Administrative Code

Title 23: Medicaid
Part 202
Hospital Services

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Part 202: Hospital Services

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Rule 2.1: General

Medicaid provides financial assistance for outpatient hospital services. An outpatient is a person who is being provided services by a hospital other than on an inpatient basis or for whom laboratory or radiology services are performed for a referring physician. All rules set forth in Part 202, Chapter 1, are applicable to outpatient services in addition to those specifically outlined in this chapter.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.20(a)

Rule 2.2: Outpatient Hospital Services

A. Medicaid defines outpatient hospital services as preventative, diagnostic, therapeutic, rehabilitative, or palliative services provided by a licensed hospital to an outpatient by or under the direction of a physician or dentist.

1. Medically necessary outpatient hospital services are covered when all of the following criteria apply:

   a. Outpatient services are provided in a clinic or other facility that is not located inside the hospital.

   b. The clinic or other facility has been designated as an outpatient facility by the hospital.

   c. The clinic or other facility was in operation or under construction on July 1, 2009, and

   d. The costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report.

2. For hospital clinics not located inside the hospital and constructed after July 1, 2009 the Medicare thirty five (35) mile rule will apply.

3. Outpatient services must be provided by hospital salaried or contracted employees. For purposes of this rule, contracted services are defined as hospital services provided according to a written agreement between a hospital and the health care professional providing the hospital services.

4. Hospitals may bill only for services provided in the hospital's outpatient department as defined above.

B. Off Site Services are services provided off site and outside of the outpatient hospital departments by contracted or employed hospital employees are not covered as outpatient hospital services.

C. Partial hospitalization programs or day treatment programs are not covered in an outpatient hospital setting. The Division of Medicaid defines partial hospitalization or day treatment programs as:

1. Those clearly billed as partial hospitalization/day treatment,

2. Those represented to the community as partial hospitalization programs or day treatment programs, or

3. Those billed to the Division of Medicaid using revenue and procedure codes reflecting multiple units or daily services.

D. Professional Fees are physician services performed in hospital owned physician clinics. Hospitals are covered and must be submitted under a physician group provider number.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.20(a)

Rule 2.3: Emergency Room Outpatient Visits

A. Emergency room services are allowed for all beneficiaries without limitations. Emergency department services provided by hospitals, except for Indian Health Services, are reimbursed using the outpatient prospective payment methodology.

B. The Division of Medicaid assigns the two (2) lowest emergency department Evaluation and Management (E&M) code descriptions for non-emergent emergency department visits. All services and ancillaries for beneficiaries over the age of twenty (20) are bundled into these E&M codes.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.230; 42 CFR § 447.204

History: Revised – 01/01/2013, 11/01/2012, 09/01/2012

Rule 2.4: Outpatient (23-Hour) Observation Services

A. Medicaid defines outpatient twenty-three (23) hour observation services as those services furnished on a hospital's premises, whether in an Emergency Department or a designated non-critical care area, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate a beneficiary's condition or determine the need for possible admission as an inpatient. The terms "outpatient observation", "twenty-three (23) hour observation", and/or "day patient" are interchangeable. The availability of outpatient observation does not mean that services for which an overnight stay is anticipated

may be performed and billed to the Division of Medicaid on an outpatient basis.

B. Covered Services - Outpatient observation status must be ordered in writing by a physician or other individual authorized by hospital staff bylaws to admit patients to the hospital or to order outpatient diagnostic tests or treatments. The decision to admit into observation or as an inpatient is solely the responsibility of the physician. Factors that must be taken into consideration by the physician or authorized individual when ordering outpatient observation:

1. Severity of the signs and symptoms of the beneficiary,

2. Degree of medical uncertainty the beneficiary may experience an adverse occurrence,

3. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the beneficiary to remain at the hospital for twenty-four (24) hours or more) to assist in assessing whether the beneficiary should be admitted, and

4. The availability of diagnostic procedures at the time and location where the beneficiary seeks services.

C. Non-Covered Services

1. Medicaid does not cover more than twenty-three (23) consecutive hours in an observation period and only covers service that are appropriate to the specific medical needs of the beneficiary.

2. Medicaid considers the following as non-covered outpatient observation services:

a. Substitution of outpatient services provided in observation status for physician-ordered inpatient services.

b. Services not reasonable, cost effective, and necessary for diagnosis or treatment of a beneficiary.

c. Services provided solely for the convenience of the beneficiary, facility, family or the physician.

d. Excessive time and/or amount of services medically required by the condition of the beneficiary.

e. Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for observation status.

f. Inpatients discharged to outpatient observation services.

g. Services for routine preparation and recovery of a beneficiary following diagnostic testing or therapeutic services provided in the facility.

h. Services provided when an overnight stay is planned prior to, or following, the performance of procedures such as surgery, chemotherapy, or blood transfusions.

i. Services provided in an intensive care unit.

j. Services provided without a physician's written order and documentation of the time, date, and medical reason for admission.

k. Services provided without clear documentation as to the unusual or uncommon reaction that would necessitate outpatient observation status.

l. Complex cases requiring inpatient care.

m. Routine post-operative monitoring during the standard recovery period.

n. Routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards.

o. Observation billed concurrently with therapeutic services such as chemotherapy or physical therapy.

D. Medical Records Documentation

1. The medical record must substantiate the medical necessity for observation including appropriateness of the setting. When the outpatient observation setting is non-covered, all services provided in the outpatient observation setting are also non-covered.

2. Documentation in the medical record must include:

a. Orders for observation status and the reason for observation must be written on the physician's order sheet, not the emergency room record, and must specify, "admit to observation." Rubber stamped orders are not acceptable.

b. Changes from "observation status" to "inpatient" must be made by a physician or authorized individual.

c. Outpatient observation to inpatient status change must be supported by documentation of medical necessity.

d. A physician's order is required for admission and discharge from an observation unit.

e. There must be documentation that a physician had personal contact with the beneficiary at least once during the observation stay.

f. Medical records must contain appropriate documentation of the actual time a patient is in the observation unit, as well as, services provided.

E. Billing

1. Medicaid considers twenty-three (23) hour outpatient observation stay as an outpatient service when the stay does not result in an inpatient admission.

2. Services provided during an observation stay that result in an inpatient hospital admission must be included on the inpatient bill. The admission date will be the date and time that observation services began.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.2(a); 42 CFR § 482.24(c)

Rule 2.5: Outpatient Dialysis

Services provided in hospital-based renal dialysis units (RDU) are covered and are not subject to any visit limitations.

Source: Miss. Code Ann. § 43-13-121, 43-13-117(2)

Rule 2.6: Mental Health Services

A. Mental Health services are covered when:

1. Provided in an outpatient department of a general hospital, and outpatient mental health services are not covered in acute freestanding psychiatric facilities.

2. Prior authorized through the Utilization Management and Quality Improvement Organization (UM/QIO). Failure to obtain prior authorization will result in denial of payment.

B. Outpatient hospital mental health services will be reimbursed using the same methodology as other outpatient hospital services.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.155

Rule 2.7: Out-of-State Facilities

Out-of-state hospitals will be reimbursed using the same methodology as Mississippi hospitals.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(2)(c); 42 CFR § 431.52

History: Revised – 09/01/2012

Rule 2.8: Outpatient Rates

A. Except as otherwise specified all outpatient hospital services for all hospitals except Indian Health Services will be reimbursed under a prospective payment methodology.

B. Hospital-based clinics may not bill facility fees unless they are a teaching hospital with a resident-to-bed ratio of 0.25 or greater.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(2)(c); 42 CFR § 447.321

History: Revised – 09/01/2012

Rule 2.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121