OUTPATIENT SERVICES

Outpatient hospital services are defined as diagnostic and therapeutic services rendered under the direction of a physician or dentist to an outpatient in an enrolled, licensed and certified hospital. The hospital must also be Medicare certified. Covered outpatient hospital services provided to Medicaid recipients are reimbursable.

Included in this section are general guidelines pertaining to Medicaid coverage of outpatient services.

Inpatient services shall not be billed as outpatient, even if the stay is less than 24 hours. Federal regulations are specific in regard to the definition of both inpatient and outpatient services. Billing outpatient services for a recipient who is admitted as an inpatient within 24 **hours of the performance of the outpatient service is not allowed and the facility may be subjected to financial sanctions.**

The following requirements apply:

- All outpatient services except outpatient therapy performed within 24 hours of an inpatient admission shall be included on the inpatient claim.

- All outpatient services except outpatient therapy performed within 24 hours before an inpatient admission and 24 hours after the discharge shall be included on the inpatient claim. This includes outpatient services that are either related or unrelated to the inpatient stay.

- If an inpatient in one hospital has outpatient services performed at another hospital, the inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may reflect the outpatient charges on its claim.

If a recipient is treated in the emergency room and requires surgery which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided that the recipient is not admitted as an inpatient.

Physicians responsible for a recipient's care at the hospital are responsible for deciding whether the recipient should be admitted as an inpatient. Physicians should use a 24 hour period as a benchmark, i.e., they should order admission for recipients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors. Admissions of particular recipients are not

covered or non-covered solely on the basis of the length of time the recipient actually spends in the hospital.

Medicaid will reimburse up to 30 medically necessary hours for a recipient to be in an outpatient status. This time frame is for the physician to observe the recipient and to determine the need for further treatment, admission to an inpatient status or for discharge. If the recipient is admitted as an inpatient, the admit date will go back to the beginning of the outpatient services.

NOTE: Outpatient ambulatory surgery and other applicable revenue codes associated with the surgery may now be billed as outpatient regardless of the duration of the outpatient stay.

Therapeutic and Diagnostic Services

All outpatient services, including, but not limited to, therapeutic and diagnostic radiology services, chemotherapy, end stage renal disease (ESRD) (formerly referred to as hemodialysis), and laboratory services, are subject to nationally mandated code editing limits. These services must be medically necessary as substantiated by the recipient's medical records.

Radiology Utilization Management

Radiology utilization management (RUM) establishes provisions requiring prior authorization (PA) for certain outpatient high-tech imaging. PA is based on best evidence medical practices as developed and evaluated by board certified physician reviewers, including board-certified radiologists and additional physical specialists who will assist in the claim evaluation process.

This program became effective February 15, 2010. The program excludes recipients who are:

- Family Planning Waivers recipients
- Dual eligible (Medicaid secondary to Medicare)
- PACE recipients
- LaCHIP Affordable Plan recipients
- Native American recipients
- Third party liability recipients (Medicaid secondary to any other insurance)

The program will include recipients not otherwise excluded above.

Services requiring PA are noted on the Medicaid fee schedule and shall include, but are not limited to the following radiology service groups:

- Magnetic resonance (MRI, MRA, MRS);
- Computerized tomography (CT/CTA); and
- Nuclear cardiac imaging.

Prior authorization applies to high tech imaging studies that are:

- Outpatient
- Elective/Non-emergent
- Outpatient Urgent/Emergent Studies (retrospective review required)

The CPT codes that require PA can be located on the Louisiana Medicaid website (see Appendix B for web site address). Reimbursement for these services is contingent upon PA.

Authorizations for Louisiana Medicaid are good for 60 days from the date issued. The authorization number must be submitted on the claim.

Prior authorization does not apply to high tech imaging studies that are:

- Performed in an emergency room as part of an ER visit
- Performed while in 23 hour observation
- Performed when the recipient is an inpatient in an inpatient hospital

Special Circumstances

Changes can be made to an approved study. The providers or requesting physicians are allowed to request a facility change, down code a study, add a study and up code a study. If there is a request to add a study to an existing authorization or up code a study then medical necessity applies and each request will be reviewed for medical necessity.

Outpatient Urgent/Emergent studies should not be delayed by the PA. Providers should provide the necessary care. These cases require retrospective review. Providers are required to contact

Med Solutions, Incorporated (MSI) within 30 days of the study to provide notification and clinical information. MSI will conduct a retrospective medical review. The study must meet urgent criteria and be medically necessary. Claims should not be submitted until authorization is granted.

Denials

If a coverage denial is issued an MSI representative will attempt to call the ordering physician's office to communicate the denial determination. A fax determination is also sent to the ordering physician. If the physician is available, MSI will communicate via telephone the rationale for the denial and the ordering physician will be given an opportunity for a peer review. The peer-to-peer review process is available to the ordering physician for three days after the denial is issued. If peer review is requested, MSI will schedule the review at a time convenient to the ordering physician. The ordering physician will discuss the case with one of MSI's physician reviewers. Written notification of the final determination is faxed to the ordering physician, mailed to the requested facility and to the recipient.

Ordering providers are allowed to start a new case in situations where the initial request is denied due to insufficient information/documentation or if the peer-to-peer conference could not be arranged within the allotted three day time period.

If a procedure delegated to the RUM program is denied then any associated charges related to that procedure are not payable by Louisiana Medicaid. Any and all associated charges are subject to post payment review by Program Integrity.

Emergency Room Services

Louisiana Medicaid is not obligated to pay for non-emergency (routine) care provided in the emergency room, unless the person has presenting 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 medical attention to result in:

- Placing the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any organ or body part

Hospitals are required by EMTALA (Emergency Medical Treatment and Labor Act) to perform a Medical Screening Exam (MSE) on all persons who present to the emergency room for services. If the MSE does not reveal the existence of an emergency medical condition, the recipient should be advised

that Medicaid does not cover routine/non-emergent care provided in the emergency room when the presenting symptoms do not meet the prudent layperson standard of an emergency condition and that he/she may receive a bill if they are treated in the emergency room. The enrollee should be referred back to his/her CommunityCARE primary care physician (PCP) for follow-up and evaluation.

Providers must bill revenue code 450 or 459 when submitting claims for outpatient emergency room services, along with the appropriate HCPCS code. Only one revenue code 450 or 459 may be used per emergency room visit. Claims for emergency room services are not to be billed as a single line item. Claims must include all revenue codes (i.e., pharmacy, lab, x-rays and supplies) which were utilized in the recipient's treatment, using the appropriate revenue code and HCPCS where applicable.

The Medicaid Program will cover up to three emergency room visits per calendar year for a recipient who is 21 years or older, or who is a state foster care child. Recipients under the age of 21 have unlimited emergency room visits. There are no exceptions to this policy; however, Medicaid will reimburse the hospital for all other covered services (i.e., lab and x-rays) which are medically necessary when the recipient presents to the emergency room.

Recipients under the age of 21 and all CommunityCARE recipients are not subject to the three visit annual limit. Post authorization from the PCP is required for the two lowest levels of emergency room codes and associated services. A request for post authorization, along with appropriate documentation of presenting symptoms should be submitted to the PCP the next business day. Post authorization requests not submitted to the PCP the next business day are not considered valid requests.

The Department of Health and Hospitals (DHH) strongly encourages hospitals and PCPs who have internet access to use the electronic referral/authorization (e-RA) application instead of the hardcopy process. The e-RA application permits CommunityCARE PCPs and hospitals to more efficiently manage the post authorization process for services provided to CommunityCARE enrollees in the emergency room. The hospital enters a post authorization request including presenting symptoms in the e-RA system; a PCP alert feature informs the PCP when there are outstanding requests pending; the PCP reviews the request and makes a determination to approve/deny/ or return for additional information. Hospitals must include all pertinent presenting symptom information in the electronic request for the PCP to make an informed decision.

Reminder: Presenting symptoms should demonstrate degree of fever, duration of symptoms and a brief history such as:

- Presenting problem: fever and headache
- Assessment: onset – two days

- Symptom/description/location: headache-frontal/ above eyes; no vision problems; temp decrease to 101R with OTC
- Pain Scale: six-headache
- Temp: 102.5R
- Treatment: Tylenol x 4 doses for two days

When the emergency visit is equivalent to HCPCS 99283, 99284, 99285 or 99291, no referral/authorization is required from the PCP. However, if the condition requires follow-up by the PCP, appropriate information shall be forwarded to the PCP for inclusion in the enrollee's medical record. Enrollees shall be referred back to their PCP for any necessary follow-up. The enrollee should not be referred directly to a specialist or advised to return to the emergency department for follow-up care.

When an emergency visit results in an inpatient admit, providers must bill all charges associated with the emergency visit on the inpatient bill. This policy applies to recipients admitted from the ER or if the recipient has been seen in the ER within 24 hours either prior to admit or after the inpatient discharge. The ER charges must be billed as a separate line. All associated charges for the emergency visit must be included by revenue code with the total charges for the inpatient stay.

Hospital-Based Ambulances (Air or Ground)

Hospital-based emergency ambulance services for Medicaid recipients may be reimbursed if circumstances exist that make the use of any conveyance other than an ambulance medically inadvisable for transport of the recipient. Such circumstances must be documented in the recipient's medical record.

Hospital-based ambulances can be used only to transport recipients to the hospital in an emergency so they may be stabilized. Any transfers to another hospital must occur only because the transporting hospital cannot provide appropriate services.

Non-emergency transport by a hospital-based ambulance is not covered. Claims for hospital-based ambulance services must be filed on the UB-04 as outpatient services under the hospital provider number. However, if the recipient is admitted to the hospital, the services must be billed on the UB-04 as part of the inpatient services, as the reimbursement for the services will be included in the per diem rate.

NOTE: Air ambulance charges are not covered as an outpatient service.

Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Medical Services (EMS). Hospitals must submit a copy of EMS certification to Provider Enrollment for recognition to bill ambulance charges.

Hospital Laboratory Services

Hospitals are allowed by Medicaid to contract with an independent laboratory for performance of outpatient laboratory services. However, it is the responsibility of the hospital to ensure that both the physician who performs the professional service and the laboratory that performs the technical service meet all state and federal requirements. One such requirement is that both the physician and laboratory have a valid Clinical Laboratory Improvement Amendments (CLIA) number.

When a hospital contracts with a free-standing laboratory for the performance of the technical service only, it is the responsibility of the hospital to pay the laboratory. The laboratory cannot bill Medicaid because there is no mechanism in the system to pay a technical component only to a free-standing laboratory.

Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy may be performed as an outpatient service and is covered by the Medicaid Program. No authorization for these rehabilitative services is required if the procedures are performed for the diagnoses specified below:

- Acute carbon monoxide intoxication
- Decompression illness
- Gas embolism
- Gas gangrene
- Acute traumatic peripheral ischemia
- Crush injuries and suturing of severed limbs
- Progressive necrotizing infections
- Acute peripheral arterial insufficiency
- Preparation and preservation of compromised skin grafts

- Chronic refractory osteomyelitis
- Osteoradionecrosis
- Soft tissue radionecrosis
- Cyanide poisoning
- Actinomycosis
- Diabetic wounds of the lower extremities in patients who meet the following three criteria:
    - Patient has type 1 or 2 diabetes and has a lower extremity wound that is due to diabetes;
    - Patient has a wound classified as Wagner grade 111 or higher; and
    - Patient has failed an adequate course of standard wound therapy

NOTE: This list may not be all-inclusive.

The covered diagnosis should be entered as the primary diagnosis for hyperbaric oxygen therapy claims. These claims will be reviewed by the Medical Director and/or other physicians in the fiscal intermediary's (FI) Medical Review Unit.

Requests for approval for hyperbaric oxygen therapy for other diagnoses must be submitted to the FI Medical Review Unit.

Outpatient Rehabilitation Services

The Medicaid Program provides coverage for outpatient rehabilitation services with prior approval. Outpatient rehabilitation services include:

- Physical therapy
- Occupational therapy
- Speech therapy
- Hearing therapy

Cardiac and Pulmonary/Respiratory therapy are not covered under Louisiana Medicaid. These services should not be prior authorized or billed using covered rehabilitation codes. Hospitals are reimbursed based on covered HCPCS for outpatient rehabilitation services including speech, occupational and physical therapies at a flat fee for service which is not cost settled (with the exception of designated small rural hospitals).

Initial therapy and extended therapy plans require PA. Evaluation codes do not require PA, but are limited to one evaluation per 180 days.

NOTE: Covered HCPCS codes are included in the fee schedule.

Initial requests must include a physician's referral or prescription, a therapist's evaluation/plan of service, the completed Request for Prior Authorization (PA-01), and Rehabilitation Services Request (PA-02) forms. Requests should be submitted within the first week of therapy. In instances where delay of therapy would result in deterioration of a medical condition (i.e., burn cases, accidents or surgery) the authorization may be obtained later.

Extension requests should be submitted at least 25 days prior to the end of the approved period. This request must include both PA-01 and PA-02 forms along with progress reports from the prior period. Authorizations may be approved for up to one year for recipients under the age of 21 and for up to six months for recipients 21 and over.

When a recipient is being discharged from an inpatient acute care stay and requires outpatient rehab services immediately, a PA request should be submitted using the recipient's anticipated discharge date as the beginning date of service.

Physician recommended durable medical equipment (DME) must be approved by the Prior Authorization Unit (PAU) whether provided by a hospital or an independent DME provider.

Initial and extension requests must also be submitted to the PAU for approval.

The PAU will recommend approval only for therapy plans for individuals who are likely to realize substantial gains in rehabilitation, self-care, or self-help.

"Rehabilitation" is defined as a program to prevent further impairment or physical deformity and malfunction, enabling a significant increase in the capacity of the individual, so the individual will require less care by others.

"Self-care" and "self-help" are defined as the ability of the individual to take care of personal needs (eating; dressing; and the ability to walk, talk, or use devices unassisted).

"Less individual care by others" is defined as the ability of the recipient to use a minimum of assistance to take care of personal needs. Optimum utilization of the device will be an additional criterion when prosthesis training is involved.

Outpatient Surgery

Certain surgical procedures usually are covered by the Medicaid Program if they are performed as outpatient services. Reimbursement to hospitals for the performance of these outpatient surgical procedures is made on a flat-fee per service basis.

Hospitals must bill all outpatient surgery charges for the specified surgeries using revenue code "490" – Ambulatory Surgery Care. All other charges associated with the surgery (for example, observation, labs, radiology) must be billed on the same claim form as the Ambulatory surgery charges. The only revenue code that will be paid will be the flat rate fee for the Ambulatory Surgery. The current payment rate for groupings can be found on the Louisiana Medicaid web site. The most appropriate CPT/HCPCS code for the surgical procedure must be entered in Form Locator 44 on the UB-04 claim form. Only one CPT/HCPCS code may be entered in the field. A list of the surgical procedures is provided on the Louisiana Medicaid web site (see appendix B). These same surgical procedures may be performed on an inpatient basis and must be prior authorized if performed on the first or second day of the inpatient stay when medically necessary. Refer to 25.5, Pre-certification and Admission section for further information.

NOTE: Providers who are performing these procedures as an inpatient should continue to use ICD-9 procedure codes on pre-certification request and billing.

Operating Room Services-Minor Surgery is now payable for billing minor surgeries that are medically necessary to be performed in the operating room but the associated CPT code is not included in the ambulatory surgery listing.

Ambulatory surgery and other applicable revenue codes associated with the surgery may now be billed as outpatient regardless of the duration of the outpatient stay.

Intraocular Lens Implants

Intraocular lens (IOL) may be billed separately by the hospital if the hospital provides the device. Only one provider may bill for the IOL. Payment for the IOL is a flat fee-for-service.

Medicaid will pay for IOLs implanted during or subsequent to cataract extraction surgery performed on an outpatient basis. Lenses will be covered under the DME program but will not require PA as for other DME. When billing on an outpatient basis, claims must be submitted on the CMS-1500 by the provider who actually supplies the lens.

Providers are required to submit separate claim forms for the surgery and for the lens. The claim form for the lens **must** be submitted to a different post office box in order to be processed correctly. Failure to follow this procedure will result in denied claims. The initials **"DME"** should be written in **bold** letters on the very top of the claim form. The address to file DME claims can be found in Appendix B.

Refer to the DME manual for procedure codes and place of service codes that should be used. These procedures codes must be in conjunction with an ICD-9 CM diagnosis code for cataracts.

NOTE: If billing as an inpatient, the charges for the lens must be included on the inpatient claim form (UB-04). The claim will be denied on an inpatient basis unless the stay has been approved through a length of stay determination.

Observation Room Charges

When applicable, hospitals should bill for treatment or observation room charges with the appropriate covered revenue codes. The entire outpatient visit, including observation, may not exceed 30 hours duration.

When billing for these services, hospitals must include the admission hour and discharge hour in addition to the other required items on the outpatient hospital claim.

Hospitals billing for any of the outpatient surgical procedures listed in the fee schedule may not bill separately for treatment and observation room charges provided on the same day. Charges for these services have been included in the flat fee reimbursement for the outpatient surgical procedures.