpatient observation is limited to 23 hours (the first three hours included in the ER facility fee plus up to 20 hours of the appropriate observation code).Observation (99218-99220) may be billed only in conjunction with procedure codes 99281-99285. It may not be billed in conjunction with outpatient surgery. If observation spans midnight, the date of admission should also be the date of discharge on the claim form even though the patient was actually discharged the following day.

Revenue Code	***Procedure Code***	***Description***
76X	99218	Each hour, 4th hour through 23rd hour (maximum units 20), low severity
76X	99219	Each hour, 4th hour through 23rd hour (maximum units 20), moderate severity
76X	99220	Each hour, 4th hour through 23rd hour (maximum units 20), high severity

Pharmacy

Revenue code 250 applies to Pharmacy - Injectable Drugs (includes immunization).

See Appendix H, Injectable Drug List, of this manual.

Esophagus

Use revenue code 309 with a valid procedure code for Esophagus - Acid reflux test.

Laboratory Services

Use revenue codes 300-310 with valid CPT codes for Laboratory services.

NOTE:

Services may be span billed if claim contains lab procedure codes. Refer to Section 5.3, UB-04 Billing Instructions, for information on span billing.

Radiology

Use revenue codes 320-331 with valid CPT codes for radiology. Refer to Chapter 22, Independent Radiology, for procedure codes that require prior authorization.

Radiation Therapy

Use revenue code 333 with procedure codes 77261-77790 for radiation therapy.

Blood Transfusions

Procedure code 36430 should be billed only once a day regardless of how many units were administered during that episode.

Revenue Code	*Procedure Code*	*Description*
39X	36430	Transfusion, blood or blood components

Respiratory Services

Revenue Code	*Procedure Code*	*Description*
412	94010	Spirometry, including graphic record, vital capacity, expiatory flow rate
412	94060	Bronchospasm evaluation
412	94150	Vital capacity total
412	94200	Maximum breathing capacity
412	94240	Functional residual capacity
412	94350	Pulmonary function test, lung volume
412	94360	Determination of resistance to airflow
412	94370	Determination of airway closing volume, (PFT S/B oxygen)
412	94375	Respiratory flow volume loop
412	94620	Pulmonary stress testing
412	94664	Aerosol or vapor inhalations for diagnosis
412	94665	Aerosol or vapor inhalations for sputums
412	94720	PFT - diffusion
412	94642	Aerosol inhalation of pentamidine for pneumocystis carinii (pneumonia treatment for Prophylaxis)
412	94650	Inhalation Services - Intermittent pressure breathing-treatment, air or oxygen, with or without medication
412	94680	Oxygen uptake
412	94770	Carbon Dioxide, expired gas determination
412	94772	Pediatric Pneumogram

Physical Therapy and Occupational Therapy

Procedure codes listed below may be billed by a PT or OT. Procedure codes marked with * must be billed in conjunction with therapeutic codes (97110-97542). Use revenue code 42X for PT claims and revenue code 43X for OT claims.

Procedure Code	*Physical Therapy*	*See Note*	*Max Units*	*Annual Limit*
97010	Application of a modality to one or more areas; hot or cold pack	1, 3	1	12
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report	1	1	12
95832	Muscle, testing, manual, hand		1	12
95833	Total evaluation of body, excluding hands		1	12
95834	Total evaluation of body, including hands		1	12
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	10

Procedure Code	***Physical Therapy***	***See Note***	***Max Units***	***Annual Limit***
97001 97001-22	Physical therapy evaluation Physical therapy evaluation-Motorized Wheelchair Assessment		1 1	1 1
97002	Physical therapy re-evaluation		1	
97003 (OT only)	Occupational Therapy evaluation		1	1
97004 (OT only)	Occupational Therapy re-evaluation		1	1
97012*	Traction, mechanical*	1	1	12
97014*	Electrical stimulation, unattended*	1, 2	4	12
97016	Vasopnueumatic device*		1	12
97018*	Paraffin bath*	1, 3	1	24
97020*	Microwave*	3	1	24
97022	Whirlpool	3	1	24
97024*	Diathermy*	1	1	24
97026*	Infrared*	1	1	24
97028	Ultraviolet		1	24
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	96
97033	Lontophoresis, each 15 minutes	3	4	96
97034	Contrast baths, each 15 minutes	3	4	96
97035	Ultrasound, each 15 minutes	3	4	96
97036	Hubbard tank, each 15 minutes	3	4	96
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3	4	96
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3	1	24
97113	Aquatic therapy with therapeutic exercises*		1	24
97116	Gait training (includes stair climbing)	4	1	18
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	3	1	8
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes		1	
97150	Therapeutic procedure(s), group (2 or more individuals)		1	12
97530	Therapeutic activities, direct pt contact by the provider, each 15 minutes	3 and 5	4	96

Procedure Code	***Physical Therapy***	***See Note***	***Max Units***	***Annual Limit***
97532	Development of cognitive skills to improve attention, memory, problem solving, (included compensatory training), direct (one on one) patient contact by the provider, each 15 minutes	3-4	4	36
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes	3-4	4	36
97542	Wheelchair management/propulsion training, each 15 minutes	3	4	24
97597	Removal of devitalized tissue from wounds		1	104
97598	Removal of devitalized tissue from wounds		1	104
97750	Physical performance test or measurement, (for example, muscoloskeletal, functional capacity) with written report, each 15 minutes	3	4	12
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3-4	4	16
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	16
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	3	4	12

NOTE:

1. Restricted to one procedure per date of service (cannot bill two together for the same date of service).
2. 97014 cannot be billed on same date of service as procedure code 20974 or 20975.
3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient on the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for the procedure, not the maximum units allowed for both providers.
4. 97760 should not be reported with 97116 for the same extremity.
5. 97530 requires an EPSDT referral

Orthotics

NOTE:

Prosthetic/Orthotic devices are covered only when services are rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 274 when billing L codes.

Orthotics provided by hospitals is limited to the L codes listed on the Outpatient Fee Schedule found on the Medicaid website: www.medicaid.alabama.gov.

Speech Therapy

NOTE:

Speech Therapy is covered only when service is rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 44X when billing speech therapy codes.

Hospitals may bill the following CPT codes for EPSDT referred speech therapy services.

92506-92508	92597

ESWL

Revenue Code	*Procedure Code*	*Description*
790	50590	Lithotripsy, Extracorporeal shock wave

19.5.3 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

19.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

19.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

19.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Outpatient Fee Schedule	www.medicaid.alabama.gov
Lab & Xray Fee Schedule	www.medicaid.alabama.gov

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