

INDEX

721 HOSPITAL SERVICES	PAGE
721.1 Eligible Providers	1
721.2 Provider Responsibilities	2
721.3 Covered Services	3
721.4 Prior Approval and Utilization Review	4
721.5 Inpatient Services	4
721.6 Outpatient Services	13
721.7 Emergency Room Services	16

MAD:95-36

**PROVIDER POLICIES
HOSPITAL SERVICES**

EFF:02/01/95

This page intentionally left blank.

MAD-721-INDEX

721 HOSPITAL SERVICES

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients receive necessary services, the New Mexico Medical Assistance Division (MAD) pays for inpatient, outpatient, and emergency services furnished in general hospital settings.

This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

721.1 Eligible Providers

Upon approval of New Mexico Medical Assistance Program Provider Participation Agreements by MAD, all general acute care hospitals are eligible to be reimbursed for providing inpatient, outpatient, and emergency services to recipients, if the institutions are licensed and certified by the Licensing and Certification Bureau of the New Mexico Department of Health (DOH) to participate in the Title XIX (Medicaid) program. Rehabilitation hospitals can be reimbursed for furnishing inpatient services if they meet these same requirements.

- (A) Free-standing psychiatric hospitals can be reimbursed for providing inpatient and outpatient services to recipients under twenty-one (21) years of age. See Section MAD-742.1, INPATIENT PSYCHIATRIC SERVICES IN FREE-STANDING HOSPITALS.
- (B) When claims for qualified Medicare beneficiaries are submitted by Medicare-certified tuberculosis or psychiatric hospitals, Medicaid pays the coinsurance and deductible amounts following Medicare payment to these providers. Tuberculosis or psychiatric hospitals are not eligible to be reimbursed by Medicaid for providing inpatient services to other Medicaid recipients.
- (C) Border and out-of-state hospitals are eligible to be reimbursed by New Mexico Medicaid if their licensure and certification to participate in their state Medicaid or Medicare program is accepted in lieu of licensing and certification by New Mexico.
- (D) Hospitals certified for emergency services only are reimbursed for furnishing inpatient and outpatient emergency services for the period during which the emergency exists.

Once enrolled, providers receive a packet of information, including Medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

721.2 Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES.

Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES.

721.3 Covered Services

Medicaid covers inpatient and outpatient hospital, and emergency services which are medically necessary for the diagnosis and/or treatment of illness or injury or required by the condition of the recipient. Medicaid covers items or services ordinarily furnished by hospitals for the care and treatment of patients.

These items or services must be furnished under the direction of a physician, podiatrist, or dentist with staff privileges in hospitals which are Medicaid providers. Services must be furnished within the scope and practice of the professional as defined by state laws and regulations.

721.4 Prior Approval and Utilization Review

All Medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, PRIOR APPROVAL AND UTILIZATION REVIEW. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

721.41 Prior Approval Certain procedures or services can require prior approval from MAD or its designee. Procedures that require prior approval are

primarily those for which the medical necessity can be uncertain, which can be for cosmetic purposes, or which can be of questionable effectiveness or long term benefit.

- (A) All transfers from one acute care DRG hospital to another DRG hospital.
- (B) All inpatient stays for Prospective Payment System (PPS) exempt psychiatric units of general acute care hospitals require admission and continued stay reviews.
- (C) All inpatient stays in rehabilitation hospitals and PPS-exempt rehabilitation units in general acute care hospitals require admission and continued stay review.
- (D) Outpatient physical, occupational, and speech therapy and MRIs require prior approval.

Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

721.42 Eligibility Determination Prior approval of services does not guarantee that individuals are eligible for Medicaid. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

721.43 Reconsideration Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS.

721.5 Inpatient Services

Medicaid coverage of some inpatient services can be conditional or limited.

721.51 Non-Medically Warranted Days General hospitals are not reimbursed for days of acute level inpatient services furnished to recipients as a result of difficulty in securing alternative placement. A lack of nursing facility placement is not sufficient grounds for continued acute-level hospital care.

721.52 Awaiting Placement Days

- (A) When the MAD utilization review (UR) contractor determines that a recipient no longer meets acute care criteria in an acute care hospital or PPS exempt rehabilitation hospital but requires a nursing facility level of care which cannot be immediately located, those days during which recipients are waiting placement in a lower level of care facility are termed "awaiting placement days".

Payment to the hospital for awaiting placement days is made at the weighted average rate paid by Medicaid for the level of nursing facility services required by the recipient (High NF or Low NF). A separate claim form must be submitted for awaiting placement days.

- (B) When the MAD UR contractor determined that a recipients under twenty-one (21) years of age no longer meets acute care criteria and the Children's Mental Health Services Review Panel has determined that the recipient requires a psychosocial residential level of care which cannot be immediate located, those days during which the recipient is awaiting placement to the lower level of care are termed "awaiting placement days".

(1) Medicaid does not cover psychosocial residential care for recipient over twenty-one (21) years of age, therefore this provision does not apply to them.

(2) Payment to the hospital for awaiting placement days is made at the weighted average rate paid for Medicaid for psychosocial accredited residential services for recipients classified as level III, IV, or IV+ plus five percent (5%). A separate claim form must be submitted for awaiting placement days.

- (C) Medicaid does not pay for any ancillary services for "awaiting placement days". The rate paid is considered all inclusive. Medically necessary physician visits, or in the case of the recipient under twenty-one (21) years of age requiring psychosocial residential services, licensed Ph.D. psychologist visits, are not included in this limitations.

721.53 Private Rooms Hospitals are not reimbursed for the cost of private rooms, unless the private room is medically necessary to protect the health of recipients or others.

- (A) To receive reimbursement for a private room for non-listed diagnoses, documentation by physicians of the necessity for private rooms must accompany claims. If the use of private rooms is not established as medically necessary, the hospital is reimbursed at the semiprivate accommodation rate.
- (B) Providers wishing to appeal accommodation decisions must submit written justification substantiating the medical necessity for a private room and a copy of the claim to the MAD utilization review (UR) contractor for review.

721.54 Services Performed in an Outpatient Setting Medicaid covers certain procedures performed in an office, clinic, or as an outpatient institutional service which are alternatives to hospitalization. Generally, these procedures are those for which an overnight stay in a hospital is seldom necessary.

- (A) Recipients can be hospitalized if they have an existing medical condition which predisposes them to complications even with minor procedures.
- (B) All claims for one or two (2) day stays for hospitalization are subject to pre-payment or post-payment review.

721.55 Observation Stay If physicians order recipients to remain in the hospital for less than twenty-four (24) hours, the stays are not covered as inpatient admissions, but are classified as observation stays. Observation stays are considered outpatient services.

- (A) The following are exemptions to the general observation stay definition:
 1. The recipient dies;
 2. Documentation in medical records indicates that recipients left against medical advice or were removed from the facility by their legal guardians against medical advice;

**PROVIDER POLICIES
HOSPITAL SERVICES**

3. Recipients are transferred to another facility to obtain necessary medical care unavailable at the transferring facility; and
 4. An inpatient admission results in delivery of a child.
- (B) The MAD UR contractor determines whether a recipient's admission falls into one of the exempt categories and considers it to be a one or two day stay.
- (1) If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.
 - (2) Hospitals must bill these services as outpatient observation services. However, outpatient observation services must be medically necessary and must not involve premature discharge of a recipient in an unstable medical condition.
- (C) The hospital or attending physician can request a re-review and reconsideration of the observation stay decisions. See Section 953, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS.
- (1) The observation stay review does not replace the usual review of one and two day stays for medical necessity.
 - (2) Medicaid does not cover medically unnecessary admissions, regardless of length of stay.

721.56 Review of Hospital Admissions All cases requiring a medical peer review decision on appropriate use of hospital resources, quality of care or appropriateness of admission, transfer into a different hospital, and readmission are reviewed by the UR contractor.

The UR contractor performs medical review to verify the following:

1. Admissions to acute care hospitals are medically necessary;

**PROVIDER POLICIES
HOSPITAL SERVICES**

2. All hospital services and surgical procedures furnished are appropriate to the recipient's condition and are reasonable and necessary to the care of the recipient;
3. Patterns of inappropriate admissions and transfers from one hospital to another are identified and are corrected. Hospitals are not reimbursed for inappropriate admissions or transfers; and
4. The method of payment and its application by hospitals does not jeopardize the quality of medical care.

721.57 Noncovered Services Medicaid does not cover the following specific inpatient benefits:

1. Hospital services which are not considered medically necessary by MAD or its designee for the condition of the recipient;
2. Hospital services that require prior approval for which the approval was not requested;
3. Hospital services which are furnished to individuals who were not eligible for Medicaid on the date of service;
4. Experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests, and imaging services. See Section MAD-765, EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES OR THERAPIES;
5. Drugs classified as "ineffective" by the federal Food and Drug Administration;
6. Private duty or incremental nursing services;
7. Laboratory specimen handling or mailing charges;
8. Formal educational or vocational training services which relate to traditional academic subjects or training for employment; and
9. Inpatient services furnished to recipients who are members of the

**PROVIDER POLICIES
HOSPITAL SERVICES**

Primary Care Network (PCN) which are not furnished or referred for performance by the member's PCN provider.

721.58 Covered Services in Hospitals Certified for Emergency Services

Only Certain inpatient and outpatient services can be furnished by hospitals certified to participate in the Title XVIII (Medicare) program as Emergency Hospitals. Medicaid reimburses these providers only for treatment of conditions considered to be medical or surgical emergencies. "Emergency" is defined as a condition which develops unexpectedly and needs immediate medical attention to prevent the death or serious health impairment of the individual which necessitates the use of the most accessible hospital equipped to furnish emergency services.

- (A) Medicaid covers the full range of inpatient and outpatient services furnished to recipients in an emergency situation in hospitals which are certified for emergency services only.
- (B) Medicaid reimbursement for emergency services furnished in a hospital certified for emergency services only is made for the period during which the emergency exists.
 - (1) Documentation of the recipient's condition, the physician's statement that emergency services were necessary, and the date when, in the physician's judgment, the emergency ceased, must be attached to the claim form.
 - (2) An emergency no longer exists when it becomes safe from a medical standpoint to move the recipient to a certified inpatient hospital or to discharge him/her.
- (C) Reimbursement for services in emergency hospitals is made at eighty percent (80%) of reasonable charges. No retroactive adjustments are made.

721.59 Patient Self Determination Act All adult recipients must be informed of their right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See Section MAD-701.9, GENERAL PROVIDER POLICIES.

721.510 Psychiatric Services Furnished to Recipients under Twenty-One

Year of Age in PPS-Exempt Units of Acute Care Hospitals Services furnished to all Medicaid recipients must be under the direction of a physician. In the case psychiatric services furnished to recipients under twenty-one (21) year of age, these services must be furnished under the direction of board prepared/ board eligible/board certified psychiatrist, or a licensed psychologist working in collaboration with a similarly qualified psychiatrist. The psychiatrist must conduct an evaluation of the recipient, in person, within twenty-four (24) hours of admission.

In the case of recipients under twelve (12) years of age, the psychiatrist must be board prepared/ board eligible/ board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for recipients under age twelve (12) and recipients under twenty-one (21) years of age can be waived when all of the following conditions are met:

1. The need for admission is urgent or emergent, and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes;
2. At the time of admission, a board prepared/ board eligible/ board certified psychiatrists, or in the case of a recipient under twelve (12) years of age, a child psychiatrist is not accessible in the community in which the facilities is located;
3. Another facility which is able to furnish a board prepared/board eligible/board certified psychiatrists, or in the case of a recipient under twelve (12) years of age, a child psychiatrist, is not available or accessible in the community; and
4. The admission is for stabilization only and transfer arrangements to the care of a board prepared/board eligible/ board certified psychiatrist, or in the case of recipients under twelve (12) years of age, a child psychiatrist are made as soon as possible with the understanding that if the recipient needs transfer to another facilities, the actual transfer will occur as soon as the recipient is stable for transfer, in accordance with professional standards.

721.511 Reimbursement for Inpatient Services Medicaid reimburses for inpatient hospital services using different methodologies. See Section MAD 721-D, METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES. The following is a summary

**PROVIDER POLICIES
HOSPITAL SERVICES**

of the Medicaid reimbursement methodology:

1. Covered inpatient services furnished to recipients admitted to in-state acute care hospitals are reimbursed at a prospectively set rate. See Section III of MAD-721-D, METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES;
2. Covered inpatient services furnished to recipients in border area hospitals, defined as those hospitals located within one hundred (100) miles of the New Mexico border (Mexico excluded), are reimbursed at a prospectively set rate. See Section III.C.16 of MAD-721-D, METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES;
3. Inpatient services furnished in specialty hospitals and Medicare PPS-exempt distinct units within hospitals are reimbursed using the provisions and principles of reimbursement, pursuant to Public Law 97-248. See Section II of MAD-721-D, METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES;
4. Indian Health Services hospitals are reimbursed using a per diem rate established by the Federal Government;
5. New prospective payment hospital providers are reimbursed at the peer group median rate for the applicable peer group, until such time as rebasing occurs, unless the new hospital meets the criteria for prospective payment exemption;
6. All hospitals which meet the criteria enumerated in Section IV.A of MAD-721-D, METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES are eligible for disproportionate share adjustment;
7. Outlier adjustments for DRG hospitals are made for medically necessary inpatient services involving exceptionally high costs or lengths of stay, for children up to age six (6) in disproportionate share hospitals and for infants under age one in all hospitals. See Section 4604 of the Omnibus Reconciliation Act (OBRA) of 1990

**PROVIDER POLICIES
HOSPITAL SERVICES**

and Section III. F. of MAD-721-D, METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES;

8. All services or supplies furnished during the hospital stay are reimbursed by the hospital payment amount and no other provider can bill for services or supplies. An exception to this general rule does apply to durable medical equipment delivered for discharge and ambulance transportation;
9. Physician services are not reimbursed to hospitals under Hospital Services regulations, but can be payable as a professional component of a service. See Section MAD-711, MEDICAL SERVICE PROVIDERS for information on the professional component of services; and
10. Transportation services are billed as part of a hospital claim if the hospital is DRG reimbursed and transportation is necessary during the inpatient stay.
 - (A) Transportation is included in a DRG payment when a recipient is transported to a different facility for diagnostic procedure(s) not available at the hospital where the recipient is a patient.
 - (B) Exceptions are considered for air ambulance services operated by a facility when air transportation constitutes an integral part of the medical services furnished by the facility. See Section MAD-756, TRANSPORTATION SERVICES.

721.512 Reimbursement Limitations for Capital Costs Reimbursement for capital costs follows the guidelines set forth in HIM-15. See P.L. 97-248 (TEFRA). In addition, MAD applies the following restrictions for new construction:

1. The total basis of depreciable assets does not exceed the median cost of constructing a hospital as listed in an index acceptable to MAD, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to become a Medicaid provider;

2. The cost of construction is expected to include only the cost of buildings and fixed equipment; and
3. A reasonable value of land and major movable equipment is added to obtain the value of the entire facility.

721.6 Outpatient Services

Medicaid covers outpatient services which are medically necessary for prevention, diagnosis or rehabilitation as indicated by the condition of recipients. Services must be furnished within the scope and practice of professional providers as defined by state laws and regulations.

721.61 Outpatient Covered Services Covered hospital outpatient care includes the use of minor surgery or cast rooms, intravenous infusions, catheter changes, first aid care of injuries, laboratory and radiology services, and diagnostic and therapeutic radiation, including radioactive isotopes.

Partial hospitalization programs in general hospital psychiatric units are considered outpatient services. See Section MAD-722, OUTPATIENT PSYCHIATRIC SERVICES AND PARTIAL HOSPITALIZATION.

721.62 Outpatient Noncovered Services Medicaid does not cover the following specific outpatient benefits:

1. Outpatient hospital services not considered medically necessary for the condition of the recipient;
2. Outpatient hospital services that require prior approval for which the approval was not requested;
3. Outpatient hospital services furnished to individuals who were not eligible for Medicaid on the date of service;
4. Experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests, and imaging services. See Section MAD-765, EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES OR THERAPIES;
5. Drugs classified as "ineffective" by the federal Food and Drug

**PROVIDER POLICIES
HOSPITAL SERVICES**

Administration;

6. Laboratory specimen handling or mailing charges;
7. Formal educational or vocational services which relate to traditional academic subjects or training for employment; and
8. Services furnished to members of the Primary Care Network (PCN) which are not furnished or referred for performance by the member's PCN provider.

721.63 Prior Approval Certain procedures or services performed in outpatient settings can require prior approval from MAD or its designee. Outpatient physical, occupational, or speech therapy services require prior approval.

721.64 Reimbursement for Outpatient Services For outpatient hospital services furnished by approved Title XIX (Medicaid) hospitals for Medicaid reimbursement purposes, the amount paid by Medicaid through its fiscal agent for services furnished to recipients and covered under Medicaid, the manner of payment and the manner of settlement of overpayments and underpayment is determined under methods and procedures furnished for determining allowable payment for outpatient hospital services under Title XVIII (Medicare) of the Social Security Act.

For those services reimbursed under the Medicare allowable cost method, Medicaid reduces the Medicare allowable costs by three (3%) percent. The interim rate of payment is seventy-seven (77%) percent of billed charges. These provisions are applicable to all hospitals approved for participation as Title XIX hospitals in the Medicaid program.

- (A) In no case can reimbursement for outpatient hospital services exceed reasonable costs as defined by Medicare, either for hospital or physician claims. Laboratory services cannot exceed maximum levels established by Medicare.
- (B) Reimbursement for oral medications dispensed in a hospital outpatient setting is limited to usual charges up to a maximum of two (\$2.00) dollars per visit per Medicaid recipient.
- (C) For services which are usually furnished in a physician's office, as

defined by Medicare, an outpatient clinic facility charge or urgent care facility charge can be billed only if it is approved by Medicare regulations.

A provider must notify MAD when he/she is approved by Medicare to bill outpatient clinic or urgent care facility fees. The corresponding hospital based physician charge is subject to reimbursement limitations. See Section MAD-711.7, MEDICAL SERVICE PROVIDERS.

- (D) Services or supplies furnished by a provider under contract or through referral must meet the contract services requirements and be reimbursed based on certain methods. See Section MAD-702, BILLING FOR MEDICAID SERVICES.

721.7 Emergency Room Services

Medicaid covers emergency room services which are medically necessary for the treatment of medical or surgical emergencies and which are within the scope of the Medicaid program.

721.71 Covered Emergency Services A medical or surgical emergency is defined as a condition which develops unexpectedly and requires immediate medical attention to prevent death or serious impairment to the health of an individual.

Hospitals which are not eligible Medicaid providers can be reimbursed for emergency room services for medical or surgical emergencies needing the most accessible hospital equipped to furnish emergency services. The facility must obtain a provider number for reimbursement purposes.

721.72 Retrospective Review All emergency room services are subject to review before payment to verify whether the circumstances warranted emergency room service. If it is determined that emergency services were furnished in a non-emergency situation, the emergency room charge is denied.

- (A) The recipient is responsible for payment of a denied emergency room charge and can be billed directly by the provider.
- (B) The use of ancillary services is reviewed and paid if medically appropriate for the condition treated, even though the condition

**PROVIDER POLICIES
HOSPITAL SERVICES**

was not an emergency. Ancillary services which are denied as not medically appropriate cannot be billed to the recipient.

721.73 Prior Approval Some services or procedures performed in an emergency room setting need prior approval from MAD or its designee. Procedures that require prior approval in non-emergency settings also require prior approval in emergency settings.

721.74 Noncovered Emergency Services Medicaid does not cover the following specific emergency services:

1. Emergency services which are not considered medically necessary as emergency services;
2. Emergency services furnished to individuals who were not eligible for Medicaid on the date of service;
3. Experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests and imaging services. See Section MAD-765, EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES OR THERAPIES;
4. Drugs classified as "ineffective" by the federal Food and Drug Administration; and
5. Laboratory specimen handling or mailing charges.

721.75 Reimbursement for Emergency Room Services Emergency services furnished by eligible providers are reimbursed at the outpatient rate. See Section MAD-721.64, REIMBURSEMENT FOR OUTPATIENT SERVICES.

- (A) Emergency room services furnished in DRG- reimbursed hospitals in conjunction with inpatient admissions are included with the charges for inpatient care. In these cases, emergency room services are included in the DRG rate.
- (B) Physician services furnished in emergency rooms are not reimbursed to hospitals but can be paid as a professional component of a service. See Section MAD-711, MEDICAL SERVICE PROVIDERS.

**PROVIDER POLICIES
HOSPITAL SERVICES**

- (C) Services furnished in an urgent care center or emergency room of a hospital which do not meet the definition of an emergency cannot be submitted as an emergency room claim.
- (D) Transportation services are usually not billed as part of emergency services. Exceptions are considered for air ambulance services operated by a facility if air transportation constitutes an integral part of the medical services furnished by the facility. See Section MAD-756, TRANSPORTATION SERVICES.