



Chapter 11

Medicaid Provider Manual

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HOSPITAL SERVICES AND DIALYSIS

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HOSPITAL SERVICES AND DIALYSIS**11.1 INPATIENT HOSPITAL SERVICES REIMBURSEMENT**

11.1.1 Description

a) Hawaii Medicaid payment of inpatient acute care services is made to qualified acute care hospitals through facility specific prospective payment system (PPS) rates. The PPS rates are derived from a facility's historical costs, its annual Medicaid discharge volume and its participation in an approved intern and resident teaching program.

b) PPS rates are developed for four (4) classifications of acute hospital facilities.

- Classification I—facilities averaging less than 250 Medicaid discharges per year—receive:

1) All-inclusive per diem rate for psychiatric services

2) All-inclusive per diem rate for non-psychiatric services

- Classification II—facilities averaging 250 or more Medicaid discharges per year and do not participate in an intern and resident teaching program—AND

- Classification III—facilities averaging 250 or more Medicaid discharges per year and participate in an intern and resident teaching program—receive:

1) All-inclusive per diem rate for psychiatric services

2) A per diem rate for the appropriate category of service (surgical, medical, or maternity services) plus an ancillary rate for the appropriate category of service per discharge.

- Classification IV—free-standing rehabilitation hospitals—receive:

1) All-inclusive per diem rate for psychiatric services

2) All-inclusive per diem rate for non-psychiatric services

11.1.2 Exclusions

a) The Medicaid Program does not permit inpatients to be on leave of absence from a facility. The patient should be discharged if well enough to leave the facility. Exceptions are made for patients on trial care home placement, or in the event of death in the family. For situations concerning psychiatric patients, please refer to Chapter 15 "Behavioral Health".

HOSPITAL SERVICES AND DIALYSIS**b) Excluded from the PPS rate are:**

- Physician services and the professional component of diagnostic and therapeutic services, including but not limited to the supervision and interpretation of radiological services, laboratory services and other imaging studies.
- Ambulance charges.
- Durable Medical Equipment, non-implanted prosthetic and orthotic devices and medical supplies that are to be used by the patient in the home setting are not payable prior to discharge.

11.1.3 Limitations

a) Except for acute inpatient services that exceed the “outlier” threshold (applicable only to Classification II and III facilities), payments made under the acute care PPS are based on discharge date and constitute payments in full.

b) Reimbursement is based upon the category of service at the time of discharge. The category of service of an acute inpatient stay is determined by a combination of ICD-9 diagnosis and procedure codes and revenue codes.

11.1.3.1 Maternity Category of Service

Are only those stays that result in the delivery of a live or stillborn infant and include cesarean section deliveries and postpartum sterilizations. The first or second diagnosis codes (without decimals) is within the following ranges:

653-653.92; V24-V242;
654-654.92; V27-V27.9;
660-660.92; V30-V39.2;
665-665.92; 650-652.92;
666-667.12; 659-659.92;
669.7; 661-663.92;
674.1; 664-664.92;
640-641.93; 668-669.62;
V22-V22.1; 669.8-669.9;

OR if there is a surgical date or an operating room revenue code and the first or second diagnosis is in one of the following ranges:

V23-V23.9; 6442-648.9;
655-658.92; 670-674.0;
642-643.9; 674.2-676.92;

HOSPITAL SERVICES AND DIALYSIS**11.1.3.2 Newborn Category of Service**

For live born infants, a payment for the normal newborn is separate from the payment made for the maternity (with delivery) category of service.

- a) Stays of newborns delivered by cesarean section are categorized as newborn.
- b) If it is medically necessary for the newborn to remain in the hospital for more than six (6) days following birth including the birth day or two (2) days after the mother's discharge, payment is based on the appropriate medical or surgical category of service.
- c) When intensive care unit (ICU) services without operating room services are medically necessary for the newborn, regardless of the newborn's length of stay at the acute level of care, the stay is categorized as medical.
- d) When operating room services are medically necessary for the newborn, regardless of the newborn's length of stay at the acute level of care, the stay is categorized as surgical. (Circumcision and other minor surgical procedures, not done in an operating room, do not categorize a stay as surgical).
- e) With multiple births, each newborn is considered as a separate discharge and a separate payment is made for each newborn following the criteria outlined above.
- f) A separate newborn payment is not made for the delivery of a stillborn. Payment is only made for the mother at the maternity (with delivery) category of service.
- g) A separate payment is made in cases when the newborn dies after a live birth. Payment can be made at the newborn, medical, or surgical category of service following criteria outlined above.

11.1.3.3 Surgical Category of Service

Are those stays that are not in the maternity category of service with a surgical ICD-9 procedure code and surgical date. (Note: only indicating an operating revenue code will not cause a claim to brand as surgical). Valid operating room ICD-9 procedure codes are listed in the ICD-9 CM Professional for Hospital coding book.

11.1.3.4 Psychiatric Category of Service

Are those stays with the first diagnosis code within the ICD-9 diagnosis code range of 290- 319.99 and that do not have an operating room revenue code.

HOSPITAL SERVICES AND DIALYSIS**11.1.3.5 Medical Category of Service**

Are those stays that are not in any of the above service categories.

When procedures, included but not limited to those listed below, are performed during an acute inpatient stay, but not in the operating room under general anesthesia or with other surgical procedures, the stay will be categorized as medical and not surgical:

- Subdural tap (through fontanel)
- Spinal tap; Lumbar puncture
- Spinal bloody patch
- Electrocochleography
- Injection of tympanum
- Control of epistaxis with or without packing
- Forceps extraction of tooth
- Restoration of tooth by filling, inlay or other dental restoration
- Application of crown
- Insertion of fixed or removable bridge
- Other dental work
- Application of orthodontic appliance, other orthodontic work, occlusal adjustment
- Removal of arch bars, repair of dental arch
- Probing of salivary duct
- Diagnostic “oscopies” such as otoscopy, rhinoscopy, pharyngoscopy, tracheoscopy, larngoscopy, anoscopy, colonoscopy, gastroscopy, esophagoscopy, vaginoscopy, culdoscopy, etc.
- Diagnostic procedures on heart and pericardium
- Right, left, and combined right and left heart catheterization
- Venipuncture, venous cutdown, puncture and/or catheterization

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- Arterial puncture and/or catheterization
- Artificial insemination
- Insertion of laminaria

11.1.4 Special Considerations

Enrollees in QUEST ACE (Adult Coverage Expansion), and adults in QUEST Net are limited to a total ten (10) inpatient days per benefit year (July 1 of one calendar year to June 30 of the following calendar year). These inpatient acute hospital services exclude care related to maternity, newborn, neonatal intensive care and services in freestanding rehabilitation hospitals.

11.1.4.1 Stays (upon admission) of Less Than One (1) day

a) Stays of less than one (1) day for Classification I and IV facilities are reimbursed at one-half of the facility's psychiatric per diem rate or one-half of the facility's non-psychiatric per diem rate or the actual ancillaries whichever is lower.

b) Stays of less than one (1) day for Classification II and III facilities are reimbursed as follows:

- Medical – One-half of the facility's medical per diem rate plus actual ancillaries or ½ of the facility's medical ancillary rate, whichever is lower.
- Surgical – The procedure specific ambulatory surgical center (ASC) rate.
- Psychiatric – One-half of the facility's all-inclusive psychiatric per diem rate.
- Maternity

1) False labor – One-half of the facility's maternity per diem rate plus actual ancillaries or one-half of the facility's maternity ancillary rates, whichever is lower.

2) Maternity with delivery – One-half of the facility's maternity per diem rate plus the facility's full maternity ancillary rate.

11.1.4.2 Transfers

Payment for transfers of a patient who is at an acute level of care from one acute inpatient facility to another acute inpatient facility is as follows:

- Classification I or IV transfers to another Classification I or IV,

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Both facilities shall receive the per diem rates for the period of time that the patient was an inpatient in their respective facilities.

- Classification I or IV transfers to Classification II or III

The transferring Classification I or IV receives the per diem rates from admission to transfer. The receiving Classification II or III facility receives the appropriate per diem for the category of service from the admit date through discharge and the full ancillary rate (if applicable).

- Classification II or III transfers to another Classification II or III

1) For **nonpsychiatric** cases when, it is medically necessary that either the patient remain in the transferring hospital three or more days or that the patient must be cared for in the intensive care or coronary care unit, both the transferring and discharging hospitals receive the full per diem rate for the specific category of service and the full medical/surgical rate.

2) For **nonpsychiatric** cases, when the patient's stay in the transferring facility is less than three days and does not involve intensive care, the payment to the transferring hospital is the per diem rate for the category of service and thirty percent (30%) of the ancillary rate. The discharging hospital receives the full per diem rate from the date the transfer was accepted and the full ancillary rate.

3) For **psychiatric services**, payment to transferring and discharging facilities is the per diem psychiatric rate for each facility from the date of admission to the facility to the date of discharge or transfer.

11.1.4.3 Readmissions

a) A readmission to the same or different facility within twenty four (24) hours of discharge for the same spell of illness and for the same general diagnosis as the original admission is considered to be the same admission and must be billed as a single stay. When two different facilities are involved, denial or partial payments may be made for the original admission, if the Department determines that the services should have been provided during the initial inpatient stay. This policy does not apply to patients who leave the original facility against medical advice.

b) Readmission to the same facility within thirty (30) days of a discharge for a similar diagnosis is subject to review by the Department. Denial or partial payment of either the original stay or readmission may be made if the Department determines that the services should have been provided during the initial inpatient stay. This policy does not apply to patients who leave the facility during the original admission against medical advice.

HOSPITAL SERVICES AND DIALYSIS**11.1.4.4 Outliers**

If charges for services rendered to a patient during an acute inpatient hospital stay exceed a specified threshold amount, billing and payment follow outlier methodology. The specified amount is set each fiscal year by the Department of Human Services.

Outlier claims for Classification I and IV facilities are paid at a per diem rate. No additional outlier payment is received by these facilities. Classification II and III facilities must submit an interim bill with a bill type of '112' and the condition code '61' for the period of admission through the dates during which covered charges equal the outlier threshold amount. For the 112 type of bill, providers are paid a per diem rate and the ancillary per discharge rate. The subsequent bills must be billed with a bill type of '113' or '114' and the condition code '61' after being classified as an outlier. Claims submitted without the condition code of '61' will not be considered for outlier payment. Outlier claims are subject to medical consultant review. The claim and inpatient medical record will be reviewed for the appropriateness of the level of care and the medical necessity of the services rendered. The department will pay claims for care delivered at the appropriate level of care and when services rendered were medically necessary.

Note: All non outlier claims acute inpatient claims should be billed with bill type 111 (admit through discharge) with an appropriate discharge status. Interim bill types 112, 113, and 114 are reserved for outlier claims an acute waitlisted long term care claims.

11.1.4.5 Changes in Level of Care

A patient's level of care (LOC) may be lowered from the inpatient hospital acute LOC to one of the following non-acute LOCs:

- Acute waitlisted subacute LOC (acuity level D) billed with a with a Revenue Code 019x
- Acute waitlisted skilled nursing facility (SNF) LOC (acuity level C) billed with a type of bill of "11x" with an occurrence span code "75"
- Acute waitlisted intermediate care facility (ICF) LOC (acuity level A) billed with a type of bill of "11x" with an occurrence span code "74"
- Acute swing bed to Skilled Nursing Facility LOC billed with a type of bill 28x.
- Acute swing bed to Intermediate Care Facility LOC billed with type of bill 68x.

Providers must submit a separate claim when a patient changes level of care. Patients should be discharged from the acute level of care and then "readmitted" to the lower level of care. For patients that are transferred to a lower LOC providers must discharge the patient from the acute level of care and admit the patient to the lower level of care. Discharge and admission must occur whether the patient continues to receive care in

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the same facility or is moved to another facility. If a patient transfers to a lower LOC in a swing-bed facility, the patient must be discharged and readmitted to the lower LOC. If a patient is SNF or ICF waitlisted in an acute facility and is a Medicaid only recipient, providers must discharge and readmit the patient to the facility's SNF or ICF. On the date that a patient's LOC is lowered to one of the levels listed above, the patient is considered formally discharged from the acute care LOC. If the patient's medical condition subsequently requires the inpatient hospital acute LOC, the patient is readmitted to the acute LOC and the UB-04 must be submitted as follows:

- Form Locator (FL) block 4 (bill type) must be either '111' or '112'
- FL 17 (admission) must be the date the patient was readmitted to the acute LOC
- FL 6 (statement covers period) must indicate the date the patient was readmitted to the acute LOC
- FL 67 (principal diagnosis code) and FL 68-77 (other diagnosis codes) must indicate diagnoses applicable on the readmission date through the date of discharge
- FL 80 (principal procedure) and FL 81 (other procedure) must indicate ICD-9 procedure codes

11.1.4.6 Continuous Confinement

Continuous confinement is when a patient has his/her Medicaid plan switched to or from FFS to QUEST or QExA or from QUEST to QExA or QExA to QUEST

- In situations where a patient is covered by FFS on admission, then enrolled into a QUEST health plan during an acute hospitalization, FFS will continue to be responsible until the patient has a level of care change.
- In situations where a patient is covered by FFS on admission, then enrolled into a QExA health plan during an acute hospitalization, the FFS admission will be changed to a QExA due to prior period coverage. Prior period coverage is the period from the eligibility effective date as determined by the DHS up to the effective date of enrollment in the health plan.
- If the level of care is lowered prior to enrollment into QUEST or QExA, Medicaid FFS is responsible for the acute care and the lower level of care until the patient is enrolled into QUEST or QExA. Note: QUEST coverage only provides for up to 60 days of long-term care. If during the confinement, the level of care is raised to acute during enrollment in QUEST or QExA, the health plan remains responsible.

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- If a patient who is a QUEST or QExA enrollee is admitted to a hospital at an acute level of care and subsequently there is a lowering in the level of care, the financial responsibility for the lower level of care is as follows:

If enrolled in QUEST when level of care is lowered, QUEST covers up to 60 days of long-term care

If enrolled in QExA when level of care is lowered, QExA is financially responsible until disenrolled from the hospital

If enrolled in FFS when level of care is lowered, FFS has full long term care financial responsibility until discharge or enrolled into a QExA plan.

If enrolled in FFS when level of care is lowered and subsequently enrolled in QUEST, QUEST begins responsible for long-term care coverage up to 60 days of long-term care

If enrolled in FFS and becomes enrolled in QUEST then level of care is lowered, QUEST has long term care financial responsibility for up to 60 days.

- If a patient, who was a QUEST member at the time of admission at an acute level of care is determined disabled during his/her confinement through the ADRC process and enrollment has changed to FFS or QExA, the QUEST plan is responsible for the acute care stay and whatever portion of the long-term care stay (up to sixty-days) until enrolled into QExA. Thus, if the patient is no longer at the acute level of care, the hospital should obtain approval from DHS or its designee for his/her appropriate level of care via the DHS 1147 process.
- Providers should refer to ACS M10-04 for detailed information regarding transition of care descriptions.

11.1.4.7 Authorization

- Authorization is required for normal newborns exceeding the six days following birth or two days after mother's discharge, and all psychiatric stays.
- Authorization is required for acute waitlisted patients. Prior authorizations are required for acute waitlisted ICF, acute waitlisted SNF, or acute waitlisted subacute stays and must be renewed monthly.

HOSPITAL SERVICES AND DIALYSIS**11.2 OUTPATIENT HOSPITAL SERVICES**

11.2.1 Description

a) Outpatient hospital services are those services provided in an acute care hospital to a patient who is not formally admitted as an inpatient and not provided with “room and board.” Stays in the outpatient hospital setting are generally less than twenty-four (24) hours duration. Some outpatient hospital services are covered in more detail in other sections. Only the coverage, exclusions, limitations and reimbursement issues specific to the outpatient hospital setting will be discussed in this chapter. Information about Ambulatory Surgical Center (ASC) Services can be referenced in Chapter 13 under “Ambulatory Surgical Centers (ASCs)”.

b) Outpatient hospital services can be grouped into certain general categories including but not limited to the following:

- Outpatient Surgery services and same-day surgery (Chapter 13 Ambulatory Surgical Centers (ASCs))
- Emergency Room Services
- Cast Room and Treatment Room Services (includes oncology services)
- Laboratory Services (Chapter 7 Laboratory and Pathology Services)
- Diagnostic and Therapeutic Radiology, Nuclear Medicine, Other Imaging Services (Example: Ultrasound), (Chapter 6 Medical/Surgical Services -Physician Services and Chapter 7 Laboratory and Pathology Services)
- Other Diagnostic Services (includes pulmonary function testing, electrocardiograms, electroencephalograms)
- Therapies (Examples: Physical therapy, occupational therapy, speech and language pathology, audiology, see Chapter 9 Home Health Services, Chapter 17 Rehabilitative Services and Chapter 18 Hospice Services - therapies are listed under the specific services)
- Other therapeutic services such as End Stage Renal Dialysis (ESRD) services
- Only those ancillary services provided to patients at the acute waitlisted skilled nursing facility (SNF), acute waitlisted intermediate care facility (ICF), SNF, or ICF levels of care in the hospital that are not included in the prospective payment system per diem payments are reimbursed. Ancillary services are not separately payable for recipients at acute waitlisted subacute and subacute level of

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care. Coding of items payable in Long Term Care facilities is similar to coding of these services when provided in the outpatient hospital setting. Refer to Chapter 12 Long Term Care – Nursing Facility Services.

11.2.2 Amount, Duration and Scope

The services listed above are covered when the following conditions are met:

- The service is prescribed/ordered by a licensed physician.
- All applicable authorization requirements have been met.
- All applicable coding and claim submittal requirements have been met.
- Prescription drugs and over the counter (OTC) drugs provided as part of an emergency room visit are covered and billable under applicable revenue codes. On and after July 1, 2008, all drugs associated with an emergency room visit must have NDC (National Drug Code) information (NDC codes, quantities, and unit form) Drugs are therapeutic agents that are ingested, inhaled or parenterally (examples are normal saline, Ringer's lactate, heparin) administered.

Exclusions

Prescription drugs and OTC drugs that are considered part of a diagnostic service are included in the diagnostic service and are not separately payable.

Prescription drugs and OTC drugs provided in outpatient settings other than the emergency room should not be billed on an UB04 claim form. These drugs should be billed to Medicaid's Pharmacy Fiscal Agent.

11.2.3 Outpatient Surgery

Complete information about Ambulatory Surgical Center (ASC) Services can be referenced in Chapter 13: Ambulatory Surgical Center Services. The following information is a description of these outpatient surgical services relevant to outpatient hospital services.

11.2.3.1 Coverage

a) The services covered in the hospital's ambulatory surgical center are surgical procedures that can safely be performed without an inpatient acute hospital admission. They are generally performed under general anesthesia. Stays are generally less than twenty-four (24) hours.

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- b)** The provider of ASC services is the acute care hospital. Professional services by the physician and anesthesiologists are distinct and separate from ASC services.
- c)** In the Medicaid Program, all outpatient surgical procedures, whether done in the distinct part of the facility called the ASC or in other operating rooms, are considered ASC services.
- d)** Covered ASC procedures in the outpatient hospital setting are those procedures identified by CPT-4 codes and classified by CMS (formerly HCFA) into one of nine (9) ASC Groups.
- e)** Other surgical procedures (identified either by CPT-4 or ICD-9 procedure codes) performed in the outpatient hospital setting but not in the hospital's ASC are considered ASC services.
- f)** Procedures identified by CPT-4 codes that are classified by CMS (formerly HCFA) as appropriate ASC codes (such as certain "oscopies") when they are performed in the outpatient hospital setting in areas other than the operating room or ASC with or without general anesthesia.

11.2.3.2 Exclusions and Limitations

- a)** Minor surgical procedures that do not require regional or general anesthesia operating room services (Examples: Suturing of simple lacerations, simple incision and drainage of abscesses, manipulative reduction of simple digital fractures/dislocations with or without digital blocks.)
- b)** Please also refer to Chapter 13 Ambulatory Surgical Services (ASCs) for more detail including a complete list of exclusions.
- c)** Observation room services are not covered (Revenue codes 0760, 0762, 0769)

11.2.3.3 Coding and Claims Submittal

- a)** Claims for outpatient hospital services are submitted on UB-04 claim forms or electronically in UB-04 format.
- b)** Revenue Codes 49X or 36X should be used. The CPT-4 code that best describes the procedure is required and must be entered in form locator (FL) block 44.
- c)** Please also refer to Chapter 13 Ambulatory Surgical Centers (ASCs) for more detail.

HOSPITAL SERVICES AND DIALYSIS**11.2.4 Emergency Room Services****11.2.4.1 Coverage**

a) Those services provided in an emergency room when a “prudent layperson” believes that his/her or his/her child’s medical condition is a serious threat to life and/or bodily function.

b) The provider of emergency room facility services is the acute care hospital. The services include all of the services provided by the acute care hospital to an outpatient in the emergency room except physician services.

c) Services provided on the same day as a covered emergency room service that are covered and separately billable include but are not limited to:

- Emergency room facility fee
- Diagnostic testing (laboratory testing, radiology, other imaging procedures)
- Therapeutic services and treatments such as inhalation treatment, intravenous infusion, injections of antibiotics, etc.
- Medical supplies such as casting material, splints, intravenous administration sets. (For a listing of medical supplies covered in the emergency room, see Appendix 6.)
- Certain durable medical equipment for use by the specific patient such as crutches.

11.2.4.2 Exclusions and Limitations

a) Emergency room services that result in an inpatient admission to the acute care hospital are considered part of the inpatient hospital stay and are discussed in Section 11.1.1 “Inpatient Hospital Services.” **Exception: Charges from different acute hospitals may be payable. Examples: if the ER visit and the IP admission occur at two different facilities or if a patient visits the ER of two or more hospitals on the same day.**

b) Physician services

c) Ambulance services

d) Standard emergency room supplies and equipment such as blood pressure monitoring devices, sheets, underpads, suction machines, sutures, scissors, oximeters, bed pans, thermometers, tongue blades, etc.

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e) Supplies that are an integral part of procedures. Examples are clean catch kits when urinalyses and/or cultures are done, electrodes when ECGs are done, blood specimen containers when blood chemistries are drawn. Usage of updraft, nebulizer and oxygen are not billable as supplies.

d) Multiple ER Visits :

1. Two ER visits on the same day and same facility, are covered if the diagnoses are not related. Supporting documentation should be submitted with the claim. If the visits are for the same or similar diagnosis, only one visit will be paid.

2. ER visit at one facility and same day ER visit at a different facility: Visits on the same day at two different facilities are covered when both are strictly outpatient ER visits.

3. The Med-QUEST Division medical review staff may make final determination of coverage for any of the above situations

11.2.4.3 Coding and Claims Submittal

Effective July 1, 2008, drugs included in emergency Room claims must be billed with their appropriate National Drug ICode (NDC) information. NDC information includes NDC number, quantity, and unit form. For revenue code 025x, HCPCS codes are optional, however, NDC numbers and quantities must be submitted. Multiple drug revenue codes with unique NDC information can be submitted. The use of HCPCS codes for drug revenue codes is encouraged. and should be inputted in form locator 44. NDC quantity and unit must be used for NDC number information. Claims submitted without the NDC will have the line non covered. The NDC requirement is applicable to all claims including Medicare secondary.

11.2.5 Cast Room and Treatment Room Service

11.2.5.1 Cast room and treatment room services are those services provided to outpatient who do not require emergency room services and/or receive services that do not result in an inpatient acute hospital admission.

Services provided on the same day as a covered cast room or treatment room service that are covered and separately billable include but are not limited to:

- Casting, strapping (not done in connection with an emergency room visit)
- Infusion/injection of fluids, antibiotics, chemotherapeutic agents, blood products, etc.
- Dressing changes that required skilled nursing
- Medical supplies associated with the above services and allowable in the treatment room (see Appendix 6)
- Infusion pumps
- Diagnostic testing (laboratory testing, radiology, other imaging procedures)

HOSPITAL SERVICES AND DIALYSIS**11.2.5.2 Exclusions and Limitations**

- Treatment room, observation, casting and strapping, and other “treatments” (Revenue codes 076X, 070X, 094X, 095X) when part of a valid emergency room visit are not covered.
- Supplies such as blood pressure monitoring devices, sheets, underpads, suction machines, sutures, scissors, oximeters, bed pans, thermometers, tongue blades, etc. are not separately covered and thus not separately reimbursable.
- Supplies that are an integral part of procedures. Examples are clean catch kits when urinalyses and/or cultures are done, electrodes when ECGs are done, blood specimen containers when blood chemistries are drawn. Usage of updraft, nebulizer and oxygen are not billable as supplies.
- When miscellaneous services, other treatment room services, therapeutic radiology services, operating room services, ambulatory surgical center (ASC) services, etc. are performed on the same day as cast room and treatment room services, there is no coverage for cast room and treatment room services. The following table identifies these services by revenue codes and descriptions

Cast Room (Revenue code 70X) and Treatment Room (Revenue Code 76X) are not covered when provided on the same day as any of the following:

Revenue Code Description

26X IV therapy
 28X Oncology
 33X Treatment-x-ray
 36X Operating room
 45X Emergency room
 49X Ambulatory surgical center
 51X Clinic
 52X Free-standing clinic
 71X Operating room
 75X Gastro-intestinal services
 82X Hemodialysis/outpatient or home
 83X Peritoneal dialysis/outpatient or home
 84X CAPD/outpatient or home
 85X CCPD

HOSPITAL SERVICES AND DIALYSIS**11.2.6 Other Diagnostic Services****11.2.6.1 Coverage**

a) Diagnostic testing such as pulmonary function testing, electrocardiograms, cardiovascular stress testing, electroencephalograms, nerve conduction testing, electromyography, etc. is covered when performed in the outpatient hospital setting.

b) Most diagnostic testing do not require authorization. (Appendix 1 lists the procedures that require authorization.)

c) The technical component modifier (TC) of the diagnostic procedure, performed by the hospital is covered.

11.2.6.2 Exclusions and Limitations

a) The professional component (modifier 26) that includes physician supervision and formal, written interpretation, is billable by the physician and not covered under the Medicaid outpatient hospital benefit.

b) Durable medical equipment and medical supplies that are an integral part of the procedure are not covered. Examples—electrodes, use of the treadmill, etc.

11.2.7 Reimbursement of Outpatient Hospital Services**11.2.7.1 Description**

Outpatient hospital services are reimbursed as follows:

a) Outpatient surgery or same-day surgery is reimbursed at the ASC rate for Groups 1, 2, 3, and 4. Groups 5 and above are reimbursed at an appropriate Group rate after review.

b) Payments for outpatient hospital services and emergency room charges are reimbursed at the lowest of the rate established by the Department or Medicare's upper limit of payment.

c) Payments for laboratory, radiology services, other diagnostic services and other procedures require the submittal of appropriate HCPCS codes. Reimbursement for these services is at the lower of the hospital's customary charge or the Medicaid fee schedule rate for the HCPCS code(s).

d) Payments for allowable ancillary services/items for patients at the acute waitlisted SNF, acute waitlisted ICF, SNF, ICF and ICF MR level of care are subject to the Medicaid fee schedule rate for the HCPCS code(s). Allowable ancillary items are those items NOT included in the prospective payment system (PPS) per diem rate.

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e) Dialysis services are reimbursed at the lowest of the rate established by the Department or Medicare's upper limit of payment. Coding and claims submittals for dialysis services are discussed in Section 11.3 and will not be covered in this section.

11.2.7.2 Coding and Claims Submittal

a) Claims for outpatient hospital services provided by a hospital are billed on the UB-04 billing form.

b) Service dates are required in Form Locator (FL) Block 45.

c) The following revenue codes require HCPCS procedure codes in FL 44:

Revenue Code Description

26X Miscellaneous Services
27X Medical/Surgical Supplies and Devices
28X Treatment Room
29X Durable Medical Equipment (Other than rental)
30X Laboratory
31X Laboratory—Pathology
32X Radiology—Diagnostic
33X Radiology—Therapeutic
34X Nuclear Medicine
35X CT Scan
36X Operation Room Services
40X Other Imaging Services
42X Physical Therapy
43X Occupational Therapy
44X Speech-Language Pathology
46X Pulmonary function
47X Audiology
48X Cardiology
49X Ambulatory Surgical Care
61X Radiology—Diagnostic
62X Dressings and Supplies
73X EKG/ECG
74X EEG
76X Treatment Room
92X Other Diagnostic Services

d) Although not mandatory, if appropriate HCPCS codes are provided with revenue codes for other outpatient hospital services, timely claims processing will be facilitated.

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e) Except in association with emergency room services, drugs billed using revenue codes 25X, 262, 263, 28X, 630, 631, 632, 633, 636, or any other revenue code with or without an HCPCS drug code and/or NDC information will be denied. Drugs provided in outpatient hospital settings other than the emergency room should be billed to FFS Medicaid's pharmacy fiscal agent—currently ACS PBM. . The following table lists drug related revenue codes and descriptions mentioned in the first sentence of this section.

Revenue Code Description

25X Pharmacy

262 IV therapy/pharmacy

263 IV therapy/drug-supply delivery

28X Oncology

630 **Drugs**

631 **Drug/single source**

632 Drug/multiple source

633 Drug/restrictive prescription

636 Drug/requiring detail code

f) If the statement period is in excess of one day (FL Block 6 “from/through dates” are not the same), dates of service must be provided for each revenue code and HCPCS code billed.

(Examples: Revenue code 260 with 2 service units on 2 separate days must be billed on 2 separate lines for the 2 dates of service [FL block 45]; Revenue Code 30X Laboratory with 3 service units on the same day, with HCPCS codes 80010, 80004, 80005 must be billed on separate lines and must have a date of service for each code [FL block 45]).

g) Reimbursement exclusions and limitations for outpatient hospital services are described in the previous section.

11.2.8 Reimbursement of Professional Services**11.2.8.1 Description**

a) For inpatients at the acute level of care in a hospital, the services of professional staff employed by hospitals, including but not limited to nurses, certified nurse anesthetists, physical therapists, occupational therapists, speech and language pathologists, physicians, respiratory therapists, social workers, etc. are included in the PPS rate and not separately billable by the staff.

b) For outpatients, certain services provided by the professional staff employed by the hospital are billable by the facility. These services include but are not limited to:

- Physical therapy, occupational therapy, speech and language pathology are billable if authorization requirements are met.

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- Other services provided by professional staff of the hospital are billable when included in the service provided by the hospital. Examples are medical radiation physics and dosimetry performed by the physicist are included in the technical component of radiation therapy; infusion of chemotherapeutic agents monitored by nurses are included in oncology services; aseptic dressing changes by nurses in outpatient treatment rooms are included in the treatment room service.

11.2.8.2 Coding and Claims Submittals

- a) Coding is by appropriate revenue codes and HCPCs codes.
- b) All applicable authorization and coding requirements must be met.
- c) Claims submitted for outpatient hospital services must include an admission date.

11.2.8.3 Exclusions and Limitations

- a) Physicians and other providers such as psychologists, podiatrists and nurse practitioners, who are Medicaid providers must submit claims for services that they actually provided, independent of the hospital. Hospitals should not bill for these professional services on a UB-04 claim form.
- b) The services of resident physicians in hospitals with research and teaching programs cannot be directly billed by the resident physician. The hospital is allowed to bill for these services on the HCFA 1500 claim form.
- c) The hospital cannot bill for services provided by a resident physician if the attending physician is billing for the same service. Examples: If the attending physician is directly supervising the resident and involved in the treatment plan and will be submitting a claim for the service, the hospital cannot submit a claim for the resident for the same visit. If the attending physician is performing surgery with the resident and submits a bill for the service, the hospital cannot submit a claim for the resident as either the surgeon or assistant surgeon.

11.2.8.4 Authorization

As described above.

HOSPITAL SERVICES AND DIALYSIS**11.3 DIALYSIS****11.3.1 Description**

Medicaid covers dialysis services provided by participating Medicare certified hospitals and Medicare certified End Stage Renal Disease (ESRD) providers. Services, equipment, supplies, diagnostic testing (including medically necessary laboratory tests) and drugs medically necessary for the dialysis treatment and covered by Medicare are provided without authorization by Medicaid.

11.3.2 Amount, Duration and Scope

a) In general, Medicaid reimbursement for dialysis services is based on Medicare's composite rate for dialysis centers and includes specified laboratory tests. At this time, Medicaid will not be implementing Medicare's dialysis PPS methodology. Most Medicaid eligible patients on dialysis are covered by Medicare. When a patient is dually eligible for Medicare and Medicaid, Medicaid's payment is the Medicare co-payment /deductible provided by Medicare either on Medicare cross-over claim or on or the Medicare EOMB. (Explanation of Medicare Benefit). The following apply only when Medicaid is a patient's primary insurer.

b) Dialysis treatments are covered in various settings: hospital inpatient, hospital outpatient, non-hospital renal dialysis facility or patients' home. In connection with covered home dialysis, those items included in Medicare's global reimbursement for home dialysis are covered. Durable medical equipment (DME) and medical supplies associated with dialysis but not specifically included in Medicare's reimbursement for home dialysis must be medically necessary and authorized. Acute hospital inpatient dialysis is not separately payable as it is included in the hospital's Medicaid acute PPS rate.

c) All facilities providing maintenance renal dialysis treatments to Medicaid beneficiaries must meet conditions for Medicare coverage before they can qualify for Medicaid reimbursement. These facilities furnishing end-stage renal disease (ESRD) treatment services must be certified as meeting the conditions for compliance with Medicare health, safety and other Medicare requirements.

d) Dialysis treatments at renal dialysis facilities are subject to some variation, depending on such things as the types of patients being treated, the type of equipment and supplies used, the preferences of the treating physician, and the capability and makeup of support staff. Although all facilities do not provide identical ranges of services, the most common elements of a dialysis are: personnel services (physician, registered nurse, licensed practical nurse, technician, social worker, dietician); equipment and supplies (dialysis machine and its maintenance, disposable supplies); some laboratory tests; overhead and general administrative services.

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Acute hospital admissions solely to provide chronic dialysis are not covered. Additional exclusions are described in Appendix 1 and Section 11.2.3.

11.3.4 Limitations

Appendix 1 and Section 11.2 includes specifics of what is covered and not covered as well as all limitations. In general, the following applies:

- Laboratory Tests including Hepatitis B surface antigen (HBsAg) and Anti-HB testing for patients on Hemodialysis, Intermittent Peritoneal Dialysis (IPD), and Continuous Cycling Peritoneal Dialysis (CCPD) are covered.
- Hepatitis B vaccines are covered. See Pharmacy Section, Chapter 19, for billing instructions.
- Alfa Epoetin (EPO) is a biologically engineered protein which stimulates the bone marrow to make new red blood cells and is covered when billed by the End Stage Renal Disease (ESRD) provider using the correct revenue, HCPCs codes, and National Drug Code (NDC). The billing of EPO by dialysis facilities is made by submitting FFS claims on a UB04 using the revenue code 0634 for <10,000 and revenue code 0635 for >10,000 units. One of these revenue codes can be billed for an individual per dialysis session; multiple units per session shall not be billed or reimbursed. On and after July 1, 2008, EPO is not payable unless NDC information (NDC numbers, quantities, and units) is submitted for revenue codes 0634 and 0635.
- Other drugs related to ESRD are covered. See Chapter 19, Pharmacy, for billing instructions.
- Home dialysis equipment prescribed by a physician is covered.
- Continuous Ambulatory Peritoneal Dialysis (CAPD). Continuous ambulatory peritoneal dialysis (CAPD), a variation of peritoneal dialysis that was developed as an alternative mode for dialysis for home dialysis patients, is a covered Medicaid service by certified facilities.
- Physician's Services are covered as described in Chapter 6 Medical/Surgical Services.
- Inpatient hospitalization is covered when the hospitalization is for an acute medical condition requiring dialysis treatments; a patient receiving chronic outpatient dialysis is hospitalized for an unrelated medical condition, or for placement, replacement or repair of the chronic dialysis route.

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11.3.5 Authorizations

As described above.