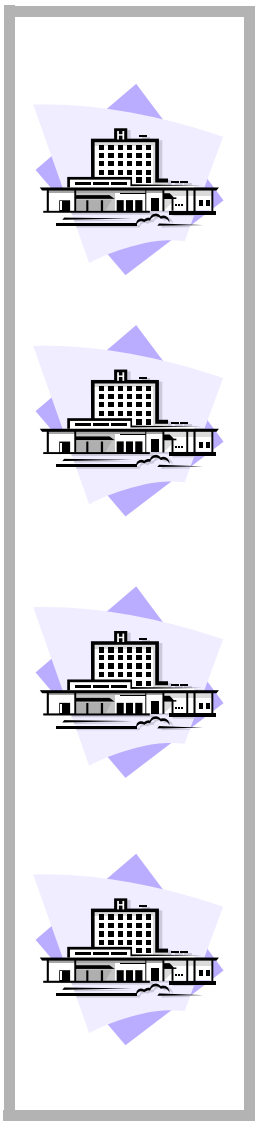

Hospital Outpatient Services

Medicaid and Other Medical Assistance Programs

June 2012

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emergency room is billed on the inpatient claim) are also exempt from Passport requirements. For emergency room visits, services will be exempt from cost share.

For prospective payment hospitals, the two lowest level emergency room visits (CPT procedure codes 99281 and 99282) will be reimbursed based on the lowest level clinic visit.

Provider-Based Services

The Department will pay for services provided in an outpatient clinic, including clinics that meet the Medicare definition of a hospital-based provider (e.g., an outpatient clinic not on the hospital campus). Hospitals that wish to have outpatient clinics paid as hospital-based providers must send a copy of the Medicare letter granting provider-based status to the Department's hospital program officer at the address shown under *Key Contacts*.

Partial Hospitalization

The partial hospitalization program is an active treatment program that offers therapeutically intensive, coordinated, structured clinical services. These services are provided only to clients who are determined to have a serious emotional disturbance (SED) or a severe disabling mental illness (SDMI). Definitions for SED and SDMI are on the Provider Information website under *Definitions and Acronyms*. Partial hospitalization services are time-limited and provided within either an acute level program or a sub-acute level program. Partial hospitalization services include day, evening, night, and weekend treatment programs that employ an integrated, comprehensive, and complementary schedule of recognized treatment or therapeutic activities. These services require prior authorization (see the *Prior Authorization* chapter in this manual). For more information, see the mental health manual, which is available on the Provider Information website (see *Key Websites*).

Sterilization (ARM 37.86.104)

To avoid denials, forms must be completely filled out.

Elective Sterilization

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when all of the following requirements are met:

1. Client must complete and sign the *Informed Consent to Sterilization* (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations (see *Appendix A: Forms* for a sample form and instructions). If this form is not properly completed, payment will be denied.

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The 30-day waiting period may be waived for either of the following reasons:

- **Premature Delivery.** The *Informed Consent to Sterilization* must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
- **Emergency Abdominal Surgery.** The *Informed Consent to Sterilization* form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.

2. Client must be at least 21 years of age when signing the form.
3. Client must not have been declared *mentally incompetent* (see *Definitions*) by a Federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.
4. Client must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The client must be made aware of available alternatives of birth control and family planning.
- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or other substance which affects his/her awareness.

- Orphan drugs
- Radiopharmaceuticals
- Certain other drugs, such as those provided in an emergency department for heart attacks

Lab services

If all tests that make up an organ or disease organ panel are performed, the panel code should be billed instead of the individual tests.

Some panel codes are made up of the same test or tests performed multiple times. When billing one unit of these panels, bill one line with the panel code and one unit. When billing multiple units of a panel (the same test is performed more than once on the same day) bill the panel code with units corresponding to the number of times the panel was performed.

Provider-Based Services

When Medicaid pays a hospital for outpatient clinic or provider-based clinic services, the separate CMS-1500 claim for the physician's services must show the hospital as the place of service (i.e., POS 22 for hospital outpatient). For imaging and other services that have both technical and professional components, physicians providing services in hospitals must bill only for the professional component if the hospital is going to bill Medicaid for the technical component. Refer to the *Physician-Related Services* manual, *Billing Procedures* chapter for more information. Manuals are on the Provider Information website (see *Key Websites*).

Partial Hospitalization

Partial hospitalization services must be billed with the national code for partial hospitalization, the appropriate modifier, and the prior authorization code.

Current Payment Rates for Partial Hospitalization

Code	Modifier	Service Level
H0035	—	Partial hospitalization, sub-acute, half day
H0035	U6	Partial hospitalization, sub-acute, full day
H0035	U7	Partial hospitalization, acute, half day
H0035	U8	Partial hospitalization, acute, full day

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Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations, including hysterectomies, oophorectomies, salpingectomies, and orchiectomies, one of the following must be attached to the claim, or payment will be denied:
  - A completed *Medicaid Hysterectomy Acknowledgement* form (MA-39) for each provider submitting a claim. See *Appendix A: Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client (or representative, if any) and physician must sign and date Section A of this form prior to the procedure (see 42 CFR 441.250 for the Federal policy on hysterectomies and sterilizations). Also, for Section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when Sections B or C are used. Refer to *Appendix A* for detailed instructions on completing the form.
  - For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
    - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
    - The reason for the hysterectomy was a life-threatening emergency.
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

  When submitting claims for retroactively eligible clients, attach a copy of the FA-454 or FA-455 (eligibility determination letters) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on sterilizations, see the *Covered Services* chapter in this manual.

Supplies

Supplies are generally bundled, so they usually do not need to be billed individually. A few supplies are paid separately by Medicaid. The fee schedule on the website lists the supply codes that may be separately payable.

Current Payment Rates for Partial Hospitalization			
Code	**Modifier**	**Service Level**	**Payment Rate**
H0035	—	Partial hospitalization, sub-acute, half day	Check current fee schedule for current payment rates.
H0035	U6	Partial hospitalization, sub-acute, full day	
H0035	U7	Partial hospitalization, acute, half day	
H0035	U8	Partial hospitalization, acute, full day	

Dental services

Some dental services have an APC assignment and are paid according to the APC payment method. Those dental services that are allowed in the outpatient setting but do not have an APC assignment are paid a fee according to the outpatient hospital fee schedule.

Blood draws

Blood draws (HCPCS Code 36415) are paid using the current fee schedule. Procedure Code 36415 is paid per visit, not per blood draw.

Immunizations

Some immunizations are paid by APC and others are not. If an immunization service is not paid in the APC section then a fee is paid in the miscellaneous services section. The fee is the same as the RBRVS-based fee paid to physicians. If the client is under 19 years old and the vaccine is available to providers for free under the Vaccines for Children program, then the payment to the hospital is zero. Immunization administration is considered an incidental service. The claims processing system bundles immunization administration with other services on the claim and pays it at zero.

Other Issues

Observation services

The Department will make separate payment for observation care procedure codes if the following criteria are met:

- Hours/units of service must be at least 8.
- Must be direct-admit or have a high-level clinic visit, high-level critical care, or high-level emergency room visit.
- Only obstetric observation must have a qualifying diagnosis and must be at least 1 hour.

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Outpatient clinic and provider-based services

When Medicaid pays a hospital for outpatient or provider-based clinic services, the separate claim for the physician's services must show the hospital as the place of service (i.e., place of service is 22 for hospital outpatient). This place of service code will result in lower payment to the physician, thus minimizing what would otherwise be double payment for office expenses.

Pass-through payments

Payments for certain drugs, devices and supplies are designated as "pass-through." In a few cases, these codes have APC weights; in most cases, payment is by report.

Packaged services

Payment for some services is always considered bundled into payment for other services. (The APC term for bundling is packaging.) In other cases, the service are bundled for some visits but not for others. For example, payment for IV therapy is considered bundled within the payment for a surgical visit but not for a medical visit. Medicare developed the relative weights for surgical, medical and other types of visits so that the weights reflect the packaging rules used in the APC method.

Procedures considered inpatient only by Medicare

Medicare has designated some procedures as "inpatient only." Medicaid has adopted that designation as well. When these procedures are performed in the outpatient hospital setting, the claim is denied.

Charge cap

For services covered in the outpatient hospital setting, Medicaid pays the lower of the Medicaid fee or the provider's charge. The charge cap is applied at the claim level for outpatient hospital services, not at the line level. Therefore it is possible that a provider may be paid more than charges for any given line on a claim.

Payment by report

A few services covered in the outpatient hospital setting do not have an established fee. For these services, payment is at the provider's outpatient cost to charge ratio as determined by the Department.

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The line-level status indicator codes explain how payment was calculated at the line. The codeset used by DPHHS is based on the codeset used by Medicare but with several additions. See the following table of status indicator codes.

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