Hospital, Outpatient

Provider Type 12 Billing Guide

Outpatient Hospital Policy

General medical/surgical hospitals commonly provide outpatient services, including but not limited to:

- Clinic, office, emergency room (ER) and urgent care
- Observation, laboratory, radiology, therapy and diagnostic services
- Simple, surgical procedures using local anesthetic or moderate sedation

Complete outpatient hospital services policy pertaining to **facility responsibility** is located in Medicaid Services Manual (MSM) Chapter 200. This chapter and all other MSM chapters are on the Division of Health Care Financing and Policy (DHCFP) website, http://dhcfp.nv.gov.

Outpatient hospitals are responsible for referencing MSM chapters and Billing Guides applicable to the type of services provided.

Examples of other MSM chapters containing provider responsibility and authorization requirements for services provided in an outpatient hospital include, but are not limited to:

- Chapter 300 - Diagnostic Testing and Radiological Services
- Chapter 600 - **Physician** and licensed professionals' **responsibilities** and some procedures performed in an outpatient hospital (e.g., wound, burn and diabetic care) and **ER policy**.
- Chapter 800 - Laboratory Services
- Chapter 1200 - Prescription/Infusion Services
- Chapter 1700 - Therapy Services
- Chapter 1900 - Transportation

Other Resources

MSM Chapter 100 provides general Nevada Medicaid policy regarding eligibility, coverage and limitations. This chapter contains important information applicable to all provider types.

For **reimbursement rates**, see the "Provider Type 12: Outpatient Hospital Rates" document on the Rates page of the DHCFP website.

The **Magellan Medicaid Administration website** at http://nevada.fhsc.com provides information on many subjects including provider training, billing, pharmacy, PA, provider appeal rights related to claim and PA determinations, and PA reconsiderations.

Refer to the Emergency Diagnosis Codes for Non-Citizen Coverage Only on the Magellan Medicaid Administration website (select "Procedure and Diagnosis Reference Lists" from the Prior Authorization menu) for services related to complications of pregnancy, childbirth, puerperium and outcome of delivery V codes that may be paid for persons eligible for emergency services only.

Prior Authorization (PA)

All program limitations for services apply (e.g., therapy, wound care, diabetic training, minor surgeries.)

Services provided in the ER do not require PA.

Emergency acute hospital admissions directly from ER require authorization within one business day of the date of admission.

A PA is required for acute hospital admission from outpatient observation status before admission. If an emergency develops during observation, the emergency admission rules apply.

To request PA, either use form FA-3 or log in to the Online Prior Authorization System (OPAS).

If Magellan Medicaid Administration requests additional information to complete a PA determination, the information must be submitted within one business day for eligible recipients or within five business days for retro-eligible recipients.

An approved PA is valid for the dates of service shown on the authorization. If service can not be provided within the authorized dates, the PA becomes invalid and the provider must obtain another authorization that reflects the proper service dates.

Any service requiring PA that is not prior authorized will be denied for payment.

An approved PA does not guarantee claims payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Managed Care vs. Fee For Service

When a recipient is enrolled in a Managed Care Organization (MCO), request PA from and submit claims to the MCO.

For recipients in the Fee For Service plan, PA is requested and payment is issued through Magellan Medicaid Administration.

Take Home Drugs

Take home drugs are billed through the Point-of-Sale (POS) system using the hospital's Pharmacy NPI and the applicable National Drug Code (NDC). Do not include take home drugs on your UB-04/837I claim.

See MSM Chapter 1200 for Nevada Medicaid coverage and criteria for medications.

Non-emergent Use of the ER

Non-emergent use of the ER must be billed at the lowest level ER service code appropriate, either 99281 or 99282.

Emergency Room Rollover Admissions

Emergency room services resulting in a direct inpatient admission in the same facility as part of one continuous episode of care are included in (rolled into) the inpatient hospital day per diem rate for the date of admission, even if the emergency services are provided on the calendar date preceding the admission date.

Mental Health Services in the ER

Recipients that require mental health services while in the ER may receive such services if medically appropriate. As soon as the recipient is stabilized, every effort must be made to transfer the recipient to a psychiatric hospital or unit, accompanied by a physician's order. Justification for all services and transfers must be documented in the recipient's medical record.

Recipients Eligible for Emergency Services Only

For recipients eligible for "emergency services only," only services to **stabilize the sudden onset** of an emergency medical condition, are reimbursed. **Services provided before the emergency or after the emergency has been stabilized are not covered by Medicaid.**

A “sudden onset” emergency medical condition does not include:

- Nonemergent or elective services.
- Services for an existing, underlying, chronic condition.
- Services once an emergency medical condition is stabilized or in the absence of an emergency medical condition.

Observation

Refer to MSM Chapter 200 for observation policy requirements.

Only use HCPC code G0378 to bill for hourly observation services. Ancillary services provided during observation hours can also be billed.

Observation is limited to 48 hours. Do not submit claims for observation hours and/or ancillary services provided during observation hours that exceed the 48-hour policy limit.

Observation and ancillary services resulting in a direct inpatient admission provided as part of one continuous episode of care *on the same calendar date* and at the same facility as the inpatient admission are included in the first inpatient day per diem rate.

Observation and ancillary services rendered on a calendar date *preceding* a rollover inpatient admission date can be billed as outpatient services.

End Stage Renal Disease Services

- Bill monthly for outpatient facility/ physician dialysis services for established recipients.
- A PA is required for treatment of recipients outside of their established treatment areas. Bill out of plan services according to PA with appropriate codes.
- Refer to the "Recipients Eligible For Emergency Services Only" section for related special billing requirements.

Billing Instructions

Use a UB claim form (for paper submissions) or a 837I transaction (for electronic submissions) to bill outpatient hospital services.

Billed services must match the approved authorization.

Contact Information

If you have any questions regarding PA, please contact Magellan Medicaid Administration at **(800) 525-2395**.

If you have questions that pertain to billing, please contact the Customer Service Center at **(877) 638-3472.**