NOTICE OF PROPOSED RULE ADOPTION

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

Miss. Division of Medicaid
c/o Ginnie McCardle, Spec. Proj. Officer
Robert E. Lee Building
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Specific Legal Authority authorizing the promulgation of Rule: Miss. Code Ann. §43-13-121(1972), as amended

Reference to Rules repealed, amended or suspended by the Proposed Rule :
Provider Policy Manual Section 26.02-26.27

Explanation of the Purpose of the Proposed Rule and the reason(s) for proposing the rule:
AP2006-73 These Proposed Rule Adoptions update pages to Section 26 (Hospital Outpatient) and creates a new page (26.27) regarding Conversion of Outpatient Status to Inpatient Status.

This rule is proposed as a ☒ Final Rule, and/or a ☐ Temporary Rule (Check one or both boxers as applicable.)

Persons may present their views on the proposed rule by addressing written comments to the agency at the above address. Persons making comments should include their name and address, as well as other contact information, and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

Oral Proceeding: Check one box below:

☐ An oral proceeding is scheduled on this rule on Date: Time:
Place:

If you wish to be heard and present evidence at the oral proceeding you must make a written request to the agency at the above address at least _____ day(s) prior to the proceeding to be placed on the agenda. The request should include your name, address, telephone number as well as other contact information; and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

☒ An oral proceeding is not scheduled on this rule. Where an oral proceeding is not scheduled, an oral proceeding will be held if a written request for an oral proceeding is submitted by a political subdivision, an agency or ten (10) persons. The written request should be submitted to the agency contact person at the above address within twenty (20) days after the filing of this notice of proposed rule adoption and should include the name, address and telephone number of the person(s) making the request; and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

Economic Impact Statement: Check one box below:

☒ The agency has determined that an economic impact statement is not required for this rule, or

☐ The concise summary of the economic impact statement required is attached.

The entire text of the Proposed Rule including the text of any rule being amended or changed is attached.

Date Rule Proposed: December 1, 2006

Proposed Effective Date of Rule: January 1, 2007

Executive Director
Signature and Title of Person Submitting Rule for Filing

~~Refer to Hospital Inpatient, Section 25.03, in this manual. Section 25.03 applies to both inpatient and outpatient.~~

Discharge against Medical Advice (AMA) occurs when a beneficiary leaves a hospital against the advice or consent of a physician. Mississippi Medicaid will reimburse covered outpatient hospital services rendered to the beneficiary even though the beneficiary leaves against medical advice.

~~Refer to Hospital Inpatient, Section 25.04, in this manual. Section 25.04 applies to both inpatient and outpatient.~~

Medically necessary ancillary services that are routinely furnished according to medically accepted standards of practice to outpatients by the hospital or by others under arrangements made by the hospital and in accordance with and subject to exclusions of this manual are covered services.

~~Refer to Hospital Inpatient, Section 25.06, in this manual. Section 25.06 applies to both inpatient and outpatient.~~

Physicians employed by or contracted with the hospital may not bill individually for services rendered to Medicaid beneficiaries. The hospital must bill for services provided by physicians employed by or contracted with the hospital (ex: hospitalists, lab directors, etc.). These services must be billed on a professional claim (i.e., ***CMS-1500 or X12N 837P***) with the physician's individual Medicaid provider number as the servicing provider and the hospital's Medicaid provider number as the billing provider. This includes services provided in the emergency room by physicians employed on a full-time or part-time basis by the hospital and other physicians employed by or with a contractual arrangement with the hospital.

A hospital that accepts a Medicaid beneficiary for treatment accepts the responsibility for making sure that the beneficiary receives all medically necessary services that are covered by Medicaid. The conditions of participation that govern hospitals providing care to Medicare and Medicaid beneficiaries require that the governing body of the hospital assures accountability of the medical staff for the quality of care provided to beneficiaries. Accordingly, if a particular physician with whom the hospital contract does not accept Medicaid, the hospital has the responsibility of assuring the delivery of these medically necessary services to a Medicaid beneficiary.

~~Refer to Hospital Inpatient, Section 25.07, in this manual. Section 25.07 applies to both inpatient and outpatient.~~

During each fiscal year, Medicaid will cover the first six (6) pints of whole blood and/or equivalent quantities of packed red blood cells for each eligible beneficiary, when they are not available from other sources (ex: family, autologous precollection, donor-directed precollection, etc.). The term "whole blood" means human blood from which none of the liquid or cellular components has been removed. Where packed red blood cells are furnished, a unit of packed red blood cells is considered equivalent to a pint of whole blood. Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the quantity limits. However, these components of blood are covered and should be billed as biologicals.

Hospitals are encouraged to make every effort to have the blood that is used by a Medicaid beneficiary replaced. If it is the hospital's usual practice to require replacement of more blood than is actually used, the practice can be continued with Medicaid beneficiaries. However, if full replacement is not received, then pint-for-pint credit must be given.

~~Refer to Hospital Inpatient, Section 25.10, in this manual. Section 25.10 applies to both inpatient and outpatient.~~

Drugs

Drugs for use in an outpatient hospital stay that are ordinarily furnished by the hospital for the care and treatment of the beneficiary are covered. Take home drugs are **NOT** covered. A beneficiary may, upon discharge from the hospital, take home remaining amounts of drugs that have been supplied for him/her either on prescription or doctor's order, if continued administration is necessary, since they already would have been charged to his/her account by the hospital.

Supplies

Supplies ordinarily furnished by the hospital for the care and treatments of the beneficiary solely during his/her outpatient stay are covered beneficiary hospital services. Under certain circumstances, supplies during the outpatient hospital stay are covered even though the beneficiary is discharged from the hospital with them. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the beneficiary's use of the item to the periods during which the beneficiary is an outpatient. Examples of items covered under this rule are cardiac valves, cardiac pacemakers, and such items as tracheotomy or drainage tubes that are temporarily installed in or attached to the patient's body while he/she is receiving treatment and which are also necessary to permit or facilitate the beneficiary's release from the outpatient hospital stay. Supplies and appliances furnished to a beneficiary for use solely outside the hospital are **NOT** covered.

Implantable Pumps

Refer to Section 25.20, Implantable Programmable Baclofen Pumps, in this manual.

Oxygen

The reasonable cost of oxygen furnished for the care and treatment of the beneficiary solely during his/her outpatient stay is covered. Oxygen furnished to a beneficiary for use solely outside the hospital is **NOT** covered.

Durable Medical Equipment

Equipment ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during his/her outpatient hospital stay is covered. Equipment furnished to a beneficiary for use solely outside the hospital is **NOT** covered.

Refer to Hospital Inpatient, Section 25.12, in ~~this~~ the provider policy manual. Section 25.12 applies to both inpatient and outpatient.

Refer to Provider information, Section 4.03, in ~~this~~ the provider policy manual.

Refer to Hospital Inpatient, Section 25.14, in ~~this~~ the provider policy manual. Section 25.14 applies to both inpatient and outpatient.

Refer to Hospital Inpatient, Section 25.15, in ~~this~~ the Provider Policy manual. Section 25.15 applies to both inpatient and outpatient.

~~Refer to Hospital Inpatient, Section 25.18, in this manual. Section 25.18 applies to both inpatient and outpatient.~~

Section 26.12 is RESERVED FOR FUTURE USE.

~~Refer to Hospital Inpatient, Section 25.19, in this manual. Section 25.19 applies to both inpatient and outpatient.~~

In keeping with the Mississippi Medicaid policy for not providing reimbursement for services that are non-covered, any non-covered procedure performed in an outpatient setting will result in this portion, or possibly the entire claim, being disallowed. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

Outpatient (23-Hour) Observation Services

Outpatient (23-hour) observation services are those services furnished on a hospital's premises, whether 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 a possible admission as an inpatient. For purposes of this policy, the terms "outpatient observation", "23 hour observation", and/or "day patient" are interchangeable. Such services are covered only when provided by order of a physician or another individual authorized by State licensure law and hospital bylaws to admit patients to the hospital or to order outpatient tests and when provided in compliance with all policies and procedures described in this manual.

DOM does not cover more than 23 consecutive hours in an observation period and only covers services that are appropriate to the specific medical needs of the beneficiary. 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.

The availability of outpatient observation does not mean that services for which an overnight stay is anticipated may be performed and billed to DOM on an outpatient basis. Outpatient observation is not covered in certain situations, including, but not limited to:

- complex cases requiring inpatient care,
- routine post-operative monitoring during the standard recovery period,
- routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards, **AND**
- observation billed concurrently with therapeutic services such as chemotherapy or physical therapy.

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 that 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;

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

Non - Covered Services

The following services are not covered outpatient observation services:

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

2. Services that are not reasonable, cost effective, and necessary for diagnosis or treatment of a beneficiary;

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

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

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

6. Inpatients discharged to outpatient observation services;

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

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

9. Services provided in an intensive care unit;

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

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

Medical Records Documentation

The following are required for documenting the medical necessity and appropriateness of outpatient observation in the medical records:

- 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.

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

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

- A physician's order is required for admission and discharge from the observation unit.
- There must be documentation that a physician had personal contact with the beneficiary at least once during the observation stay.
- Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as services provided.

Billing

A 23-hour outpatient observation stay is considered an outpatient service. If the beneficiary is not admitted as a hospital inpatient at the end of the observation period, charges must be submitted as an outpatient billing even though a facility may choose to keep a beneficiary longer than 23 hours.

The appropriate observation CPT codes are to be used with revenue code 762. For billing outpatient observation services, the entire period of observation services from beginning date to ending date must be billed on one claim. The facility should report the number of hours in the units field rounded to the nearest hour.

If after the observation period the beneficiary is admitted as a hospital inpatient, charges for the observation period must be included on the inpatient bill. The date of admission is defined as the date the beneficiary is converted to inpatient status as documented by the physician's order. ~~The admission date will be the date and time that observation services began~~ All outpatient observation charges and other outpatient charges will be included in the inpatient APR-DRG payment.

Dialysis treatments are excluded.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: ~~02/01/06~~ 01/01/07
Section: Hospital Outpatient Subject: Outpatient Therapies	Section: 26.15 Pages: 1 Cross Reference: Outpatient Physical Therapy 47 Outpatient Occupational Therapy 48 Outpatient Speech-Language Pathology 49	

Refer to the appropriate therapy section in ~~this~~ the Provider Policy manual:

Outpatient Physical Therapy, Section 47
Outpatient Occupational Therapy, Section 48
Speech-Language Pathology, Section 49

~~Section 26.17 is RESERVED FOR FUTURE USE.~~

Diagnostic services provided to a beneficiary by the admitting hospital or by an entity wholly owned or operated by the hospital or under arrangements with the hospital within three days prior to the date of admission are deemed to be inpatient and are included in the inpatient APR-DRG payment. Additionally, non-diagnostic services provided during the three-day window are deemed inpatient if the principal diagnosis billed is identical for both the inpatient and outpatient services. When a patient is admitted through the emergency room, the ER services are not payable separately.

Exclusion to the three-day window is dialysis services.

~~Refer to Hospital Inpatient, Section 25.23, in this manual. Section 25.23 applies to both inpatient and outpatient.~~

Elective Cancellation of Procedures Not Related to the Beneficiary's Medical Condition

When a surgical or other procedure is canceled due to scheduling conflicts of the operating suite or physician, beneficiary request, or other reason not related to medical necessity, the procedure may not be billed to Medicaid and no payment will be made for the procedure. Services provided prior to the procedure may be billed and will be covered subject to usual Medicaid policies for those services.

Canceled or Incomplete Procedures Related to the Beneficiary's Medical Condition

When a surgical or other procedure is canceled or terminated before completion due to changes in the beneficiary's medical condition that threaten his/her well-being, the services that were actually performed may be billed and will be covered subject to usual Medicaid policies for those services. There must be clear documentation regarding the medical necessity for cancellation or termination of the procedure.

Hospital-based renal dialysis units (RDU) that execute a provider agreement with DOM can be reimbursed for services provided to Medicaid beneficiaries and are not subject to any visit limitations.

Refer to Section 41.0 Dialysis of ~~this~~ the Provider Policy manual for policy related to dialysis in an outpatient facility.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: ~~11/01/01~~ 01/01/07
Section: Hospital Outpatient Subject: Split Billing	Section: 26.21 Pages: 1 Cross Reference: ~~Hospital Inpatient 25.26~~ Outpatient (23-Hour) Observation Services 26.14	

~~Refer to Hospital Inpatient, Section 25.26, in this manual. Section 25.26 applies to both inpatient and outpatient.~~

Mississippi Medicaid requires split billing for Medicaid and crossover claims in the following situations:

- If dates of service span Medicaid's fiscal year, July 1 through June 30, the hospital must submit a bill for the dates of service that span the fiscal year.
- If dates of service span the hospital's fiscal year, the hospital must submit a bill for the dates of service that span the hospital's fiscal year.

For Mississippi Medicaid, the 23-hour observation stay is not considered a split bill. See 23 Hour Observation Services, Section 26.14, in this manual for detailed billing instructions.

~~Refer to Hospital Inpatient, Section 25.28, in this manual. Section 25.28 applies to both inpatient and outpatient.~~

Each hospital participating in the Mississippi Medicaid Hospital Program will submit a Uniform Cost Report to DOM. The year-end adopted for the purpose of this program shall be the same as for Title XVIII (Medicare). Any deviations to the reporting year such as a Medicare approved change in fiscal year end should be submitted to DOM in writing. In cases where there is a change in the fiscal year end, the most recent cost report will be used to determine the prospective rate. All other filing requirements shall be the same as those for Title XVIII unless specifically outlined in the Hospital State Plan.

Each facility must submit a cost report on or before the last day of the fifth (5th) month following the close of the reporting period. Should the due date fall on a weekend, a State of Mississippi holiday, or a federal holiday, the due date shall be the first business day following such weekend or holiday. DOM will not grant extensions for cost reports, except extensions granted by Medicare, beyond the five (5) months given to complete the cost report.

Refer to Hospital Inpatient, Section 25.29, in ~~this~~ the Provider Policy manual. Section 25.29 applies to both inpatient and outpatient.

Refer to Hospital Inpatient, Section 25.31, in ~~this~~ the Provider Policy manual. Section 25.31 applies to both inpatient and outpatient.

~~Refer to Hospital Inpatient, Section 25.32, in this manual. Section 25.32 applies to both inpatient and outpatient~~.

Hearing screens should be conducted on all newborns to detect hearing impairment and to alleviate the adverse effects of hearing loss on speech and language development, cognitive and social development, and academic performance. Screening consists of a test or battery of tests administered to determine the need for in-depth diagnostic evaluation. Screens may be performed using auditory brainstem response, evoked otoacoustic emissions, or other appropriate technology approved by the United States Food and Drug Administration.

Newborn hearing screens should be administered as follows:

- The initial screen should be conducted during the same hospital admission as the infant's birth.
- If the infant fails the initial screen, a second screen should be administered prior to hospital discharge.
- If the infant fails the second screen, a third screen should be scheduled in a setting other than inpatient hospital.
- If the infant fails the third screen, the infant should be referred to a physician or audiologist for diagnostic testing.

Hearing screens are a covered service for all Medicaid eligible infants. No prior authorization is required.

Billing Requirements for Newborn Screens

Outpatient Hospital - Hearing screens performed after discharge in the outpatient department of a hospital must be billed on the UB92 claim form using revenue code 470. The hospital receives an outpatient reimbursement rate.

Billing Requirements for Diagnostic Testing

Infants failing three (3) hearing screens should be referred to a physician or audiologist for in-depth diagnostic testing.

Outpatient Hospital - Diagnostic testing performed in the outpatient hospital must be billed on the UB92 claim form using revenue code 471. Reimbursement for outpatient services is made according to the hospital's outpatient reimbursement rate.

Documentation

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and paid for by Medicaid, the provider must maintain legible and auditable records that will substantiate the claim submitted to Medicaid. At a minimum, medical record documentation must contain the following on each beneficiary:

- Date(s) of service;
- Demographic information (Example: name, Medicaid number, date of birth, etc.);
- Reason for testing (i.e., universal or hearing loss risk factors);
- Interpretation/Results of testing;
- Recommendations;
- Follow-up, if applicable;
- Parent's or guardian's refusal of services, if applicable; **AND**
- Provider's signature or initials.

Records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. DOM, the UM/QIO, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.

Refer to Section 7.0, General Policy for additional documentation requirements.

When a beneficiary is initially admitted to outpatient status, and subsequently is converted to inpatient status, the date of admission is defined as the date the beneficiary is converted to inpatient status as documented by the physician's order.