

Chapter Six

Outpatient Hospital Services

Chapter Overview

Introduction This chapter describes covered services, programs, restrictions, and exclusions in the outpatient hospital services category of North Carolina Medicaid Program.

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Outpatient Hospital Services

Definition Outpatient hospital services are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under direction of a physician or dentist to a recipient by an institution that is licensed or formally approved as a hospital. All medical services performed must be medically necessary and not experimental in nature.

All hospitals that elect to participate in the Medicaid program must meet the qualifications previously described in *Chapter Five, Inpatient Hospital Services*.

Availability Outpatient hospital services are available to all eligible Medicaid recipients who are not inpatients.

Visit Limitations Ambulatory medical visits are limited to a total of 24 visits per year beginning July 1 of each year and ending June 30 of the following year. These visits include visits to any combination of physicians, clinics, chiropractors, optometrists, and hospital outpatient facilities, other than the emergency room.

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Outpatient Hospital Services, Continued

Exemptions to 24-Visit Limitations

Exemptions to the 24-visit limit include:

- recipients being treated for end-stage renal disease
 - recipients receiving chemotherapy, and radiation therapy of malignancy
 - recipients being treated for acute sickle cell disease
 - recipients being treated for hemophilia, or other blood-clotting disorder
 - recipients being treated for end-stage lung disease
 - recipients being treated for unstable diabetes
 - recipients being treated for terminal stage—any illness—life-threatening
 - recipients under the age of 21
 - prenatal care visits
 - mental health clinic visits/services
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Copayment

Some outpatient hospital services are subject to a \$3.00 copayment. Copayments may not be charged for the following:

- Health Check (EPSDT) services
 - family planning services
 - services covered by both Medicare and Medicaid
 - services to persons under age 21
 - services related to pregnancy
 - services provided to residents of NF, ICF-MR, and mental hospitals
 - Community Alternatives Program (CAP) services
 - services to enrollees of prepaid health plans
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Outpatient Covered Services

The following services are covered by Medicaid:

- outpatient services incident to the services of physicians and dentists in treating their patients
 - physician and dentist professional component
 - outpatient diagnostic services
 - outpatient therapy services
 - outpatient speech pathology services
 - outpatient therapeutic and rehabilitative services including
 - ◆ the use of hospital facilities
 - ◆ clinic and emergency room services
 - ◆ services of hospital personnel
 - medical supplies, drugs, and biologicals used by physicians or hospital personnel in treatment
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Outpatient Hospital Services, Continued

Outpatient Noncovered Services

This list not all-inclusive, and Medicaid guidelines can change. For questions about a service or procedure, call EDS:

- experimental drugs and procedures
 - medical photography
 - biofeedback
 - disability, prevocational, or preschool examinations
 - infertility tests
 - corsets and back supports
 - cervical glomectomy for asthma
 - earplugs
 - brain pacemaker
 - penile prostheses
 - telephonic pacemaker monitoring
 - guest meals
 - silastic gel or inflatable implant prostheses for urinary incontinence or impotence
 - bladder stimulators
 - charge for venipuncture
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Routine Dialysis

Routine hemodialysis or peritoneal dialysis is considered an outpatient service and is subject to outpatient screens regardless of the location of the bed utilized or the length of time required for completion of the dialysis. Only those hospitals that are approved end-stage renal disease providers will receive reimbursement from Medicaid.

Foot Care

Routine foot care is only covered when the services are medically necessary and

- are an integral part of otherwise covered services (such as plantar warts);
- and/or there exists the presence of metabolic, neurological, and/or peripheral vascular disease;
- and/or there is evidence of mycotic nails that, in the absence of a systemic condition, result in pain or secondary infection

Foot care services, including cutting or removal of corns and calluses, trimming, cutting, clipping, and debriding of nails and other hygienic care, are normally considered routine and are not covered by Medicaid.

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Outpatient Hospital Services, Continued

Routine Physicals

Routine physicals and related diagnostic tests are covered in the following cases:

- patients under age 21 who receive screening examinations under Health Check
 - annual physicals performed as part of an ongoing family planning program
 - annual physicals for recipients in domiciliary care facilities, nursing facilities, or intermediate care facilities
 - adult health screening
 - ◆ only one screening per calendar year is covered by Medicaid
 - ◆ screening is counted toward the 24-visit limit
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Take-Home Supplies

“Take-home” drugs, medical supplies, equipment, and appliances are not covered, except for small quantities of medical supplies, legend drugs, or insulin needed by the patient until such time as the patient can obtain a continuing supply.

Outpatient Services Requiring Prior Approval

Introduction

Certain outpatient procedures require prior authorization from EDS.

Hospital admitting staff must confirm that the physician has obtained the necessary prior approval (PA) forms before admitting a patient for these procedures. If there are questions regarding prior approval, contact the EDS prior approval unit. See Appendix B for contact numbers.

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Outpatient Services Requiring Prior Approval, Continued

Reconstructive Surgery Photographs may be requested. To differentiate between cosmetic and reconstructive surgery, cosmetic surgery is not considered medically necessary and is, therefore, not covered. Reconstructive surgery may have cosmetic effects, but is done to help the patient reach optimal functioning.

Use form 372-118, "Request for Prior Approval."

Excision of Keloids

The excision of keloids requires the following information on the PA:

- ◆ location and description
- ◆ size of the lesion
- ◆ cause of the lesion

Approval will be granted when there is evidence of pain, local irritation and/or rapid increase in the size of the keloid, or when an inflammatory epidermal cyst with sinus drainage exists.

Use form 372-118, "Request for Prior Approval."

Outpatient Psychiatric Visits

Outpatient psychiatric visits are covered. Up to two visits allow the physician to evaluate the patient's needs and do not require PA. The third outpatient psychiatric visit and each subsequent visit requires prior approval. Use form 372-115 "Prior Approval for Psychiatric Outpatient Services." PA is required when rendered in an office, clinic, outpatient hospital, domiciliary care facility, intermediate or skilled care facility. PA is not required for inpatient visits or for the services of mental health centers.

Outpatient psychiatric visits are counted toward the 24-visit limit per year on all Medicaid-eligible recipients age 21 and older. (Medicaid-eligible children ages 0-21 are exempt from the 24-visit limitation.) For children ages 0-21, prior approval can be granted for a maximum of six months. For adults, prior approval can be granted up to a maximum of 12 months.

Out-of-State Services

All nonemergency services provided by a hospital outside a 40-mile radius of North Carolina's borders require prior approval.

Out-of-State Services for Foster Children and Children in Adoptive Care

Foster children and children in adoptive care living outside North Carolina are eligible for the same services provided in state for children, and are subject to the same prior approval requirements. Contact EDS with questions on prior approval requirements. See Appendix B for contact numbers.

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Outpatient Services Requiring Prior Approval, Continued

Dental Services

The Administrative Procedure Act defines routine dental services (R) as:

- examinations
- radiographs
- preventive services
- tooth extractions
- minor oral surgical procedures
- restorative services
- prosthetic repairs
- certain adjunctive services such as:
 - ◆ general anesthesia
 - ◆ professional consultations and visits
 - ◆ intramuscular injections of medicaments and drugs

These services may be performed without prior approval.

If a dentist has a question regarding whether a specific procedure code designated as routine will be reimbursed for an individual recipient, then the prior approval mechanism can be utilized. For example, if the dentist does not know the recipient's past utilization of Medicaid services (e.g., previous sealants), then a request for prior approval would be appropriate to avoid denial of payment.

Routine services provided to recipients that violate the specified restrictions will not be reimbursed.

Health Check

What is Health Check?

Health Check is a preventive care program for Medicaid children ages birth through age 20. A Health Check screening is the only well child care visit reimbursed by Medicaid. Health Check Coordinators are located in 54 North Carolina counties and are available to assist both parents and providers in assuring that Medicaid-eligible children have access to Health Check services.

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Health Check, Continued

Health Check Screening Components

A complete Health Check screening consists of the following age-appropriate components required to be done at each visit unless otherwise noted:

- comprehensive unclothed physical examination
 - comprehensive health history
 - nutritional assessment
 - anticipatory guidance/health education
 - measurements, blood pressure, vital signs
 - developmental screening, including mental, emotional, and behavioral
 - immunizations
 - vision and hearing screenings
 - laboratory procedures
 - ◆ hemoglobin/hematocrit
 - ◆ urinalysis
 - ◆ sickle cell
 - ◆ tuberculin skin test
 - ◆ lead screening
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Recommended Screening

The following schedule is the recommended frequency of screenings dependent on the age of the Medicaid child. This schedule is one screening at each of the following ages:

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| • within the first month | • 18 months |
| • 2 months | • 2 years |
| • 4 months | • 3 years |
| • 6 months | • 4 years |
| • 12 months | • 5 years |
| • 15 months (this screening may be done at 9 months of age instead) | • 6 years and older (one checkup every three years) |
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Billing

Lab work done in conjunction with Health Check can be billed on the UB-92 claim form under the hospital provider number. Services for Health Check must be billed on a HCFA-1500 using the professional staff's provider number.

Additional Information

To obtain more information on the Health Check program, see Appendix B.

Family Planning Services

Definition	Family planning services include those services, procedures, and supplies that enable individuals of childbearing age, including minors considered to be sexually active, to freely determine the size of their families and/or to space their children.
Availability	Family planning services are available to all eligible Medicaid recipients of childbearing age who are in need of such services.
Copayment	Medicaid recipients are not responsible for a copayment when receiving family planning services.
Covered Services	Family planning services covered under Medicaid include the following: <ul style="list-style-type: none">• consultation (including counseling and patient education), examination, and treatment prescribed by a physician and furnished by or under his supervision<ul style="list-style-type: none">◆ counseling and patient education services are critical in helping the recipient choose and effectively use the method best suited to him or her. Counseling must include information on natural family planning methods since this may be the only contraceptive method acceptable to some individuals for personal and/or health reasons• laboratory examinations and tests• medically-approved methods, procedures, pharmaceutical supplies and devices to prevent conception through chemical, mechanical, or other means• natural family planning methods• voluntary sterilization in accordance with the procedures outlined under “Sterilizations” in <i>Chapter Five, Inpatient Hospital Services</i>
Norplant Insertion	Payment for Norplant insertion is made if diagnosis code V25.5 is reported on the claim.

End-Stage Renal Disease Services

Requirements for Participation	Hospital-based dialysis facilities file formal participation agreements with the Division of Medical Assistance. They must provide services in accordance with the rules and regulations of the Medicaid and Medicare programs, and 42 CFR Chapter IV, subpart U.
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End-Stage Renal Disease Services, Continued

Definition End-stage renal disease (ESRD) means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.

Provision of Services End-stage renal disease services include those services and procedures designed to promote and maintain the normal functioning of the kidneys and related organs. These services are covered only when provided by a certified end-stage renal facility.

Rates Dialysis rendered as an outpatient hospital service is reimbursed as ratio of cost to charge.

Availability Medicare coverage (Part A and B) is available to most people under age 65 if it is medically determined that they have end-stage chronic kidney disease and require kidney dialysis or transplant. Generally, coverage is available to anyone under 65 years of age who meets the following requirements:

1. The patient has chronic kidney disease which requires dialysis or transplant.
2. The patient is either fully or currently insured under Social Security, or is receiving monthly Social Security benefits, or
3. The patient is the spouse or dependent child of someone who meets the insured status or monthly benefit requirements.

Medicare coverage for people under 65 years of age with severe kidney impairment is the same as Medicare coverage for the elderly.

Note: When any claim with a diagnosis of end-stage or chronic renal disease is received, Medicare eligibility must be checked. If Medicare eligibility has not been established, patient information is transferred to the Buy-In program for Part B investigation (See *Chapter Three, Medicaid Overview*, “Medicaid Eligibility,” Medicare Part B Buy-In block.) If the patient meets the requirements for Medicare listed above, the original claim will be returned to the provider for submission to Medicare. Medicaid will pay the coinsurance and deductible, if any, after Medicare has made payment.

Copayment Most eligible Medicaid recipients who are receiving dialysis maintenance services from a hospital are responsible for a \$3.00 copayment for each outpatient visit or \$3.00 for each physician service. The only exceptions are the exempt recipients listed under “Copayment Exemptions” in *Chapter Three, Medicaid Overview*.

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End-Stage Renal Disease Services, Continued

Covered Services

Covered services include:

- maintenance hemodialysis, including blood transfusion administered during dialysis treatment
 - peritoneal dialysis, including blood transfusion administered during dialysis treatment
 - continuous ambulatory peritoneal dialysis, including blood transfusion administered during dialysis treatment
 - continuous cycling peritoneal dialysis, including blood transfusion administered during dialysis treatment
 - kidney transplant services
 - physical therapy
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Noncovered Services and Restrictions

An inpatient hospital stay is not considered medically necessary if the patient was admitted for the sole reason of receiving routine hemodialysis or peritoneal dialysis. The dialysis is considered an outpatient service and is subject to outpatient screens regardless of the location of the bed utilized (inpatient routine bed, intensive care bed, renal dialysis department bed, etc.) or the length of time needed to complete the dialysis procedures.

Charges for the following services are not covered:

- take-home supplies (e.g., 4x4, tape, etc.)
 - take-home drugs
 - ultra filtration apheresis
 - specimen collection fee
 - IV fluids (unless justified by diagnosis)
 - oral medication
 - observation room
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Prior Approval

Chronic kidney disease services or renal transplants do not require PA.

Laboratory Services and Restrictions

Restrictions for covered laboratory services are as follows:

- bone survey may be performed annually
 - Hepatitis B surface antibody or Hepatitis C core antibody (one, not both) may be performed once a month
 - bone mineral density may be performed every six months
 - chest x ray may be performed every six months
 - The following may be done every three months:
 - ◆ serum aluminum
 - ◆ serum ferritin
 - ◆ platelet count
 - ◆ nerve conduction velocity
 - ◆ EKG
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