Title 23: Division of Medicaid

Part 202: Hospital Services

Part 202 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 (IHS), are reimbursed using the outpatient prospective payment methodology.

B. The date of service for evaluation and management procedure code line items for outpatient hospital emergency department claims must be the date the beneficiary enters the emergency department even if the beneficiary's encounter spans multiple dates of service.

C. 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 Number (TAN) on the inpatient hospital claim is received from the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity 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.

    b) A TAN issued by the UM/QIO, the Division of Medicaid, or a designated entity is only required for an inpatient admission or continued stay.

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

History: Revised eff. 09/01/2018. 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.