commonly, specialty or LTAC hospitals treat patients who require ventilator, wound care, or stroke-related services.

Inpatient specialty or LTAC services may be provided in either a freestanding specialty/long-term acute care hospital or a specialty/long-term acute unit of a general hospital.

Pain Management Services standing alone (e.g., relaxation techniques, stress management, coma stimulation, biofeedback) are not a DHCFP benefit.

203.3 SWING - BED SERVICES POLICY

Reference Chapter 200, Attachment #02-03, Hospitals with Swing Beds. ~~Pursuant to federal regulations at 42 CFR 482.66 and 409.30, rural hospitals may be swing-bed certified by the CMS provided the hospital:~~

~~a. has a Medicare provider agreement;~~

~~b. has been granted approval by CMS to provide post-acute NF care;~~

~~c. has less than 100 beds; and~~

~~d. is located in a rural area.~~

~~These swing-beds must be utilized on a temporary, not long-term, basis, and only when a recipient, who is in an acute bed but no longer, meets acute criterion, requires NF care, but because there are no beds available, cannot be admitted into the hospital's NF unit. The recipient may remain in the same bed, which then may "swung" over to, or designated as a swing-bed. Efforts must be made to transfer the recipient from the swing-bed to a NF unit bed as soon as one becomes available. As with acute beds, all swing-bed stays must be certified by Medicaid's QIO-like vendor for payment purposes.~~

~~203.3A COVERAGE AND LIMITATIONS~~

~~1. The intent and purpose of swing-beds is to provide temporary placement for recipients who require post-acute NF care. Rural hospitals must always utilize available NF beds for Medicaid eligible recipients prior to using a swing-bed designation. Recipients who are in a swing-bed must be transferred to the first available NF bed in the hospital, or the next closest hospital or NF. (Exceptions may be made to the "next closest hospital or NF" requirement only if the hospital documents, in writing, the recipient's and/or family's objection to the recipient having to leave the hospital and rural community, and why). So long as the hospital clearly documents efforts to transfer the recipient from the swing-bed and admit into the hospital's NF unit or the next closest NF unit, when a bed becomes available, the recipient may remain in the swing-bed.~~

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~~2. To qualify for swing-bed pre-admission status, all Medicaid recipients must:~~

~~a. have been hospitalized in an acute care hospital receiving inpatient services for at least three consecutive calendar days (not counting the day of discharge).~~

~~b. receive prior authorization for swing-bed admission/status from the QIO-like vendor.~~

~~3. Medicaid eligible recipients cannot be admitted directly from the community, or from a skilled or intermediate administrative day LOC hospital bed, to a swing-bed.~~

~~4. If all licensed NF beds and swing-beds are occupied, the hospital may bill for administrative days at the SNL or intermediate (ICL) payment rates, if certified as such by the QIO-like vendor.~~

~~5. As with acute and administrative day beds, all swing-bed stays must be prior authorized and certified by the QIO-like vendor for payment purposes.~~

~~203.3B PROVIDER RESPONSIBILITIES~~

~~1. Swing Bed providers must secure a prior authorization from the QIO-like vendor.~~

~~2. Prior to transferring a recipient from a swing bed to a NF bed within the hospital or to another NF bed, the hospital must obtain both a Pre-Admission Screening and Resident Review (PASRR) screening and NF LOC screening to ensure the recipient meets the criteria for the NF placement. The hospital may request these screenings from the QIO-like vendor.~~

~~203.3C AUTHORIZATION PROCESS~~

~~1. Admissions to swing-beds involving Medicaid eligible recipients, or recipients with primary insurance (except Medicare Part A) must be prior authorized by the QIO-like vendor.~~

~~a. Prior Authorization~~

~~The QIO-like vendor's swing-bed prior authorization decisions will be based on the following criteria being met:~~

~~1. The recipient must be admitted to swing bed status from an acute level of are following a minimum 72 hour stay (not counting the day of discharge)~~

~~2. The recipient requires skilled or intermediate nursing services; and~~

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~~3. The hospital must provide documentation that no other NF beds are available, and that efforts are being made to place the recipient in either its own in house NF unit, or the next closest NF (unless the exception criterion previously discussed has been met).~~

~~b. Concurrent Review and Certification~~

~~1. The QIO-like vendor conducts a concurrent review for the initial interim certification of a Medicaid eligible recipient in a swing bed, if the recipient has been in swing bed status for a full calendar month. Interim certifications are issued on a month-to-month basis thereafter.~~

~~2. The QIO-like vendor will notify the Medicaid District Office of the Swing Bed admission for care coordination services related to potential NF placement.~~

~~3. At least monthly, the hospital must provide documentation of efforts to locate and place a patient in the hospitals or another facility's NF unit for those unique and infrequent swing-bed cases which go beyond 30 calendar days.~~

~~c. Retrospective and Retroactive Eligibility Review and Certification~~

~~1. Retrospective review is not generally available for services requiring prior authorization. The only exception that applies is for cases which eligibility is determined after admission to the swing bed. For recipients who are in a swing bed at the time of the determination of Medicaid eligibility, the facility must notify the QIO-like vendor to initiate admission and concurrent review.~~

~~2. For recipients found to be retroactively eligible for Medicaid (generally after discharge), the QIO-like vendor will conduct review and certification retrospectively. The required documentation (detailed below) must be submitted to the QIO-like vendor within 90 calendar days of the date of the Medicaid eligibility decision.~~

~~3. Prior to expiration of the existing authorization, the facility must contact the QIO-like vendor in order to extend the authorization. The facility must provide evidence that the recipient meets either a skilled or intermediate LOC and also of its efforts to identify a NF placement for the recipient.~~

~~At least monthly the hospital must provide documentation, of efforts to locate and place a recipient in the hospital's or other NF unit for those~~

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~~4. unique and infrequent swing-bed cases which go beyond 30 calendar days.~~

~~5. If medically necessary as evidenced by swing-bed criterion being met, the QIO-like vendor issues a certification within 30 calendar days of receipt of the complete medical record (for retrospective cases), and both complete medical record and eligibility verification documentation (for retroactive eligible cases).~~

~~d. Required Concurrent Retro-eligible Swing-bed Documentation~~

~~The following swing-bed medical record documentation must be submitted to the QIO-like vendor with the request for interim certification.~~

~~1. History and Physical (H and P).~~

~~2. Physician orders including order to admit to swing bed.~~

~~3. Monthly nursing assessment summary.~~

~~4. Documentation that an NF bed was not available.~~

~~5. The QIO-like vendor may request additional records if a determination cannot be made from the above records.~~

~~2. Hospital Swing-Bed Billing Requirements~~

~~Medicaid requires all swing-bed days be billed on the UB-92 claim form using the hospital's provider number and bill classification code 281 in locator number 4, entitled "Type of Bill." Revenue code 0550 must be used for skilled days and 0559 for intermediate days. Therapies, laboratory and radiology must be billed by the independent service providers.~~

~~Prescription drugs may be billed by either an independent service provider or the hospital's outpatient pharmacy provider using the hospital's outpatient pharmacy provider number.~~

~~Swing-bed hospitals may bill for a stay after discharge (if less than 30 days) on an all-inclusive UB-92 claim form. Or, swing-bed hospitals may interim bill, month-by-month (for stays more than 30 days). If it certifies the stay with a SNL or ICL LOC, the QIO-like vendor electronically sends the certification to Medicaid's fiscal agent. It is not necessary for the hospital to attach a copy of the certification. The QIO-like vendor provides the hospital with a hard copy of the certification for the hospital's records.~~

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203.4 OUTPATIENT HOSPITAL SERVICES POLICY

General Medical/Surgical Hospitals commonly provide several outpatient services, included but not limited to general, clinic, office, emergency room, ambulatory surgery center, and observation services.

203.4A COVERAGE AND LIMITATIONS

1. Outpatient hospital services provided by hospitals are subject to the same service limitations as other outpatient service providers. Providers must refer to Medicaid/DHCFP service manuals relevant to the specific services being provided. The following is a list of some of the chapters a hospital should reference:

   a. For physician, advanced practitioner of nursing, physician assistants, urgent care sites, and outpatient hospital clinic visits, refer to MSM Chapter 600.

   b. For radiologic services, refer to MSM Chapter 300.

   c. For pharmaceutical services, refer to MSM Chapter 1200.

   This is not an all inclusive list. The MSM in its entirety needs to be reviewed.

2. Emergency Room Services

   Emergency services are defined as a case in which delay in treatment of more than 24 hours could result in severe pain, loss of life, limb, eyesight or hearing, injury to self or bodily harm to others.

   Laboratory and radiological services ordered during the course of emergency room services (when it is an emergency diagnosis and not a clinic diagnosis) are payable without prior payment authorization.

   Charges made for stat performance of laboratory or radiological procedures ordered during a hospital's normal operating hours in the applicable department are not a DHCFP benefit.

   Patients requiring mental health services while in the emergency room may receive such services if medically appropriate, but must first be stabilized. Every effort must be made to transfer the patient to a psychiatric hospital or unit, accompanied by a physician's order. Authorization from the DHCFP's QIO-like vendor is also required.

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3. Observation Services
Reference Chapter 200, Attachment #02-05, Observation Services

~~a. Outpatient observation status – Consistent with federal Medicare regulation, Medicaid reimburses for hospital observation stays for a period up to, but no more than, 48 hours. Observation services are conducted by the hospital to evaluate the recipient's condition to assess the need for inpatient admission. Observation services refer to short term care provided at the appropriate location of the hospital when the recipient's medical needs do not meet acute care guidelines.~~

~~Observation begins when the physician writes and dates the observation orders, not when the recipient is placed in an observation bed. Observation services end when a physician writes an order for either inpatient admission, transfer to another health care facility, or discharge. Time related to the provision of medically necessary services after a physician writes the discharge order, but prior discharge, are reimbursed as long as the total time in observation does not exceed 48 hours. Inpatient admission from observation begins at the time and on the calendar date that a physician writes an inpatient admission order.~~

~~b. Observation days are covered when:~~

~~1. diagnosis is uncertain (diagnosis not established, additional information required by physician, more time is required to assess and evaluate systems, or an appropriate plan of care is undefined).~~

~~2. specialized diagnostic tools and services are required (diagnostic services are only available onsite, proximity to testing equipment is required, diagnostic testing results are not yet available).~~

~~3. observation days may be authorized when inpatient days are denied.~~

~~c. Observation days are not covered when:~~

~~1. a recipient's medical condition or treatment needs meet acute inpatient guidelines and standards of care.~~

~~2. services are ordered as inpatient by the admitting physician.~~

~~3. the recipient requires preoperative diagnostic test that cannot be performed in an outpatient setting.~~

~~4. the recipient requires therapeutic interventions (measures) that can only be performed in an acute hospital setting.~~

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~~5. the probability of significant, rapid onset of complications is exceptionally high. Actual manifestation of such complications would require prompt intervention/measures available only in an inpatient setting.~~

~~6. complications occur during or following an outpatient procedure that require acute inpatient treatment and intervention.~~

~~7. services are not reasonable and medically necessary for diagnosis or treatment of the recipient when provided for the convenience of the recipient, recipient's family, or the physician.~~

~~8. services can be provided in a less restrictive setting (e.g., physician's office, emergency room, clinic, urgent care setting).~~

~~9. the recipient is admitted to the hospital on the same calendar date as observation services were rendered as part of one continuous encounter at that facility. Ancillary services, provided during observation hours that are incorporated into the inpatient per diem rate, are also included in the per diem rate. Ancillary services rendered during observation hours that exceed the 48 hour limit are not reimbursed.~~

~~10. following outpatient same-day surgery.~~

203.5 AMBULATORY SURGICAL SERVICES POLICY

Ambulatory Surgical Centers refers to freestanding or hospital based licensed ambulatory surgical units that can administer general anesthesia, monitor the recipient, provide postoperative care, and provide resuscitation as necessary. These recipients receive care in a facility operated primarily for performing surgical procedures on recipients expected to return safely home within 24 hours.

By contrast, physician office (MD-Office) services refers to a setting limited to use of local anesthesia, including private physician office, emergency room, urgent care centers, and clinic settings.

Observation/Medical short stay refers to the "ambulatory" recipient with a coexisting medical condition or some unforeseen medical situation who may remain in a hospital environment for an extended period. This extended stay, called observation or medical short stay can be used to assure recipient stability without an inpatient admission. The recipient may occupy any hospital unit. Observation recipients may be rolled over for inpatient admission any time the patient requires acute care services. All rollovers to inpatient care require QIO-like vendor's authorization within 24 hours of the admission/rollover. Observation stays which do not rollover to inpatient status are limited to 48 hours.

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