



# Florida Medicaid

## **Outpatient Hospital Services Coverage Policy**

Agency for Health Care Administration

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## 1.0 Introduction

### 1.1 Description

Florida Medicaid outpatient hospital services provide preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist.

#### 1.1.1 Florida Medicaid Policies

This policy is intended for use by outpatient hospital providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

#### 1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of outpatient hospital services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

### 1.2 Legal Authority

Outpatient hospital services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), section 440.20
- Sections 409.815 and 409.905, Florida Statutes (F.S.)
- Rule 59G-4.160, F.A.C.

### 1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

#### 1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

#### 1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

#### 1.3.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

#### 1.3.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

#### 1.3.5 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

### **1.3.6 Recipient**

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

## **2.0 Eligible Recipient**

### **2.1 General Criteria**

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

### **2.2 Who Can Receive**

Florida Medicaid recipients requiring medically necessary outpatient hospital services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, the service is covered for recipients of all ages.

### **2.3 Coinsurance, Copayment, or Deductible**

Recipients are responsible for the following copayment, unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For information on copayment requirements and exemptions, please refer to Florida Medicaid's copayment and coinsurance policy:

- Five percent of the first \$300.00 of the Florida Medicaid payment for non-emergency services provided in an emergency department, per day (maximum of \$15.00 per day)
- \$3.00 per day for outpatient services provided in an outpatient setting other than the emergency department.

## **3.0 Eligible Provider**

### **3.1 General Criteria**

Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

### **3.2 Who Can Provide**

Hospitals licensed as a general or specialty hospital in accordance with section 395.003, F.S.

Providers must have an outpatient end-stage renal dialysis program that is certified by the Centers for Medicare and Medicaid Services (CMS), as required in 42 CFR 494, to provide dialysis services in the outpatient setting.

## **4.0 Coverage Information**

### **4.1 General Criteria**

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

## 4.2 Specific Criteria

Florida Medicaid reimburses for outpatient hospital services when recipients are admitted and discharged home or to a non-acute care facility on the same day.

Outpatient hospital services include the following items or services:

- Emergency or observation services
- Laboratory tests
- Medical supplies, drugs, and biologicals used by physicians or hospital personnel in treatment
- Radiology services
- Services in an outpatient clinic, including same-day surgery
- Therapy services

### 4.2.1 Emergency Department Services

Florida Medicaid reimburses for emergency department visits, once per day, per recipient.

Florida Medicaid reimburses for emergency services, as defined in Rule 59G-1.010, F.A.C., provided by a hospital that is not enrolled as a Florida Medicaid provider until the recipient can be moved to a participating hospital.

### 4.2.2 Emergency Services For Undocumented Aliens

Florida Medicaid reimburses for emergency services (including labor and delivery and dialysis services) provided to undocumented aliens who otherwise meet all eligibility requirements except citizenship status. Florida Medicaid will not pay for continuous or episodic services after the emergency has been alleviated.

### 4.2.3 Non-Emergency Services

Florida Medicaid reimburses for non-emergency outpatient services, as follows:

- As medically necessary for recipients under the age of 21 years
- Up to \$1500 per fiscal year for recipients age 21 years and older, with the exception of labor and delivery services, surgical procedures, dialysis services, and chemotherapy services which are reimbursable when medically necessary

#### 4.2.3.1 Observation Services

Florida Medicaid reimburses for up to 48 hours of observation services without a subsequent inpatient admission.

For more information, please refer to Florida Medicaid's inpatient hospital service coverage policy.

#### 4.2.3.2 Therapy Services

Florida Medicaid reimburses for therapy services as follows:

- Physical, respiratory, occupational, and speech-language pathology therapy services as medically necessary, for recipients under the age of 21 years
- Physical and respiratory therapy services subject to the coverage specified in section 4.2.3 of this policy for recipients age 21 years and older

## 4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule

may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

## 5.0 Exclusion

### 5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

### 5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Blood replacement fees
- Child health check-up services
- Drugs and supplies for use outside the hospital
- Durable medical equipment and supplies for use outside of the hospital
- Detoxification that is not medically necessary to treat an emergency
- Laboratory, pathology, organ, and disease panels that contain duplicate components
- More than three pints of blood for dually eligible recipients
- Personal items not directly related to the treatment and care of an illness or injury
- Routine primary care services
- Services for cosmetic purposes
- Specimen collection (venipuncture, collection, handling, or transportation of specimens)
- Services that are more than 24 hours in duration, except for observation

Some services may be reimbursable through another Florida Medicaid-covered service. Please refer to the service-specific coverage policy for more information.

## 6.0 Documentation

### 6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

### 6.2 Specific Criteria

Providers must submit the following AHCA forms, incorporated by reference in Rule 59G-1.045, F.A.C., with the claim, as applicable:

- State of Florida Abortion Certification Form - AHCA-Med Serv Form 011, June 2016
- State of Florida Exception to Hysterectomy Acknowledgement Requirement – ETA-5001, June 2016
- State of Florida Hysterectomy Acknowledgement Form – HAF-5000, June 2016

Providers must submit the U.S. Department of Health and Human Services' Consent for Sterilization Form - HHS-687, (10/12), incorporated by reference and available at <http://www.hhs.gov/opa/pdfs/consent-for-sterilization-english-updated.pdf>, with the claim, as applicable.

## 7.0 Authorization

### 7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

## 7.2 Specific Criteria

The treating practitioner or hospital provider must obtain authorization from the quality improvement organization for the following:

- Cochlear device implantation
- Radiology and nuclear medicine services
- Physical, occupational, and speech-language pathology services for recipients under the age of 21 years

## 8.0 Reimbursement

### 8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

### 8.2 Specific Criteria

Florida Medicaid reimburses for outpatient services by line item using the outpatient rate, in accordance with Rule 59G-6.030, F.A.C, with the exception of the following services:

- Clinic services billed on the CMS 1500 claim form
- Infant and newborn hearing screening
- Intrathecal baclofen therapy pump
- Transplant services
- Vagus nerve stimulator device

#### 8.2.1 Clinic Services

Public hospital providers that have assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government must include revenue code 0510 to be reimbursed for clinic services using the UB-04 claim form. Otherwise, providers must submit claims for clinic services using the CMS 1500 claim form.

#### 8.2.2 Drugs and Biologicals

Providers must include the National Drug Code (NDC) combination on the claim form when billing revenue code 0636 for medications listed in the Physician Injectable Medications-Non-Oncology Medications and the Physician Injectable Medications-Oncology Medications Fee schedules.

Providers may include revenue code 0636 multiple times on the same outpatient claim form.

#### 8.2.3 Emergency Department (ED) Visits Spanning Two Dates of Service

Providers must include the following on the claim form:

- Revenue code 0451x for ED services
- The date the recipient entered the ED as the date of service for the ED visit
- The date the provider rendered any service related to the ED visit as the date of service for that line item

### 8.3 Claim Type

Institutional (837I/UB-04)

### 8.4 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

### 8.5 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

Providers must include the appropriate Healthcare Common Procedure Coding System or Current Procedural Terminology code on the claim form for all revenue codes.

**8.6 Rate**

For outpatient rates, see [http://ahca.myflorida.com/medicaid/cost\\_reim/index.shtml](http://ahca.myflorida.com/medicaid/cost_reim/index.shtml).

For a schedule of rates for services reimbursed outside of the outpatient rates, see <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

**8.6.1 Out-of-State Providers**

Florida Medicaid reimburses out-of-state providers at the out-of-state outpatient hospital rates for emergency services. For a schedule of rates, see [http://ahca.myflorida.com/medicaid/cost\\_reim/index.shtml](http://ahca.myflorida.com/medicaid/cost_reim/index.shtml).