SECTION 2

HOSPITAL SERVICES

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1 GENERAL POLICY

Hospital services are available to eligible Medicaid clients with surgical, medical, diagnostic, or level of care needs which require the availability of specialized diagnostic and therapeutic services, and close medical supervision of care and treatment directed toward maintenance, improvement, or protection of health or lessening of illness, disability or pain.

A hospital which accepts a Medicaid patient for treatment accepts the responsibility to make sure that the patient receives all medically necessary services from Medicaid providers. This includes physicians, surgeons, anesthesiologists, laboratory, X-ray, pharmacy, rehab and other providers on staff. The hospital administration is accountable for the quality of care provided to patients. Quality care includes the provision of care by practitioners who meet all requirements of the Utah Medicaid program, who agree to abide by Medicaid rules to provide medically necessary services, and who accept the Medicaid reimbursement as payment in full.

If providers (including but not limited to anesthesiologists) do not accept a particular patient for treatment, or will not accept the Medicaid payment as payment in full, the hospital is still responsible for assuring delivery of medically necessary services.

Should the Medicaid client receive medically necessary services from a non-Medicaid provider, the hospital is financially responsible for covering the services. Neither the provider nor the hospital may bill the patient for such services. For example, if the hospital's anesthesiologist does not accept Medicaid as payment in full, the hospital must provide an anesthesiologist who will accept the payment without requiring a co-payment or any other charge. Under federal Medicaid law, pregnant women in particular may not be subjected to cost sharing for Medicaid services.

A. *Inpatient Hospital* services can only be provided appropriately by bed occupancy in an approved acute care general hospital; must be provided to a client under the care of a physician or dentist; and must be furnished in an institution that:

   (1) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
   (2) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;
   (3) Meets the requirements for participation in Medicare as a hospital; and
   (4) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30 [October 1, 2010] which is incorporated by reference;
   (5) Has an interdisciplinary team, as specified in 42 CFR 441.153, which must certify and recertify the need for inpatient psychiatric services for individuals under age 21, as described in 42 CFR 441.152 [October 1, 2010 edition] which is incorporated by reference; and
   (6) Recognizes that all hospital admissions are subject to review by the Department for appropriateness and medical necessity.

For the purpose of documenting admission and length of stay, the day of admission to an acute care hospital facility is counted as a full day stay and the day of discharge is not counted.

Readmissions within 30 days - Refer to Utah Administrative Rule R414-1-12 and readmission review information outlined in the Superior Systems Waiver.

When a patient receives either nursing facility-level of care or other sub-acute care in either an acute-care hospital or a swing bed approved hospital, reimbursement will be at the nursing facility rate.

Authority for *Inpatient Hospital* service is found at Section 1901, et seq., and Section 1905(a)(1) of the Social Security Act; 42 Code of Federal Regulations, Section 440.10 [October 1, 2010 edition], and Utah Code Annotated, Sections 26-1-5, 26-1-15, 26-18-6, and Subsections 26-18-3(2) and 26-18-5(3), and (4).

B. *Outpatient Hospital* service is preventive, diagnostic, therapeutic, rehabilitative, or palliative service. Covered services must be services that meet the following conditions:

(1) Are furnished to outpatients;
(2) Are furnished by or under the direction of a physician or dentist; and
(3) Are furnished by an institution that —
  (a) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;
  (b) Meets the requirements for participation in Medicare as a hospital;
(4) May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the state.

Outpatient hospital services must be medically necessary and appropriate to diagnose or treat illness, disability or pain.

Evaluation and Management Services – Outpatient Hospitals

Currently, there is no published standard for determining the level of the Evaluation and Management (E/M) service provided by hospital staff in the outpatient setting.

The process to determine a level of service for the facility can be unique to each billing facility or hospital network. Outpatient hospitals should devise a consistent and reproducible leveling methodology to be used to determine the level of the E/M service for facility code assignment. This methodology should be published within the facility.

When a level of E/M service is assigned and coded (CPT 99201-99215 and 99241-99245) it should never incorporate services that can be separately reported with a CPT code (e.g. ECG, venipuncture, etc.). The facility is permitted to code these services separately. The services documented in the patient medical record must support the level of service billed.

The authority for Outpatient Hospital services is found in section 1901 et seq. and section 1905(a)(2) of the Social Security Act, and by 42 Code Of Federal Regulations 440.20 [October 1, 1996], and Utah code Annotated, Sections 26-1-5, 26-18-2.3, and by subsection 26-18-3(2).

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed care plan, such as a Managed Care Plan (MCP) or Prepaid Mental Health Plan (PMHP), must receive all health care services through that plan. The name of the managed care plan responsible for the Medicaid client's care is specified on the Medicaid Identification Card. Refer to SECTION 1, General Information, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan.

For clients in need of emergency services and who are either enrolled in a managed care plan, or who may qualify for Medicaid, refer to Chapter 3, LIMITATIONS, item 25 B, Emergency Services for Clients in a Managed Care Plan.

Mental Health Services: Unless there are extenuating circumstances, a provider must request authorization from the client's Prepaid Mental Health Plan for inpatient mental health services within 24 hours of admission. If the provider does not have a contract with the PMHP responsible for the inpatient stay, the PMHP may choose to transfer the individual to one of its contracting hospitals. If you think an individual may qualify for Medicaid, you should contact the appropriate PMHP to obtain authorization for outpatient services. Even if the individual is not yet enrolled with a PMHP, he or she may be entitled to retroactive Medicaid eligibility. (See SECTION 1 of this manual, Chapter 1 - 3, Retroactive Medicaid). If so, the PMHP contractor will be responsible for services.

For more information about managed health care plans, refer to SECTION 1, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of MCPs and PMHPs with which Medicaid has a contract to provide health care services is included as an attachment to this provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to which plan the patient must use is available to providers, a fee-for-service claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Definitions

In addition to the definitions in R414-1 of the Utah Administrative Code and SECTION 1 of this Medicaid Provider Manual, the following definitions apply.

Admission

The acceptance of a Medicaid client for inpatient hospital care and treatment when the client meets established criteria for severity of illness and intensity of service, and the required service cannot be provided in an alternative setting.

Bundling

The concept used by Medicare and adopted by Medicaid, to cover all inpatient hospital services by the DRG. The DRG payment includes the use of hospital facilities, technical portion of clinical laboratory and radiology services, nursing, therapy services, medical social services, and other related services furnished by the hospital as part of the general accommodations for inpatient service.

Clinical Laboratory Improvement Amendments

The Centers for Medicare and Medicaid Services (CMS) program which limits reimbursement for laboratory services based on the equipment and capability of the physician or laboratory to provide an appropriate, competent level of laboratory service.

Diagnostic Related Group (DRG)

The system established to recognize and reimburse for the resources used to treat a client with a specific diagnosis or medical need. The DRG weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files or from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

Fee for Service

Reimbursement term for service provided to a client that is not enrolled in a Prepaid Mental Health Plan (PMHP) or Managed Healthcare Organization.

Hysterectomy

A surgical procedure or operation for the purpose of removing the uterus.

Inpatient Hospital Services

An inpatient stay is defined as an admission which meets established criteria for severity of illness and intensity of service. The patient receives room, board, and professional services in an institution. The physician identifies the patient as inpatient status.

Intensive Inpatient Hospital Rehabilitation Service

An intensive rehabilitation program provided in an acute care general hospital through the services of a multidisciplinary, coordinated, team approach directed toward improving the ability of the patient to function.

Leave of Absence

An absence from an inpatient facility for therapeutic or rehabilitative purposes where the patient does not return by midnight of the same day.

Observation

Observation services are those services, including use of a bed and monitoring by hospital staff, furnished by physician order, which are reasonable and necessary to evaluate the outpatient's condition or determine the need for a possible admission to the hospital.

Outlier Days

Those days by which a patient's length of stay in a hospital exceeds the predetermined limit for a specific service referred to as the "trim point" or "threshold". Outlier days are subject to prepayment review.

Other Practitioner of The Healing Arts

A doctor of osteopathy, doctor of dental surgery or dental medicine, or doctor of podiatric medicine.

Outpatient

An individual who receives physician professional services and prescribed preventive, diagnostic, therapeutic, rehabilitative, or palliative services through the outpatient area of the hospital.

Outpatient Hospital

A facility that:

(a) is in, or physically connected to, a hospital licensed by the Department as a general hospital, as defined by Section 26-21-2(8), and meets the standards set forth in R432-100, Utah Administrative Code, and 42 CFR Part 482 [October 1, 2010 edition];

(b) meets the requirements for participation in the Medicare program; and

(c) has a current provider agreement with the Department.

Package Surgical Procedure

Bundling of preoperative office visits and preparation, the operation, local infiltration, topical or regional anesthesia when used, and the normal, uncomplicated follow-up care extending up to six weeks post-surgery.

Personal Supervision

Critical observation and guidance by a physician of a non-physician's activities within the non-physician's licensed scope of service.

Prepaid Mental Health Plan (PMHP)

The Medicaid managed care plan that is responsible for all needed inpatient and outpatient mental health care for Medicaid clients living in certain geographic areas of the state. Medicaid clients enrolled in the PMHP must receive inpatient and outpatient mental health services through PMHP contractors (mental health centers) paid on a capitation basis. Children in state custody, and children with an adoption subsidy exempted from PMHP, are not enrolled in the PMHP for outpatient mental health services; they are enrolled in the PMHP for inpatient mental health services.

Secondary Diagnosis

Includes all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Secondary diagnostic code(s) are listed after the principle diagnosis. The codes are sequenced in the proper order, not in random order.

Citations: ICD-9-CM, 6th Edition; UHDDS; July 31, 1985, Federal Register (Vol. 50, No. 147), pp. 31038-40; Medicaid Information Bulletin: April 2012, Hospital Services Manual, 1-2 Covered Services.

Sterilization

Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Take Home Supplies

Medical supplies or equipment to be used by the patient at home for follow-up care.

Technical Component

That part of laboratory or radiology service, provided with hospital supplies or equipment, necessary to secure a specimen and prepare it for analysis, or to take an x-ray and prepare it for reading and interpretation.

UB-04 Manual

The Utah Uniform Billing Instruction Manual developed and maintained by the Association of Health Care Providers which contains information specific to third party payers and billing instructions for use of the UB-04 Inpatient and Outpatient billing form seeking reimbursement for services.

2 COVERED SERVICES

All hospital inpatient and outpatient services are subject to review by the Department of Health for medical necessity and appropriateness of the admission according to R414-1-12 and R414-1-14 of the Utah Administrative Code.

1. Inpatient Hospital services encompass medically necessary, therapeutic services and supplies that are ordered by a physician or other practitioner of the healing arts which are appropriate for the adequate diagnosis and treatment of a patient's illness. These services include use of hospital facilities, the technical portion of clinical laboratory and radiology services, nursing, medical social services, and therapy services. The principal reason for the hospital admission is listed as the primary or first diagnosis on the claim.

   Inpatient Stay Defined

   The definition of inpatient hospital services also applies if the patient:

   A. Is admitted for a normal delivery;

   B. Is admitted and expires; or

   C. Is admitted and is then transferred to a distinct-part or another acute care hospital.

   Medicaid will pay at least one day stay for an admission meeting one of the above listed situations.

2. Continuing Care/Admission Following Outpatient Surgery

   The Centers for Medicare and Medicaid Services (CMS) has provided direction for the coding of services for patients admitted for continuing care following outpatient surgery. (CMS Region VIII letter 91-26.)

   A. Vague symptoms should be coded diagnosis V58.8 — Other Aftercare Following Surgery

      A physician may be concerned about the progress the patient is making after outpatient surgery. The patient may not have any clearly identifiable, specific condition that leads to the admission. However, several factors such as pain, nausea, or slow recovery from anesthesia, in combination with the general progress and condition of the patient may lead the physician to admit the patient for closer monitoring to observation or inpatient status.

   B. Well defined symptoms that are identified by the physician should be coded as the reason for the admission using the ICD-9-CM diagnosis for that specific condition. An example is post-operative hemorrhage 998.1

      The admission hour, in these instances, is the hour the patient is actually admitted as an inpatient.

C. If the patient leaves the hospital as scheduled after outpatient surgery and is later admitted as an inpatient, the principal diagnosis on the claim must be the ICD-9-CM diagnosis code which is the reason for the admission. An example is Pneumonia 997.3 or post-operative wound infection 998.5. Non-covered diagnoses are not recognized for coverage.

3. Services performed for a Medicaid client by the admitting hospital or by an entity wholly owned or wholly operated by the hospital, on either the date of an inpatient admission or during the three calendar days immediately preceding admission, are considered inpatient services. This three-day payment window applies to diagnostic and non-diagnostic services that are clinically related to the reason for the inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same.

4. Drugs and biologicals appropriate for inpatient care and approved by the federal Food and Drug Administration are covered Medicaid services based on individual need and physician's written order. The drug must be given in accordance with accepted standards of medical practice and within the protocol of accepted use for the drug. Coverage requirements are described in the Utah Medicaid Provider Manual for Pharmacy Services. A copy of the Pharmacy Manual is available at https://medicaid.utah.gov.

5. Medical supplies, appliances, and equipment required for the care and treatment of a client during an inpatient stay are covered Medicaid services under the DRG, provided four conditions are met: (1) The supplies and equipment are medically necessary; (2) they are ordered by a physician; (3) they meet the standards stated in policy and the Medical Supplies List, and they are within the limits specified; and (4) they are listed on the Medical Supplies List. This list is included with two Utah Medicaid Provider Manuals: Physician Services and Medical Suppliers. Coverage requirements are described in the manual for medical suppliers. A copy of the list or the Medical Suppliers Manual may be obtained by contacting Medicaid Information.

6. Services associated with pregnancy, labor and delivery are covered under the DRG as inpatient services when the patient is an admitted hospital inpatient for a normal vaginal delivery or a C-section delivery.
   False Labor: False labor may occur after 37 completed weeks of gestation. At this point in a pregnancy, changes begin to occur, and contraction-like activity may be present. It is often difficult to identify true labor, especially for a first time mother. If the threatened labor is of such a nature that a hospital admission is determined necessary by the physician, but does not progress to delivery through the current admission, a payment separate from the global maternity fee can be made for the service. The hospital should identify the admission with ICD.9.CM code 644.13 and appropriately selected Evaluation and Management codes. Repeated admissions through the final three weeks of pregnancy are subject to review through the post payment review process.

7. Organ transplantation services are covered Medicaid services as specified in R414-10A, Utah Administrative Code.

8. Inpatient and outpatient hospital psychiatric services are covered under the Medicaid fee-for-service program for clients not enrolled in a Prepaid Mental Health Plan. Inpatient service is approved only when care needs are determined by established criteria and utilization review standards to be of such severity and intensity that appropriate service cannot be provided in any alternate setting.

   Inpatient Hospital Psychiatric Admissions for Fee-for-Service Areas

Fee-for-Service inpatient hospital psychiatric services are available only to clients not residing in a county covered by a prepaid mental health plan as defined in Utah Administrative Code R414-2A-2(9).

The provider must seek authorization for emergency and crisis psychiatric admissions within 24 hours of admission. For admissions that occur after hours, on weekends, or holidays, authorization must be obtained during the next business day. The initial request may be made by telephone. In order to obtain authorization, all telephone requests require the submission of documentation that is sufficient to justify the clinical necessity or the admission and the proposed psychiatric treatment. Medicaid has the right to request additional documentation at any time, as needed to complete the assessment process.

A list of covered inpatient psychiatric ICD-9-CM codes, and those requiring prior authorization, can be found as an attachment to this manual.

9. Outpatient hospital services:

Note: This section does not apply to Long-Term Acute Care hospitals, Ambulatory Surgical Centers, or ambulance claims.

A. Effective September 1, 2011, Utah Medicaid began paying outpatient hospital claims like Medicare's Outpatient Prospective Payment System (OPPS) methodology. Hospitals are paid accord to their Medicare-designated facility type. Due to differences in clientele, Utah Medicaid may choose to differ in coverage from Medicare's coverage and edits. Coverage is displayed by the Outpatient fee schedule posted to the Medicaid website. Please refer to Utah State Plan, Attachment 4.19-B for specifics.

B. Critical Access Hospitals (CAH) are paid 101% of costs for covered procedure codes.
   B.1. Costs are determined using the hospital-specific cost-to-charge ratio (CCR) multiplied by the submitted charges.
   B.2. The Medicare CCR will be used for in-state facilities.
   B.3. The Medicare CCR will be used for out-of-state facilities.
   B.4. Claims will be edited using the Center for Medicare & Medicaid Service's (CMS) Outpatient Code Editor (OCE). Edits will apply, but reimbursement for CAH facilities is contained within this section.

C. OPPS hospitals are paid on a line-item level based upon the procedure code.
   C.1. Claims will be edited using the Centers for Medicare & Medicaid Services (CMS) Outpatient Code Editor (OCE)
      C.1.1. Line items with a Medicare status indicator 'A' (Paid …under a fee schedule…) will be paid by the applicable Medicare fee schedule. Fee schedules that apply include Medicare's Lab, DME, DME Penpuf, Physician, and ASP fee schedules (ambulance and ASC fee schedules are not applied for Utah Medicaid). Medicare lab panel methodology applies.
      C.1.2. Line items with a Medicare status indicator shown below will only be paid if Medicaid has the code open for outpatient billing. Such claim lines will be paid based on the Medicaid fee schedule rate.
         - 'B' (Codes not recognized by OPPS)
         - 'E' (Items, codes, & services…Not paid by Medicare)

- 'M' (Items & services not billable to the fiscal intermediary)
- 'Y' (Non-Implantable Durable Medical Equipment)

C.1.3. Line items with a Medicare status indicator shown below will **NOT** be paid by Medicaid.

- 'C' (Inpatient procedures)
  Refer to the Coverage and Reimbursement Lookup Tool for exceptions at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php
- 'D' (Discontinued)

C.1.4. Line items with a Medicare status indicator shown below will be paid reasonable cost (charges multiplied by the hospital-specific CCR).

- 'F' (Corneal tissue, Hepatitis B vaccines)
- 'L' (Influenza, Pneumococcal vaccines)

C.1.5. Line items with a Medicare status indicator shown below will be paid at the pass-through rate. (Pass-through rate means that the provider's charges reflect the cost of the item only.)

- 'G' (Pass-through drugs & biologicals)
- 'H' (Pass-through device categories)

C.1.6. Line items with a Medicare status indicator shown below will be paid the APC-calculated rate.

- 'K' (Non-Pass-Through Drugs…)
- 'N' (Items and Services Packaged into APC Rates)
- 'P' (Partial Hospitalization)
- 'Q1' (STVX-Packaged Codes)
- 'Q2' (T-Packaged Codes)
- 'Q3' (Codes That May Be Paid Through a Composite APC)
- 'R' (Blood & blood products)
- 'S' (Significant Procedure, Not Discounted When Multiple)
- 'T' (Significant Procedure, Multiple Reduction Applies)
- 'U' (Brachytherapy Sources)
- 'V' (Clinic or Emergency Department Visit)
- 'X' (Ancillary Services)

C.2. Rural Sole Community Hospitals (RSCH)

C.2.1. Receive a 7.1% bonus (or current Medicare rate) for APC-calculated items.

C.2.2. Lab fees are paid at 62% of base rate. This follows Medicare methodology for a 3.3% increase (base is 60%).

C.3. Vaccines & Injectables

C.3.1. Vaccines for children (VFC) payments are reimbursable at Medicaid VFC-established rates.

C.3.2. Non-VFC Covered vaccines and injectables are paid through OPPS pricing.

C.3.3. Non-VFC Non-covered vaccines and injectables are not reimbursed, nor are the associated administration charges.

D. Updates to coverage and pricing will occur quarterly with Medicare's release of OCE and pricer software. Medicaid will review coverage to match these releases. Due to software release timing, claims may be held for up to 15 days. If additional time is required, claims will be initially

processed to make payments and then reprocessed after updates are made in the system.

E. Effective 10/1/2012, pharmaceutical claims lines without a valid NDC will be denied. This includes services billed with revenue codes 450 and 459.

F. Since July 1, 2010, outpatient hospital-based clinics (facilities) have been eligible to receive reimbursement to the facility, for evaluation and management (E&M) codes (99201-99215). Centers for Medicare and Medicaid Services (CMS) have proposed changes to the methodology for how these codes are billed. Effective January 1, 2014, OPPS will reimburse one code, G0463, instead of the E&M code range above.

Hospital-based clinics are defined as those clinics having an approval letter from CMS designating them as meeting the policy requirements for provider-based designation as described in 42 CFR 413.65. Providers having such an approval letter may submit that documentation to Andrew Ozmun at aozmun@utah.gov for review.

Payments for these services will be through the usual claims process for outpatient hospital services.

10. ALL rehabilitation services require prior approval from Medicaid. Requirements and criteria for rehabilitation services are specified in the attachment *Rehabilitation Program*.

A. Inpatient hospital intensive physical rehabilitation services are covered Medicaid services, as specified in R414-2B, Utah Administrative Code.

B. Outpatient rehabilitation service is a special, limited service covered for individual clients who qualify and who have neither received nor qualify for the intensive, inpatient physical rehabilitation program. Prior authorization is given based on established criteria.

C. For approval, rehabilitation services must meet the following criteria:

(1) The patient is medically and surgically stable. The patient's physical condition will allow the patient to participate in the rehabilitation service (e.g., the stump has healed).
(2) This is the first admission, or the patient has developed a new problem, and now meets other admission criteria.
(3) The patient has a reasonable expectation of improvement in his/her activities of daily living which are appropriate for his/her chronological age and development that will be of significant functional improvement when measured against his/her documented condition at the time of the initial evaluation.
(4) The patient requires close medical supervision by a physician with specialized training or experience in rehabilitation.
(5) The patient requires 24-hour nursing care or supervision by a registered nurse with specialized training or experience in rehabilitation.
(6) The patient's cognitive and sensory capacity allows active participation in an intense rehabilitation program which includes, at a minimum, 3 hours of physical and/or occupational therapy and/or speech therapy in addition to any other necessary therapeutic

disciplines which will restore function rather than maintain existing function at the time of admission, 5 ½ days/week.

D. The physician or his/her designee must initiate the request for prior authorization no later than the 5th working day after admission to the Rehab Unit. The request can be made by telephone, by FAX, or in writing. The request can be initiated before the patient is admitted to the Rehab Unit if there is sufficient documentation to substantiate the request for admission. The information required information for a request is as follows:

(1) Telephone contact: Information must be sufficient to complete the Medicaid Rehab intake worksheet.

(2) Fax (801)536-0955 or in writing:
a. Completed Medicaid Rehab intake worksheet, or
b. Section I of the Medicaid Rehab intake worksheet completed with supporting documentation i.e.:
- History and Physical
  - Rehab evaluation, including patient goals and prognosis
  - Physical therapy evaluation
  - Occupational therapy evaluation
- Speech therapy evaluation with audiology evaluation, if applicable:
  - Nursing evaluation

Reminder: Coverage requirements apply **ONLY** when the Medicaid client is assigned to a Primary Care Provider or not enrolled in a managed care plan. Medicaid does **NOT** process Prior Authorization (PA) requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting PA for services to a client enrolled in a managed care plan will be referred to that plan.

E. At the time of the telephone contact, or receipt of the FAX, a decision will be made by Medicaid staff regarding the appropriateness of the admission. The provider will be informed via phone of the decision. A letter of approval, denial or pending status will be mailed to the provider.

F. Notice of Rights

(1) The Medicaid agency will give advance notice in accordance with State and Federal regulations whenever payment is not approved for services which prior authorization was requested. The notice will specify (1) the service(s) for which payment has not been authorized, (2) the reason(s) the authorization was not granted, (3) the regulations or rules which apply, and (4) the appeal rights of the provider.

(2) The physician and/or hospital may not charge the patient for services that are denied (1) because the provider failed to advise the patient that the services were not a covered Medicaid benefit, (2) because the provider failed to follow prior authorization procedures, or (3) because payment has been denied. The provider may charge the patient for services that are not covered by Medicaid only when the provider has advised the patient in advance that the services are not covered and the patient has agreed in writing to pay for the services. Refer to SECTION 1, General Information, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients.

2 - 1 Co-payment Requirements for Hospital Services

Many adult Medicaid clients are required to make a co-payment for hospital services. Both MCP and fee-for service clients can have a co-pay. The client's Medicaid Identification Card will state when a co-pay is required and for what type of services. The provider is responsible to collect the co-pay at the time of service or bill the client. The amount of the client's co-pay will be deducted from the claim reimbursement.

Requirements specific to hospital services are stated below. For general information about the co-payment requirement, clients required to make a co-pay, exempt clients, co-pay maximums, and an example of the co-pay message on the Medicaid Identification Card, refer to SECTION 1 of this manual, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Medicaid Co-payments.

Medicaid requires a co-payment when the conditions listed below are met.

1. The Medicaid Identification Card must state a co-pay is required for the individual client. If there is not a co pay message by a client's name, the client does not have a co-pay. Also, do not require a co-pay for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

2. The service must be subject to a co-pay. Hospital services subject to co-pay are non-emergency use of the emergency department, outpatient hospital, and inpatient hospital. Exceptions: Do not require a co-pay for family planning services, emergency services in a hospital emergency department, lab and X-ray services, including both technical and professional components, or anesthesia services.

   A. **Non-emergency Use of the Emergency Department:** Except for exempt clients and exempt services described in items 1 and 2 above, Medicaid clients have a **$6.00** co-payment for non-emergency use of the Emergency Department. When a client comes to the Emergency Department for services, he or she should be assessed. If the condition is not an emergency, refer the client to his or her Primary Care Provider, or after-hours care if appropriate.

      Do not require a co-pay when the **discharge diagnosis** is one of those listed in the table attached titled Utah Medicaid Table of Authorized Emergency Diagnoses.

   B. **ER only** coverage requires entering the primary reason for the visit at the time of discharge as the principle or primary diagnosis on the claim.

   C. **Outpatient Hospital Services:** Except for exempt clients and exempt services described in items 1 and 2 above, effective October 1, 2011, Medicaid clients have a **$3.00** co-payment for outpatient hospital services. Twice that amount will be charged for non-emergent use of the Emergency Department.

   D. **Inpatient Hospital Services:** Except for exempt clients and exempt services described in items 1 and 2 above, Medicaid clients have a **$220.00** co-insurance payment for inpatient hospital services.

2 - 2 Emergency Department Coverage

The "emergency" designation is based on the principal diagnosis (ICD-9-CM code). The diagnosis primarily responsible for the patient's outpatient service must appear as the principal diagnosis on the claim.

Please see SECTION 1 (All Providers), *Emergency Services Program for Non-Citizens*, for information relating to that program.

For clients enrolled in a managed care plan, refer to Chapter 1 - 1, Clients Enrolled in a Managed Care Plan, and Chapter 3, LIMITATIONS, item 25 B, Emergency Services for Clients in a Managed Care Plan.

2 - 3 Ambulatory Surgery Center Coverage and Reimbursement

Ambulatory surgical centers are reimbursed as outlined in the Utah State Plan, 42CFR 440.90, Attachment 4.19-B.

Please note that the Medicaid policy determinations for non-covered codes or codes requiring prior authorization on the Medicare list remain. Medicaid will also cover some podiatry, dental, and lithotripsy codes which frequently require ASC services.

For code coverage, see the lookup table found at:
http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php

3 LIMITATIONS

1. Inpatient hospital care for treatment of alcoholism or drug dependency is limited to medical treatment of withdrawal symptoms associated with drug or alcohol detoxification under the DRG 896 or 897. Any continuing therapy must be accessed under the outpatient mental health or psychiatric services benefit as appropriate. Drug and alcohol rehabilitation is not a covered service under these codes.

2. Cosmetic, reconstructive, or plastic surgery is limited to:
   (a) correction of a congenital anomaly;
   (b) restoration of body form following an accidental injury; or
   (c) revision of severe disfiguring and extensive scars resulting from neoplastic surgery

3. Abortion procedures are limited to:
   (a) those where the pregnancy is the result of an act of rape or incest; or
   (b) a case with medical certification of necessity where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(42 CFR 441.203 and Public Law Number 105-78 Section 509 and 510, pertaining to revisions of the Hyde Amendment, 1998.)

(Note: Please note that the emphasis is on physical disorder or illness.)

4. Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441, Subpart F which is adopted and incorporated by reference.

A. Voluntary Sterilization

An individual decision made by the client, male or female, for the purpose of preventing conception, therefore, making the voluntary sterilization a benefit under family planning. The following criteria must be met:

(1) A prior authorization must be obtained, by the physician, prior to the service being provided. (The prior authorization number will be provided to the facility identified by the physician as the place for the procedure.

(2) A sterilization consent form (Form 499-A) must be signed.

(3) A 30 day waiting period must be observed. The prior authorization will not become effective until 31 days after the date the consent form is signed.

A hysterectomy, when no medical pathology is present, does not meet the criteria for a voluntary sterilization.

B. Sterilizations Incident to Surgical Procedures for Medical Reasons

The 30 day waiting period for sterilization does not apply where the sterilization is incident to a surgery that is performed for medical reasons, e.g., a tumor or cancer of the uterus, ovary, testes or prostate. Surgical procedures require the following:

(1) Prior authorization must be obtained before the procedure is completed. In the case of an emergency procedure, the authorization should be requested by the physician as soon as possible after the procedure by submitting documentation for review to support the emergency nature of the service.

(2) A hospital surgical consent must be provided with clear indication of the procedure(s) to which the patient consented. (This consent is different than the Form 499-A required for voluntary sterilization.)

(3) Documentation from the patient's medical record clearly showing the indications for the surgical procedure that resulted in sterilization. Refer to SECTION 1, General Information, Chapter 9 - 7, Retroactive Authorization.

A complete list of criteria can be found in the attachment Criteria for Surgical Procedures. A sample Form 499-A, Hysterectomy Information and Consent Form, is also included with this manual.

5. Labor and delivery are considered emergency services for pregnant women who are eligible for "Emergency Services Program", as stated on the Medicaid Identification Card.

Information about this program can be found in SECTION 1, Chapter 13 - 8, Emergency Services Program For Non-Citizens.

A. The following criteria must be met for covering "Emergency Only Services":

- The condition manifests itself by sudden onset.
- The condition manifests itself by acute symptoms (including severe pain).
- The condition requires immediate medical attention.
- Immediate medical attention will require attention within 24 hours of the onset of symptoms or within 24 hours of diagnosis, whichever comes earlier (no delay for scheduled or convenient time for service).
- The condition requires acute care, and is not chronic (Does not include any chemotherapy or follow-up care.
- Coverage will only be allowed until the condition is stabilized sufficient that the patient can leave the acute care facility, or no longer needs constant attention from a medical professional.
- The condition is not related to an organ transplant procedure.
- Prenatal or postpartum care are not covered.

B. Some selected conditions are representative of those in the prenatal period which meet the intent of the act, require "immediate medical attention", and if coded appropriately warrant payment without prior review. Records may still be subject to review if pulled in the mandated monthly sample or targeted for a focused review. The following codes are approved and may bypass prepayment review:

(1) Diagnosis Code V22.2 - Pregnant state incidental, must appear on every claim as one of the diagnosis codes.

(2) Vaginal Bleeding – Diagnosis codes 641.01, 641.03, 641.11, 641.13, 641.21, 641.23, 641.31, 641.33, 641.81, 641.83

(3) Threatened abortion – Diagnosis Code 640.03

(4) Spontaneous abortion – Diagnosis 634.92 Accommodation, without review, for complete spontaneous abortion was made some time ago for Medicaid clients. The appropriate related diagnosis and procedure codes must be on the claim for payment to be made without review. Note: An incomplete abortion which requires a D&C or vacuum extraction to complete must have medical record review, including operative and pathology reports, for approval before payment.

(5) Missed abortion – (Fetal death without spontaneous abortion) Diagnosis code - 632 Abortion will inevitably occur, but D&C or D&E may be indicated to prevent any maternal complications. Documentation of fetal demise by ultrasound is required for post payment review.

(6) Premature rupture of membranes – Diagnosis code 658.13 requires documentation for review. If delivery occurs within 24 hours of admission, no separate payment is warranted for the ruptured membrane services. Labor and Delivery codes only should be billed.

(7) Threatened premature labor -- Diagnosis code 644.03 (After 22 weeks but before 37 weeks gestation, without delivery). Depending on how premature and how advanced the labor is, it could lead to delivery or be treated to preserve the pregnancy for more development. However, any follow up or continuing care following the stabilization could not be covered.

(8) Decreased fetal movement – Diagnosis code 655.73 is subject to review. This could be an indication of symptoms which may or may not require emergency service. The evaluation should not require hospital service.

(9) All other services to the undocumented population beyond those listed above, must still be edited and reviewed before payment.

Other codes which may be associated with the above services are listed below. Codes should be selected carefully based on the condition and the necessary services to stabilize the problem. Appropriate diagnosis to procedure edits must apply. All codes will not be appropriate for all complaints and may not be associated in the system editing and payment will be denied.

C. Revenue codes for hospital emergency department use: (UB-04)

450	Emergency room
300 - 301	Lab work with appropriate CPT codes (Diagnosis to procedure must agree)
383-389	Blood or blood products
258	IV fluids
270	Medical/surgical supplies
402	Ultrasound with appropriate CPT code
729	Other labor and delivery room may be used instead of emergency room. Mutually exclusive to 450 - both will not be paid.
760	Observation must be used on a very limited basis and must meet the criteria for observation.

Fetal non-stress test – ICD.9 code 75.35 to be used with CPT code 59025. Other fetal monitor – ICD.9 code 75.34 to be used with CPT codes 59050, 59051.

Special Limitation: Abortion or early induced labor and delivery because of fetal anomalies, are non-covered services.

6. Organ transplant services are limited to approved procedures for the specific type of transplant.

7. Inpatient rehabilitation or psychiatric patient off-unit pass is limited to a written order by the attending physician. The written order should identify objectives of the pass which support the patient's plan of care, be planned by the physician and/or interdisciplinary team, and be documented and evaluated in the progress notes of the patient's chart upon return to the unit.

8. A therapeutic leave of absence is limited to inpatient rehabilitation patients to test their ability to manage in a community setting in preparation for discharge. Such leave is pursuant to a written order by the attending physician, planned by the physician and/or the interdisciplinary team, and adequately documented and evaluated in the progress notes of the patient's chart as supporting the patient's plan of care.

9. Review of inpatient "outlier days" is limited to cases where full payment of the DRG has been made to the hospital. The following exceptions apply:

   A. Neonatal admissions assigned to DRG's 789, 790, 791 go into outlier status the day after admission. A length of stay less than 20 days does not require review. Payment will automatically be calculated to include the outlier days.

      If a case with stay of less than 21 days is submitted in error, the entire case will be reviewed for severity of illness and intensity of service.

   B. When the stay for a Medicaid patient eligible for Emergency Services Only goes into outlier days, the entire record must be submitted with a transmittal sheet for one review. The

emergency circumstances and the outlier days can be evaluated in the same review – a benefit to both the hospital and the agency.

10. Readmissions Within 30 days of Previous Discharge

Please refer to Utah Administrative Rule R414-1-12.

11. Exceptions to the 30 Day Readmission Policy

Please refer to Utah Administrative Rule R414-1-12.

12. Laboratory services are limited to those tests identified by CMS for which the individual laboratory is CLIA certified to provide, bill and receive Medicaid payment.

13. Occupational therapy services are limited to those cases identified and approved for children through a CHEC/EPSDT screen, or to a special group of services identified and approved through a cooperative occupational therapy/physical therapy program. Refer to the Medicaid Provider Manual for Child Health Evaluation and Care or for Physical Therapy.

14. Outpatient Hospital Services are limited to services that are medically necessary and appropriate for the outpatient setting. Determinations of medical necessity and appropriateness are based on utilization management review and use of Inter-Qual medical review criteria as outlined in R414-1-12, Utah Administrative Code.

Under the current Outpatient Prospective Payment System (OPPS) configuration, there are procedure codes that are designated as only payable on inpatient claims. Utah Medicaid follows Medicare's Addendum B to determine which codes will be listed as inpatient-only. If Utah Medicaid determines that procedure codes currently listed as inpatient-only would be appropriately applied in an outpatient hospital setting, those exceptions will be listed in the Hospital Provider Manual.

15. Observation services are limited to cases where time is needed for observation and evaluation to establish a diagnosis and/or the appropriateness of an inpatient admission.

Observation services are defined as use of a bed and periodic patient monitoring, on the hospital's premises, by hospital nursing or other appropriate staff. Observation services are considered reasonable and medically necessary when needed to evaluate an outpatient's condition and assess the need for possible inpatient admission. Observation services are covered only under physician's written orders. [Taken from UB-04 Billing Instruction Manual.]

A. Coverage of Observation Service may be appropriate when:

— A patient arrives at the facility in an unstable condition with vague symptoms which do not point to a definitive diagnosis. Observation and testing are indicated to identify the nature of the complaint and establish a treatment plan.
— An unusual reaction follows an outpatient surgical procedure and requires monitoring or treatment beyond that customarily provided in the immediate post operative period, i.e., a drug reaction; delayed recovery from anesthesia; or acute pain unresolved by usual medication administration.
— A significant, adverse reaction, above and beyond the usual response expected as a result of a scheduled diagnostic test or outpatient therapeutic services.

B. Observation Service must be medically necessary, and the following criteria and guidelines must be met:

- Reason for observation must be stated in the physician's orders for observation. The patient's condition is clinically unstable as characterized by:
  - ✓ Variance from generally accepted, safe laboratory values, or
  - ✓ Clinical signs and symptoms above or below those of normal range which indicates need for evaluation and monitoring, or
  - ✓ Uncertain severity of illness or condition exists. Change in status is anticipated and immediate medical intervention may be needed.

- Laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization.
- Diagnosis and treatment plan are undefined until further evaluation is completed.

C. Documentation in the medical record must support the medical necessity of observation services and justify the amount of time spent in observation. Documentation must include, but is not limited to:
- The written physician's order
- The differential diagnosis(es)
- Signs and symptoms; vital signs; lab values, etc.
- Documented complications
- Recorded observations and interventions (tests, x-rays, EKG, etc.),
- Findings/Response to interventions
- Interval assessments and charting
- Status change - improvement/deterioration
- Recorded time in and time out

D. Reimbursement is limited to credentialed outpatient clinics.

Limitations

- Observation services must be patient specific and not part of standard operating procedure or facility protocol for a given diagnosis or service.

- Use of observation status to submit ancillary charges associated with outpatient surgery, other outpatient diagnostic services, or other outpatient stays for any reason is excluded from reimbursement. Observation services must not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure.

- Observation services are limited only to those provided under orders specifically written by the physician or other provider authorized to admit patients to the hospital or to order outpatient tests. Reason for the observation service must be clearly stated in the order.

- Observation services are not covered for the convenience of the hospital, physicians, patients, or patient's families or while awaiting placement in another health care facility.

- Observation services are an outpatient procedure -- surgical and/or diagnostic, which becomes an observation because of a complication or an adverse reaction. As time proceeds, the need for admission or discharge must be determined through use of the Medicaid agency's standard criteria, if applicable, or through severity of illness and intensity of service criteria.

- When a patient is admitted to the hospital at the end of the observation period, observation services are included within the inpatient admission DRG.
- Observation services cannot be covered or billed for routine preoperative preparation associated with an outpatient surgery. These services are included as part of the surgical procedure and do not warrant additional payment.
- Observation services cannot be covered or billed for the routine preparation time before a scheduled invasive outpatient diagnostic procedure or the recovery period following the procedure. For most procedures, this time is included in the procedure itself.
- Scheduled ongoing therapeutic services associated with a known medical condition include a required period of time to evaluate response to the service. This period of evaluation is not a separate observation service and must not be billed as such.
- Outpatient administration of blood or IV fluids associated with no other medical treatment does not qualify as an observation service. The use of the hospital facilities, including staff time, is inherent in the administration of the blood or fluids and is included in the payment for the administration of the blood or fluids.
- Outpatient services for dressing changes, IV administration or medication administration as follow-up care related to a surgical procedure and within the normal recovery period following surgery (42 days) are the responsibility of the surgeon, and do not qualify as separate hospital observation or treatment services.
- Units are not required for billing or payment of observation services. The important parameters are a clear recording of admission time and discharge time along with detailed recording of services provided during the observation time.

<u>Exception</u>

There are circumstances in which a patient is admitted to inpatient service with the intent of remaining more than 24 hours and later improves to the point discharge is indicated (i.e. cardiac arrhythmia, asthma, congestive heart failure). The stay may be covered and billed as Observation providing all criteria for observation admission are met, including the hospital admission order, and documentation in the medical record is consistent with that noted above as justification and support of medical necessity for observation.

16. Post Anesthesia Recovery Services Recovery services are limited to provision in a designated unit or area of the hospital staffed with personnel knowledgeable about this care. Post anesthesia recovery is not an observation room service for either inpatients or outpatients.

- The Joint Commission on Accreditation of Health Care Organizations (JCAHO) requires that hospitals have policies and procedures for safe recovery after anesthesia and criteria for discharge.
- Accepted criteria sets and standards are also available on which to base appropriate post anesthesia recovery services. Through all services billed as recovery, the medical record must have documentation of the medical need for service and active medical observation and monitoring.

- An order to discharge from Post Anesthesia Care Unit (PACU) does not equate to discharge from recovery services. It means the patient has reached an appropriate level of activity and consciousness with adequate respirations, circulation and oxygenation to be moved to a less intense care unit to complete the recovery process and be ready for discharge to the nursing unit.

- The person having same day surgery may need to meet some additional criteria to assure readiness for "street fitness" and home readiness.

- Billing for recovery services is limited to Revenue Code 710 to include time in the PACU and the "step-down" unit for all appropriate recovery services. No charges will be allowed for services rendered after indication that the patient is ready for discharge to the nursing unit or to home. When nursing services are not being provided, or time is spent waiting for transportation or an escort, no bill can be submitted to Medicaid.

- If, during the recovery process, the patient develops a complication such as excessive bleeding, a medication reaction, or pain which cannot be relieved by usual medication administration, or general slow recovery from anesthesia, an extended stay may be warranted either by admission to inpatient status, or to Observation services for further determination of the severity of illness and intensity of service required. Admission to observation status must meet the established criteria for observation services.

17. Recovery Services Associated with Radiologic and other Diagnostic Procedures

- Invasive or interventional procedures such as cardiac services require some time for recovery. As a result, billing for an outpatient stay may also be warranted with appropriate orders and documentation.

- "Oscopy" procedures may require limited recovery time, but no observation or short stay.

- For non-invasive procedures (MRI, CT scans, etc.), preparation time and any necessary recovery time would be included as part of the procedure and no additional time or billing would be covered.

18. Outpatient hospital psychiatric services are limited to services provided in an outpatient unit of a general acute care hospital that is licensed and approved for psychiatric care.

19. Non-physician psychosocial counseling services are limited to evaluations and may be provided only through the Prepaid Mental Health Program by a licensed psychologist for:

a. mentally retarded persons
b. cases identified through a CHEC/EPSDT screening; or
c. victims of sexual abuse

20. Lithotripsy, extracorporeal shock wave for *treatment of kidney stones is covered*. The payment rate and conditions for coverage are the same regardless of the site of service. This payment covers all hospital related services for lithotripsy on the same kidney for 90 days. No additional payment will be made for repeat procedures on the same kidney within the 90-day period. Lithotripsy for treatment of the kidney on the opposite side is considered a separate service. The same policy applies: payment covers all hospital or free standing ambulatory surgical center related services for lithotripsy on the same kidney for 90 days.

21. The Hyperbaric Oxygen Therapy (HBOT) unit is covered only for facilities pending or having achieved certification through the Undersea and Hyperbaric Medical Society. Medicaid will allow a period of one year to obtain or be listed by the Hyperbaric Undersea Medical Society for a quality review. If an HBOT unit does not have a quality review after one year or does not have a review date, Medicaid will not be able to provide patient approval for HBOT coverage until the quality review is completed.

22. Emergency Services for Clients in a Managed Care Plan

Managed care plans, both MCPs and Prepaid Mental Health Plans (PMHP), are responsible for covering all emergency services for enrollees, regardless of where the emergency occurred and was treated. Providers who render emergency care to a patient enrolled in a managed care plan must obtain approval from the plan within the time frame specified by the plan, which is usually within 24 hours of service. (A list of telephone numbers for managed care plans is in the GENERAL ATTACHMENTS Section of this manual.) The provider will be reimbursed only when the provider has made a good faith effort to obtain approval from the plan within the time frame specified. If you do not have a contract with the plan responsible for the services, the plan may choose to transfer the patient to one of its contracting hospitals.

When the diagnosis is for emergency mental health services, and the patient is enrolled in a PMHP, bill the facility charge directly to Medicaid. The PMHP covers services, but not the facility charge.

23. Private Room Payment Requirements

Medicaid will pay for a private room when clinically indicated to prevent the spread of an infectious disease and in cases where the patient is colonized with a multi-drug-resistant organism which may present a serious risk of spread to other patients. Coverage will be based on current Centers for Disease Control and Prevention (CDC) guidelines.

Cognitive services by a provider are limited to one service per client per day. For more details, refer to the *Physician Services Utah Medicaid Provider Manual*, Limitations, available at: https://medicaid.utah.gov.

A. Indications for Coverage

1. Payment for patient isolation in a negative pressure room will be limited to patients requiring isolation to prevent the spread of infectious disease through airborne droplets. This category includes patients with active infection with Mycobacterium Tuberculosis (pulmonary or laryngeal), Measles (Rubeola), Chickenpox (Varicella) or disseminated Shingles (Herpes Zoster) in an immune compromised patient.

2. Since the infectious respiratory droplets may be spread within a five foot radius of the patient, provision for a private room will be covered for those diseases transmitted by respiratory droplets. Infections in this category include meningitis, pneumonic plague, pharyngeal Diphtheria, Whooping Cough (Pertussis), Mycoplasma pneumonia, Small pox (Variola), Rubella (German Measles), or Mumps (Infectious parotitis).

3. Contact isolation for some infectious diseases is required until appropriate treatment has been provided or infectious period has passed. Diseases in this category include African hemorrhagic fevers (Marburg, Ebola, Lassa), cutaneous diphtheria, cutaneous tuberculosis, herpes zoster, bubonic plaque, impetigo, and resolving viral infections in which infectious lesions are still

present (Varicella, Variola). Diseases in this category which apply just to infants and young children include respiratory syncytial virus, adenovirus, parainfluenza viral infection, enteroviral infection, staphylococcal cutaneous infections and group A streptococcus.

4. Patients colonized with multi drug resistant organisms may not have a severe infection themselves but because of the nature of the organism may pose a threat to others. Patients infected or colonized with methicillin-resistant Staphyloccocus aureus (MRSA), Vancomycin-resistant enterococci, and multi-drug-resistant Streptococcus pneumoniae may be eligible for a private room. Documentation of drug resistance should be submitted. Cohorting or placing patients with the same infection into the same room should be done whenever feasible.

5. Infectious disease codes (ICD-9-CM) which qualify for a private room until the infectious stage wanes or antibiotic therapy is sufficient to ensure the patient is no longer infectious may be found in the provider and hospital sections of the Medicaid manual.

B. Limitations/Non-coverage

1. Neutropenic patient with a neutrophil count < 500 are more at risk for picking up serious life threatening infections. The Center for Disease Control states that these patients can be in a regular room if standard precautions are followed. Therefore, these patients are excluded from the private room policy.

2. A private room is no longer covered when the appropriate antibiotic therapy has been provided, making the patient no longer infectious. For those diseases with a known infectious period, a private room is no longer covered when the duration of infectiousness has passed.

C. ICD.9 Codes

Resistant organisms of concern must be listed with appropriate V code (V09.0-V09.91) as the secondary diagnosis on the claim:

041.3 Klebsiella pneumoniae
041.4 Escherichia coli
041.04 Enterococcus or Streptococcus type D
041.11 Staphylococcus aureus
041.2 Streptococcus pneumoniae or pneumococcus
041.85 Other gram negative (acinetobacter baumanni, Klebsiella oxytoca)

002.0	Typhoid fever listed with meningitis code 320.7
003.21	Salmonella meningitis
008.67	Coxsackie virus and echovirus (enteroviral infection)

011.9	Pulmonary tuberculosis
012.3	Laryngeal tuberculosis
013.0	Tuberculosis meningitis
020.0	Bubonic plague

020.3, 020.4, 020.5	Pneumonic plague
027.0	Listerosis with meningitis code 320.7
032.1, 032.2, 032.3	nasal pharyngeal and laryngeal Diphtheria
033.0	Bordetella pertussis
033.9	Whooping cough with meningitis code 320.7
034.0	Group A streptococcus pharyngitis
036.0	Diplococcal, meningococcalmeningitis
039.8	actinomycosis with meningitis code
047.0	Coxsackie virus related meningitis
047.1	Echo virus meningitis
047.8	other specified viral meningitis
047.9	unspecified viral meningitis
049.0	lymphocytic choriomeningitis virus
049.1	Meningitis related to adenovirus or enterovirus
050.0, 050.1, 050.2, 050.9	Small pox
052.0, 052.1, 052.7, 052.8, 052.9	Varicella or chickenpox

053.0	Herpes Zoster with meningitis
053.79	Herpes Zoster with other specified complication –-must specify in the medical record that infection is disseminated inimmunocompromised patient.
054.72	Herpes simplex meningitis
055.9	Rubeola
056.9	Rubella
072.1	Mumps meningitis
072.0, 072.2, 072.3, 072.7, 072.71, 072.72, 072.79, 072.8, 072.9	Mumps
078.89	other unspecified disease due to virus Marburg, Lassa, Ebola
079.82	SARS – associated cornovirus
079.9	Respiratory syncytial virus
094.2	Syphilitic meningitis
112.83	Candidal meningitis
114.2	Coccidioidal meningitis
115.91	Histoplasmosis meningitis
320.0	Gram positive: Hemophilus meningitis
320.1	Pneumococcal meningitis
320.2	Streptococcal meningitis

320.3	Staphlococcal meningitis
320.7	Actinomycotic
320.81	Anaerobes: Bacteroides fragilis,Clostridium, peptostreptococcus, proprionbacterium, Treponemadenticola, Treponema macrodenticum, Veillonella,
320.82	Gram negative: Proteus morganii, Pseudomonas aeruginosa, Serratiamarcescens, Vibrio vulnificus, Klebsiella pneumoniae, Escherichiacoli, Aerobacter aerogenes
320.89	Meningitis due to specified bacteria: Bacillus pyocyaneus
320.9	Septic meningitis unspecified: bacterial, pyogenic, purulent, suppurative
321.0	Crytococcal meningitis with code 117.5
321.1	Meningitis from fungal disease with a code from range 110.0 to 118
321.2	Viral meningitis with a code from range 060.0 to 066.9
321.8	Nonbacterial organisms must include a code with the underlying disease
480.0	Adenoviral pneumoniae
480.1	Respiratory syncytial pneumonia
480.2	Parainfluenza
483.0	Mycoplasma pneumonia
488.0-488.1	Avian or H1N1 Influenza
684	Inpetigo or Staphylococcal infection

4 NON-COVERED SERVICES

Certain services have been identified by Medicaid agency staff and medical review to be non-covered by the Utah Medicaid Program because medical necessity, appropriateness, and cost effectiveness cannot be readily identified or justified for the purposes of medical assistance under Title XIX of the federal Social Security Act and Title 42 Code of Federal Regulations (CFR). The general exclusions are listed below:

1. Services rendered during a period the client was ineligible for Medicaid.
2. Services medically unnecessary or unreasonable.
3. Services which fail to meet existing standards of professional practice, which are currently professionally unacceptable, or which are investigational or experimental in nature.
4. Services requiring prior authorization, but for which such authorization was not requested, was not obtained, or was denied.
5. Services, elective in nature, and requested or provided only because of the client's personal preference.

6. Services for which third party payers are primarily responsible, e.g., Medicare, private health insurance, liability insurance. Medicaid may make a partial payment up to the Medicaid maximum if limit has not been reached by third party.
7. Services fraudulently claimed.
8. Services which represent abuse or overuse.
9. Services rejected or disallowed by Medicare when the rejection was based on any of the reasons set forth above.
10. When a procedure or service is not covered for any of the above reasons or because of specific policy exclusion, all related services and supplies, including institutional costs will be excluded for the standard post-operative recovery period.
11. Cosmetic, reconstructive, or plastic surgery procedures, including all services, supplies, and institutional costs related to services which are elective or desired primarily for personal, psychological reasons or as a result of the aging process.
12. Chemical peeling, dermabrasion or laser therapy of the face.
13. Removal of tattoos.
14. Hair transplants.
15. Panniculectomy and body sculpturing procedures.
16. Procedures related to transsexualism.
17. Surgical procedures to implant prosthetic testicles or provide penile implants.
18. Certain services are excluded as family planning services:
    (1) Surgical procedures for the reversal of previous elective sterilization, both male and female
    (2) Infertility studies
    (3) In-vitro fertilization
    (4) Artificial insemination
    (5) Surrogate motherhood, including all services, tests, and related charges
    (6) Abortion, except when the life of the mother would be endangered, or when the pregnancy is the result of rape or incest.
19. Certain services are excluded from coverage because medical necessity, appropriate utilization, and cost effectiveness of the service cannot be assured. A variety of lifestyle factors contribute to the "syndromes" associated with such services, and there is no specific therapy or treatment identified except for those that border on behavior modification, experimental or unproven practices. Services include:

    (1) Eating disorders

20. An inpatient admission solely for observation or diagnostic evaluation is not a covered Medicaid service.
21. Non-physician psychosocial counseling is not a covered Medicaid service. The personal supervision policy may not be applied to psychiatric or any other inpatient hospital services.
22. Miscellaneous supplies, dressings, durable medical equipment, and drugs to be used as take-home supplies are not covered Medicaid services.

23. Prescriptions to take home following inpatient or outpatient service are not a covered Medicaid benefit for persons with the designation "Emergency Services Only Program" printed on the Medical Identification Card.
24. Surgical procedures that are unproven or experimental are non-covered Medicaid services.
25. For Inpatient Hospital claims, adverse events or "Never Events" are non-covered in Medicare crossover patients.

    Medicaid will not pay for provider preventable conditions. See Provider Preventable Conditions (PPC) Diagnosis List in the attachments section.

    To qualify as a PPC, one of the listed diagnoses must develop during hospitalization. When present on admission, these diagnoses are not considered to be a PPC for that hospitalization. Providers are expected to identify ***Present on Admission*** (POA) status for all diagnoses on each claim according to correct coding standards.

    Providers should assure all PPC related diagnoses, services, and charges are noted as "non-covered charges" on the claim. Non-covered charges will not be used in calculating the hospital reimbursement.

    If a PPC related claim will result in an outlier payment, it will be denied and medical records will be required. Providers will receive Remittance Advice (RA) confirming the occurrence of a PPC outlier claim and requesting medical records. Medical records are expected to be submitted within 30 days of the RA notification. Providers should pay close attention to the RA to know that medical records are needed. In addition, at the time of RA notification, a confirmatory letter may be generated reiterating the occurrence of a PPC outlier and the need for the requested submission of medical records. If the medical records are submitted within the 30-day period, the claim will be reviewed and, if appropriate, reprocessed and paid. If medical records are not submitted within the 30-day period, the claim will be denied for failure to submit the requested documentation in a timely fashion.

    PPCs include those conditions noted in 42 CFR 447.26 (e.g., wrong procedure, wrong body part, wrong patient).

    Providers are required to report PPCs in accordance with Utah Administrative Rule R414-1.

5 BILLING

Effective March 1, 2007, Medicaid requires UB-04 inpatient and outpatient claims to be billed **electronically**. The Utah Medicaid agency will return UB-04 claims submitted on a paper form to the provider with a cover letter requesting the claim be submitted electronically.

A. Paper Claim Exceptions:

Medicaid accepts paper UB-04 claims in three circumstances only:

1. UB-04 claims billed by out-of-state providers

2. Dialysis claims
3. Crossover claims where the Medicare carrier is out of state

When necessary and appropriate to file a paper claim, refer to the Utah Uniform Billing Instruction Manual

(UB-04 Manual) for the Utah Medicaid UB-04 Billing Instructions.

B. Electronic Billing with AcClaim Software

The Utah Health Information Network (UHIN) provides AcClaim software for billing UB-04 claims electronically. Providers who need AcClaim software and be set up to bill through UHIN may call (801) 466-7705. Providers who need additional assistance may call Medicaid Information, 801-538-6155 or toll-free 1-800-662-9651, and ask for Medicaid Electronic Billing.

The requirement to bill electronically through UHIN is supported by the Administrative Simplification Clause in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). An advantage of electronic billing for providers is that mistakes, such as placement of the provider number, can be corrected immediately. Because billing errors are reduced, claims can be processed without delays. Also, electronic claims can be submitted until noon on Friday for processing that week.

C. Crossover Claims with EOMB attachment

Medicaid processes crossover claims in two circumstances only:

A. Inpatient claim, Part B Only. After Medicare pays the claim, it is processed as a Medicaid claim with the Medicare payment on the claim. Medicaid then pays the Part A (hospital) charges.

B. Out of plan claims such as mammography with the EOMB denial attached.

D. Manual Adjustments Accepted

When submitting a paper UB-04 claim as an adjustment to an original paid or denied claim, write the seventeen-digit transaction control number (TCN) of the original claim on the paper claim or write **PAR** (Payment Adjustment Request) on the claim. The claim will be adjusted to correct billing errors or add charges.

5 - 1 Inpatient Hospital Claims with Third Party Insurance

SECTION 1, GENERAL INFORMATION, Chapter 11 - 4, Billing Third Parties, states the general policy in regard to patients who have liable third parties such as private insurance, a health maintenance organization, Medicare Part A and B or B only, or Qualified Medicare Benefits (QMB), in addition to Medicaid. However, when a patient with third party insurance receives inpatient hospital services, there are two clarifications to the general information:

1. If the third party pays on the claim, submit the claim to Medicaid and show the TPL amount and the due from patient amount.

2. Payment is limited to patient liability. However, if the adjusted DRG amount from the TPL is less than the patient liability, the adjusted DRG amount is paid. Likewise, Medicare cross-over claims are paid by Medicaid according to the lower of the DRG amount less amounts paid by Medicare and other payers, or the Medicare patient liability - co-insurance and/or deductible.

5 - 2 Outpatient and Inpatient Hospital Revenue Codes

Effective October 1, 2011, Medicaid is following the national standard to require CPT codes to be listed with the revenue code. This standard will apply with the exception of the following revenue codes: 0360, 0361, 0451-0452, 0459-0460, and 0469, wherein CPT codes will not be required.

6 REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

Reimbursement for inpatient hospital services is covered in the Utah State Plan, Attachment 4.19-A.

The following applies to hospitals that are paid using a DRG: Excepting PPCs, Utah Medicaid uses all submitted diagnoses in determining the DRG on which to base reimbursement. If all submitted diagnoses are not covered by Utah Medicaid, then the claim will deny. Otherwise, all submitted diagnoses, whether covered or not, are used to calculate the DRG. Providers must ensure that all submitted diagnoses are appropriate and documented in the patient's medical record.

Only covered charges will be included in the calculation of the hospital's reimbursement. Denied or non-covered charges will be excluded.

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