Title 23: Division of Medicaid

Part 202: Hospital Services

Chapter 2: Outpatient Services

Rule 2.3: Emergency Department Outpatient Visits

A. Emergency department services, also referred to as 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. Services provided during an emergency department visit resulting in an inpatient hospital admission must be included on the inpatient hospital claim.

1. The "Statement Covers Period From Date" on the inpatient hospital claim is the first date the beneficiary enters the emergency department.

2. The "Treatment Authorization Code" on the inpatient hospital claim is the Treatment Authorization Number (TAN) received from the Utilization Management and Quality Improvement Organization (UM/QIO) which corresponds with the date the physician documents the inpatient hospital admission in the physician's orders.

a) A TAN is not required for an emergency department visit directly preceding an inpatient admission.

b) A TAN issued by the UM/QIO is only required for an inpatient admission/continued stay.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 440.230, 447.204; SPA 2012-008; SPA 2012-009.

History: Removed Rule 2.3.B language to correspond with SPA 2012-009 (eff. 09/01/2012) and added language for clarification with SPA 2012-008 (eff. 10/01/2012) eff. 11/01/2013, Revised eff. 01/01/2013, Revised eff. 11/01/2012, Revised eff. 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.

1. The terms "outpatient observation", "twenty-three (23) hour observation", and/or "day

patient" are interchangeable.

2. The availability of outpatient observation services 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. Outpatient observation services must be documented in the physician's orders 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 for ordering outpatient hospital observation services or an inpatient hospital admission is solely the responsibility of the physician. Factors that must be taken into consideration by the physician or authorized individual when ordering outpatient observation are:

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

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 more than twenty-three (23) hours to assist in assessing whether the beneficiary should be admitted, and

4. 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 outpatient observation for physician-ordered inpatient hospital services.

b) Services not reasonable, necessary or cost effective for the 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 outpatient observation services.

f) Discharging beneficiaries receiving inpatient hospital services 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 order and without documentation of the time, date, and medical reason for outpatient observation services.

k) Services provided without clear documentation as to the unusual or uncommon circumstances that would necessitate outpatient observation services.

l) Complex cases requiring inpatient hospital services.

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) Outpatient observation services 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 outpatient observation services and the reason for outpatient observation services must be documented in the physician's orders and not the emergency department record and must specify "admit to observation." Only an original or electronic signature is acceptable.

b) Changes from "outpatient observation to "inpatient hospital" must be ordered by a physician or authorized individual.

c) Changes from outpatient observation services to inpatient hospital services must be

supported by documentation of medical necessity.

d) A physician's order for inpatient hospital admission and discharge from outpatient observation.

e) Documentation a physician had face-to-face contact with the beneficiary at least once during outpatient observation.

f) The actual time of outpatient observation and the services provided.

E. Billing

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

2. Services provided during outpatient observation resulting in an inpatient hospital admission must be included on the inpatient hospital claim.

   a) The "Statement Covers Period From Date" on the inpatient hospital claim is the first date the beneficiary received outpatient observation services.

   b) The "Treatment Authorization Code" on the inpatient hospital claim is the Treatment Authorization Number (TAN) received from the Utilization Management and Quality Improvement Organization (UM/QIO) which corresponds with the date the physician documents the inpatient hospital admission in the physician's orders.

      1) A TAN is not required for outpatient observation services directly preceding an inpatient admission.

      2) A TAN issued by the UM/QIO is only required for an inpatient admission/continued stay.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 440.2(a) 482.24(c); SPA 2012-008.

History: Revised E.2. to correspond with SPA 2012-008 (eff. 10/01/2012) and added language for clarification to E.2. eff. 11/01/13.