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CHAPTER SEVEN

HOSPITALS

Rule No. 560-X-7-.01 Hospital Program – General

The Title XIX (Medicaid) Plan for Alabama provides for inpatient care for adults and children in accordance with 42 C.F.R. § 440.10 and for preventive, diagnostic, therapeutic, rehabilitative, or palliative outpatient services in accordance with 42 C.F.R. § 440.20. Inpatient hospital days will be reimbursed as described in Chapter 23, Hospital Reimbursement.

Author: Solomon Williams, Associate Director, Institutional Services.
Statutory Authority: State Plan; Attachment 3.1-A, pp 1 and 1.1; 42 C.F.R. Sections 440.10, 440.20, 441.57; Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272). Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).
History: Rule effective October 1, 1982. Amended July 8, 1983; February 8, March 12, June 8, October 9, 1984; June 8, September 9, 1985; October 11, 1986; September 9, 1987; July 1, 1988; October 12, 1988; January 1, 1989; March 14, 1989; July 1, 1989; January 12, 1990; October 1, 1990; January 15, 1991; July 1, 1991; January 14, 1992; and April 11, 1997. **Amended:** Emergency Rule filed and effective April 9, 2004. **Amended:** Filed April 21, 2004; effective July 16, 2004. **Emergency Rule:** Filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010. **Amended:** Filed June11, 2015; effective July 16, 2015.

Rule No. 560-X-7-.02 Participation

(1) Eligibility. In order to participate in the Title XIX Medicaid program and to receive Medicaid payment for inpatient and outpatient hospital services, a hospital provider must meet the following requirements:

(a) Be certified for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital. Hospital types are identified on the Hospital Request for Certification in the Medicare/Medicaid Program (HCFA-1514) or its successor.

(b) Be licensed as a hospital by the State of Alabama in accordance with current rules contained in the Alabama Administrative Code Chapter 420-5-7.

(c) Be in compliance with Title VI of the Civil Rights Act of 1964 and with Section 504 of the Rehabilitation Act of 1973.

(d) Submit a letter requesting enrollment.

(e) Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new facility.

(f) Execute the Alabama Medicaid Provider Agreement for participation in the Medicaid program.

(g) Submit a written description of an acceptable utilization review plan currently in effect.

(2) Enrollment. Hospitals should refer to the Alabama Medicaid Provider Manual (Becoming a Medicaid Provider - Chapter 2) for complete enrollment instructions.

(a) The effective date of enrollment cannot be earlier than the date of the Medicare certification.

(3) Participating out-of-state (border) hospitals are subject to all program regulations and procedures that apply to participating Alabama hospitals and shall submit copies of their annual certification from CMS, State licensing authority, and other changes regarding certification. "Border" is defined as within 30 miles of the Alabama state line.

(4) Nonparticipating hospitals are those hospitals which have not executed an agreement with Alabama Medicaid covering their program participation, but provide medically necessary covered out-of-state services.

(a) All Medicaid admissions to participating and nonparticipating facilities are subject to program benefits and limitations based on current Medicaid eligibility.

(b) Out-of-state prior authorization is required for organ transplants and select surgical procedures. (Refer to Rule No. 560-X-1-.27 and Rule No. 560-X-6-.13 respectively.

(5) The Fiscal Agent will be responsible for enrolling any Title XVIII (Medicare) certified hospital that wishes to enroll as a Qualified Medicare Beneficiary (QMB-only) provider.

Author: Solomon Williams, Associate Director, Institutional Services.
Statutory Authority: State Plan, Section 2.7, 4.11, 4.10 and Attachment 7.2A; Title XIX, Social Security Act; 42CFR Sections 405.191, 431.51, 431.52, 431.107, 440.10, 440.20. Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).
History: Rule effective October 1, 1982. **Amended:** November 10, 1983; November 11, 1985; December 10, 1986; February 9, 1988; July 13, 1989; October 13, 1992; April 11, 1997. **Amended:** Filed June 18, 1999; effective September 9, 1999. **Amended:** Filed July 12, 2018; effective August 27, 2018.

Rule No. 560-X-7-.03 Inpatient Benefits

(1) An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he will remain at least overnight and occupy a bed (even though it later develops he can be discharged or is transferred to another hospital and does not use a bed overnight.)

(2) The number of days of care charged to a recipient for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in reporting days of care for the recipients, even if the hospital uses a different definition of day for statistical or other purposes.

(3) Medicaid covers the day of admission, but not the day of discharge. If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day.

(4) Newborn well-baby nursery charges will be covered by an eligible mother's claim for up to ten days nursery care for each baby if the mother is in the hospital and is otherwise entitled to such coverage.

(a) For well-baby nursery charges, revenue codes 170 and 171 are reflected on the mother's claim in conjunction with her inpatient stay for the delivery. The hospital per diem rate includes charges for the mother and newborn.

(b) Newborn "well-baby" care is not separately billable. Nursery charges for "boarder babies", infants with no identified problems or condition whose mothers have been discharged, were never admitted to the hospital, or are not otherwise eligible for Medicaid are not separately billable.

(5) Newborns admitted to accommodations other than the well-baby nursery must be eligible for Medicaid benefits in their own right (claim must be billed under the baby's own name and Medicaid number). Example: If an infant is admitted to an intensive care or other specialty care nursery, the claim must be billed under the infant's number even if the mother is still an inpatient.

(a) If revenue codes 172, 175 or 179 are to be billed, the newborn infant's condition must meet the medical criteria established for each revenue code.

(b) Revenue codes 172, 175 and 179 are to be billed utilizing the infant's name and Medicaid number. These charges are to be billed on a separate UB-04 claim form. ICD-9-CM diagnosis codes (dates services prior and up to September 30, 2015) or ICD-10-CM diagnosis codes (dates of services October 1, 2015 and forward) identifying the conditions that required the higher level of care must be on the claim.

(c) Medicaid will routinely monitor the coding of neonatal intensive care claims through post-payment review.

(6) Hospitals should refer to the Alabama Medicaid Provider Manual (Hospital Chapter 19) for the criteria established for each revenue code.

Author: Solomon Williams, Associate Director, Institutional Services.
Authority: State Plan, Attachment 3.1-A, 4.19-A; Title XIX, Social Security Act; 42 C.F.R. Section 409.10, Subpart B.
History: Rule effective October 1, 1982. Amended November 10, 1983, March 8, 1986; April 11, 1986, and November 10, 1987. Effective date of this amendment is April 11, 1997. **Amended:** Filed March 22, 2010; effective June 16, 2010. **Amended:** Filed August 27, 2015; effective October 1, 2015.

Rule No. 560-X-7-.04 Bed and Board in Semi-Private Accommodations

(1) Medicaid will pay for semi-private accommodations (two, three, or four bed accommodations). When accommodations other than semi-private are furnished, the following rules will govern:

(a) Private rooms medically necessary - Payment may be made for private room or other accommodations more expensive than semi-private only when such accommodations are medically necessary. Private rooms will be considered medically necessary when the patient's condition requires him to be isolated for his own health or

that of others. The term isolation may apply when treating a number of physical or mental conditions. These include communicable diseases which require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatments are likely to alarm or disturb others in the same room. Payment will be made for the use of intensive care facilities where medically necessary. In order for the private room to be covered by Medicaid, the following conditions must be met:

1. The physician must certify at the time of admission or within 48 hours of the onset of the need for a private room, and the specific medical condition requiring a private room.
2. Such certification must appear in the hospital records as a written order by the physician.
3. At the time the physician certifies the need for continued hospitalization, the private room must also be recertified as being medically necessary. Medicaid will not cover a private room on the basis of a retroactive statement of medical necessity by the physician. At the time the medical necessity for a private room ceases, the patient should be placed in the type accommodation covered by Medicaid.

(2) Private rooms not medically necessary - When accommodations more expensive than semi-private are furnished the patient because at the time of admission less expensive accommodations are not available or because the hospital has only private accommodations, Medicaid may pay for the semi-private accommodations. THE PATIENT IS NOT TO BE BILLED OR REQUIRED TO PAY THE DIFFERENCE. When accommodations more expensive than semi-private are furnished the patient at his request, the hospital may charge the patient no more than the difference between the customary charge for the most prevalent semi-private accommodations and the more expensive accommodations at the time of admission. The hospital must require the patient to sign a form requesting the more expensive accommodation and agreeing to pay the difference. This form must be on file for review if questions arise regarding payment of private room charges.

(3) Customary charges mean amounts which the hospital is uniformly charging patients currently for specific services and accommodations. The most prevalent rate for semi-private accommodations is the rate which applies to the greatest number of semi-private beds.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq.
Rule effective October 1, 1982.
Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.05 Nursing and Other Services

(1) Nursing and other related services, use of hospital facilities, and the medical social services ordinarily furnished by the hospital for the care and treatment of inpatients are covered.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982.

Rule No. 560-X-7-.06 Drugs and Biologicals

(1) Drugs and biologicals for use in the hospital which are ordinarily furnished by the hospital for the care and treatment of inpatients are covered.

(2) Take-home drugs and medical supplies are not covered in the Medicaid Program.

(3) A patient may, on discharge from the hospital, take home remaining amounts of drugs which have been supplied for him either on prescription or doctor's order, if continued administration is necessary, since they already would have been charged to his account by the hospital.

(4) Medically necessary take-home drugs should be provided by written prescription either through the hospital pharmacy or any other Medicaid approved pharmacy.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982.

Rule No. 560-X-7-.07 Supplies, Appliances, and Equipment

(1) Supplies, appliances, and equipment furnished by the hospital solely for the care and treatment of a recipient during an inpatient stay in the hospital are covered as part of the hospital per diem payment.

(2) Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not generally covered as inpatient hospital services. A temporary or disposable item, however, which is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply is covered as part of the hospital per diem payment.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42CFR Section 401, et seq.
History: Rule effective October 1, 1982. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.08 Hemodialysis

(1) Hemodialysis for chronic renal cases is provided under the Medicaid Program when the patient is not authorized this care under Medicare.

(2) Refer to Chapter One, Rule No. 560-X-1-.27, of the Administrative Code for kidney transplant coverage.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 401, et seq. Rule effective October 1, 1982. Rule amended April 11, 1997. Effective date of this amendment is January 12, 1998.

Rule No. 560-X-7-.09 Blood

(1) Charges for whole blood or equivalent quantities of packed red cells are not allowable since Red Cross provides blood to hospitals; however, blood processing and administration is a covered service.

Authority: State Plan, Attachment 3.1-A; Title XIX, Social Security Act; 42 C.F.R. Section 409.87. Rule effective October 1, 1982, and November 10, 1987. Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.10 Sterilization and Hysterectomy

(1) Surgical procedures for male and female recipients as a method of birth control are covered services under the conditions set forth in the chapter pertaining to Family Planning.

(2) Any Alabama Medicaid hospital claim that relates to any sterilization or hysterectomy must have documentation attached to it showing or consisting of a consent form or an acknowledgement of receipt of hysterectomy information. These attachments must meet the criteria set forth under the sterilization and hysterectomy regulations. See the Physician' Chapter and the Family Planning Chapter for further details.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.11 Abortions

(1) Payment for abortions under the Medicaid Program is subject to the conditions in the chapter pertaining to Physicians. See the Physicians' Chapter for further details.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Effective date of amendment May 11, 1987.

Rule No. 560-X-7-.12 Physical Therapy

(1) Physical therapy is a covered service based on medical necessity. Physical therapy services that do not require the professional skills of a qualified physical therapist

to perform or supervise are not considered medically necessary. Physical therapy is covered:

(a) in a hospital outpatient setting, and
(b) for acute conditions.

(2) Rehabilitative services are not covered. Rehabilitative services are defined as the restoration to useful activity of people with chronic physical or disabling conditions.

(3) Physical therapy services are limited to those CPT codes listed in the Hospital Billing Manual. Maximum units for daily and annual limits are noted for each covered service.

(4) Physical therapy records will be reviewed retrospectively as part of the Provider Review Program. The following medical criteria must be met and the treatment plan must be stated in the recipient's medical record. If the medical criteria are not met and/or documentation of the treatment plan is not stated in the medical record relevant claims will be recouped. The medical criteria are:

(a) Physical therapy is covered for acute conditions only. An acute condition is a new diagnosis which has been made within three months of the beginning date of the physical therapy treatments.

(b) Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition where the diagnosis is made more than three months before the beginning date of the physical therapy treatments.

(c) An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition.

(5) In addition to the recipient meeting the above stated medical criteria, the provider of service is responsible for developing a plan of treatment. This plan of treatment must be readily available at all times for review in the recipient's medical record. The plan of treatment should contain, but is not limited to, the following information:

(a) Recipient's name
(b) Recipient's current Medicaid number
(c) Diagnosis(es)
(d) Date of onset or the date of the acute exacerbation, if applicable
(e) Type of surgery performed, if applicable
(f) Date of surgery, if applicable
(g) Functional status prior to and after physical therapy is completed
(h) Frequency and duration of treatment
(i) Modalities
(j) For ulcers, the location, size, and depth should be documented.

(6) The plan of treatment must be signed by the physician who ordered the physical therapy and the therapist who administered the treatments. The information contained in the treatment plan must be documented in the recipient's medical record.

Author: Solomon Williams, Associate Director, Institutional Services.
Statutory Authority: State Plan, Attachment 3.1-A; Title XIX, Social Security Act; 42 C.F.R. Sections 440.10, 440.20, 440.50.
History: Rule effective July 1, 1991. Amended October 12, 1991; April 11, 1997. Amended: Filed June 18, 1999; effective September 9, 1999. **Amended:** Filed June 11, 2015; effective July 16, 2015..

Rule No. 560-X-7-.13 Adverse Events, Hospital-Acquired Conditions, and Present on Admission Indicators

(1) This rule applies to inpatient hospital admissions beginning dates of admission on or after July 1, 2010.

(2) Adverse Events are the events that must be reported to Medicaid by the hospital. To be reportable, these events must meet the following criteria:

(a) The event must be reasonably preventable as determined by a root cause analysis or some other means.

(b) The event must be within the control of the hospital.

(c) The event must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.

(d) The error or event must result in significant harm. The events for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.

(e) Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

(3) Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from adverse events.

(4) Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient

hospital admission occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered POA.

(5) Details on billing claims and reporting Adverse Events, Present on Admission and Hospital-Acquired Conditions may be obtained in the Alabama Medicaid Provider Manual (Hospital-Chapter 19).

Author: Jerri Jackson, Associate Director, Institutional Services.
Statutory Authority: Section 1862(a)(1)(A) of the Social Security Act; Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, Section 5001(c) of the Deficit Reduction Act of 2005.
History: New Rule: Filed March 22, 2010; effective June 16, 2010.

Rule No. 560-X-7-.14 Dental Services

Items and services in connection with the care, treatment, filling, removal or replacement of teeth, or structures directly supporting the teeth are covered for those recipients eligible for treatment under the Early and Periodic Screening, Diagnosis, and Treatment Program. See Chapter 15, Dental Services for details.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Sections 441.50, 441.56. Rule effective October 1, 1982. Amended March 11, 1985 and June 8, 1985. Emergency rule effective December 5, 1986. Effective date of this emergency rule March 12, 1987. Effective date of this amendment April 13, 1987.

Rule No. 560-X-7-.15 Inpatient Non-Covered Services

(1) Items and Services for which there is no legal obligation to pay - Free services are excluded from coverage, (e.g., chest x-rays provided without charge by health organizations).

(2) Items and Services which are required as a result of war - Those required as a result or act of war, occurring after the effective date of the patient's current coverage are not covered.

(3) Personal comfort items, such as radio, television, telephone, beauty and barber services, which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

(4) Routine physical check-ups required by third parties, such as insurance companies, business establishments or other government agencies are not covered.

(5) Braces, orthopedic shoes, corrective shoes, or other supportive devices for the feet are not covered.

(6) Custodial care or sitters are not covered.

(7) Cosmetic surgery or expenses in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the function of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic service, which coincidentally also serves some cosmetic purpose.

(8) Items and services to the extent that payment has been made, or can reasonably be expected to be made under a Workman's Compensation Law, or plan of the United States, or a state may not be paid for by Medicaid.

(9) Inpatient hospitalization for routine diagnostic evaluations that could be satisfactorily performed in the outpatient department of the hospital, or in a physician's office or appropriate clinic is not covered.

(10) Psychological evaluations and testing and psychiatric evaluations are not covered by Medicaid except where actually performed by a physician in person.

(11) Speech therapy is not covered by Medicaid unless actually performed by a physician in person.

(12) Reserved Bed Charges - There is no provision under the Alabama Medicaid Program for payment of reserved inpatient hospital beds for patients on a pass for a day or more.

(13) Inpatient services provided specifically for a procedure that requires prior approval is not covered unless prior authorization from Medicaid for the procedure has been obtained by the recipient's physician. In the event that the recipient is receiving other services which require inpatient care at the time the procedure is performed, any charges directly related to the procedure will be non-covered and subject to recoupment. Additionally, all admissions must meet the Adult and Pediatric Inpatient Care Criteria (SI/IS).

Author: Jerri Jackson, Associate Director, Institutional Services.
Statutory Authority: 42CFR Section 405.310, 405.311, 405.314, 405.316.
History: Rule effective October 1, 1982. Amended June 14, 1990, and April 11, 1997. Amended: Filed June 18, 1999; effective September 9, 1999. **Amended:** Filed March 22, 2010; effective June 16, 2010.

Rule No. 560-X-7-.16 Utilization Review for Inpatient Hospital Admissions and Concurrent Stays

(1) Medicaid will utilize Alabama Medicaid Adult and Pediatric Inpatient Care Criteria (SI/IS) for utilization review, billing and reimbursement purposes.

(a) It is the hospital's responsibility to utilize its own physician advisor.

(b) The attending physician and/or resident may change an order up to 30 days after discharge, as long as the patient met criteria for inpatient or observation services.

(c) Refer to Chapter 3 of this Administrative Code for the fair hearings/appeals process.

(2) A percentage of admissions and concurrent stay charts will be reviewed by the Alabama Medicaid Agency and a Quality Improvement Organization contracted by the Agency.

(3) All in-state and border hospitals must submit Medical Care Evaluation (MCE) Studies (i.e. Performance Improvement Studies) and Utilization Review (UR) Plans to the contracted Quality Improvement Organization every year upon request.

Author: Solomon Williams, Associate Director, Institutional Services.
Statutory Authority: State Plan; 42 C.F.R. 456, Subpart C; Section 1902 (d), Title XIX, Social Security Act.
History: Emergency rule effective April 1, 1983, permanent rule effective July 8, 1983. Effective date of this amendment October 12, 1988. **Amended:** Filed March 22, 2010; effective June 16, 2010. **Amended:** Filed July 12, 2018; effective August 27, 2018.

Rule No. 560-X-7-.17 Outpatient Hospital Services

(1) "Outpatient hospital services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician/dentist at a licensed hospital.

(2) Medical services provided in the outpatient department must be identified and the specific treatment documented in the medical record.

(3) Outpatient surgical services are those covered procedures commonly performed on an inpatient basis that may be safely performed on an outpatient basis. Only those surgeries included on the Medicaid outpatient hospital fee schedule will be covered on an outpatient basis. Surgeries included on the Medicaid outpatient surgical list are reimbursable when provided on an inpatient basis if utilization review criteria are met.

(a) Surgical procedures that are not listed on Medicaid's outpatient fee schedule may be sent to the Institutional Services Unit to be considered for coverage in the outpatient setting if medically necessary and the procedure is approved by the Medical Director.

(b) Refer to the Outpatient Hospital Fee Schedule on the Medicaid website for a list of covered surgical codes.

(4) Reimbursement of outpatient hospital visits includes the use of the facility and no additional facility fee may be billed.

(a) All outpatient hospital services provided by the hospital from admission to discharge of the outpatient will constitute a visit.

(b) Specimens and blood samples sent to the hospital for performance of tests are classified as non-patient hospital services since the patient does not directly receive services from the hospital; therefore, this does not constitute a visit and is not subject to program limitations.

(c) Providers who send specimens to independent laboratories for analysis may bill Medicaid for a collection fee. This fee shall not be paid to anyone who has not actually collected the specimen from the patient.

(d) Routine venipuncture for collection of laboratory specimens may be billed only when sending blood specimens to another site for analysis. The collection fee may not be billed if the lab work is done at the same site where the specimen was drawn.

(e) Hospital labs may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. Payment may be made to the referring laboratory but only if one of the following conditions is met:

1. the referring laboratory is located in, or is part of, a rural hospital;
2. the referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity; or
3. the referring laboratory does not refer more than 30 percent of the clinical laboratory tests for which it receives requests for testing during the year (not counting referrals made under the wholly-owned condition described above).

(f) Radiology services are defined as CPT-4 procedure codes 70000 through 79999. Laboratory services are defined as procedure codes 80000 through 89999.

(g) Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure indicated on the Medicaid outpatient hospital fee schedule on the Medicaid website. This rate is established as a facility fee for the hospital and includes all nursing and technician services; diagnostic, therapeutic and pathology services; pre-op and post-op lab and x-ray services; materials for anesthesia; drugs and biologicals; dressings, splints, casts, appliances, and equipment directly related to the surgical procedure.

(h) Multiple surgical procedures on the claim will be reimbursed the lesser of charges or 100% of the fee on the pricing file for the initial procedure and the lesser of charges or 50% of the fee on the pricing file for subsequent procedures.

(5) "Emergency services" are services that are furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. A "certified emergency" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a

pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part."

(6) Emergency medical services provided in the hospital emergency room must be certified and signed by the attending licensed physician, nurse practitioner or physician assistant at the time the service is rendered, and documented in the medical record if the claim is filed as a "certified emergency."

(7) Certified emergency visits are unlimited if the medical necessity is properly documented and certified in the medical record by the attending licensed physician, nurse practitioner or physician assistant at the time services are rendered. Certified emergency visits do not require a PMP referral.

(8) UB 04 claims for emergency department services must be coded with the appropriate CPT code according to the criteria established by Medicaid to be considered for payment.

(9) Outpatient dialysis services are covered under the End-Stage Renal Disease Program and cannot be reimbursed as an outpatient hospital service. See Chapter 24 for details.

(10) Inpatient Admission after Outpatient Hospital Services-If the patient is admitted as an inpatient before midnight of the day outpatient services were rendered at the same hospital all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient will be considered as the first day of inpatient hospital services.

(11) Outpatient Observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

(a) Outpatient observation is defined as the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to no more than 23 hours.

(b) Outpatient observation is considered an outpatient visit.

(c) An observation unit is defined as an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires either additional observation before a decision is made about admission to the hospital or prolonged patient care is rendered. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient. The following guidelines apply:

1. A physician's order is required for admission and discharge from the observation unit.

2. A physician must have personal contact with the patient at least once during the observation stay.

3. Patients in the observation unit must be monitored by a registered nurse or an employee under his/her direct supervision.

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

5. A recipient must be in the observation unit a minimum of three hours but no more than 23 hours.

(d) Outpatient observation charges must be billed in conjunction with the appropriate emergency room facility fee.

(e) Observation coverage is billable in hourly increments only; therefore, a recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed.

(f) The first three hours of observation are included in the emergency room facility fee.

(g) Observation services should be billed according to the instructions in Chapter 19, (Hospital) of the Alabama Medicaid Provider Manual. The appropriate HCPCS or CPT code may be billed up to 20 units (unit=one hour) per day.

(h) Ancillary charges (lab work, x-ray, etc.) may be billed with the emergency room facility fee and observation charge.

(i) If the observation spans midnight and the recipient is discharged from the observation unit the following day, the provider should bill all observation charges using the date of admission to the observation unit on the outpatient claim form.

(j) If a recipient is admitted to the hospital from outpatient observation, all outpatient charges must be combined and billed with the inpatient charges. The provider should indicate the date of admission to the inpatient hospital as the admission date on the claim form for inpatient services.

(k) Outpatient observation charges cannot be billed in conjunction with outpatient surgery or critical care.

(l) Medical records will be reviewed retrospectively by Medicaid to ensure compliance with the above stated guidelines and criteria.

(12) Medicaid will cover two obstetrical ultrasounds per year for Medicaid recipients that are not participating in the maternity care program. Additional ultrasounds may be approved if a patient's documented medical condition meets the criteria established by Medicaid. Providers should contact Medicaid's Prior Authorization Unit in writing to request approval for additional ultrasounds.

Author: Solomon Williams, Associate Director, Institutional Services.
Statutory Authority: State Plan, Attachment 4.19-B, page 8.1, Attachment 3.1-A, page 1.2; Title XIX, Social Security Act, Section 1833(h) (5) (A); 42C.F.R. Sections 440.20, 440.170, 440.255, 447.321.
History: Rule effective October 1, 1982. **Amended:** October 1, 1983; June 9, 1986; February 9, 1987; May 1, 1987; August 10, 1987; November 10, 1987; August 10, 1988; January 12, 1990; July 1, 1990; October 1, 1991; December 12, 1991; January 14, 1992; April 11, 1997; June 18, 1999; September 10, 1999; December 16, 1999; March 13, 2000; April 20, 2000; July 11, 2000. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed March 22, 2010; effective June 16, 2010. **Amended:** Emergency rule filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010. **Amended:** Emergency rule filed September 16,

2011 and effective October 1, 2011. **Amended:** Filed October 20, 2011; effective January 16, 2012. **Amended:** Filed June 11, 2015; effective July 16, 2015. **Amended:** Filed February 11, 2016; effective: March 28, 2016.

Rule No. 560-X-7-.18 Patient Signature

(1) While a recipient signature is not required on individual claim forms, all providers must obtain a signature to be kept on file, (e.g., release forms or sign in sheets), as verification that the recipient was present on the date of service for which the provider seeks payment. Exceptions to the recipient signature requirement are listed below.

(a) When there is no personal recipient/provider contact, such as laboratory or radiology services.

(b) Illiterate recipients may make their mark, for example, "X", witnessed by someone with their dated signature after the phrase "witnessed by."

(c) If the patient cannot sign due to physical or mental impairment or because of age, an authorized person may sign for the patient indicating his/her relationship to the patient.

(2) The signature alone or on other insurance forms is not acceptable for payment under Medicaid.

(3) The signature and accompanying authorization and certification must be available for review by Medicaid and/or the Medicaid fiscal agent.

(4) When the acceptable signature is not available or is on an incorrect form and payment has been made, the funds covering this period of care will be recouped.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Amended January 14, 1992. Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.19 Reserved

Rule No. 560-X-7-.20 Hospital-Based Physicians, Submission of Claims

Reference Chapter 6 Physicians and Chapter 23 Hospital Reimbursement Program for details.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Sections 405.401, 405.522, 405.523. Rule effective October 1, 1982. Amended January 8, 1985 and June 8, 1985. Effective date of this amendment May 11, 1987.

Rule No. 560-X-7-.21 Outpatient and Inpatient Tests

(1) Based on PL 97-35, the "Omnibus Budget Reconciliation Act of 1981, "Section 2164(a) and 42 CFR Part 441.12, effective October 1, 1981, Medicaid will pay only for laboratory tests or x-rays or any other type of test provided in inpatient or outpatient hospital facilities which have been ordered by the attending physician or other staff physician. There will be no payment made for tests under "standing orders" or "routine orders."

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.22 Claim Filing Guidelines

(1) For claim filing guidelines, refer to Chapter 5, (Filing Claims) of the Provider Manual or Chapter 19 (Hospital) of the Provider Manual.

(2) Claims containing fragmentation of services may be recouped through post-payment review.

Author: Jerri Jackson, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 419-E, page 1, Title XIX, Social Security Act; 42 CFR 447.45, et seq.
History: Rule effective October 1, 1982. Amended November 11, 1985, and April 11, 1997. Amended: Filed June 18, 1999; effective September 9, 1999. **Emergency Rule:** Filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-7-.23 Third Party Payment Procedures

For guidelines on submitting claims to Medicaid when a third party is involved, refer to the Hospital Billing Manual.

Author: Lynn Sharp, Associate Director, Policy Development Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42CFR, Section 401, et seq.
History: Rule effective October 1,1982. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.24 Sending Bills and Statements to Medicaid Recipients

(1) Providers should not send recipients bills or statements for covered services once that recipient has been accepted as a Medicaid patient.

(2) Providers may send a notice to the recipient stating their claim is still outstanding if the notice indicates in bold letters: "THIS IS NOT A BILL."

(3) Providers are responsible for follow-up with the fiscal agent or Medicaid on any billing problems or unpaid claims.

(4) The Recipients are not responsible for the difference between charges billed and the amount paid by Medicaid for covered charges services.

(5) Providers agree to accept the amount paid by Medicaid as payment in full.

(6) Recipients may be billed only for the allowable copayment amount, for services not covered by Medicaid, or when benefits have been exhausted.

(7) Providers may not deny services to any eligible recipient due to the recipient's inability to pay the allowable copayment amount.

Author: Lynn Sharp, Associate Director, Policy Development Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42CFR Sections 447.15, 447.50, 447.55.
History: Rule effective October 1, 1982. Amended July 9, 1984; June 8, 1985, and April 11, 1997. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.25 Prior Authorization

(1) Out-of-State Referrals - Prior authorization will be required for organ transplants and select surgical procedures. (Refer to Rule No. 560-X-1-.27 and Rule No. 560-X-6-.13 respectively).

(2) Dental Hospitalization - See Chapter 15, Dental Services, for details.

Author: Solomon Williams, Associate Director, Institutional Services.
Authority: State Plan, Attachment 3.1A; Title XIX, Social Security Act; 42 C.F.R. Section 431.25.
History: Rule effective October 1, 1982. Amended July 8, October 1, November 10, 1983; May 9, 1984; June 9, October 11, 1986; April 1, 1988 and October 12, 1988. Emergency Rule effective January 1, 1989. Amended March 14, 1989; April 17, 1990; January 15, 1991; October 12, 1991, and October 13, 1992. Effective date of this amendment is April 11, 1997. **Emergency Rule:** Filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010. **Amended**: Filed June 11, 2015; effective July 16, 2015.

Rule No. 560-X-7-.26 Medicare/Medicaid Eligible Recipients

(1) Inpatient - Refer to Rule 560-X-1-.14. for details.

(2) Outpatient - Part B. Payment for outpatient crossover claims shall be based on the lesser of the coinsurance and/or deductible amount or the Medicare allowed amount times the outpatient percentage rate minus the Medicare paid amount.

Authority: State Plan, Attachment 3.1-A, 3.2-A; 42 C.F.R., Section 409.60, .80, & .83; Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360). Rule effective October 1, 1982. Rule amended October 9, 1984; March 7, 1986, April 11, 1986, September 8, 1986, and January 1, 1988. Emergency rule effective February 1, 1989. Amended May 12, 1989. Effective date of this amendment is January 11, 1996.

Rule No. 560-X-7-.27 Reserved

Rule No. 560-X-7-.28 Copayment (Cost Sharing)

(1) The Medicaid recipient shall pay the allowable copayment amount for each inpatient admission under the Medicaid program, except for the designated exemptions. The copayment amount does not apply to services provided for the following:

(a) Recipients under 18 years of age
(b) Pregnancy
(c) Renal dialysis
(d) Emergencies
(e) Family planning
(f) Chemotherapy
(g) Radiation therapy
(h) Nursing home residents

(2) The Medicaid recipient shall pay the allowable copayment amount for each outpatient visit received under the Medicaid program, except for designated exemptions. The copayment amount does not apply to services provided for the following:

(a) Recipients under 18 years of age
(b) Pregnancy
(c) Renal dialysis
(d) Emergencies
(e) Family planning
(f) Chemotherapy
(g) Radiation therapy
(h) Physical therapy
(i) Nursing home residents

Author: Lynn Sharp, Associate Director, Policy Development Unit.
Statutory Authority: State Plan, Attachments 4.18-A; 42CFR Sections 447.15, 447.50, 447.55.
History: Rule effective June 8, 1985. Amended September 13, 1994. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.29 Payment of Outpatient Hospital Services

(1) Payment for all outpatient hospital services will be from approved rates as established by Medicaid.

(2) Publicly owned hospitals and hospitals which predominately treat children under the age of 18 years may be paid at an enhanced payment. These payments shall not exceed combined payments for providing comparable services under comparable circumstances under Medicare.

Authority: State Plan, 42 CFR 447.321, 447.325, Title XIX Social Security Act. Rule effective September 8, 1986. Effective date of this amendment October 1, 1994. Emergency rule effective January 1, 1995. Effective date of this amendment March 15, 1995.

Rule No. 560-X-7-.30 Post-Hospital Extended Care Services

(1) Inpatient hospital services rendered at an inappropriate level of care (lower than acute) are considered post-hospital extended care services. The patient must have received a minimum of three consecutive days of acute care services in the hospital requesting Post-Hospital Extended Care (PEC) reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. (Refer to Chapter 10). Such medically necessary services include, but are not limited to:

(a) Nursing care provided by or under the supervision of a registered nurse on a 24-hour basis;

(b) Bed and board in a semi-private room. Private accommodations may be utilized if the patient's condition requires that he/she be isolated, the facility has no ward or semi-private rooms, or all ward or semi-private rooms were full at the time of admission and remain so during the recipient's stay;

(c) Medically necessary over-the-counter (non-legend) drug products ordered by physician. Generic brands are required unless brand name is specified in writing by the attending physician;

(d) Personal services and supplies ordinarily furnished by a nursing facility for the comfort and cleanliness of the patient;

(e) Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W, and normal saline);

(f) Services ordinarily furnished to an inpatient of a hospital.

(2) In order for such services to be reimbursed, the hospital must submit a written request to Medicaid to receive a provider number that will allow them to use up to ten beds for these services for hospitals with up to 100 beds, with an additional ten beds per each additional 100 beds. Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available

within a reasonable proximity, and the recipient must require on a regular basis two of the following medically necessary services:

(a) Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis;

(b) Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis;

(c) Nasopharyngeal aspiration required for the maintenance of a clear airway;

(d) Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, or other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created;

(e) Administration of tube feedings by naso-gastric tube;

(f) Care of extensive decubitus ulcers or other widespread skin disorders;

(g) Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse;

(h) Use of oxygen on a regular or continuing basis;

(i) Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, post operative, or chronic conditions; or

(j) Receive routine medical treatment as a comatose patient.

(3) To establish medical necessity, an application packet must be furnished to the Medicaid Admissions Program within 60 days from the date Medicaid coverage is requested. The 60 days will be calculated from the date the application is received and date stamped in the Admissions Program. All applications with a date greater than 60 days old will be assigned an effective date that is 60 days prior to the Admissions Program date stamp. No payment will be made for the days prior to the assigned Admissions Program effective date. The facility will be informed in writing of the assigned effective date. The application packet will consist of:

(a) A fully completed Medicaid Status Notification Form XIX-LTC-4 including all documentation certified by the applicant's attending physician to support the need for nursing home level of care.

(b) Documentation certifying the patient has received inpatient acute care services for no less than three consecutive days during the current hospitalization in the requesting hospital prior to the commencement of post-extended care services. These days must have met the Medicaid Agency's approved acute care criteria; and

(c) Documentation certifying contact was made with each nursing facility within a reasonable proximity to determine bed non-availability prior to or on the date coverage is sought, and every 15 days thereafter;

(4) In order to continue Post-Hospital Extended Care eligibility, recertification must be made every 30 days. Nursing facility bed non-availability must be forwarded along with request for recertification.

(5) Reimbursement for post-hospital extended care services will be made on a per diem basis at the average unweighted per diem rate paid by Medicaid to nursing facilities for routine nursing facility services furnished during the previous fiscal year ended June 30. There shall be no separate year end cost settlement. Refer to Chapter 22 of the Alabama Administrative Code for details on rate computation.

(6) A provider must accept as payment in full the amount paid by Medicaid plus any patient liability amount to be paid by the recipient and further agrees to make no additional charge or charges for covered services.

(7) Any day a patient receives such post-hospital extended care services will be considered an acute care inpatient hospital day. These beds will not be considered nursing facility beds.

(8) These services are not subject to the inpatient hospital benefit limitations. At this level of care, post-hospital extended care days are unlimited if a nursing home bed is not located as described in paragraphs (2) and (3)(d) above.

Author: Beverly Rotton, Project Development/Policy Unit, Long Term Care Division
Statutory Authority: Social Security Act, Title XIX; State Plan; and 42 C.F.R. Section 447.253(b).
History: Rule effective July 13, 1994. Amended May 11, 1995 and April 11, 1997. Amended: Filed August 20, 1999; effective November 10, 1999.