510.4 HOSPITAL OUTPATIENT SERVICES

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510.4 HOSPITAL OUTPATIENT SERVICES

BACKGROUND

This policy sets forth requirements of the West Virginia Bureau for Medical Services (BMS) regarding coverage, payment and processing for outpatient hospital services provided to eligible West Virginia Medicaid members by acute care, critical access, psychiatric, and medical rehabilitation hospitals in the outpatient setting. All requirements in *Chapter 510.1, Hospital Services Overview* also apply and any distinct part units therein.

POLICY

510.4.1 Hospital - Outpatient Services

The following outlines outpatient hospital services which are covered by Medicaid. Services must be medically necessary and ordered by medical practitioner acting within the scope of their license. All outpatient services are not defined within this policy.

510.4.1.1 Laboratory, Radiology and Other Diagnostic Procedures

Medicaid coverage for outpatient laboratory, radiology, and other diagnostic services must be performed by facilities which meet all applicable professional and regulatory certification. Reimbursement may be made only for medically necessary tests ordered by a medical practitioner acting within the scope of their license. Medicaid does not reimburse for clinical laboratory tests or radiology procedures performed for quality assurance, or paternity determination. Refer to *Chapter 529.1, Laboratory and Pathology* and *Chapter 528, Radiology Services*.

510.4.1.2 Emergency Room Services

Emergency Department services must be reported using the applicable Current Procedural Terminology (CPT) code for the appropriate level of service. The reimbursement is an all-inclusive fee, which is considered to include the following items and additional procedures billed using revenue code 450:

- Use of emergency room
- Routine supplies (such as sterile dressings)
- Minor supplies (bandages, slings, finger braces, etc.)
- Pharmacy charges
- Suture, catheter, and other trays
- IV fluids and supplies
- Routine Electrocardiogram (EKG) monitoring
- Oxygen administration and O_2 saturation monitoring

Charges for moderate to complex surgical procedures, diagnostic procedures including lab and radiology, casting supplies, and certain drugs may be billed separately. Unusual and/or high cost drugs and supplies may be covered by exception following review of documentation.

Payment for two Emergency Department visits within 24 hours for the same problem is not allowed. When more than one visit occurs in a day, the charges must be rolled to the highest level appropriate to the

visits. All inpatient and outpatient services, including emergency services, provided within 72 hours of the hospital admission are considered to be part of the inpatient services and are to be billed on one claim.

West Virginia has established a system of Health Homes in certain counties which are designed to provide comprehensive care coordination for members with certain chronic conditions. Section 1945(3)(d) of the Social Security Act requires all hospitals to have procedures in place to refer all eligible individuals with chronic conditions, who seek or need treatment in a hospital emergency department, to their designated health home. See the WV Health Homes website and *Chapter 535, Health Homes* for further information, including covered counties and chronic conditions.

510.4.1.3 Observation Services

Outpatient observation services are the medical services provided to a patient with a condition requiring additional monitoring by hospital nurses and staff, beyond the initial assessment by a physician or advanced level practitioner. The services must be reasonable and necessary to evaluate a patient's condition and determine the need for an admission to the hospital. Services are covered when provided by the order of a medical practitioner and within the limitations defined in Medicaid policy.

Observation is billed using the appropriate revenue codes and time units reported in one-hour increments. The maximum number of units allowed for an episode of care is 48. All inpatient and outpatient services, including observation services, provided within 72 hours of the hospital admission are considered to be part of the inpatient services and are to be billed on one claim. Observation bed charges and inpatient hospital charges will not be reimbursed separately for the same day of service.

Medical records are reviewed retrospectively by West Virginia Medicaid to ensure compliance with the above-stated guidelines and criteria.

The criteria for observation services include the following basic provisions:

- Observation services are covered only upon written order of a medical practitioner acting within the scope of their license. This order must document the medical necessity for the services and is retained as part of the patient's medical record. Documentation requirements for admission to observation are essentially the same as for inpatient admission; however, the medical necessity criteria are less stringent.
- Observation does not require prior authorization.
- Coverage of observation may not exceed 48 hours.
- Charges for observation services which result in an inpatient admission are deemed to be part of the admission and not separately billable.
- Ancillary services, laboratory, x-ray and other diagnostic procedures, performed during the observation period, may be billed separately.
- Observation services are appropriate for labor and delivery monitoring when the medical necessity criteria are met.

510.4.1.4 Outpatient Surgery

Outpatient surgery procedures are those which can safely be performed in the outpatient department of the hospital or ambulatory surgical center (ASC). Refer to *Chapter 507, Ambulatory Surgical Centers* for information on outpatient surgery procedures performed in an ASC. Procedures performed in an

outpatient or ambulatory surgery center do not require the same level of nursing services and care as an inpatient and discharge will occur on the same day as the procedure. See prior authorization section below for further information about outpatient surgeries that require prior authorization.

Surgical procedures must be billed with the appropriate CPT or Healthcare Common Procedure Coding System (HCPCS) code and revenue code. Units are reported in 15-minute time increments. Charges and total time units for the procedure(s) must be rolled to the primary, most complex procedure and billed on one line. To report multiple procedures, bill all additional lines with zero units and zero charges. The maximum number of payable time units for any outpatient surgery is 16, but depending upon the procedure, a lower maximum may apply.

Some procedures in the surgical range are divided into technical and professional components and must be billed with the appropriate modifier.

Recovery room charges must be billed with the appropriate revenue code. Payment will be made based on the combination of revenue code and units billed. Units are reported in 15-minute time increments. The maximum units allowed are 24. For minor procedures and those not requiring anesthesia, the billing of recovery is not appropriate. No procedure code is required.

510.4.2 Outpatient Psychiatric Facilities

Outpatient psychiatric facilities may render all of the outpatient services for which they meet applicable federal and state regulatory requirements. Outpatient services are reimbursed on fee-for-service basis, utilizing appropriate HCPCS and CPT codes. Services rendered in the outpatient setting may also include partial hospitalization services in Medicaid-approved Partial Hospitalization Programs. Refer to *Chapter 510.5, Partial Hospitalization Services.*

510.4.3 Outpatient Medical Rehabilitation Facility

A medical rehabilitation facility must meet certification requirements of the Office of Health Facility Licensure and Certification (OHFLAC). Outpatient rehabilitative services and therapies are covered by Medicaid. Please review specific service or therapy policy for any prior authorization requirements or coverage.

510.4.4 Service Limits for Outpatient Services

Physical, occupational, and speech therapy rendered in the hospital outpatient setting are also subject to prior authorization by the appropriate Utilization Management Contractor (UMC). Please review specific therapy policy for any prior authorization requirements or coverage.

510.4.4.1 Prior Authorization Requirements for Outpatient Services

Prior authorization requirements governing the provision of all West Virginia Medicaid services will apply pursuant to *Chapter 100, General Administration and Information*.

Medicaid covered outpatient services which require medical necessity review and prior authorization are:

1. Partial hospitalization as required by *Chapter 510.5, Partial Hospitalization Services.*

2. Physical and occupational therapy only as required under *Chapter 515, Occupational Therapy and Physical Therapy Services*.
3. Speech therapy and audiology services only as required under *Chapter 530, Speech and Audiology Services*.
4. Durable medical equipment and supplies as required under *Chapter 506, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)*
5. Outpatient radiological services including, but are not limited to, Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to obtain authorization for these services.
6. A select list of surgeries performed in place of service 22 (outpatient hospital) and 24 (ASC) require prior authorization. Services that require prior authorization are identified on the appropriate UMC website. For outpatient surgical procedures that require prior authorization, the surgeon must request prior authorization from the appropriate UMC. If the surgery is authorized by the appropriate UMC, a prior authorization number for the surgeon and for the outpatient facility will be assigned and provided by the appropriate UMC. The prior authorization number must be included on the claim form in order to be eligible for reimbursement.

510.4.4.2 Outpatient Non-Covered Services

In addition to the exclusions listed in *Chapter 100, General Administration and Information*, BMS will also exclude the following from coverage in the outpatient setting:

- Charges related to use of hospital facilities by attending physician
- Services requiring prior authorization that was not obtained or not authorized by the appropriate UMC
- Services known as alternative therapies, including but not limited to acupressure, acupuncture, chelation therapy, massage therapy, naturopathy, reflexology, tai chi, and yoga
- Mass screenings for any condition
- Convenience items or services; items or service for the convenience of the patient or caregiver that are not related to medical care or treatment
- Infertility services
- Lift chairs and/or comparable items
- Prenatal sex determination services
- Maintenance services provided when a person's highest level of function has been reached and no progress is being made
- Experimental or investigational medical or surgical procedures, services, treatment, and/or therapies
- Observation services resulting in a hospital admission
- Educational services or nutritional counseling
- Injections or visits solely for the administration of injections unrelated to a medical encounter in emergency room or observation area
- Reimbursement for preoperative testing performed on the same date as surgery in the hospital outpatient department, or preoperative monitoring during a normal recovery period

- Enhanced Extracorporeal Counterpulsion (EEC)
- Cosmetic surgery

510.4.5 Interfacility Transports Via Ambulance

See *Chapter 510.2, Hospital Inpatient Services* Interfacility Transports Via Ambulance section for details.

510.4.6 340B Hospital Program

Section 340B of the Public Health Services Act of 1992 provides access to deeply discounted drugs for certain provider entities who meet the qualifications for participation in the 340B Program, as established by the Health Resources and Services Administration (HRSA). This program allows participating providers, including eligible hospitals, to offer medications to their patients at deeply discounted prices.

Per federal law, drugs with discounts generated from participation in the 340B Program are not eligible for Medicaid federal drug rebates. Drug claims from these provider entities must be exempted from Medicaid drug rebate invoicing. All provider entities must submit their **actual acquisition costs (AAC)** when submitting claims for drugs purchased under the 340B Program. Submission of drug purchase invoices may be required for audit purposes.

All covered entities must ensure that the drugs purchased through this program are used for **outpatients only**. This program does not apply to drugs supplied to inpatients. Covered entities are prohibited from transferring or reselling 340B purchased drugs to individuals who are not patients of the facility. The entity is responsible for implementing systems to ensure compliance and maintain documentation of these practices.

All entities must apply to HRSA for participation in the 340B Program. At the time of application, providers must determine whether they will use 340B drugs for their Medicaid patients (carve-in) or whether they will purchase drugs for their Medicaid patients through other sources (carve-out):

- Entities that carve-in are required to inform HRSA of their decision by providing their Medicaid provider number/National Provider Identifier (NPI) at the time they enroll in the 340B Program that they will purchase and dispense 340B drugs for their Medicaid patients. If covered entities bill Medicaid for drugs purchased under 340B, then ALL drugs billed with that number must be purchased under 340B and that Medicaid provider number/NPI must be listed on the HRSA Medicaid Exclusion File.
- In addition to the HRSA application process, the BMS requires that participating 340B Program providers certify their participation by completing the 340B Certification Form located on the BMS website.
- Entities that opt to carve-out of the 340B program must purchase drugs from another source and that Medicaid provider number/NPI should not be included on the HRSA Medicaid Exclusion File.

The HRSA maintains a current listing of eligible providers on the HRSA website. It is the providers' responsibility to verify that the HRSA listing of their participation is current and accurate. Providers must report any changes in Medicaid 340B Program participation to HRSA and to the BMS **before** implementing this change. A written notice of a change in participation must be received no later than 30 days prior. Notices must be sent to:

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The Bureau for Medical Services
Attn: Pharmacy Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301

REFERENCES

West Virginia State Plan references outpatient hospital services at sections 3.1-A(1)(a), 3.1-B(2)(a), supplement 2 to attachments 3.1-A and 3.1-B(2)(a).

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in *Chapter 510.1, Hospital Services Overview* also apply to this policy.

CHANGE LOG

SECTION	TITLE	EFFECTIVE DATE
Entire Chapter	Hospital Outpatient Services	January 1, 2024