

## 19 Hospital

The Alabama Medicaid Program provides inpatient and outpatient hospital care. The policy provisions for hospitals can be found in the *Alabama Medicaid Agency Administrative Code*, chapter 7.

### 19.1 Enrollment

HP enrolls hospitals and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

#### National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a hospital provider is added to the Medicaid system with the National Provider Identifier provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for hospital-related claims.

#### NOTE:

The 10-digit NPI is required when filing a claim.

Hospitals are assigned a provider type of 01 (Hospital). Valid specialties for hospitals include the following:

- Post-extended care (PEC) hospital (540)
- General hospital (010)
- Inpatient psychiatric hospital under 21 (017)
- Inpatient psychiatric hospital over 65 (011)
- Lithotripsy (520)
- Mammography (292)
- Organ transplants (530)
- Long Term Care Hospital Unit (014)—for crossover claims only

- Psychiatric Unit (011)—for crossover claims only
- Rehabilitation Unit (012)—for crossover claims only

### **Enrollment Policy for Hospital Providers**

In order to participate in the Alabama Medicaid Program and to receive Medicaid payment for inpatient and outpatient hospital services, a hospital provider must meet the following requirements:

- Receive certification for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital. Hospital types are identified on the "Hospital/CAH Medicare Database Worksheet" completed by the State Agency Surveyor.
- Possess a license as a hospital by the state of Alabama in accordance with current rules contained in the *Rules of Alabama State Board of Health Division of Licensure and Certification Chapter 420-5-7*.
- Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new facility.
- Submit a written description of an acceptable utilization review plan currently in effect.

The effective date of enrollment cannot be earlier than the Medicare certification dates.

Participating out-of-state (border) hospitals are subject to all program regulations and procedures that apply to participating Alabama hospitals and must submit copies of their annual certification from CMS, State licensing authority, and other changes regarding certification. "Border" is defined as within 30 miles of the Alabama state line.

Nonparticipating hospitals are those hospitals that have not executed an agreement with Alabama Medicaid covering their program participation, but that provide medically necessary covered out-of-state services. Application by nonparticipating hospitals is made to HP Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124-1685.

All Medicaid admissions to participating and nonparticipating facilities are subject to program benefits and limitations based on current Medicaid eligibility.

### **Enrollment Policy for Lithotripsy**

The facility must submit an application to HP Provider Enrollment along with documentation that the lithotripsy machine is FDA approved.

## **19.2 Benefits and Limitations**

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Refer to Appendix A, EPSDT for details on benefit limits for medically necessary services provided as a result of an EPSDT screening referral.

This section includes the following:

<b>Section</b>	<b>Title</b>	<b>Topics Covered</b>
19.2.1	Inpatient Benefits	<ul style="list-style-type: none"> <li>• Routine Benefits</li> <li>• Extended Hospital Days for Delivery</li> <li>• Other Extended Benefits</li> <li>• Newborn Inpatient Benefits</li> <li>• Bed and Board and Semi-private Accommodations</li> <li>• Nursing and Other Services</li> <li>• Drugs and Biologicals</li> <li>• Supplies, Appliances, and Equipment</li> <li>• Hemodialysis</li> <li>• Organ Transplants</li> <li>• Blood</li> <li>• Sterilization and Hysterectomy</li> <li>• Abortions</li> <li>• Dental Services</li> <li>• Inpatient Noncovered Services</li> <li>• Payment of Inpatient Hospital Services</li> <li>• Utilization Review for Inpatient Hospital Admissions and Concurrent Stays</li> <li>• Adverse Events, Hospital-Acquired Conditions, and Present on Admission Indicators</li> </ul>
19.2.2	Post-hospital Extended Care (PEC) Services	<ul style="list-style-type: none"> <li>• General Information</li> <li>• PEC NPI</li> <li>• Admitting a Recipient to a PEC</li> <li>• Reimbursement for PEC Services</li> </ul>
19.2.3	Swing Beds	<ul style="list-style-type: none"> <li>• General Information</li> <li>• Level of Care for Swing Beds</li> <li>• Benefit Limitations for Swing Beds</li> <li>• Admission and Periodic Review</li> </ul>
19.2.4	Billing Medicaid Recipients	Describes conditions under which Medicaid recipients may be billed for services rendered
19.2.5	Outpatient Services	<ul style="list-style-type: none"> <li>• Outpatient Surgical Services</li> <li>• Injectable Drugs and Administration</li> <li>• Emergency Hospital Services</li> <li>• Outpatient Hemodialysis</li> <li>• Obstetrical Ultrasounds</li> <li>• Inpatient Admission after Outpatient Hospital Services</li> <li>• Outpatient Observation</li> <li>• Outpatient Hyperbaric Oxygen Therapy</li> <li>• Outpatient Lab and Radiology</li> <li>• Outpatient Chemotherapy and Radiation</li> <li>• Outpatient Physical Therapy</li> <li>• Outpatient Sleep Studies</li> <li>• Outpatient Cardiac Rehabilitation</li> <li>• Prior Authorization for Outpatient Service</li> <li>• Payment of Outpatient Hospital Services</li> <li>• Pulse Oximetry Services</li> </ul>
19.2.6	Outpatient and Inpatient Tests	Describes program benefits and limitations for tests
19.2.7	Crossover Reimbursement	Provides crossover reimbursement benefit information for inpatient and outpatient services

### **19.2.1 Inpatient Benefits**

This section describes benefits and policy provisions for the following:

#### **Routine Benefits**

An inpatient is a person admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he will remain overnight and occupy a bed (even if he is later discharged or is transferred to another hospital and does not use a bed overnight.)

Except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or additional inpatient days that have been authorized for deliveries or children who have been referred for treatment as a result of an EPSDT screening, the first 16 days in a calendar year will be reimbursed on an established per diem rate. Subsequent days will be factored into the establishment of cost as described in the *Alabama Medicaid Agency Administrative Code, Chapter 23, Hospital Reimbursement*. Since subsequent days are factored into the establishment of cost for inpatient hospital stays, the recipient **may not** be billed for services past the 16 day payment. The number of days of care billed to Medicaid for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is used to report days of care for Medicaid recipients even if the hospital uses a different definition of day for statistical or other purposes. When a claim is submitted to Medicaid for inpatient hospital services past the 16 day payment; Medicaid will zero pay the claim.

Medicaid covers the day of admission but not the day of discharge. If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day.

#### **Extended Hospital Days for Delivery**

Medicaid authorizes additional inpatient days for delivery for recipients who have exhausted their initial 16 covered days.

When medically necessary, additional days may be approved for deliveries, from onset of active labor to discharge. The number of extended days must meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria in order to be approved. Inpatient days prior to the onset of active labor will not be approved for extended benefits.

Requests for authorization should not be made prior to delivery. QA personnel issue a ten-digit authorization number for the approved stays.

Claims for extended benefit days should be filed separately from all other inpatient stays.

#### **Other Extended Benefits**

Medically necessary inpatient days are unlimited for recipients under the age of one in all hospitals.

Medically necessary inpatient days are unlimited for children under the age of six if the services are provided by a hospital that has been designated by Medicaid as a disproportionate share hospital.

### **Newborn Inpatient Benefits**

Newborn well-baby nursery charges will be covered by an eligible mother's claim for up to ten days nursery care for each baby if the mother is in the hospital and is otherwise entitled to such coverage. For well-baby charges, revenue codes 170 and 171 are reflected on the mother's claim in conjunction with her inpatient stay for the delivery. The hospital per diem rate includes charges for the mother and newborn. Newborn well-baby care is not separately billable. Nursery charges for "boarder babies", infants with no identified problems or condition whose mothers have been discharged, were never admitted to the hospital, or are not otherwise eligible for Medicaid are not separately billable.

**Criteria for Revenue Codes 170/171** - The infant is considered to have received "well baby" care if any of these criteria are met in the absence of more severe conditions:

1. Premature infants greater than 5.5 lbs. (2500) grams and/or greater than 35 weeks who are not sick;
2. Stable infants receiving phototherapy for less than 48 hours duration or while the mother is an inpatient receiving routine postpartum care, such as physiologic jaundice, breast milk jaundice, etc;
3. Infants on intake and output measurements;
4. Stable infants on intermittent alternative feeding methods, such as gavage, or frequent feedings;
5. Stabilized infants with malformation syndromes that do not require acute intervention;
6. Infants with suspected infection on prophylactic IV antibiotics while the mother is an inpatient;
7. Infants receiving close cardiorespiratory monitoring due to family history of SIDS;
8. Infants in stable condition in isolation;
9. Observation and evaluation of newborns for infectious conditions, neurological conditions, respiratory conditions, etc., and identifying those who require special attention;
10. Oliguria;
11. Stable infants with abnormal skin conditions;
12. Routine screenings, such as blood type, Coombs test, serologic test for syphilis, elevated serum phenylalanine, thyroid function tests, galactosemia, sickle cell, etc.;
13. Complete physical exam of the newborn, including vital signs, observation of skin, head, face, eyes, nose, ears, mouth, neck, vocalization, thorax, lungs, heart and vascular system, abdomen, genitalia, extremities, and back.

Newborns admitted to accommodations other than the well-baby nursery must be eligible for Medicaid benefits in their own right (claim must be billed under the baby's own name and Medicaid number). Example: If an infant is admitted to an intensive care or other specialty care nursery, the claim must be billed under the infant's number even if the mother is still an inpatient.

**NOTE:**

When billing for multiple births, list each baby's accommodation separately, noting "Baby A," "Baby B," and so on. Also, use the diagnosis codes that indicate multiple live births. For multiple births, nursery days equals the sum of the number of infants times the number of the mother's days.

Unless the newborn infant needs medically necessary, specialized care as defined below, no additional billings for inpatient services are allowed while the mother is an inpatient.

To bill Medicaid utilizing revenue codes 172 (Nursery/Continuing Care), 173 (Nursery/Intermediate Care), 174 (Nursery Intensive Care), and 179 (Nursery/Other), the infant must meet the following criteria established by Medicaid.

**Criteria for Revenue Codes 172/173** - The infant must be 36 weeks gestation or less, or 5.5 lbs. (2500 grams) or less, AND have at least one of the following conditions which would cause the infant to be unstable as confirmed by abnormal vital signs or lab values:

1. Respiratory distress requiring significant intervention, including asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc;
2. Any nutritional disturbances, intestinal problems or known necrotizing enterocolitis;
3. Cardiac disease requiring acute intervention;
4. Neonatal seizures;
5. Conditions which require IV intervention for reasons other than prophylaxis;
6. Apgar scores of less than six at five minutes of age;
7. Subdural and cerebral hemorrhage or other hemorrhage caused by prematurity or low birthweight;
8. Hyperbilirubinemia requiring exchange transfusion, phototherapy or other treatment for acute conditions present with hyperbilirubinemia, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
9. Pulmonary immaturity and/or without a pliable thorax, causing hypoventilation and hypoxia with respiratory and metabolic acidosis.

**Criteria for Revenue Code 174** – Services must be provided in a neonatal intensive care unit due to the infant's unstable condition as confirmed by abnormal vital signs or lab values AND at least one of the following conditions:

1. Confirmed sepsis, pneumonia, meningitis;
2. Respiratory problems requiring significant intervention, such as asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc.;
3. Seizures;
4. Cardiac disease requiring acute intervention;
5. Infants of diabetic mothers that require IV glucose therapy;
6. Congenital abnormalities that require acute intervention;

7. Total parental nutrition (TPN) requirements;
8. Specified maternal conditions affecting fetus or newborn, such as noxious substances, alcohol, narcotics, etc., causing life threatening or unstable conditions which require treatment;
9. IV infusions which are not prophylactic, such as dopamine, isoproterenol, epinephrine, nitroglycerine, lidocaine, etc.
10. Dialysis;
11. Umbilical or other arterial line or central venous line insertion;
12. Continuous monitoring due to an identified condition;
13. Cytomegalovirus, hepatitis, herpes simplex, rubella, toxoplasmosis, syphilis, tuberculosis, or other congenital infections causing life threatening infections of the perinatal period;
14. Fetal or neonatal hemorrhage;
15. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
16. Necrotizing enterocolitis, diaphragmatic hernia, omphalocele.

**Criteria for Revenue Code 179** – The infant must be unstable as confirmed by abnormal vital signs or lab values AND have one of the following conditions:

1. Close observation after operative procedures;
2. Total parenteral nutrition (TPN);
3. Umbilical or other arterial line or central venous line insertion;
4. Cardiac disease requiring acute intervention;
5. Neonatal seizures;
6. Neonatal sepsis, erythroblastosis, RH sensitization or other causes, or jaundice, requiring an exchange transfusion;
7. Respiratory distress, oxygen requirements for three or more continuous hours, apnea beds, chest tubes, etc.;
8. IV therapy for unstable conditions or known infection;
9. Any critically ill infant requiring 1:1 monitoring or greater may be maintained on a short term basis pending transfer to a Level III nursery;
10. Apgar scores of less than six at five minutes of age;
11. Congenital anomalies requiring special equipment, testing, or evaluation;
12. Bleeding disorders;
13. Hyperbilirubinemia of a level of 12 or greater requiring treatment.
14. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.

These charges are to be billed on a separate UB-04 claim form. ICD-9-CM diagnosis codes identifying the conditions that required the higher level of care must be on the claim. Medicaid will routinely monitor the coding of neonatal intensive care claims through post-payment review.

### **Bed and Board in Semi-Private Accommodations**

Medicaid pays for semi-private accommodations (two-, three-, or four-bed accommodations). When accommodations more expensive than semi-private are furnished the patient because less expensive accommodations are not available at the time of admission or because the hospital has only private accommodations, Medicaid pays for the semi-private accommodations. In this case, the patient is not required to pay the difference.

When accommodations more expensive than semi-private are furnished the patient at his request, the hospital may charge the patient no more than the difference between the customary charge for semi-private accommodations and the more expensive accommodations at the time of admission. The hospital must have the patient sign a form requesting the more expensive accommodation and agreeing to pay the difference. This form must remain on file for review if questions arise regarding payment of private room charges.

Accommodations other than semi-private are governed by the following rules for private rooms.

### **Medically Necessary Private Rooms**

Payment may be made for a private room or for other accommodations more expensive than semi-private only when such accommodations are medically necessary. Private rooms are considered medically necessary when the patient's condition requires him to be isolated for his own health or for that of others. Isolation may apply when treating a number of physical or mental conditions. Communicable diseases may require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatments are likely to alarm or disturb others in the same room. Medicaid pays for the use of intensive care facilities where medically necessary.

For the private room to be covered by Medicaid, the following conditions must be met:

- The physician must certify the specific medical condition requiring the need for a private room within 48 hours of admission.
- The physician's written order must appear in the hospital records.
- When the physician certifies the need for continued hospitalization, the private room must also be re-certified as being medically necessary. Medicaid will not cover a private room on the basis of a retroactive statement of medical necessity by the physician.
- When medical necessity for a private room ceases, the patient should be placed in the semi-private accommodation.

### **Nursing and Other Services**

Medicaid covers nursing and other related services, use of hospital facilities, and the medical social services ordinarily furnished by the hospital for the care and treatment of inpatients.

**Drugs and Biologicals**

Medicaid covers drugs and biologicals for use in the hospital that are ordinarily furnished by the hospital for the care and treatment of inpatients.

A patient may, on discharge from the hospital, take home remaining drugs that were supplied by prescription or doctor's order, if continued administration is necessary, since they have already been charged to his account by the hospital.

Medically necessary take-home drugs should be provided by written prescription either through the hospital pharmacy or any other Medicaid-approved pharmacy. Take-home drugs and medical supplies are not covered by Medicaid as inpatient hospital services.

**Supplies, Appliances, and Equipment**

Medicaid covers supplies, appliances, and equipment furnished by the hospital solely for the care and treatment of the Medicaid recipient during his inpatient stay in the hospital.

Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not generally covered as inpatient hospital services. A temporary or disposable item, however, that is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

The reasonable cost of oxygen furnished to hospital inpatients is covered under Medicaid as an inpatient hospital service.

Colostomy bags are provided for inpatients only for use while they are hospital patients. Hospitals cannot supply colostomy bags using Medicaid funds for home or nursing facility use.

**Hemodialysis**

Medicaid provides hemodialysis for chronic renal cases when the patient is not authorized this care under Medicare.

**Organ Transplants**

Medicaid-covered organ transplants require prior approval, which will be coordinated by the prime contractor. Medicaid's approved prime contractor is responsible for the coordination and reimbursement of all Medicaid-reimbursed organ transplants with the exception of cornea transplants. The Medicaid Professional Services staff has final approval. Contact the Medicaid Clinic Services Unit at (334) 242-5580 for contractor information.

Letters of approval or denial will be sent to the requesting provider by Medicaid's coordinating entity upon completion of review by both the appropriate Medicaid Transplant Consultant and Medicaid's Medical Director.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). Alabama Medicaid's Transplant Program must receive the request for appeal within 30 calendar days from the date of the denial letter, or the decision will be final and no further review will be available.

Coordination services begin at initial evaluation and continue through a five-year post-operative period. Medicaid covers the following organ transplants for any age:

- Bone marrow transplants
- Kidney transplants
- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Liver/Small Bowel
- Small Bowel
- Pancreas
- Pancreas/Kidney

For Medicaid-eligible children through the age of 20, EPSDT-referred transplants not listed above will be considered for approval if the transplant is medically necessary, therapeutically proven effective, and considered non-experimental.

Reimbursement for all prior authorized transplants will be an all-inclusive global payment. This global payment includes pre-transplant evaluation; organ procurement; hospital room, board, and all ancillary costs both in and out of the hospital setting; inpatient postoperative care; and all professional fees. All services, room, board, pharmacy, laboratory, and other hospital costs are included under the global payment. All charges for services provided after the discharge, such as patient services, drugs, professional services, and other services will be reimbursed as fee-for-service.

The global payment represents payment in full. Any monies paid outside the global payment will be recouped. The recipient cannot be billed for the difference between the submitted amount and what the contractor pays.

For transplants performed at another in-state facility or at an out-of-state facility, the contractor negotiates the reimbursement rate with the facility and is responsible for global payment of the transplant from evaluation through hospital discharge. Medicaid reimburses the prime contractor for services provided.

The global payment for covered transplants performed out of state will be inclusive of all services provided out of state for the transplant, including all follow-up care, medications, transportation, food and lodging for caretaker/guardian of minor (if applicable), and home health. Once the patient has been discharged back to Alabama after transplant, services will be reimbursed fee for service and will count against applicable benefit limits.

Medicaid reimbursement is available only to the extent that other third party payers do not cover these services.

### **Blood**

Charges for whole blood or equivalent quantities of packed red cells are not allowable since Red Cross provides blood to hospitals; however, blood processing and administration is a covered service.

### **Sterilization and Hysterectomy**

Surgical procedures for male and female recipients as a method of birth control are covered services under the conditions set forth in Appendix C, Family Planning.

Any Medicaid service that relates to sterilization or hysterectomy must have documentation on file with Medicaid that shows consent or an acknowledgement of receipt of hysterectomy and sterilization information. This documentation must be submitted by the attending physician and is required to be on file at HP. This documentation must meet the criteria set forth under the sterilization and hysterectomy regulations. See Chapter 28, Physician and Appendix C, Family Planning, for further details.

#### **NOTE:**

Please refer to Section 5.7, Attachments, for information on billing electronic claims with attachments.

### **Abortions**

Payment for abortions under Medicaid is subject to the conditions in the chapter pertaining to Physicians. Refer to Chapter 28, Physician, for further details.

### **Dental Services**

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are covered for those recipients eligible for treatment under the EPSDT Program. See Chapter 13, Dentist, for details.

#### **NOTE:**

All inpatient hospital claims for dental services require prior authorization with the exception of children aged five and under.

### **Payment for Inpatient Hospital Services**

Refer to the *Alabama Medicaid Administrative Code, Chapter 23, Hospital Reimbursement* for details on current hospital payment methodology.

### **Repeat Inpatient Admission**

When a recipient is discharged and admitted to the same hospital on the same date of service, the hospital should completely discharge the recipient and then readmit on separate UB-04's (even if the readmission was for the same diagnosis).

### **Inpatient Services for Non-Citizens**

- Sterilization codes are non-covered for non-citizens.
- Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid must be processed manually. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the SOBRA worker, who determines eligibility; then forwards information to the Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.
- Delivery Services must be billed through HP for Non-Citizens.
- For UB-04 inpatient claims, the following per diem is covered: Up to 2 days per diem for vaginal delivery and up to 4 days per diem for c-section delivery.
- Allowable diagnosis codes for UB-04 are: V270-V279, V300-V3921, 65100-65993, and 6571-6573.
- Allowable surgical codes for UB-04 are 740-7499.

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### **Inpatient Non-covered Services**

Medicaid does not cover the following items and services:

- Free items and services for which there is no legal obligation to pay are excluded from coverage, (for example, chest x-rays provided without charge by health organizations).
- Items and services that are required as a result of an act of war, occurring after the effective date of the patient's current coverage are not covered.
- Personal comfort items that do not contribute meaningfully to the treatment of an illness or injury or to functioning of a malformed body member are not covered. Charges for special items such as radio, telephone, television, and beauty and barber services are not covered.
- Routine physical check-ups required by third parties, such as insurance companies, business establishments or other government agencies are not covered.
- Braces, orthopedic shoes, corrective shoes, or other supportive devices for the feet are not covered.
- Custodial care and sitters are not covered.
- Cosmetic surgery or expenses in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the function of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic service, that coincidentally also serves some cosmetic purpose.

- Items and services to the extent that payment has been made, or can reasonably be expected to be made under a Workman's Compensation Law, a plan of the United States, or a state plan may not be paid for by Medicaid.
- Inpatient hospitalization for routine diagnostic evaluations that could be satisfactorily performed in the outpatient department of the hospital, in a physician's office, or in an appropriate clinic, are not covered.
- Medicaid does not cover psychological evaluations and testing, or psychiatric evaluations, unless actually performed by a psychiatrist in person.
- Medicaid does not cover speech therapy unless actually performed by a physician in person.
- There is no provision under Medicaid for payment of reserved inpatient hospital beds for patients on a pass for a day or more.
- Inpatient services provided specifically for a procedure that requires prior approval is not covered unless prior authorization from Medicaid for the procedure has been obtained by the recipient's attending physician. In the event that the recipient is receiving other services that require inpatient care at the time the procedure is performed, any charges directly related to the procedure will be noncovered and subject to recoupment. Additionally, all admissions must meet Alabama Medicaid Adult and Pediatric (SI/IS) Inpatient Care criteria.

### **Utilization Review for Inpatient Hospital Admissions and Concurrent Stays**

Medicaid will utilize Alabama Medicaid Adult and Pediatric Inpatient Care Criteria (SI/IS) for utilization review, billing and reimbursement purposes.

- It is the hospital's responsibility to utilize its own physician advisor.
- The attending physician and/or resident may change an order up to 30 days after discharge, as long as the patient met criteria for inpatient or observation services.

A percentage of admissions and concurrent stay charts will be reviewed by the Alabama Medicaid Agency and a Quality Improvement Organization contracted by the Agency.

All in-state and border hospitals must submit Medical Care Evaluation (MCE) Studies (i.e. Performance Improvement Studies) and Utilization Review (UR) Plans to the contracted Quality Improvement Organization every year upon request.

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services.

### **Provider Preventable Conditions (PPCs)**

Provider Preventable Conditions (PPCs) are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPC's).

Healthcare Acquired Conditions include Hospital Acquired Conditions (HAC's).

Other Provider Preventable Conditions refer to OPPCs (sugery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient).

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, these events must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the hospital.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some OPPCs may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from PPCs.

### **Reporting Other Provider-Preventable Conditions (OPPS)**

The following OPPC policy applies to inpatient and outpatient hospitals.

OPPCs must be reported to Medicaid by encrypted emailing of the required information to:

*AdverseEvents@medicaid.alabama.gov*. Each hospital will receive a password specifically for e-mail reporting. Reportable "OPPCs" include, but are not limited to:

- Surgery on a wrong body part
- Wrong surgery on a patient
- Surgery on a wrong patient

Reports will require the following information: Recipient first and last name, date of birth, Medicaid number, date event occurred and event type. A sample form is on the Alabama Medicaid Agency website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) under Programs /Medical Services/Hospital Services although hospitals may submit their own form as long as it contains all required information.

**NOTE:**

**\*Reporting is required only when not filing a UB-04 claim.**

### Reporting Hospital–Acquired Conditions (HAC) and Present on Admission (POA) on the UB-04 Claim Form

Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient hospital occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered POA.

Hospitals should use the POA indicator on claims for these. HACs as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. If no claim is submitted for the event or the event cannot be filed on a UB-04 claim form, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at [AdverseEvents@medicaid.alabama.gov](mailto:AdverseEvents@medicaid.alabama.gov). The following information will be required: Recipient first and last name, date of birth, Medicaid number, date of event occurrence and event type. A sample form can be found on the Alabama Medicaid Agency website or a hospital may submit their own form as long as it contains all of the required information. Below are Hospital Acquired Conditions (HACs) with ICD-9 Codes that hospitals are required to report on the UB-04 claim form.

Selected HAC	CC/MCC (ICD-9-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) and 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829.1 830-839.9 850-854.1 925-929.9 940-949.5 991-994.9
Catheter-Associated Urinary Tract Infection (UTI)	996.64—Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC),

Selected HAC	CC/MCC (ICD-9-CM Codes)
	590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of poor glycemic control	250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10-249.11 (MCC), 249.20-249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) and one of the following procedure codes: 36.10-36.19.
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) OR 998.59 (CC) and one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85.
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis code-278.01 OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC), 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 81.51-81.52, 81.54.

The hospital may use documentation from the physician's qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the event be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

No reduction in payment for a PPC will be imposed on a hospital provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in Provider payment may be limited to the extent that the following apply:

- The Identified PPC would otherwise result in an increase in payment.
- Hospitals are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC. In reducing the amount of days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

It is the responsibility of the hospital to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.

- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

It is the hospital's responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid's contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services.

### **19.2.2 Post Extended Care (PEC) Services**

#### **General Information**

Inpatient hospital services rendered at a level of care lower than acute are considered post extended care services (PEC). The patient must have received a minimum of three consecutive days of acute care services in the hospital requesting PEC reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. Refer to Chapter 26, Nursing Facilities, for details.

Medically necessary services include, but are not limited to the following:

- Nursing care provided by or under the supervision of a registered nurse on a 24-hour basis
- Bed and board in a semi-private room; private accommodations may be used if the patient's condition requires isolation, if the facility has no ward or semi-private rooms, or if all ward or semi-private rooms are full at the time of admission and remain so during the recipient's stay
- Medically necessary over-the-counter (non-legend) drug products ordered by physician (Generic brands are required unless brand name is specified in writing by the attending physician)
- Personal services and supplies ordinarily furnished by a nursing facility for the comfort and cleanliness of the patient
- Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W, and normal saline)
- Services ordinarily furnished to an inpatient of a hospital

#### **PEC National Provider Identifier**

In order to receive reimbursement for PEC, the hospital must have a NPI. The NPI allows the hospital to designate up to ten beds for these services for hospitals with up to 100 beds, and an additional ten beds per each 100 beds thereafter. **All PEC services must be billed using a 'PEC' NPI.**

### **Determining the Availability of Nursing Facility Beds**

Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available within a reasonable proximity and that the recipient requires two of the following medically necessary services on a regular basis:

- Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis
- Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis
- Nasopharyngeal aspiration required for the maintenance of a clear airway
- Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, or other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
- Administration of tube feedings by naso-gastric tube
- Care of extensive decubitus ulcers or other widespread skin disorders
- Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
- Use of oxygen on a regular or continuing basis
- Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post operative, or chronic conditions
- Routine medical treatment for a comatose patient

### **Admission and Periodic Review for PECs**

To establish medical necessity, an application packet must be submitted to Medicaid within 60 days from the date Medicaid coverage is requested. The 60 days are calculated from the date the application is received and date stamped. All applications with a date over 60 days old will be assigned an effective date that is 60 days prior to the date stamp. No payment will be made for the days prior to the assigned effective date. The facility will be informed in writing of the assigned effective date.

The application packet consists of the following:

- A fully completed Medicaid Status Notification form XIX-LTC-4 including documentation certified by the applicant's attending physician to support the need for nursing home care
- Documentation certifying the patient has received inpatient acute care services for no less than three consecutive days during the current hospitalization in the requesting hospital prior to the commencement of post-extended care services. These days must have met the Medicaid Agency's approved acute care criteria
- Documentation certifying contact was made with each nursing facility within a reasonable proximity to determine bed non-availability prior to or on the date coverage is sought, and every 15 days thereafter

In order to continue PEC eligibility, re-certification must be made every 30 days. Nursing facility bed non-availability must be forwarded along with request for re-certification.

### **Reimbursement for PEC Services**

Reimbursement for PEC services is made on a per diem basis at the average unweighted per diem rate paid by Medicaid to nursing facilities for routine nursing facility services furnished during the previous fiscal year. There shall be no separate year-end cost settlement. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 22, for details on rate computation.

A provider must accept the amount paid by Medicaid plus any patient liability amount to be paid by the recipient as payment in full, and further agrees to make no additional charge or charges for covered services.

Any day a patient receives such PEC services is considered an acute care inpatient hospital day. These beds are not considered nursing facility beds.

These services are not subject to the inpatient hospital benefit limitations. At this level of care, PEC days are unlimited if a nursing facility bed is not located.

All PEC services must be billed using the PEC NPI with the exception of outpatient services, pharmaceutical items to include over-the counter products, and prescription drugs.

- Outpatient services such as lab and x-ray services should be billed under the hospital National Provider Identifier number.
- Pharmaceutical items, to include over-the-counter products and prescription drugs should be billed separately under the hospital's pharmacy National Provider Identifier number.
- A Medicaid pharmacy provider outside of the hospital may fill the prescriptions if the hospital pharmacy is not a Medicaid provider.

### **19.2.3 Swing Beds**

#### **General Information**

Swing beds are hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services.

Swing bed hospitals must meet all of the following criteria:

- Have fewer than 100 beds (excluding newborn and intensive care beds) and be located in a rural area as defined by the Census Bureau based on the most recent census
- Be Medicare certified as a swing bed provider
- Have a certificate of need for swing beds
- Be substantially in compliance with SNF conditions of participation for patient rights, specialized rehabilitation services, dental services, social services, patient activities, and discharge planning. (Most other SNF conditions would be met by virtue of the facilities compliance with comparable conditions of participation for hospitals.)
- Must not have in effect a 24 hour nursing waiver

- Must not have had a swing bed approval terminated within the two years previous to application for swing bed participation

### **Level of Care for Swing Beds**

To receive swing bed services, recipients must require SNF level of care on a daily basis. The skilled services provided must be ones that, on a practical basis, can only be provided on an inpatient basis.

A condition that does not ordinarily require skilled care may require this care because of a special medical condition. Under such circumstances the service may be considered skilled because it must be performed by or supervised by skilled nursing or rehabilitation personnel.

The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. A patient may need skilled services to prevent further deterioration or preserve current capabilities.

Swing bed admissions not covered by Medicare because they do not meet medical criteria are also considered noncovered by Medicaid. These services cannot be reimbursed as a straight Medicaid service.

### **Benefit Limitations for Swing Beds**

Swing bed services are unlimited as long as the recipient meets the SNF level of care medically and meets all other eligibility criteria, including financial criteria.

### **Admission and Periodic Review for Swing Beds**

The Medicaid Long Term Care Admissions/Records (LTC ADMS/Records) Unit performs a pre-admission review of all Medicaid admissions to assure the necessity and appropriateness of the admission and that a physician has certified the need for swing bed care. Medicaid certifies the level of care required by the patient at the time of admission using the XIX-LTC-4 form. A control number is provided for each patient that is admitted.

The Medicaid staff physician(s) will review applications not initially approved by LTC ADMS/Records.

Recipients must meet SNF medical and financial requirements for swing bed admissions just as they are required for SNF admissions.

For recipients who receive retroactive Medicaid eligibility while using swing bed services, the hospital must furnish a form MED-54 to Medicaid. Attach all doctors' orders, progress and nurses' notes for the time in question.

LTC ADMS/Records issues medical approvals if the information provided to Medicaid documents the need for SNF care and the recipient meets criteria set forth in Rule 560-X-10-13 for SNF care.

The admission application packet must be sent to LTC ADMS/Records within 30 days from the date Medicaid coverage is sought and most contain a fully completed Medicaid status notification (form XIX-LTC-4), including documentation certified by the applicant's attending physician to support the need for the nursing home care.

Once the LTC-4 is reviewed and approved, a prior control number is issued and entered into the Long Term Care Record file.

An LTC-2 form notifies the facility that the patient is medically eligible if the financial eligibility of the patient has been established and entered on the file. If financial eligibility has not been established and noted in the file, an XIX-

LTC-2A is sent to the facility advising that medical eligibility is established but financial eligibility is not. If an LTC-2A is received, the facility should advise the patient or sponsor of the need to establish financial eligibility by applying at the District Office.

Continued stay reviews are required to assure the necessity and appropriateness of skilled care and effectiveness of discharge planning. Re-certification of SNF patients is required 30, 60, and 90 days after admission and then every 60 days thereafter. Physicians must state "I certify" and specify that the patient requires skilled care for continued stay in the facility. Facilities must have written policies and procedures for re-certification. The Inspection of Care team will monitor these during medical reviews to assure compliance.

#### **19.2.4 Billing Medicaid Recipients**

Providers may bill recipients for noncovered services, for example, days that do not meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria. private room accommodation charges incurred due to patient's request, or personal comfort items.

The provider is responsible for informing the recipient of noncovered services. Medicaid recipients in hospitals may be billed for noncovered inpatient care occurring **after** they have received written notification of Medicaid non-coverage of hospital services. If the notice is issued prior to the recipient's admission, the recipient is liable for full payment if he enters the hospital. If the notice is issued at or after admission, the recipient is responsible for payment for all services provided **after** receipt of the notice.

#### **19.2.5 Outpatient Hospital Services**

Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician or dentist at a licensed hospital. Medical services provided in an outpatient setting must be identified and the specific treatment must be documented in the medical record. Outpatient visits (99281, 99282, 99283, 99284 and 99285) are limited to 3 per calendar year unless certified as an emergency. Providers must meet Medicare "provider based status determination" criteria in order to bill Medicaid for outpatient services provided in an 'off-campus' location. Refer to 42 CFR 413.65 for details on "provider based status determination".

#### **Outpatient Surgical Services**

Outpatient surgical services are those covered procedures commonly performed on an inpatient basis that may be safely performed on an outpatient basis. Only those surgeries included on the Medicaid outpatient hospital fee schedule will be covered on an outpatient basis. Surgeries included on the Medicaid outpatient surgical list are reimbursable when provided on an inpatient basis if utilization review criteria are met. Hospitals may bill other procedures (within the 90000 range) if they are listed on the Outpatient Fee Schedule located on the Medicaid website: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) . Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

Surgical procedures that are not listed on Medicaid's outpatient fee schedule may be sent to the Institutional Services Unit to be considered for coverage in the outpatient setting if medically necessary and the procedure is approved by the Medical Director. Refer to the Hospital Fee Schedule on the Medicaid website for a list of covered surgical codes.

Patients who remain overnight after outpatient surgery, will be considered as an outpatient UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

Patients who remain overnight after outpatient surgery, will be considered as an outpatient UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

**NOTE:**

Claims for outpatient surgical procedures that are discontinued prior to completion must be submitted with modifier 73 or 74.

Lab and x-ray not directly related to the surgical procedure are not included in the fee and may be billed in addition to the surgical procedures that are reimbursed. Outpatient visits for surgical procedures do not count against the recipient's outpatient visit limit. Surgery procedure codes are billed with units of one.

Any lab and x-ray procedures considered 'directly related' to the surgical procedure are part of the reimbursement for the surgical fee if performed within 3 days (or 72 hours) prior to the surgery.

Any lab and x-ray procedures done as a pre-op for surgery will be covered by Medicaid in instances where the recipient is a 'no-show' for a scheduled surgical procedure.

In instances where a surgical procedure code has not been established or is an unlisted code the provider may bill the most descriptive procedure code with modifier 22 (unusual procedural services) until a covered procedure code is established.

Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure on the Medicaid outpatient surgical list. This rate is established as a facility fee for the hospital and includes the following:

- All nursing and technician services
- Diagnostic, therapeutic and pathology services
- Pre-op and post-op lab and x-ray services
- Materials for anesthesia
- Drugs and biologicals
- Dressings, splints, casts, appliances, and equipment directly related to the surgical procedure.

In order to bill for bilateral procedures (previously identified by modifier 50), the most appropriate procedure code must be billed on two separate lines and appended by the most appropriate anatomical modifier (i.e. RT, LT, etc).

Medicaid will automatically pay the surgical procedure code with the highest reimbursement rate at 100% of the allowed amount and the subsequent surgical procedures at 50%, minus TPL and copay.

Providers may visit the Medicaid website: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and click on the link for "Outpatient Fee Schedule", or continue to use the AVRS line at HP (1 (800) 727-7848) to verify coverage.

**NOTE:**

Procedures not listed in Appendix I or the Outpatient Fee Schedule may be covered for special circumstances. Approval must be obtained prior to the surgery. Refer to Chapter 4, Obtaining Prior Authorization. Providers should inform recipients prior to the provision of services as to their responsibilities for payment of services not covered by Medicaid.

**Injectable Drugs and Administration**

Injectable drugs from the Alabama Medicaid injectable drug list do not count against the yearly outpatient visit limitation. Medicaid has adopted Medicare's Drug Pricing Methodology utilizing the Average Sale Price (ASP) for HCPCS injectable drug codes. Hospitals are required to bill the current CPT codes for chemotherapy and non-chemotherapy administration. Please refer to the Alabama Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) for a listing of injectable drug codes.

The following CPT drug administration code-ranges will remain as covered services:

- CPT code ranges 90760 through 90775, and CPT code ranges 96401 through 96542.

These guidelines should be followed by hospitals for billing administration codes:

- No administration fee (infusions, injections, or combinations) should be billed in conjunction with an ER visit (99281 – 99285).
- When administering multiple infusions, injections, or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the services the patient is receiving and the additional codes are secondary to the initial one.
- "Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.
- If the patient has to come back for a separately identifiable service on the same day, or has two IV lines per protocol, these services are considered separately billable with a modifier 76.

### **340-B Hospitals**

340-B hospitals may bill 'total charges' on the UB-04 claim form when billing for outpatient pharmacy charges.

### **Hospital-Based Clinics**

Effective for dates of service on or after October 1, 2012, Medicaid will allow revenue code 51X, clinic, to be billed with evaluation and management procedure codes 99201-99215. Only one visit per day will be allowed.

### **Emergency Hospital Services**

Emergency medical services provided in the hospital emergency room must be certified and signed by the attending physician at the time the service is rendered and documented in the medical record if the claim is filed as a "certified emergency."

When filing claims for recipients enrolled in the Patient 1<sup>st</sup> Program, refer to Chapter 39, Patient 1<sup>st</sup>, to determine whether your services require a referral from the Primary Medical Provider (PMP).

A certified emergency is an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

The attending physician is the only one who can certify an emergency visit. In determining whether a claim should be submitted and documented as a certified emergency, consider the following guidelines:

- The case should be handled on a situational basis. Take into consideration the recipient, their background, extenuating circumstances, symptoms, time of day, and availability of primary care (if a weekend, night or holiday).
- Determine whether the presenting symptoms as reported would be expected to cause the patient to believe that a lack of medical care would result in an unfavorable outcome.
- Document why this case is a certified emergency. Documentation does not need to be extensive but should justify the certification.
- If it is not an emergency, do not certify the visit as one. Follow-up care (such as physical therapy, suture removal, or rechecks) should not be certified as an emergency.
- Children or adults brought to the emergency department for exam because of suspected abuse or neglect may be certified as an emergency by virtue of the extenuating circumstances.

Certified emergency visits are unlimited if the medical necessity is properly documented and certified in the medical record by the attending physician at the time services are rendered. The claim form for a certified emergency must have an "E" in field 73 on the UB-04 claim form.

UB-04 claims for emergency department services must be coded according to the criteria established by Medicaid to be considered for payment.

These procedure codes (99281-99285) may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450.

Hospitals shall not be paid more than three non-certified emergency room visits per year, but the costs of providing additional care shall be accounted for and reported to Alabama Medicaid as a cost of providing care to Medicaid eligible recipients. A recipient **may not** be billed for non-certified emergency room visits past the three day limitation. The line item on the claim will zero pay for all non-certified emergency room visits past the three day limit.

Only one emergency room visit per day per provider will be reimbursed by Medicaid.

### **Outpatient Hemodialysis**

Outpatient dialysis services are covered under the End-Stage Renal Disease Program and cannot be reimbursed as an outpatient hospital service. See Chapter 35, Renal Dialysis Facility, for details.

### **Obstetrical Ultrasounds**

Medicaid covers two obstetrical ultrasounds per year for recipients under fee-for-service. Ultrasound payment is limited to one per day. Medicaid may approve additional ultrasounds if a patient's documented medical condition meets the established criteria. Requests for additional obstetrical ultrasounds must include the required patient information as well as the following:

- Date of requested ultrasound
- Date of request
- A list of all dates of prior ultrasounds for the current pregnancy
- A diagnosis code for each ultrasound that has been done, starting with number one
- Recipient date of birth and Medicaid number
- HP-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

With supportive documentation, the time limit for filing ultrasound claims may be extended for extenuating circumstances, such as TPL claims, miscarriages not known to providers, and dropouts. In these instances the time limit would revert to the 1 year time limit from date of service.

For patients covered under the Maternity Care Program, refer to Chapter 24, Maternity Care Program. Refer to Chapter 4, Obtaining Prior Authorization, for more information.

### **Inpatient Admission After Outpatient Hospital Services**

If the patient is admitted as an inpatient before midnight of the day the outpatient services were rendered at the same hospital, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered to be the first day of inpatient hospital services.

### **Outpatient Observation**

Outpatient observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

Outpatient observation is the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to 23 hours or less.

Outpatient observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit unless documented as a certified emergency by the attending physician at the time of service.

An observation unit is an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires additional observation. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient. The following guidelines apply:

- Patient must be admitted through the emergency room.
- A physician's order is required for admission and discharge from the observation unit.
- A physician must have personal contact with the patient at least once during the observation stay.
- A registered nurse or an employee under his/her direct supervision must monitor patients in the observation unit.
- Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as the services provided.
- A recipient must be in the observation unit at least three hours but no more than 23 hours.

Outpatient observation charges must be billed in conjunction with the appropriate facility fee (99281 – 99285).

Observation coverage is billable in hourly increments only. A recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed. Observation charges are billed as follows:

- For the first three hours of observation the provider should bill a facility fee (99281 - 99285) with units of one.
- Procedure code G0378 should be used to bill the 4<sup>th</sup> through 23<sup>rd</sup> hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

Procedure codes G0378 must be billed with a facility fee (99281-99285). The facility fee is billed with units of one and covers the first three hours.

Ancillary charges (lab work, x-ray, etc.) may be billed with the facility fee and observation charge.

If the observation spans midnight and the recipient is discharged from the observation unit the following day, the provider should bill all observation charges using the date of admission to the observation unit on the claim form.

If a recipient is admitted to the hospital from outpatient observation before midnight of the day the services were rendered at the same hospital, all observation charges must be combined and billed with the inpatient charges.

The provider should indicate the date of admission to the inpatient hospital as the admission date on the claim form for inpatient services.

Outpatient observation charges cannot be billed in conjunction with outpatient surgery.

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

### **Outpatient Hyperbaric Oxygen Therapy (HBO)**

Hyperbaric oxygen therapy (HBO) is covered in an outpatient hospital setting under the guidelines listed below. HBO should not be a replacement for other standard successful therapeutic measures. Medical necessity for the use of HBO for more than two months duration must be prior approved. Prior approval (PA) requests for diagnoses not listed below or for treatment exceeding the limitations may be submitted for consideration to the Office of the Associate Medical Director. No approvals will be granted for conditions listed in the exclusion section. HBO should be billed on the UB-04 by the outpatient facility using revenue code 413 and procedure code 99183. Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Reimbursement for HBO is limited to that which is administered in a chamber for the following diagnoses:

#### Air or Gas Embolism

9580          9991

Limited to five treatments per year.  
PA required after five treatments.

#### Acute Carbon Monoxide Poisoning

986

Limited to five treatments per Incidence.

Treatment should be discontinued when there is no further improvement in cognitive functioning. PA required after five treatments

#### Decompression Illness

9932          9933

Limited to ten treatments per year.  
Treatment should continue until Clinical exam reveals no further Improvements in response to therapy.

#### Gas Gangrene

0400

Limited to ten treatments per year. PA required after ten treatments.

#### Crush Injury

92700 92701 92702  
92703 92709 92710  
92711 92720 92721  
9278 9279 92800  
92801 92810 92811  
92820 92821 9283  
9288 9290 9299  
99690 99691 99692  
99693 99694 99695  
99696 99699

Limited to 15 treatments per year. Early application of HBO, preferably within four - six hours of injury, is essential for efficacy. The recommended treatment schedule is three 90 minute treatments per day over the first 48 hours after the injury; followed by two 90 minute treatments per day over the second period of 48 hours; and one 90 minute treatment over the third period of 48 hours.

Chronic Refractory Osteomyelitis

73010 - 73019

Limited to 40 treatments per year. To be utilized for infection that is persistent or recurring after appropriate interventions.

Diabetic wounds of lower extremities

70710 70711  
70715 70719  
70712 70714

Limited to 30 treatments per year. To be utilized only when wound fails to respond to established medical/surgical management. Requires an aggressive multidisciplinary approach to optimize the treatment of problem wounds. Diabetic wounds of the lower extremities are covered for patients who have type I or II diabetes and if the wound is classified as Wagner grade III or higher.

Radiation tissue damage

52689  
990

Limited to 60 treatments per year. To be utilized as part of an overall treatment plan, including debridement or resection of viable tissues, specific antibiotic therapy, soft tissue flap reconstruction and bone grafting as may be indicated.

Skin grafts and flaps

99652

Limited to 40 treatments per year. Twenty treatments to prepare graft site and 20 after graft or flap has been replaced.

Progressive necrotizing infection  
(necrotizing fasciitis)  
72886

Limited to 10 treatments per year.

PA required after 10 treatments.

Acute traumatic peripheral  
Cyanide poisoning  
Ischemia

90253 90301 9031  
9040 90441

Limited to 15 treatments per year.

Acute peripheral arterial  
insufficiency

44421 44422 44481

Limited to five treatments  
per year.

PA required after five  
treatments.

9877 9890

Limited to five treatments  
per incident. PA required  
after five treatments.

Actinomycosis

0390 - 0394

0398 - 0399

Limited to 10 treatments per year.

PA required after 10 treatments.

Exclusions

No reimbursement will be made for HBO provided in the treatment of the following conditions.

Cutaneous, decubitus, and stasis ulcer

Chronic peripheral vascular insufficiency  
 Anaerobic septicemia and infection other than clostridial  
 Skin burns  
 Senility  
 Myocardial Infarction  
 Cardiogenic Shock  
 Sickle Cell Crisis  
 Acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency)  
 Acute or chronic cerebral vascular insufficiency  
 Hepatic necrosis  
 Aerobic Septicemia  
 Nonvascular causes of common brain syndrome (i.e., Pick's disease, Alzheimer's disease, Korsakoff's disease)  
 Tetanus  
 Systemic aerobic infection  
 Organ transplantation  
 Organ storage  
 Pulmonary emphysema  
 Exceptional blood loss anemia  
 Multiple sclerosis  
 Arthritic diseases  
 Acute cerebral edema

### **Nerve Conduction Studies and Electromyography**

Refer to Chapter 22 of Medicaid's Provider manual for more information on this policy.

Added: [Nerve Conduction Studies and Electromyography](#)

### **Outpatient Lab and Radiology**

Outpatient visits made solely for lab and radiology procedures do not count against a recipient's outpatient visit limits.

Claims containing only lab and radiology procedures may be span billed for one calendar month.

Specimens and blood samples sent to the hospital for performance of tests are classified as non-patient hospital services since the patient does not directly receive services from the hospital; therefore, this does not constitute a visit and is not subject to program limitations.

Added: [Refer to Chapter...on this policy.](#)

### **Outpatient Chemotherapy and Radiation**

Visits for these services do not count against the outpatient visit limitations and may be span billed for a calendar month. Diagnostic lab, diagnostic x-ray, and blood administration may be span billed in conjunction with outpatient chemotherapy and radiation.

### **Outpatient Physical Therapy**

Physical therapy is a covered service based on medical necessity. Physical therapy is covered in a hospital outpatient setting for acute conditions. Recipients receiving therapy must be under the care of a physician or non-physician practitioner who certifies the recipient's need for therapy.

For all physical therapy services performed as a result of an EPSDT screening refer to Chapter 37, Therapy, for policy only. Outpatient hospital physical therapy services will continue to be limited to those CPT codes listed in this chapter.

If the therapy continues past the 60<sup>th</sup> day, there must be documentation in the patient's medical record that a physician or non-physician practitioner has recertified the patient within 60 days after the therapy began and every 30 days past the 60<sup>th</sup> day. Therapy services are not considered medically necessary if this requirement is not met. The 60-day period begins with the therapist's initial encounter with the patient (i.e., day the evaluation was performed). In the event an evaluation is not indicated, the 60-day period begins with the first treatment session. The therapist's first encounter with the patient should occur in a timely manner from the date of the physician's therapy referral.

Documentation in the patient's medical record must confirm that all patients receiving physical therapy services have been seen by the certifying physician as specifically indicated above. Having a physician signature on a certification or re-certification will not meet this requirement.

Therapy performed in an outpatient hospital setting does not count against the recipient's three non-emergency outpatient visit limits. Rehabilitative services are not covered. Rehabilitative services are the restoration of people with chronic physical or disabling conditions to useful activity.

Physical therapy services are limited to those CPT codes listed in this chapter. Maximum units for daily and annual limits are noted for each covered service.

Form 384 (Motorized/Power Wheelchair Assessment Form) may be obtained by contacting the Long Term Care Provider Services at 1-800-362-1504, option 1 for providers.

Records are subject to retrospective review. Physical therapy records must state the treatment plan and must meet the medical criteria below. If the medical criteria are not met or the treatment plan is not documented in the medical record, Medicaid may recoup payment.

### ***Medical Criteria for Physical Therapy***

Physical therapy is subject to the following criteria:

- Physical therapy is covered for acute conditions only. An acute condition is a new diagnosis that was made within three months of the beginning date of the physical therapy treatments.
- Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition that was diagnosed more than three months before the beginning date of the physical therapy treatments. An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition. For EPSDT recipients with chronic conditions refer to Chapter 37, Therapy, for policy only regarding physical therapy services. Physical therapy services are limited to those CPT codes listed in this chapter.

### **Plan of Treatment**

In addition to the above stated medical criteria, the provider of service is responsible for developing a plan of treatment. This plan of treatment must be readily available at all times for review in the recipient's medical record. The plan of treatment should contain at least the following information:

- Recipient's name

- Recipient's current Medicaid number
- Diagnosis
- Date of onset or the date of the acute exacerbation, if applicable
- Type of surgery performed, if applicable
- Date of surgery, if applicable
- Functional status prior to and after therapy is completed
- Frequency and duration of treatment
- Modalities
- For ulcers, the location, size, and depth should be documented

The plan of treatment must be signed by the physician who ordered the physical therapy and the therapist who administered the treatments.

### **Physical Therapy (PT) Assistants**

Physical therapy services provided in an outpatient hospital setting must be ordered by a physician and must be provided by or under the supervision of a qualified physical therapist.

Physical therapy assistants must work under the direction of a physical therapist with the following provisions:

- The PT must interpret the physician's referral.
- The PT must perform the initial evaluation.
- The PT must develop the treatment plan and program, including long and short-term goals.
- The PT must identify and document precautions, special problems, contraindications, goals, anticipated progress and plans for reevaluation.
- The PT must reevaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
- The PT must implement (perform the first treatment) and supervise the treatment program.
- The PT must co-sign each treatment note written by the physical therapy assistant.
- The PT must indicate he/she has directed the care of the patient and agrees with the documentation as written by the physical therapy assistant for each treatment note.

**The PT must render the hands-on treatment, write and sign the treatment note every sixth visit.**

### **Outpatient Sleep Studies**

Sleep studies are covered services in an outpatient hospital. Medicaid does not enroll sleep study clinics. Indications for coverage are as follows:

Polysomnography includes sleep staging that is refined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). For a study to be reported as polysomnography, sleep must be recorded and staged for 6 hours and an attendant must be present throughout the course of the study.

The following are required measurements:

- Electrocardiogram (ECG)
- Airflow
- Ventilation and respiratory effort
- Gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis
- Extremity muscle activity, motor activity-movement
- Extended EEG monitoring
- Gastroesophageal reflux
- Continuous blood pressure monitoring
- Snoring
- Body positions, etc.

For a study to be reported as a polysomnogram:

- Studies must be performed for 6 hours
- Sleep must be recorded and staged
- An attendant must be present throughout the course of the study

Diagnostic testing is covered when a patient has the symptoms or complaints of one of the following conditions:

- Narcolepsy
- Sleep Apnea
- Parasomnias

(Refer to LMRP for further definition of conditions.)

#### Limitations

Diagnostic testing that is duplicative of previous sleep testing done by the attending physician to the extent the results are still pertinent is not covered because it is not medically necessary if there have been no significant clinical changes in medical history since the previous study.

Home sleep testing is not covered.

Polysomnography will not be covered in the following situations:

- For the diagnosis of patients with chronic insomnia
- To preoperatively evaluate a patient undergoing a laser assisted uvulopalatopharyngoplasty without clinical evidence that obstructive sleep apnea is suspected.

- To diagnose chronic lung disease (nocturnal hypoxemia in patients with chronic, obstructive, restrictive, or reactive lung disease is usually adequately evaluated by oximetry.)
- In cases where seizure disorders have not been ruled out
- In cases of typical, uncomplicated, and noninjurious parasomnias when the diagnosis is clearly delineated.
- For patients with epilepsy who have no specific complaints consistent with a sleep disorder.
- For patients with symptoms suggestive of the periodic limb movement disorder or restless leg syndrome unless symptoms are suspected to be related to a covered indication for the diagnosis of insomnia related to depression
- For the diagnosis of insomnia related to depression
- For the diagnosis of circadian rhythm sleep disorders (i.e., rapid time-zone change (jet lag), shift-work sleep disorder, delayed sleep phase syndrome, advanced sleep phase syndrome, and non 24-hour sleep wake disorder)

Revenue Codes associated with OP hospital billing:

074X	EEG-general classification
0920	Other diagnostic services-general classification

Refer to the LMRP for ICD-9 Codes that support medical necessity. These ICD-9 Codes are updated occasionally by Medicare.

### **Outpatient Cardiac Rehabilitation**

The following conditions must be met in order for an outpatient hospital based cardiac rehabilitation clinic to provide services:

- Recipient must be referred by their attending physician
- Services must be medically necessary and include at least one of the following medical conditions:
  1. Have a documented diagnosis of acute myocardial infarction within the preceding 12 months.
  2. Began the program within 12 months of coronary bypass surgery.
  3. Have stable angina pectoris (evaluation of chest pain must be done to determine suitability to participate in the cardiac rehabilitation program).
  4. Had heart valve repair/replacement.
  5. Had a percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
  6. Had a heart or heart lung transplant.
- The frequency and duration of the program is usually two to three sessions per week for 12 to 18 weeks. Any services provided past 36 in a year will require prior authorization by Medicaid.

- Coverage may be extended with sufficient documentation that the patient has not reached the exit level, but will not exceed a maximum of 72 visits annually.
- Each exercise session must include at least one of the following: Continuous cardiac monitoring during exercise and EKG rhythm strip with interpretation and physician's revision of treatment; or examination by the physician to adjust medications or for other treatment changes.
- No more than one EKG stress test with physician monitoring at the beginning of the exercise program with a repeat test in three months is reasonable and necessary. The medical necessity for stress tests in excess of the two allowed must be clearly established in the recipient's medical record.
- A physician must be immediately available in the exercise program area in case of emergency.
- Formal patient education services are not reasonable and necessary when provided as part of a cardiac rehabilitation exercise program; therefore, Medicaid will not pay for these services.

#### **Outpatient Newborn Hearing Screenings**

Inpatient newborn hearing screenings are considered an integral part of inpatient hospital services. Outpatient facility services for newborn screenings are considered covered only in the following circumstances:

- Comprehensive hearing screen codes 92585, 92588 or 92558 may be billed in an outpatient hospital setting for the following circumstances: 1) infants who fail the newborn hearing screening prior to discharge from the hospital, or 2) infants/children fail a hearing screening at any time following discharge. Comprehensive hearing screenings should be performed on infants by three months of age if they failed the newborn hearing screening prior to discharge.
- Limited hearing screen codes 92586 and 92587 may be billed in an outpatient hospital setting for the following circumstances: 1) an infant was discharged prior to receiving the inpatient hearing screen, or 2) an infant was born outside a hospital or birthing center.

#### **Prior Approval for Outpatient Services**

Certain procedures require prior authorization. Please refer to Section 19.5.2, Revenue Codes, Procedure Codes, and Modifiers, and Appendix I, ASC Procedures List. Medicaid will not pay for these procedures unless authorized prior to the service being rendered. All requests for prior approval must document medical necessity and be signed by the physician. It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

For all MRI's, MRA's, CT scans, CTA's, and PET scans performed on or after March 2, 2009, providers will be required to request prior authorization from MedSolutions. Scans performed as an inpatient hospital service, as an emergency room service, or for Medicaid recipients who are also covered by Medicare are exempt from the PA requirement.

Prior authorization requests for outpatient diagnostic imaging procedures may be made to MedSolutions by phone at (888) 693-3211 or by fax at (888) 693-3210 during normal business hours 7:00 a.m. to 8:00 p.m. C.T. Requests can also be submitted through MedSolutions' secure website at [www.MedSolutionsOnline.com](http://www.MedSolutionsOnline.com). Please refer to Chapter 22, Independent Radiology, for procedure codes that require prior authorization.

### **Payment of Outpatient Hospital Services**

Refer to the *Alabama Medicaid Administrative Code, Chapter 23, Hospital Reimbursement* for details on current hospital payment methodology.

### **Extracorporeal Shock Wave Lithotripsy (ESWL)**

Extracorporeal Shock Wave Lithotripsy (ESWL) is a covered benefit for treatment of kidney stones in the renal pelvis, uretero-pelvic junction, and the upper one-third of the ureter. ESWL is **not** a covered service for urinary stones of the bladder and the lower two-thirds of the ureter.

For ESWL treatment to both kidneys during the same treatment period, Medicaid will pay the facility one-and-a-half times the regular reimbursement rate for this procedure. Repeat ESWL treatments on the same recipient within a ninety-day period will be reimbursed at half the regular reimbursement rate for this procedure.

ESWL treatments are not subject to outpatient benefit limitations.

The ESWL reimbursement rate is an all-inclusive rate for each encounter and all services rendered in conjunction with the treatment (with the exception of the physician's and the anesthesiologist's) are included in the rate, such as lab, x-ray, and observation.

For repeat ESWL treatments on the same recipient within a ninety-day period, Medicaid will reimburse the surgeon at half the regular reimbursement rate for the surgical procedure.

Physician (surgeon) services for the ESWL procedure are not included in the facility's reimbursement rate and can be billed separately. No assistant surgeon services will be covered.

Anesthesiologist services are not included in the facility's or physician's reimbursement rate and can be billed separately.

### **19.2.6 Outpatient and Inpatient Tests**

Medicaid pays for medically necessary laboratory tests, x-rays, or other types of tests that have been ordered by the attending physician or other staff physician provided in inpatient or outpatient hospital facilities.

Hospital labs may bill 'routine venipuncture' only for collection of laboratory specimens when sending blood specimens to another site for analysis. Hospital labs may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. Payment may be made to the referring laboratory but only if one of the following conditions is met:

- The referring laboratory is located in, or is part of, a rural hospital;
- The referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity; or

- The referring laboratory does not refer more than 30 percent of the clinical laboratory tests for which it receives requests for testing during the year (not counting referrals made under the wholly-owned condition described above).

### **Chlamydia and Gonorrhea**

Effective for dates of service on or after September 1, 2012, Chlamydia (87491) or gonorrhea (87591), when billed on the same date of service for any one patient will deny. If both procedures are performed on the same date of service, procedure code 87801 (infectious agent antigen detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique) should be billed instead.

### **19.2.7 Crossover Reimbursement**

#### *Part A*

Medicaid inpatient hospital days run concurrently with Medicare days. Medicaid covers the Part A deductible, coinsurance, or lifetime reserve days, less any applicable copayment. Medicaid will not make such payments if the Medicaid covered days for the calendar year have been exhausted. This benefit limit does not apply for QMB recipients.

Medicaid covers Medicare coinsurance days for swing bed admissions for QMB recipients. Medicaid pays an amount equal to that applicable to Medicare Part A coinsurance, but not greater than the Medicaid swing bed rate.

#### *Part B*

Medicaid pays the Medicare Part B deductible and coinsurance according to lesser of the following:

- Reimbursement under Medicare rules
- Total reimbursement allowed by Medicaid

Medicare-related claims for QMB recipients are reimbursed in accordance with the coverage determination made by Medicare. Medicare-related claims for recipients not categorized as QMB recipients are paid only if the services are covered under the Medicaid program.

Hospital outpatient claims are subject to Medicaid reimbursement methodology.

When a Medicaid recipient has third party health insurance of any kind, including Medicare, Medicaid is the payer of last resort. Thus, provider claims for Medicare/ Medicaid-eligible recipients and QMB-eligible recipients must be sent first to the Medicare carrier.

Providers complete the appropriate Medicare claim forms and ensure that the recipient's 13-digit Recipient Identification (RID) is on the form, then forward the completed claim to a Medicare carrier for payment.

QMB-only recipients are eligible for crossover services and are not eligible for Medicaid-only services.

Refer to Chapter 5, Filing Claims, for complete instructions on how to complete the claim form.

Providers in other states who render Medicare services to Medicare/Medicaid-eligible recipients and QMB-eligible recipients should file claims first with the Medicare carrier in the state in which the service was performed.

### 19.3 **Prior Authorization and Referral Requirements**

Some procedure codes for hospitalizations require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1<sup>st</sup> Program, refer to Chapter 39, Patient 1<sup>st</sup>, to determine whether your services require a referral from the Primary Medical Provider (PMP).

Prior authorization is required for certain outpatient surgical procedures. Refer to Appendix I or the Outpatient Fee Schedule on the website: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov). Prior authorization is not required for inpatient admissions.

Medicaid issues a 10-digit prior authorization number for those stays. This number must appear in form locator 91 on the hospital claim form.

#### **NOTE:**

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

### 19.4 **Cost Sharing (Copayment)**

The copayment amount for an inpatient admission (including crossovers) is \$50.00 per admission. This includes bill types 111, 112, 121, and 122 only (with the exception of admit types 1-emergency and 5-trauma).

The copayment amount for an outpatient visit (99281– 99285) is \$3.90 per visit or \$3.90 per total bill for crossover outpatient hospital claims. The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost - sharing (copayment) amount imposed.

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Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, family planning, renal dialysis, chemotherapy, radiation therapy, physical therapy, and certified emergencies (excluding crossovers). Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

#### **NOTE:**

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-04.

### 19.5 **Completing the Claim Form**

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hospitals that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions

- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

**NOTE:**

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-04.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

All inpatient and outpatient claims must contain a valid physician's license number in field 76 of the UB-04 claim form.

**Certified Emergency Outpatient Visits**

Non-certified visits to the emergency room are limited to three per year. Section 19.2.5, Outpatient Hospital Services, states the visit must be certified as such in the medical record and signed by the attending physician at the time of the visit. Certified emergency claims are also exempt from requiring the Patient 1<sup>st</sup> referral. Only one emergency room visit per day per provider will be reimbursed by Medicaid. Refer to Chapter 5 (Filing Claims) for claim filing information.

**Nonpatient Visits**

Specimen and blood samples sent to the hospital for lab work are classified as "nonpatient" since the patient does not directly receive services. This service does not count against the outpatient visit limitations and should be billed as bill type 14X. Refer to Section 5.3, UB-04 Billing Instructions, for description of Type of Bill values.

**Recipients with Medicare Part B (Medical Only)**

If a Medicaid recipient is Medicare Part B/Medicaid eligible, lab and x-ray procedures are covered under Medicare Part B for eligible recipients. Charges that are covered by Medicare must be filed with Medicare, and Medicaid will process the claim as a crossover claim. The following revenue codes are normally covered for Part B reimbursement (bill type 121): 274, 300, 310, 320, 331, 340, 350, 400, 420, 430, 440, 460, 480, 540, 610, 636, 700, 730, 740, 770, 920, and 942.

Charges that are covered by Medicaid but not by Medicare should be filed directly to Medicaid for consideration. It is not necessary to indicate Medicare on the claim. Providers are not required to file claims with Medicare if the service is not a Medicare-covered service.

**Split Billing for Inpatient Claims**

Claims that span more than one calendar year must be split billed.

Claims that span a Medicaid per diem rate change must be split billed in order for the hospital to receive the correct reimbursement.

Claims that span a recipient's eligibility change must be split billed.

### **19.5.1 Time Limit for Filing Claims**

Medicaid requires all claims for inpatient and outpatient services and psychiatric hospitals to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

### **19.5.2 Revenue Codes, Procedure Codes, and Modifiers**

Revenue codes are used for both inpatient and outpatient services. Procedure codes must be used for outpatient services.

Refer to the Official UB-04 Data Specifications Manual for a complete listing of valid revenue codes.

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

This section covers revenue codes, procedure codes, and modifier information under the following topics:

- Emergency department
- Pharmacy
- Laboratory services
- Radiation therapy
- Respiratory services
- Occupational therapy
- Speech therapy
- Miscellaneous procedures
- Outpatient revenue codes
- Outpatient observation
- Esophagus
- Radiology
- Blood
- Physical therapy
- Orthotics
- ESWL

#### **Outpatient Revenue Codes**

Medicaid will accept all valid revenue and procedure codes on outpatient claims for dates of service 10/1/04 and after. Reimbursement methodology has not changed; therefore, detail lines with noncovered revenue and procedure codes will continue to deny.

#### **Emergency Department**

Emergency and/or outpatient hospital services performed on the day of admission (at the same hospital) must be included on the inpatient billing.

Hospital providers should use the following procedure codes when billing for emergency department services:

Hospitals are to utilize the definitions from the 'old Z codes' when billing for ER visits as described in the two tables below:

'Old Z Codes'	Description
Z5299	Brief – Emergency Department Includes use of facility, equipment, oral medications and incidental supplies, e.g., linens, tongue blades, and tissue.

<b>'Old Z Codes'</b>	<b>Description</b>
Z5300	Limited – Emergency Department Includes use of facility, equipment, oral medications and additional supplies, e.g., IV solutions, splints, dressing, sterile trays, etc.
Z5301	Critical Care – Emergency Department Includes use of facility, equipment, oral medication and additional supplies for the treatment of multiple injured, critically ill and/or comatose patients. This code should not be used unless critical care is rendered.

<b>CPT Code</b>	<b>Rev Code</b>	<b>Description</b>
99281  (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: <ul style="list-style-type: none"> <li>• A problem-focused history,</li> <li>• A problem-focused examination, and</li> <li>• Straightforward medical decision making</li> </ul>
99282  (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: <ul style="list-style-type: none"> <li>• An expanded problem-focused history,</li> <li>• An expanded problem-focused examination, and</li> <li>• Medical decision making of low complexity</li> </ul>
99283  (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: <ul style="list-style-type: none"> <li>• An expanded problem-focused history,</li> <li>• An expanded problem-focused examination, and</li> <li>• Medical decision making of moderate complexity</li> </ul>
99284  (old code Z5300)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: <ul style="list-style-type: none"> <li>• A detailed history,</li> <li>• A detailed examination, and</li> <li>• Medical decision making of moderate complexity</li> </ul>
99285  (old code Z5301)	450	Emergency department visit for the evaluation and management of a patient that requires these three components within the constraints imposed by the urgency of the patient's clinical condition and mental status: <ul style="list-style-type: none"> <li>• A comprehensive history,</li> <li>• A comprehensive examination, and</li> <li>• Medical decision making of high complexity</li> </ul>

**NOTE:**

The above procedure codes may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450. Revenue code 450 should not be billed for surgical procedures provided in the emergency room. In these instances the appropriate ER facility fee (99281-85) must be used. Surgical procedures may be billed only when an operating room has been opened for the surgery. Surgical codes must be billed with revenue code 360.

**Outpatient Observation**

Outpatient Observation is medically necessary extended outpatient care provided to a patient who presents to the emergency department and whose condition warrants more than the three hours of care already included in the emergency department procedure codes 99281-99285. This service is covered only when certified by the attending physician at the time of the service.

Outpatient observation is limited to 23 hours (the first three hours included in the ER facility fee plus up to 20 hours of the appropriate observation code). Observation (G0378) may be billed only in conjunction with procedure codes 99281-99285. It may not be billed in conjunction with outpatient surgery. If observation spans midnight, the date of admission should also be the date of discharge on the claim form even though the patient was actually discharged the following day.

<i>Revenue Code</i>	<i>Procedure Code</i>	<i>Description</i>
76X	G0378	Each hour, 4th hour through 23rd hour (maximum units 20), low severity

**Pharmacy**

Revenue code 250 applies to Pharmacy - Injectable Drugs (includes immunization).

See Appendix H of this manual for more information.

**Esophagus**

Use revenue code 309 with a valid procedure code for Esophagus - Acid reflux test.

**Laboratory Services**

Use revenue codes 300-310 with valid CPT codes for Laboratory services.

**NOTE:**

Services may be span billed if claim contains lab procedure codes. Refer to Section 5.3, UB-04 Billing Instructions, for information on span billing.

### Radiology

Use revenue codes 320-331 with valid CPT codes for radiology. Refer to Chapter 22, Independent Radiology, for procedure codes that require prior authorization.

### Radiation Therapy

Use revenue code 333 with procedure codes 77261-77790 for radiation therapy.

### Blood Transfusions

Procedure code 36430 should be billed only once a day regardless of how many units were administered during that episode.

<i>Revenue Code</i>	<i>Procedure Code</i>	<i>Description</i>
39X	36430	Transfusion, blood or blood components

### Respiratory Services

<i>Revenue Code</i>	<i>Procedure Code</i>	<i>Description</i>
412	94010	Spirometry, including graphic record, vital capacity, expiratory flow rate
412	94060	Bronchospasm evaluation
412	94150	Vital capacity total
412	94200	Maximum breathing capacity
412	94240	Functional residual capacity
412	94350	Pulmonary function test, lung volume
412	94360	Determination of resistance to airflow
412	94370	Determination of airway closing volume, (PFT S/B oxygen)
412	94375	Respiratory flow volume loop
412	94620	Pulmonary stress testing
412	94664	Aerosol or vapor inhalations for diagnosis
412	94665	Aerosol or vapor inhalations for sputums
412	94720	PFT - diffusion
412	94642	Aerosol inhalation of pentamidine for pneumocystis carinii (pneumonia treatment for Prophylaxis)
412	94650	Inhalation Services - Intermittent pressure breathing-treatment, air or oxygen, with or without medication
412	94680	Oxygen uptake
412	94770	Carbon Dioxide, expired gas determination
412	94772	Pediatric Pneumogram

### Physical Therapy and Occupational Therapy

Procedure codes listed below may be billed by a PT or OT. Procedure codes marked with \* must be billed in conjunction with therapeutic codes (97110-97542). Use revenue code 42X for PT claims and revenue code 43X for OT claims.

<i>Procedure Code</i>	<i>Physical Therapy</i>	<i>See Note</i>	<i>Max Units</i>	<i>Annual Limit</i>
97010	Application of a modality to one or more areas; hot or cold pack	1, 3	1	12
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report	1	1	12
95832	Muscle, testing, manual, hand		1	12
95833	Total evaluation of body, excluding hands		1	12
95834	Total evaluation of body, including hands		1	12
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	10
97001	Physical therapy evaluation		1	1
97001-22	Physical therapy evaluation-Motorized Wheelchair Assessment		1	1
97002	Physical therapy re-evaluation		1	
97003 (OT only)	Occupational Therapy evaluation		1	1
97004 (OT only)	Occupational Therapy re-evaluation		1	1
97012*	Traction, mechanical*	1	1	12
97014*	Electrical stimulation, unattended*	1, 2	4	12
97016	Vasopneumatic device*		1	12
97018*	Paraffin bath*	1, 3	1	24
97020*	Microwave*	3	1	24
97022	Whirlpool	3	1	24
97024*	Diathermy*	1	1	24
97026*	Infrared*	1	1	24
97028	Ultraviolet		1	24
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	96
97033	Lontophoresis, each 15 minutes	3	4	96
97034	Contrast baths, each 15 minutes	3	4	96
97035	Ultrasound, each 15 minutes	3	4	96
97036	Hubbard tank, each 15 minutes	3	4	96
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3	4	96

<b>Procedure Code</b>	<b>Physical Therapy</b>	<b>See Note</b>	<b>Max Units</b>	<b>Annual Limit</b>
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3	1	24
97113	Aquatic therapy with therapeutic exercises*		1	24
97116	Gait training (includes stair climbing)	4	1	18
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	3	1	8
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes		1	
97150	Therapeutic procedure(s), group (2 or more individuals)		1	12
97530	Therapeutic activities, direct pt contact by the provider, each 15 minutes	3 and 5	4	96
97532	Development of cognitive skills to improve attention, memory, problem solving, (included compensatory training), direct (one on one) patient contact by the provider, each 15 minutes	3-4	4	36
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes	3-4	4	36
97542	Wheelchair management/propulsion training, each 15 minutes	3	4	24
97597	Removal of devitalized tissue from wounds	3	1	104
97598	Removal of devitalized tissue from wounds	3	8	104
97750	Physical performance test or measurement, (for example, musculoskeletal, functional capacity) with written report, each 15 minutes	3	12	12
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3-4	4	16
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	16
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	3	4	12

**NOTE:**

1. Restricted to one procedure per date of service (cannot bill two together for the same date of service).
2. 97014 cannot be billed on same date of service as procedure code 20974 or 20975.
3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient on the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for the procedure, not the maximum units allowed for both providers.
4. 97760 should not be reported with 97116 for the same extremity.
5. 97530 requires an EPSDT referral

**Orthotics****NOTE:**

Prosthetic/Orthotic devices are covered only when services are rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 274 when billing L codes.

Orthotics provided by hospitals is limited to the L codes listed on the Outpatient Fee Schedule found on the Medicaid website: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

**Speech Therapy****NOTE:**

Speech Therapy is covered only when service is rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 44X when billing speech therapy codes.

Hospitals may bill the following CPT codes for EPSDT referred speech therapy services.

92506-92508	92597
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**ESWL**

Revenue Code	Procedure Code	Description
790	50590	Lithotripsy, Extracorporeal shock wave

**19.5.3 Diagnosis Codes**

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

**NOTE:**

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

### **19.5.4 Place of Service Codes**

Place of service codes do not apply when filing the UB-04 claim form.

### **19.5.5 Required Attachments**

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

#### **NOTE:**

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

## **19.6 For More Information**

This section contains a cross-reference to other relevant sections in the manual.

<b>Resource</b>	<b>Where to Find It</b>
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Outpatient Fee Schedule	<a href="http://www.medicaid.alabama.gov">www.medicaid.alabama.gov</a>
Lab & Xray Fee Schedule	<a href="http://www.medicaid.alabama.gov">www.medicaid.alabama.gov</a>

## PLAN OF CARE

**§ 456.80 Individual written plan of care.**

(a) Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the care of the individual must establish a written plan of care for each applicant or beneficiary.

(b) The plan of care must include—

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Any orders for—

(i) Medications;

(ii) Treatments;

(iii) Restorative and rehabilitative services;

(iv) Activities;

(v) Social services;

(vi) Diet;

(4) Plans for continuing care, as appropriate; and

(5) Plans for discharge, as appropriate.

(c) Orders and activities must be developed in accordance with physician's instructions.

(d) Orders and activities must be reviewed and revised as appropriate by all personnel involved in the care of an individual.

(e) A physician and other personnel involved in the beneficiary's case must review each plan of care at least every 60 days.

UTILIZATION REVIEW (UR) PLAN:  
GENERAL REQUIREMENT**§ 456.100 Scope.**

Sections 456.101 through 456.145 of this subpart prescribe requirements for a written utilization review (UR) plan for each hospital providing Medicaid services. Sections 456.105 and 456.106 prescribe administrative requirements; §§ 456.111 through 456.113 prescribe informational requirements; §§ 456.121 through 456.129 prescribe requirements for admission review; §§ 456.131 through 456.137 prescribe requirements for continued stay review; and §§ 456.141 through 456.145 prescribe requirements for medical care evaluation studies.

**§ 456.101 UR plan required for inpatient hospital services.**

(a) A State plan must provide that each hospital furnishing inpatient services under the plan has in effect a written UR plan that provides for review of each beneficiary's need for the services that the hospital furnishes him.

(b) Each written hospital UR plan must meet the requirements under §§ 456.101 through 456.145.

UR PLAN: ADMINISTRATIVE  
REQUIREMENTS**§ 456.105 UR committee required.**

The UR plan must—

(a) Provide for a committee to perform UR required under this subpart;

(b) Describe the organization, composition, and functions of this committee; and

(c) Specify the frequency of meetings of the committee.

**§ 456.106 Organization and composition of UR committee; disqualification from UR committee membership.**

(a) For the purpose of this subpart, "UR committee" includes any group organized under paragraphs (b) and (c) of this section.

(b) The UR committee must be composed of two or more physicians, and assisted by other professional personnel.

(c) The UR committee must be constituted as—

(1) A committee of the hospital staff;

(2) A group outside the hospital staff, established by the local medical or osteopathic society and at least some of the hospitals and SNFs in the locality;

(3) A group capable of performing utilization review, established and organized in a manner approved by the Secretary.

(d) The UR committee may not include any individual who—

(1) Is directly responsible for the care of the patient whose care is being reviewed; or

(2) Has a financial interest in any hospital.

**§ 456.111**

UR PLAN: INFORMATIONAL  
REQUIREMENTS

**§ 456.111 Beneficiary information re-  
quired for UR.**

The UR plan must provide that each beneficiary's record includes information needed for the UR committee to perform UR required under this subpart. This information must include, at least, the following:

- (a) Identification of the beneficiary.
- (b) The name of the beneficiary's physician.
- (c) Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission.
- (d) The plan of care required under § 456.70.
- (e) Initial and subsequent continued stay review dates described under §§ 456.128 and 456.133.
- (f) Date of operating room reservation, if applicable.
- (g) Justification of emergency admission, if applicable.
- (h) Reasons and plan for continued stay, if the attending physician believes continued stay is necessary.
- (i) Other supporting material that the committee believes appropriate to be included in the record.

**§ 456.112 Records and reports.**

The UR plan must describe—

- (a) The types of records that are kept by the committee; and
- (b) The type and frequency of committee reports and arrangements for their distribution to appropriate individuals.

**§ 456.113 Confidentiality.**

The UR plan must provide that the identities of individual beneficiaries in all UR records and reports are kept confidential.

UR PLAN: REVIEW OF NEED FOR  
ADMISSION<sup>1</sup>

**§ 456.121 Admission review required.**

The UR plan must provide for a review of each beneficiary's admission to

<sup>1</sup>The Department was enjoined in 1975 in the case of American Medical Assn. et al. v. Weinberger, 395 F. Supp. 515 (N.D. Ill., 1975),

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the hospital to decide whether it is needed, in accordance with the requirements of §§ 456.122 through 456.129.

**§ 456.122 Evaluation criteria for admission review.**

The UR plan must provide that—

- (a) The committee develops written medical care criteria to assess the need for admission; and
- (b) The committee develops more extensive written criteria for cases that its experience shows are—
  - (1) Associated with high costs;
  - (2) Associated with the frequent furnishing of excessive services; or
  - (3) Attended by physicians whose patterns of care are frequently found to be questionable.

**§ 456.123 Admission review process.**

The UR plan must provide that—

- (a) Admission review is conducted by—
  - (1) The UR committee;
  - (2) A subgroup of the UR committee; or
  - (3) A designee of the UR committee;
- (b) The committee, subgroup, or designee evaluates the admission against the criteria developed under § 456.122 and applies close professional scrutiny to cases selected under § 456.129(b);
- (c) If the committee, subgroup, or designee finds that the admission is needed, the committee assigns an initial continued stay review date in accordance with § 456.128;
- (d) If the committee, subgroup, or designee finds that the admission does not meet the criteria, the committee or a subgroup that includes at least one physician reviews the case to decide the need for admission;
- (e) If the committee or subgroup making the review under paragraph (d) of this section finds that the admission is not needed, it notifies the beneficiary's attending physician and gives him an opportunity to present his views before it makes a final decision on the need for the continued stay;

aff'd., 522 F2d 921 (7th cir., 1975) from implementing the admission review requirements contained in §§ 456.121-456.127. This case was dismissed on the condition that these requirements be revised. They are presently being revised, and will not be in force until that revision is completed.

(f) If the attending physician does not present additional information or clarification of the need for the admission, the decision of the committee or subgroup is final; and

(g) If the attending physician presents additional information or clarification, at least two physician members of the committee review the need for the admission. If they find that the admission is not needed, their decision is final.

**§ 456.124 Notification of adverse decision.**

The UR plan must provide that written notice of any adverse final decision on the need for admission under § 456.123 (e) through (g) is sent to—

- (a) The hospital administrator;
- (b) The attending physician;
- (c) The Medicaid agency;
- (d) The beneficiary; and
- (e) If possible, the next of kin or sponsor.

**§ 456.125 Time limits for admission review.**

Except as required under § 456.127, the UR plan must provide that review of each beneficiary's admission to the hospital is conducted—

- (a) Within one working day after admission, for an individual who is receiving Medicaid at that time; or
- (b) Within one working day after the hospital is notified of the application for Medicaid, for an individual who applies while in the hospital.

**§ 456.126 Time limits for final decision and notification of adverse decision.**

Except as required under § 456.127, the UR plan must provide that the committee makes a final decision on a beneficiary's need for admission and gives notice of an adverse final decision—

- (a) Within two working days after admission, for an individual who is receiving Medicaid at that time; or
- (b) Within two working days after the hospital is notified of the application for Medicaid, for an individual who applies while in the hospital.

**§ 456.127 Pre-admission review.**

The UR plan must provide for review and final decision prior to admission for certain providers or categories of admissions that the UR committee designates under § 456.142(b) (4)(iii) to receive pre-admission review.

**§ 456.128 Initial continued stay review date.**

The UR plan must provide that—

(a) When a beneficiary is admitted to the hospital under the admission review requirements of this subpart, the committee assigns a specified date by which the need for his continued stay will be reviewed;

(b) The committee bases its assignment of the initial continued stay review date on—

- (1) The methods and criteria required to be described under § 456.129;
- (2) The individual's condition; and
- (3) The individual's projected discharge date;

(c)(1) The committee uses any available appropriate regional medical care appraisal norms, such as those developed by abstracting services or third party payors, to assign the initial continued stay review date;

(2) These regional norms are based on current and statistically valid data on duration of stay in hospitals for patients whose characteristics, such as age and diagnosis, are similar to those of the individual whose case is being reviewed;

(3) If the committee uses norms to assign the initial continued stay review date, the number of days between the individual's admission and the initial continued stay review date is no greater than the number of days reflected in the 50th percentile of the norms. However, the committee may assign a later review date if it documents that the later date is more appropriate; and

(d) The committee ensures that the initial continued stay review date is recorded in the individual's record.

**§ 456.129 Description of methods and criteria: Initial continued stay review date; close professional scrutiny; length of stay modification.**

The UR plan must describe—

**§ 456.131**

(a) The methods and criteria, including norms if used, that the committee uses to assign the initial continued stay review date under § 456.128.

(b) The methods that the committee uses to select categories of admission to receive close professional scrutiny under § 456.123(b); and

(c) The methods that the committee uses to modify an approved length of stay when the beneficiary's condition or treatment schedule changes.

UR PLAN: REVIEW OF NEED FOR  
CONTINUED STAY

**§ 456.131 Continued stay review required.**

The UR plan must provide for a review of each beneficiary's continued stay in the hospital to decide whether it is needed, in accordance with the requirements of §§ 456.132 through 456.137.

**§ 456.132 Evaluation criteria for continued stay.**

The UR plan must provide that—

(a) The committee develops written medical care criteria to assess the need for continued stay.

(b) The committee develops more extensive written criteria for cases that its experience shows are—

(1) Associated with high costs;

(2) Associated with the frequent furnishing of excessive services; or

(3) Attended by physicians whose patterns of care are frequently found to be questionable.

**§ 456.133 Subsequent continued stay review dates.**

The UR plan must provide that—

(a) The committee assigns subsequent continued stay review dates in accordance with §§ 456.128 and 456.134(a);

(b) The committee assigns a subsequent review date each time it decides under § 456.135 that the continued stay is needed; and

(c) The committee ensures that each continued stay review date it assigns is recorded in the beneficiary's record.

**§ 456.134 Description of methods and criteria: Subsequent continued stay review dates; length of stay modification.**

The UR plan must describe—

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(a) The methods and criteria, including norms if used, that the committee uses to assign subsequent continued stay review dates under § 456.133; and

(b) The methods that the committee uses to modify an approved length of stay when the beneficiary's condition or treatment schedule changes.

**§ 456.135 Continued stay review process.**

The UR plan must provide that—

(a) Review of continued stay cases is conducted by—

(1) The UR committee;

(2) A subgroup of the UR committee; or

(3) A designee of the UR committee;

(b) The committee, subgroup or designee reviews a beneficiary's continued stay on or before the expiration of each assigned continued stay review date;

(c) For each continued stay of a beneficiary in the hospital, the committee, subgroup or designee reviews and evaluates the documentation described under § 456.111 against the criteria developed under § 456.132 and applies close professional scrutiny to cases selected under § 456.129(b);

(d) If the committee, subgroup, or designee finds that a beneficiary's continued stay in the hospital is needed, the committee assigns a new continued stay review date in accordance with § 456.133;

(e) If the committee, subgroup, or designee finds that a continued stay case does not meet the criteria, the committee or a subgroup that includes at least one physician reviews the case to decide the need for continued stay;

(f) If the committee or subgroup making the review under paragraph (e) of this section finds that a continued stay is not needed, it notifies the beneficiary's attending physician and gives him an opportunity to present his reviews before it makes a final decision on the need for the continued stay;

(g) If the attending physician does not present additional information or clarification of the need for the continued stay, the decision of the committee or subgroup is final; and

(h) If the attending physician presents additional information or clarification, at least two physician members of the committee review the need

for the continued stay. If they find that the beneficiary no longer needs inpatient hospital services, their decision is final.

**§ 456.136 Notification of adverse decision.**

The UR plan must provide that written notice of any adverse final decision on the need for continued stay under § 456.135 (f) through (h) is sent to—

- (a) The hospital administrator;
- (b) The attending physician;
- (c) The Medicaid agency;
- (d) The beneficiary; and
- (e) If possible, the next of kin or sponsor.

**§ 456.137 Time limits for final decision and notification of adverse decision.**

The UR plan must provide that—

(a) The committee makes a final decision on a beneficiary's need for continued stay and gives notice under § 456.136 of an adverse final decision within 2 working days after the assigned continued stay review dates, except as required under paragraph (b) of this section.

(b) If the committee makes an adverse final decision on a beneficiary's need for continued stay before the assigned review date, the committee gives notice under § 456.136 within 2 working days after the date of the final decision.

UR PLAN: MEDICAL CARE EVALUATION STUDIES

**§ 456.141 Purpose and general description.**

(a) The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

(b) Medical care evaluation studies—

- (1) Emphasize identification and analysis of patterns of patient care; and
- (2) Suggest appropriate changes needed to maintain consistently high quality patient care and effective and efficient use of services.

**§ 456.142 UR plan requirements for medical care evaluation studies.**

(a) The UR plan must describe the methods that the committee uses to select and conduct medical care evaluation studies under paragraph (b)(1) of this section.

(b) The UR plan must provide that the UR committee—

(1) Determines the methods to be used in selecting and conducting medical care evaluation studies in the hospital;

(2) Documents for each study—

- (i) Its results; and
- (ii) How the results have been used to make changes to improve the quality of care and promote more effective and efficient use of facilities and services;

(3) Analyzes its findings for each study; and

(4) Takes action as needed to—

(i) Correct or investigate further any deficiencies or problems in the review process for admissions or continued stay cases;

(ii) Recommend more effective and efficient hospital care procedures; or

(iii) Designate certain providers or categories of admissions for review prior to admission.

**§ 456.143 Content of medical care evaluation studies.**

Each medical care evaluation study must—

(a) Identify and analyze medical or administrative factors related to the hospital's patient care;

(b) Include analysis of at least the following:

- (1) Admissions;
- (2) Durations of stay;
- (3) Ancillary services furnished, including drugs and biologicals;
- (4) Professional services performed in the hospital; and

(c) If indicated, contain recommendations for changes beneficial to patients, staff, the hospital, and the community.

**§ 456.144 Data sources for studies.**

Data that the committee uses to perform studies must be obtained from one or more of the following sources:

- (a) Medical records or other appropriate hospital data;

**§ 456.145**

(b) External organizations that compile statistics, design profiles, and produce other comparative data;

(c) Cooperative endeavors with—

- (1) QIOs;
- (2) Fiscal agents;
- (3) Other service providers; or
- (4) Other appropriate agencies.

[43 FR 45266, Sept. 29, 1978, as amended at 51 FR 43198, Dec. 1, 1986]

**§ 456.145 Number of studies required to be performed.**

The hospital must, at least, have one study in progress at any time and complete one study each calendar year.

**Subpart D—Utilization Control: Mental Hospitals**

**§ 456.150 Scope.**

This subpart prescribes requirements for control of utilization of inpatient services in mental hospitals, including requirements concerning—

- (a) Certification of need for care;
- (b) Medical evaluation and admission review;
- (c) Plan of care; and
- (d) Utilization review plans.

**§ 456.151 Definitions.**

As used in this subpart:

*Medical care appraisal norms* or *norms* means numerical or statistical measures of usually observed performance.

*Medical care criteria* or *criteria* means predetermined elements against which aspects of the quality of a medical service may be compared. These criteria are developed by health professionals relying on their expertise and the professional health care literature.

CERTIFICATION OF NEED FOR CARE

**§ 456.160 Certification and recertification of need for inpatient care.**

(a) *Certification.* (1) A physician must certify for each applicant or beneficiary that inpatient services in a mental hospital are or were needed.

(2) The certification must be made at the time of admission or, if an individual applies for assistance while in a mental hospital, before the Medicaid agency authorizes payment.

(b) *Recertification.* (1) A physician, or physician assistant or nurse practi-

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tioner (as defined in § 491.2 of this chapter) acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify for each applicant or beneficiary that inpatient services in a mental hospital are needed.

(2) Recertification must be made at least every 60 days after certification.

[46 FR 48561, Oct. 1, 1981]

MEDICAL, PSYCHIATRIC, AND SOCIAL EVALUATIONS AND ADMISSION REVIEW

**§ 456.170 Medical, psychiatric, and social evaluations.**

(a) Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each applicant's or beneficiary's need for care in the hospital; and appropriate professional personnel must make a psychiatric and social evaluation.

(b) Each medical evaluation must include—

- (1) Diagnoses;
- (2) Summary of present medical findings;
- (3) Medical history;
- (4) Mental and physical functional capacity;
- (5) Prognoses; and
- (6) A recommendation by a physician concerning—

(i) Admission to the mental hospital; or

(ii) Continued care in the mental hospital for individuals who apply for Medicaid while in the mental hospital.

**§ 456.171 Medicaid agency review of need for admission.**

Medical and other professional personnel of the Medicaid agency or its designees must evaluate each applicant's or beneficiary's need for admission by reviewing and assessing the evaluations required by § 456.170.

PLAN OF CARE

**§ 456.180 Individual written plan of care.**

(a) Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must establish a written

**ADULT CRITERIA (GENERIC) – SI**  
**Clinical Conditions**  
**Lab Values**

1. Hemoglobin less than 7 grams or above 20 grams
2. Hematocrit below 27% or above 55%
3. Serum sodium less than 125mEq/L or above 155mEq/L
4. WBC below 3,000/cu mm or above 15,000/cu mm
5. BUN below 4mg/dl or above 28mg/dl
6. Serum potassium below 2.5 mEq/L or above 6.0mEq/L
7. Glucose below 50mg/dl or above 250/dl
8. Fasting blood glucose below 70mg/dl or above 250mg/dl
9. Platelet count below 60,000/cu mm or above 1,000,000/cu mm
10. Blood pH below 7.20 or above 7.50
11. PTT greater than 40 seconds or three times control level. Activated PT greater than 90 seconds
12. Serum magnesium below 0.8mEq/L or above 12mEq/L
13. Serum calcium below 7mg/dl or above 12 mg/dl
14. Blood PO2 below 65 mm Hg or above 100mm Hg
15. Blood PCO2 below 30mm Hg or above 48mm Hg
16. Blood culture positive for bacteria or fungi
17. Presence of toxic serum level of drugs or other chemical substances
18. Serum chloride below 90mEq/l or above 110mEq/l
19. Creatinine above 1.5mg/dl
20. Liver function studies elevated at twice the normal value
21. Blood ammonia > 110mg/100cc
22. Urine specific gravity > 1.026
23. CPK 2 times above normal range
24. LDH 2 times above normal range

**Other categories/ subcategories of conditions to consider as follows:**

**I. Cardiovascular**

1. Chest pain
2. Acute MI
3. CHF
4. Cardiac arrhythmia's

**II. Endocrine**

1. Diabetes ketoacidosis
2. Diabetes insipidus
3. Coma
4. Hyperthyroidism
5. Addison 's disease
6. Crushing disease
7. Diabetes mellitus, newly diagnosed or uncontrolled
8. Hypoglycemia
9. Thyroid mass resulting in airway obstruction

**III. Gastrointestinal**

1. GI bleeding
2. Acute gastroenteritis
3. Peptic ulcer
4. Hemorrhage
5. Neoplasm's of stomach
6. Abd. Pain
7. Bowel obstr.
8. Penetrating wound of abd wall

**Gastrointestinal (continue)**

9. Appendicitis
10. Peritonitis
11. Pancreatitis
12. Diarrhea
13. Botulism
14. Ulcerative colitis
15. Anorectal disorders
16. Anal fissure
17. Distended bowel with air fluid levels
18. Excessive vomiting

**IV. Genitourinary**

1. Acute renal failure
2. Chronic renal failure
3. Acute nephritic syndrome
4. Pyelonephritis
5. Neurogenic bladder
6. Urinary Calculi

**V. Gynecology and Obstetrics**

1. Amenorrhea
2. Abn. genital bleeding
3. Dysfunctional uterine bleeding (DUB)
4. Endometriosis
5. Pelvic pain
6. Salpingitis
7. Dysmenorrhea
8. Spontaneous vaginal delivery
9. Cesarean section
10. Ectopic pregnancy
11. Hyperemesis gravidarum
12. Preeclampsia and eclampsia
13. Abruptio placenta
14. Placenta previa
15. Pregnancy complicated by disease
16. Cardiac disease
17. Thrombophlebitis
18. Hypertension
19. Renal disease
20. UTI
21. Diabetes mellitus
22. Gestational diabetes
23. Premature labor
24. Premature rupture of membranes (PROM)
25. Puerperal infection
26. Postpartum hemorrhage
27. Inverted uterus
28. Leaking amniotic fluid
29. Bleeding in first, second, or third trimester
30. Suspected fetal distress or fetal demise

**IV. Male Reproductive**

1. Inability to void (acute)
2. Testicular pain (acute)
3. Genital trauma
4. Painful sustained erection (acute)
5. Loss of portion of genitalia (acute)

**VII. Hematology**

1. Iron deficiency anemia
2. Aplastic anemia
3. Megaloblastic anemia
4. Sickle cell anemia
5. Vitamin K deficiency
6. Disseminated intravascular coagulation (DIC)
7. Leukopenia

**VIII. Hepatic and Biliary**

1. Jaundice
2. Hepatomegaly
3. Ascites
4. Cirrhosis
5. Hepatitis
6. Portal Hypertension
7. Cholecystitis

**IX. Musculoskeletal and Connective**

1. Rheumatoid arthritis
2. Loss of limb (acute)
3. Severe crushing injury
4. Lyme disease
5. Infectious arthritis
6. Gout
7. Osteomyelitis
8. Fracture of femur, pelvis, tibia, ankle, elbow, shoulder, spine
9. Neoplasm's of bones and joints
10. Dislocation of spine, hip, ankle, elbow, shoulder

**X. Neurologic**

1. Focal brain disorders
2. Uncontrollable pain
3. Headache
4. Vertigo
5. Seizure disorder
6. Sleep apnea
7. Unconsciousness
8. Disorientation (acute)
9. Weakness without paralysis
10. Tachypnea due to cardiac problems
11. Cerebrovascular accident (Stroke)
12. Acute digitalis toxicity
13. Cerebrovascular disease (CVD)
14. Transient ischemic attack (TIA)
15. Intracranial Hemorrhage
16. Subarachnoid hemorrhage
17. Loss of sensation or movement of any extremity
18. Head injury
19. Spinal cord injury
20. Meningitis
21. Absence of pulse (axilla, groin, knee, etc.)

Neurologic (continue)

22. Parenthesis
23. Paralysis
24. Sight, hearing, or speech loss (acute)

**XI. Nutritional and Metabolic**

1. Vitamin deficiency
2. Electrolyte imbalance
3. Respiratory acidosis/alkalosis

**XII Oncology**

1. Acute leukemia
2. Lymphomas
3. Hodgkin's disease
4. Multiple myeloma
5. Wilms tumor
6. Retinoblastoma
7. Metastatic cancer

**XIII Psychiatric**

1. Neurosis
2. Schizophrenia
3. Suicidal behavior
4. Failure of outpatient treatment
5. Bipolar disorders
6. Psychosis

**XIV Pulmonary**

1. Dyspnea
2. Chest pain
3. Hemoptysis
4. Acute respiratory failure
5. Respiratory distress syndrome
6. Bronchial asthma
7. Acute bronchitis
8. Chronic obstructive pulmonary disease (COPD)
9. Bronchiectasis
10. Atelectasis
11. Pulmonary embolism
12. Pneumonia
13. Pleurisy
14. Pneumothorax
15. Tumor of the lung
16. Tuberculosis
17. Lung abscess

**XV Substance abuse**

1. Seizures
2. Tachycardia
3. Marked elevated blood pressure
4. Vivid hallucinations
5. Agitation requiring restraints
6. Disorientation
7. Reduced level of consciousness

**XVI Miscellaneous**

1. Oral temperature below 95 degree F and above 103 degrees F
2. Blood pressure systolic below 80mm/Hg or above 200mm/Hg
3. Blood pressure diastolic above 110mm Hg
4. Generalized edema 1+ or greater
5. Poisoning including botulism
6. Mass identified or suspected
7. Cellulitis
8. Viral infection
9. Ingestion of life threatening substance
10. HIV related complexes
11. Wound disruption and/or signs and symptoms of infection

***ADULT CRITERIA-IS***

Prescribed Treatment

1. Blood transfusion
2. IV infusion for dehydration supplement ( excluding KVO)
3. Intra- arterial infusions
4. IV nutritional supplements requiring monitoring (TPN)
5. IV infusion for antibiotic therapy or other indicated parenteral medication (steroids, anticonvulsant bronchodilators, etc.)
6. Diabetic teaching
7. Blood cultures
8. Blood cultures pending not to exceed 48 hrs.
9. Extensive diagnostic procedures requiring observation, preps, etc.
10. Respiratory assistance
11. Respiratory treatment and medications at least every 4 hrs.
12. Exchange transfusion
13. Hydration and monitoring of chemotherapy treatment
14. Emergency radiation therapy
15. Invasive diagnostic procedures which cannot be safely performed outpatient
16. Surgical procedures which cannot be done outpatient
17. Medication adjustment with lab follow-up at least daily
18. Admission to special care unit
19. Vital signs, BP monitoring, and neurochecks at least every 4 hrs
20. Surgery requiring general or regional anesthesia
21. Protective isolation
22. Serial enzymes q 8 hrs x 3
23. Skeletal traction
24. Tube feeding
25. IV medication to control premature labor
26. Induction of labor
27. Vaginal delivery
28. Cesarean section
29. Physical therapy for acute condition at least 2 x daily
30. Alcohol and drug detoxification
31. Burn therapy
32. Wound treatment including sterile dressing changes at least 2 x daily
33. Wound debridement
34. Skin grafts
35. Special precautions
36. Restraints
37. Adjustment of psychotropic medication
38. Therapies including group, activity, or individual at least 3 x daily

**Adult Criteria**

**I. Discharge Indicators**

1. Temperature below 100.2F orally for the last 24hrs without antipyretic medication.
2. Urine output at least 800 ml for 24 hrs
3. Tolerating prescribed medication
4. Tolerating diet for 24 hrs without nausea and vomiting
5. Serum drug levels in therapeutic range
6. No pain medication required for last 24 hrs
7. Patient, responsible caregiver, home health agency can provide care
8. Refuses therapy or treatment
9. Documentation by physician that maximum hospital benefit has been reached
10. Patient or caregiver education can be provided in outpatient setting
11. No evident of cardiac damage after 3 days of hospitalization.
12. No EKG changes for 72 hrs without MI
13. Normal telemetry with ambulating
14. No chest pain
15. No seizures for 24 hrs
16. Repeat chest xray within normal limits.
17. Bowel movement after major surgery particularly abdominal surgery
18. Normal bowel sounds
19. Incision/ wound healing without signs and symptoms of infections
20. GI tests for patient with negative cardiac tests
21. Blood glucose in stable range for 24 hrs
22. No evidence of bleeding for 24 hrs
23. In preeclampsia/eclampsia patients, a negative urine protein, negative edema, a BP of 20mm/Hg systolic or 10mm/Hg diastolic of baseline blood pressure.

**PEDIATRIC CRITERIA (GENERIC)- SI**

**Clinical Conditions**

**Lab Values**

1. Hemoglobin less than 8 mg and above 20 grams
2. Hematocrit below 25% and above 60%
3. Serum sodium less than 130mg or greater than 150mg
4. WBC below 3,000amd above 15,000
5. BUN greater than 20 and creatinine greater than 1.0
6. Serum potassium below 2.5 mEq/L and above 6.0 mEq/L
7. Blood pH below 7.3 or above 7.5
8. PaO2 below 60 torr
9. PaCO2 above 50 torr
10. Hypoglycemia < 40mg/dl in full term or <30 in premature infant
11. PTT greater than or equal to 15 seconds. Activated PT greater than or equal to 40 seconds
12. Jaundice appearing on the first day in newborns and a bilirubin concentration > 10mg/dl in premature infants or full term infants
13. Protein of spinal fluid greater than 40mg
14. Urine specific gravity greater than or equal to 10.25

**Other categories/ subcategories of conditions to consider as follows:**

**I. Cardiovascular**

1. Congenital heart deformity
2. Heart disease
3. Congestive heart failure

**II. Endocrine and Metabolic**

1. Congenital goiters
2. Hypothyroidism
3. Hyperthyroidism
4. Newly diagnosed diabetes mellitus
5. Unstable diabetes mellitus
6. Diabetes insipidus
7. Drug withdrawal syndrome
8. Hypoglycemia
9. Hyperbilirubinemia
10. Hypothermia

**III. Gastrointestinal**

1. Recurrent abdominal pain
2. Peptic ulcer
3. Meckel's diverticulum
4. Acute gastroenteritis
5. Excessive vomiting
6. Persistent constipation
7. Bowel obstruction
8. Appendicitis
9. Necrotizing enterocolitis
10. Pyloric stenosis
11. Diarrhea
12. Chronic diarrhea unresponsive to outpatient treatment
- 13.

**IV. Hematology**

1. Acute blood loss/anemia
2. RH incompatibility
3. Sickle cell anemia

**V. Infectious disease**

1. Chicken pox
2. Impetigo
3. Gonorrhea
4. Congenital syphilis
5. Chlamydia
6. Trichomonas
7. Viral infection

**VI. Musculoskeletal and Connective**

1. Rheumatoid arthritis
2. Fractures soft tissue injuries

**VII. Neurologic**

1. Cerebral palsy
2. Hydrocephalus
3. Suspected increase of intracranial pressure
4. Rapid growth of head circumference
5. Progressive neuromuscular weakness
6. Head trauma
7. Seizure disorder
8. Injuries to central and peripheral nervous system
9. Spinal cord injury
10. Meningitis
11. Encephalitis

**Nutritional**

1. Anorexia nervosa
2. Bulimia
3. Failure to thrive

**VIII. Oncology**

1. Wilms' tumor
2. Neuroblastoma
3. Retinoblastoma
4. Acute leukemia's
5. Mass identified or suspected

**IX. Psychiatric – Adolescent/Child**

1. Suicidal ideation in children and adolescents
2. Adjustment disorder
3. Attention deficit disorder
4. Psychosis
5. Schizophrenia
6. Schizophrenia
7. Affective disorders ( depression and mania)
8. Failed outpatient treatment

**X. Pulmonary**

1. Pneumonia
2. Anoxia
3. Bronchiolitis
4. Croup
5. Apnea
6. Meconium aspiration syndrome
7. Cystic fibrosis
8. Acute asthma
9. Respiratory distress syndromes (RDS)

**XI. Miscellaneous**

1. Ingestion of life threatening substance
2. Poisoning
3. Lead poisoning
4. Colt and/ or infection of a shunt
5. Neonatal sepsis
6. Birth weight not exceeding 5 lbs.
7. Fever of unknown origin
8. Generalized edema 1 + or greater
9. Otitis media
10. Cellulitis
11. Urinary tract infection (UTI)
12. Acute epiglottitis
13. Fetal alcohol syndrome
14. Suspected child abuse or neglect
15. HIV related complex
16. Rectal temperature above 102F for 48 hrs
17. Less than 3 month old with rectal temperature above 101F
18. Pulse rate below 55/minute or above 180/minute
19. Blood pressure
  - Systolic- Greater than 120mm/Hg- 0-6 year  
Greater than 130m/Hg- 7-10 year  
Greater than 140mm/Hg- 10 and above
  - Diastolic Greater than 90mm/Hg  
Less than 40mm/Hg
20. Dehydration 5% or greater

**PEDIATRIC CRITERIA IS**  
Prescribed Treatment

1. Blood transfusion
2. IV infusion for dehydration or supplement
3. IV nutritional supplement requiring monitoring TPN
4. IV infusions for antibiotic therapy or other indicated parenteral medications (steroids, anticonvulsant, etc)
5. Intra- arterial infusion
6. Insulin therapy and patient education
7. Dietary management and education
8. Blood cultures
9. Extensive diagnostic procedures requiring observation, prep, etc.
10. Respiratory assistance
11. Respiratory treatment and medication at least every 4 hrs
12. Exchange transfusion
13. Hydration and monitoring of chemotherapy
14. Emergency radiation therapy
15. Phototherapy
16. Invasive diagnostic procedures
17. Medication adjustment with lab follow-up at least daily
18. I & O and weight monitoring daily for FTT patient
19. Admission to special care unit
20. Vital signs, BP monitoring and neurological checks
21. Surgery requiring general or regional anesthesia
22. Protective isolation
23. Patient requires monitoring to facilitate recovery
24. Telemetry
25. Blood gases
26. Oxygen therapy
27. General state of consciousness
28. Suicidal and homicidal precautions
29. Adjustment of psychotropic med.
30. Patient unwilling or unable to comply
31. Physical restraint/seclusion/isolation
32. Therapies including group, activity, or individual at least 3 times daily
33. Monitoring at least hourly
34. IV or IM medications
35. Stabilization using PO medication
36. Traction
37. Control of hemorrhage
38. Initial tracheostomy care
39. Nasogastric tube feeding
40. Chest tube drainage
41. Gastrostomy feeding
42. Complications of surgery (fever, bleeding, swelling, etc.)
43. Surface burn therapy
44. Wound debridement requiring analgesia or anesthesia daily
45. Skin care requiring skill nursing care at least 6 hours per day
46. Skin grafting

**PEDIATRIC CRITERIA**

**I. Discharge Indicators**

1. Temperature below 100.2 F orally for at least 24 hr without antipyretic medication
2. Urine output adequate for age
3. Tolerating prescribed medications
4. Passing flatus/fecal material
5. Tolerating diet of 24 hr without nausea or vomiting
6. Serum drug level in therapeutic range
7. No pain medication required for last 24 hrs
8. Wound healing without signs or symptoms of infection
9. Patient, responsible caregiver, home health agency can provide care
10. Refuses therapy or treatment
11. Documentation by physician that maximum hospital benefit has been reached
12. No evidence of cardiac damage after 3 days hospitalization
13. No EKG changes for 72hrs without MI
14. Normal telemetry with ambulating
15. No chest pain
16. No seizure for 24 hrs
17. Weight greater than or equal to 5 1/4 lbs. and taking feeding well
18. Infant maintains a stable body temperature
19. No evidence of respiratory distress
20. Repeat CXR within normal limits
21. Stable weight for 72 hrs

Selected HAC	Frequency as a Secondary Diagnosis	Not Present on Admission				Present on Admission			
		POA=N		POA=U		POA=Y		POA=W	
		No.	%	No.	%	No.	%	No.	%
1. Foreign Object Retained After Surgery									
2. Air Embolism									
3. Blood Incompatibility									
4. Pressure Ulcer Stages III & IV									
5. Falls and Trauma									
6. Catheter-Associated UTI									
7. Vascular Catheter-Associated Infection									
8. Poor Glycemic Control									
9. Surgical Site Infection Mediastinitis CABG									
10. Pulmonary Embolism & DVT Orthopedic-excluding pediatric and obstetrical patients									

**All Other Provider-Preventable Conditions will be tracked using Medicaid's encrypted e-mail at [AdverseEvents@medicaid.alabama.gov](mailto:AdverseEvents@medicaid.alabama.gov).**

Acknowledgement of Receipt of  
Amendment One to  
ITB 14-X-2250221  
Alabama Medicaid Agency  
Inpatient Hospital Quality Assurance Program  
September 24, 2013

I hereby certify that I have received and read this amendment. I understand that the changes contained herein are legally binding.

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Signature

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Printed Name

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Bidder Name

Amendment One  
ITB 14-X-2250221  
Inpatient Hospital Quality Assurance Program

The above referenced Invitation to Bid (ITB), released September 9, 2013, is amended as outlined below: Changes to text are characterized by quotation marks. **The attached Acknowledgement of Receipt of this Amendment must be signed and returned with the bid response which must be received no later than 5:00 p.m. Central Daylight Time on October 7, 2013, or the bid will not be considered.**

1. Page 9, Section 1.8(c)(2) Bid Submission Requirements has been amended to read as follows: “Two electronic (Word 6.0 or later version format) copies of the Bid response on CD, jump drive, or disc clearly labeled with the Bidder’s name. One electronic copy MUST be a complete version of the bid and the second electronic copy MUST have any confidential/proprietary information removed. Attachments may be submitted in PDF or similar formats.”
2. Page 6, Section 1.3 Schedule of Activities has been amended to read as follows: The schedule of activities for this bid process is listed below. All dates are estimated and are subject to change. All times are central time (CT).

Bid Released	September 9, 2013
Pre-Bid Questions Due	September 19, 2013
Answers to Pre-Bid Questions Posted	September 24, 2013
Last Date to Submit Questions	September 27, 2013
Final Posting of Questions	“October 2, 2013”
Bids Due	October 7, 2013
Bids Opened	October 8, 2013
Bids Evaluated	October 9-11, 2013
Contract Award	October 17, 2013
Contract Start Date	November 1, 2013
Program Start Date	February 1, 2014

3. Page 22, Section 3.2(d)(1) Admission and Continued Stay Criteria has been amended to read as follows: “Number of cases selected for review, number of cases completed to date, number of cases referred for Physician review,

number of cases to Physician for reconsideration, number of referred cases completed by Physician, number of reconsiderations completed by Physician, number of cases approved, number of cases denied, number of cases carried over from previous quarter, admission utilization concerns, length of stay utilization concerns, quality concerns, number and type of billing errors, and any patterns present with corrective action plan.”

4. Page 23, Section 3.2(c) Admission and Continued Stay Criteria has been amended to read as follows: “The first chart review will be selected January 1<sup>st</sup> 2014 and will be based on dates of service April 1, 2013 through September 30, 2013 (a six month review).”
5. Page 23, Section 3.3 Provider Preventable Conditions (PPCs) has been amended to read as follows: “(4) Medical record reviews are required on a 10% random sample of identified HAC’s.”
6. Page 26, Section 3.8 (2) InterQual® Criteria has been amended to read as follows: “(2) to convene and chair a committee of hospital representatives, ALAHA representatives, Medicaid staff and Contractor staff to identify potential issues.”

**AGREEMENT BETWEEN**  
**HP ENTERPRISE SERVICES, LLC**  
**AND**  
**SUBSCRIBER**

This Agreement, by and between HP ENTERPRISE SERVICES, LLC (hereafter referred to as “HPES”), and approved value added network suppliers and certain health care providers (hereafter referred to as “SUBSCRIBERS”), for the provision of a connection to the Alabama Medicaid Management Information System (AMMIS).

**WHEREAS**, the Alabama Medicaid Agency (the “State Agency”) designated by Alabama law to administer the medical assistance program for the State of Alabama as provided for in Title XIX of the Social Security Act (Medicaid); and

**WHEREAS**, the Alabama Medicaid Agency operates AMMIS through its fiscal agent to allow verification of eligibility, benefits coverage and other insurance, as well as submission of claims for Medicaid recipients by Medicaid providers;

**WHEREAS**, HPES is the fiscal agent of the AMMIS system;

**NOW THEREFORE**, in consideration of the mutual promises herein contained, the parties have agreed and do hereby enter into this agreement according to the provisions set out herein:

**A. TERM**

This agreement shall be effective upon signature of both parties and shall remain in effect until terminated by either party upon at least thirty (30) days prior written notice to the other party. HPES may terminate this agreement immediately in the event of a violation by SUBSCRIBERS of any term of the agreement.

**B. SITE TO SITE VPN CONNECTION**

**Connection** – Connection between Subscriber and the AMMIS system is a site to site VPN over the public internet. It is the responsibility of the clearinghouse to provide their own connection to the public internet at a size and speed suitable for the traffic intended at their facility. HPES will provide the connection to the public internet for Alabama Medicaid MMIS system for the purposes of this connection.

**Connection Termination** – Service may be terminated by either party. A written 30 day notice is required for termination with the exception of the following circumstances:

- Should the Subscriber not pay their account within terms, the connection will be severed.
- Should HPES require the connection to be severed per the State Agency, Subscriber will comply within the cancellation terms herein.
- To restore the connection, Subscriber must cure breach or make the account current and pay the setup fee detailed in the **Charges** section of this document.

**Response Time** – The maximum expected response time by HPES is 30 minutes Monday through Friday (8AM to 5PM central time) and 2 hours otherwise. Actual incident recovery time will be dependent on the resolution of the incident. Subscriber should thoroughly test Subscriber owned equipment and connection before contacting HPES for testing.

**Charges** (“Charges”) – HPES will bill Subscriber \$ 1,350.00 per quarter (3 month period) to maintain the site to site VPN connection. A setup fee of \$1,600.00 is required to establish the connection and test. Subscriber agrees to pay within 30 days of the date of the invoice. Any prorated amounts will be determined by mutual agreement. HPES shall reevaluate charges every twelve (12) months. Subscriber agrees that the acceptance of market driven increases shall be a condition of continued performance under this agreement.

**C. INDEMNIFICATION**

The SUBSCRIBERS agrees to indemnify, defend, save and hold harmless HPES from all claims, demands, liabilities, and suits of any breach of this agreement by the SUBSCRIBERS, its Subscribers or employees, including but not limited to any occurrence of omission or negligence of the SUBSCRIBERS, its Subscribers or employees, and more specifically, without limitations:

1. Any claims or losses for services rendered by a subcontractor, consultant, person or firm performing or supplying services, materials or supplies in connection with the performance of the contract;
2. Any claims or losses to any person or firm injured or damaged by the erroneous or negligent acts, including disregard of Federal or State regulations or Federal statutes, of the SUBSCRIBERS, its Subscribers, consultants, officers and employees, or subcontractors in the performance of this agreement;
3. Any claims or losses resulting to any person or firm injured or damaged by the SUBSCRIBERS, its Subscribers, consultants, officers, employees, or subcontractors by the publications, translation, reproduction, delivery, performance, use or disposition of any data processed under the contract in any manner not authorized by the contract, or Federal or State regulations or statutes; and
4. Any failure of the SUBSCRIBERS, its officers, Subscribers, consultants, employees, or subcontractors to observe State or Federal laws, including but not limited to labor laws and minimum wage laws.

**D. NON-EXCLUSIVITY**

HPES shall not be in any way limited from entering into similar contracts with other Subscribers desiring to provide the same or similar service, nor shall HPES be in any way limited from providing the same or similar service directly to health care providers. HPES shall in no way be limited in its use of any information it obtains from the SUBSCRIBERS in connection with this Agreement, and the parties hereto agree that no such information shall be considered proprietary or trade secret information of the SUBSCRIBERS.

**E. Changes and Amendment Language**

Requests for changes will be submitted to the other party in writing for consideration of feasibility and the likely effect on the cost and schedule for performance of the Services. The parties will mutually agree, in writing, upon any proposed changes, including resulting equitable adjustments to costs and performance of the Services

**F. ENTIRE AGREEMENT**

This written Agreement constitutes the entire Agreement between the parties, and no additional representatives, writings or documents are a part hereof, unless specifically referred to herein above. The requirements in the Alabama Data Switch Agreement are hereby incorporated. This Agreement may be amended by written agreement of the parties hereto.

**G. CONTACT PERSONS**

HPES:  
 Lamar Smith  
 Systems Supervisor  
 301 Technacenter Drive  
 Montgomery, AL 36117  
  
 Phone: (334) 215-4201

SUBSCRIBER:  
 Contact: \_\_\_\_\_  
 E-Mail: \_\_\_\_\_  
 Company: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State and Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**IN WITNESS WHEREOF**, the parties have by their duly authorized representatives set their signatures.

**SUBSCRIBER**

**HP ENTERPRISE SERVICES, LLC**

\_\_\_\_\_  
 (sign)  
 BY: \_\_\_\_\_  
 (print)  
 TITLE: \_\_\_\_\_  
  
 DATE: \_\_\_\_\_

\_\_\_\_\_  
 BY: \_\_\_\_\_  
  
 TITLE: \_\_\_\_\_  
  
 DATE: \_\_\_\_\_

**Questions and Answers for Alabama Medicaid Agency Inpatient Hospital Quality Assurance Program ITB**  
**ITB# (14-X-2250221)**  
**September 24, 2013**

<p><b>Page 21, Section 3.2 (b) Sampling:</b> After reviewing the ITB, I was unable to locate the actual, annual volume of retrospective reviews. I realize that this is based off of a 5% sample from each hospital however, I need to know the total number of Medicaid admissions in Alabama per year to calculate our pricing. thanks</p>	<p><b>Alabama Medicaid Agency Response:</b> See page 17 section 2.3. There were 113,246 inpatient admissions in fiscal year 2012.</p>
<p>What is the current annual dollar value of this contract?</p>	<p><b>Alabama Medicaid Agency Response:</b> This information may be obtained from the Finance Department Division of Purchasing of the State of Alabama in person. A three day advance notice must be given.</p>
<p>What are the major differences between the scope of work found in this ITB and the current scope of work/contract?</p>	<p><b>Alabama Medicaid Agency Response:</b> Addition of: review of PPCs (HAC/POA); four full time RN's; requirement to complete 80-90% of selected cases each quarter; addition of the schedule of review table; more specificity to Report of Findings and Claims Adjustment/Recoupment sections; change to UR Plan and MCE Study timeframes and report of findings.</p>
<p>What is the budget for this contract?</p>	<p><b>Alabama Medicaid Agency Response:</b> The FY 14 budget is subject to change based on the new ITB.</p>
<p>To allow for anticipated increase in Medicaid enrollment - will Medicaid allow for a modification of the contract if reviews exceed the estimates provided in the ITB?</p>	<p><b>Alabama Medicaid Agency Response:</b> There is no expectation that the number of hospital admissions or reviews will increase or decrease significantly.</p>
<p><b>Page 17, Section 2.4 Reporting:</b> Will monthly meetings be via teleconference or onsite in Montgomery?</p>	<p><b>Alabama Medicaid Agency Response:</b> Monthly meetings will be held via conference call.</p>
<p><b>Page 18, Section 2.5 Additional Contractor Responsibilities:</b> How many presentations to groups/associations were made by the contractor in the last 12 months?</p>	<p><b>Alabama Medicaid Agency Response:</b> None.</p>
<p><b>Page 18, Section 2.5 Additional Contractor Responsibilities:</b> How many education/outreach presentations were made to providers by the contractor in the last 12 months?</p>	<p><b>Alabama Medicaid Agency Response:</b> None.</p>
<p><b>Page 18, Section 2.6 (a) Informal Review and Fair Hearing:</b> Is an Informal Review the same as reconsideration?</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes.</p>

**Questions and Answers for Alabama Medicaid Agency Inpatient Hospital Quality Assurance Program ITB**  
**ITB# (14-X-2250221)**  
**September 24, 2013**

<p><b>Page 18, Section 2.6 (a) Informal Review and Fair Hearing:</b> How many informal reviews/reconsiderations were completed in the last 12 months?</p>	<p><b>Alabama Medicaid Agency Response:</b> There were 30 Informal Reviews (reconsiderations) in the last 12 months.</p>
<p><b>Page 18, Section 2.6 (b) Fair Hearing:</b> Where are Fair Hearings conducted?</p>	<p><b>Alabama Medicaid Agency Response:</b> Fair Hearings are conducted at the Medicaid Agency Central office located in Montgomery, AL.</p>
<p><b>Page 18, Section 2.6 (b) Fair Hearing:</b> How many fair hearings were completed in the last 12 months?  How many were held in Montgomery?  How many were held by teleconference or other means?</p>	<p><b>Alabama Medicaid Agency Response:</b> There were no Fair Hearings in the last 12 months</p>
<p><b>Page 19, Section 2.8 Operational Requirements:</b> Are the costs associated with site to site VPS (set-up &amp; quarterly maintenance) connection considered a pass-thru cost for the contractor or will these costs be paid by Medicaid?</p>	<p><b>Alabama Medicaid Agency Response:</b> This is a cost incurred by the Contractor.</p>
<p><b>Page 21, Section 3.1 Key Personnel:</b> May the Project Manager and Clinical Director position be combined? Assumes the person is qualified for both position.</p>	<p><b>Alabama Medicaid Agency Response:</b> No.</p>
<p><b>Page 21, Section 3.2 Admission and Continued Stay Criteria:</b> Are post-Hospital Extended Care Services cases included in the medical necessity and continued stay reviews for this contract?</p>	<p><b>Alabama Medicaid Agency Response:</b> No, these reviews are only for acute care hospital services, PEC is not included.</p>
<p><b>Page 21-22, Section 3.2 Admission and Continued Stay Criteria (a) and (b):</b> Will the contractor have access to the claims data to do the sampling?</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes.</p>

**Questions and Answers for Alabama Medicaid Agency Inpatient Hospital Quality Assurance Program ITB**  
**ITB# (14-X-2250221)**  
**September 24, 2013**

<p><b>Page 22, Section 3.2 Admission and Continued Stay Criteria, Sampling (b) (5):</b>  Under what circumstances will a chart need to be reviewed by a physician advisor? (1) If the chart is identified by the nurse reviewer as not medically necessary per Medicaid approved criteria? (2) Or charts that are deemed questionable by the nurse reviewer? (3) All of the above?</p>	<p><b>Alabama Medicaid Agency Response:</b> All of the above.</p>
<p><b>Page 22, Section 3.2 Admission and Continued Stay Criteria, Sampling (b) (5):</b>  What is the current % of cases that are sent to the physician reviewer for review? (Referral rate)</p>	<p><b>Alabama Medicaid Agency Response:</b> 4%</p>
<p><b>Page 22, Section 3.2 Admission and Continued Stay Admission Criteria, Report of Findings, (d) (1):</b>  Explain “any patterns present with corrective action plan.” Is this for quality concerns only or for admission/continued stay denials as well?</p>	<p><b>Alabama Medicaid Agency Response:</b> Both.</p>
<p><b>Page 22, Section 3.2 Admission and Continued Stay Admission Criteria, Report of Findings, (d) (1):</b>  Will Medicaid share a copy of the latest quarterly “Report of Findings” prepared by the current Contractor</p>	<p><b>Alabama Medicaid Agency Response:</b> No.</p>
<p><b>Page 22, Section 3.2 Admission and Continued Stay Admission Criteria, Report of Findings, (d) (2):</b>  Explain “Deficiency Occurrence”.</p>	<p><b>Alabama Medicaid Agency Response:</b> Please refer to 42 CFR Subpart C-Utilization Control Hospitals, 456.60 Certification and recertification of need for inpatient care. Any deficiency in this area should be reported. This would include all cases that are determined on physician review to have medically unnecessary days, but record documentation indicates the days were approved by the hospital UR committee.</p>
<p><b>Page 23, Section 3.3 Provider Preventable Conditions (PPCs)</b>  Will PPCs information be obtained from claims data only or will any medical record review be required</p>	<p><b>Alabama Medicaid Agency Response:</b> The information will be obtained from claims data. Medical record requests for review will be required on a 10% sample for each quarter. If the Contractor identifies questionable POA indicators on the report (e.g., recipient with fracture and POA indicator of N) medical record review may then be indicated as well in those instances. An amendment will be made to the ITB.</p>
<p><b>Page 23, Section 3.3 (2) Provider Preventable Conditions (PPCs):</b>  Provide a sample of the CMS report concerning HAC’s and whether or not they are POA.</p>	<p><b>Alabama Medicaid Agency Response:</b> Please refer to the bidder’s library for this ITB located on the Alabama Medicaid website under Newsroom; Procurement. A copy of the current CMS report is posted.</p>

**Questions and Answers for Alabama Medicaid Agency Inpatient Hospital Quality Assurance Program ITB**  
**ITB# (14-X-2250221)**  
**September 24, 2013**

<p><b>Page 23, Section 3.4 (d) Internal Utilization Review Plans:</b>          How will the Contractor be expected to notify hospitals of findings? Via mail, electronic, fax, etc.</p>	<p><b>Alabama Medicaid Agency Response:</b> This will be discussed between the Contractor and Medicaid.</p>
<p><b>Page 25-26, Section 3.8 InterQual® Criteria:</b>          Explain the requirement to provide a copy of InterQual® Criteria to the Agency annually.</p>	<p><b>Alabama Medicaid Agency Response:</b> InterQual® Level of Care Criteria is updated annually. The Contractor will need to provide a current copy of both the Acute Care Adult and Acute Care Pediatric versions to the Agency.</p>
<p><b>Page 25-26, Section 3.8 InterQual® Criteria:</b>          Does the Agency have a timeline of when it plans to begin utilizing InterQual® Criteria?</p>	<p><b>Alabama Medicaid Agency Response:</b> No.</p>
<p><b>Page 26, Section 3.9 (a) Medicaid's Responsibilities:</b>          Where will the review of the random sample of charts be performed by Medicaid? (Montgomery or the Contractor's office?)</p>	<p><b>Alabama Medicaid Agency Response:</b> The review will be done as a desk review at the Medicaid Agency central office location in Montgomery.</p>
<p><b>Page 40-41, Section 4.36 Contract Sanctions-Liquidated Damages:</b>          How much has been imposed/assessed in contract sanctions/liquidated damages to the current contractor in the last 12 months? The category and dollar amounts.</p>	<p><b>Alabama Medicaid Agency Response:</b> None</p>
<p><b>Page 6, Section 1.3 Schedule of Activities:</b>          Please explain the difference between contract start date (November 1, 2013) and the program start date (February 1, 2014) and clarify when the Contractor will begin providing services as described in the ITB.</p>	<p><b>Alabama Medicaid Agency Response:</b> This time frame allows the vendor a startup time-frame for obtaining VPN access, running queries for data, data connectivity, to request selected records for review, policy and procedure manual development, etc. The Contractor will be performing services as described in the ITB (reviews, etc.) no later than February 1, 2014.</p>
<p><b>Page 6, Section 1.3, Schedule of Activities:</b>          The Schedule of Activities says that the Final Posting of Questions will be on October 4, 2013, which is a Friday, and that Bids due on October 7, 2013, which is the following Monday. Proposals will need to be mailed out on Friday, October 4 to</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes. Section 1.3 of the Schedule of Activities will be amended to change the Final Posting of Questions from "October 4, 2013" to "October 2, 2013."</p>

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<p>ensure their delivery on Monday, October 7. It does not seem reasonable for the Final Posting of Questions to be scheduled for the same day that bidders must mail in their proposal responses, as there is no time allowance for bidders to update their Transmittal Letter to acknowledge receipt of the information, nor to make any changes, if desired, to their proposal response based on information in the Final Posting of Questions. We would like to request that the Final Posting of Questions be scheduled for at least a couple of days prior to the date that the proposal will need to be shipped so that any information contained therein can be incorporated into the bids being prepared.</p>	
<p><b>Page 6, Section 1.3, Schedule of Activities:</b> Will Regional Care Organizations have an impact on the contract implementation and planned time frames?</p>	<p><b>Alabama Medicaid Agency Response:</b> Unknown at this time.</p>
<p><b>Page 8, Section 1.5, Pre-Bid Questions:</b> Please list the names of the organizations who submitted questions</p>	<p><b>Alabama Medicaid Agency Response:</b> Medicaid cannot release this information until after the bid process is complete.</p>
<p><b>Page 9, Section 1.8, Bid Submission Requirements, (c)(2):</b> The RFP specifies there are to be three electronic copies of the Bid response submitted in Word, while Attachments may be submitted in PDF. The Invitation to Bid (ITB) section that Vendors must complete, sign, and notarize (i.e., the six ITB pages that include the Price Sheet), will need to be scanned as a PDF for electronic submission. Please confirm that the electronic copies can include PDF materials for other than Attachment materials.</p>	<p><b>Alabama Medicaid Agency Response:</b> Please review page 2, Bid response instructions, of the Invitation to Bid provided to you from State Purchasing. This document has specific instructions on how to submit the proposal.</p> <p>The electronic copies can include PDF materials other than Attachment materials.</p>

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<p><b>Page 9, Section 1.8 Bid Submission Requirements, (c) (2):</b> One electronic copy MUST be a complete version of the bid and the second electronic copy MUST have any confidential/proprietary information removed. Are there any special instructions for what is to be included on the third electronic copy?</p>	<p><b>Alabama Medicaid Agency Response:</b> Section 1.8 c. (2) specifies that three electronic copies should be provided on CD, jump drive, or disc clearly labeled with the Bidder's name. An amendment will be made to this section to change "three" to "two".</p>
<p><b>Page 9, Section 1.8 Bid Submission Requirements, (h):</b> Each bid must contain a price bid and a technical component. Please confirm that the Invitation to Bid (ITB) section that Vendors must complete, sign, and notarize, which includes a Price Sheet as Page 6, is the only Price Sheet that needs to be completed.</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes.</p>
<p><b>Page 10, Section 1.8 Bid Submission Requirements (i):</b>  Price Sheet – Which of the following should the firm fixed price that is reflected on Line 0001 of the Price Sheet represent:</p> <p style="padding-left: 40px;">Annual firm fixed price?  Two-year firm fixed price for 11/01/13 – 10/31-15?  Firm fixed price for 02/01/14 (program start date) – 10/31/15?  Other – Please Explain?</p>	<p><b>Alabama Medicaid Agency Response:</b> See page 10, Section 1.8 BID Submission Requirements (i): "The bid price is a firm and fixed price for <u>each</u> year of the contract, including any extensions. The bid must appear on the Division of Purchasing Pricing page."</p> <p>The price should be the annual firm fixed price.</p>
<p><b>Page 9, Section 1.8 Bid Submission Requirements, (h):</b> Can the Price Sheet be included in the same binder as the Technical Proposal? If not, please provide instructions for how it is to be submitted.</p>	<p><b>Alabama Medicaid Agency Response:</b> Please review page 2, BID response instructions, of the Invitation to Bid provided to you from State Purchasing. This document has specific instructions on how to submit the proposal.</p>
<p><b>Page 11, Section 1.9 Bid Submission Format (a):</b> The RFP instructions are to submit each bid in three-inch, 3-ring binders. Due to the page limitations, bid responses will fit into smaller than three-inch binders (e.g., 1 or 1½ inch 3-ring binders). Is it permissible to submit bids in smaller than three-inch size three-ring binders?</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes. An amendment will be made to this section to remove "three-inch".</p>

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<p><b>Page 13, Section 1.13 Transmittal Letter (n) and Pages 51 and 52, Attachment C:</b> Section 1.13.n says the successful bidder will be required to complete the financial disclosure statement (Attachment C) with the executed contract. However on the bottom of Attachment C, Page 52, it says that Act 2001-955 requires the financial disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State in excess of \$5,000. Please clarify whether or not Attachment C is to be completed and submitted with the bid response.</p>	<p><b>Alabama Medicaid Agency Response:</b> The disclosure statement is to be completed and returned with the signed contract with the successful bidder.</p>
<p><b>Page 17, Section 2.2 History of Program:</b> What is the expected timing for transition to InterQual® criteria?</p>	<p><b>Alabama Medicaid Agency Response:</b> Unknown at this time.</p>
<p><b>Page 17, Section 2.3 Inpatient Services:</b> What has been the volume of hospital admissions by facility for 2012?</p>	<p><b>Alabama Medicaid Agency Response:</b> We do not have data for each hospital. For FY 2012 there were 113,246 hospital inpatient admissions.</p>
<p><b>Page 17, Section 2.3 Inpatient Services:</b> What are the expected total hospital admissions for fiscal years 2013, 2014, and 2015?</p>	<p><b>Alabama Medicaid Agency Response:</b> We would not anticipate much if any variance from previous years.</p>
<p><b>Page 17, Section 2.3 Inpatient Services:</b> How will the migration of Medicaid recipients to the Regional Care Organizations starting in 2016 impact the anticipated hospital admissions volume for this Contract?</p>	<p><b>Alabama Medicaid Agency Response:</b> Unknown at this time.</p>
<p><b>Page 17, Section 2.3 Inpatient Services:</b> Please clarify whether Children's Health Insurance Program (CHIP) are included in the cases that are subject to review under this contract.</p>	<p><b>Alabama Medicaid Agency Response:</b> CHIP is not included.</p>

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<p><b>Page 17, Section 2.4 Reporting:</b> After the initial start-up period of the contract, will scheduled meetings be onsite or telephonic?</p>	<p><b>Alabama Medicaid Agency Response:</b> Initial meetings may be held onsite at the Agency as indicated with regular monthly meetings via conference call.</p>
<p><b>Page 18, Section 2.6 Informal Review and Fair Hearing:</b> How many Informal Reviews and Fair Hearings did the incumbent contractor's personnel participate in 2012?</p>	<p><b>Alabama Medicaid Agency Response:</b> No Fair Hearings were held in 2012.</p>
<p><b>Page 18, Section 2.6 Informal Review and Fair Hearing:</b> How many Informal Reviews and Fair Hearings are anticipated in fiscal years 2014, 2015, and 2016?</p>	<p><b>Alabama Medicaid Agency Response:</b> Unknown.</p>
<p><b>Page 18, Section 2.5 Additional Contractor Responsibilities (a):</b> How will the fair hearing dates and times be coordinated between the State and the Contractor?</p>	<p><b>Alabama Medicaid Agency Response:</b> These dates are set at the availability of the Fair Hearing Officer.</p>
<p><b>Page 18, Section 2.5 Additional Contractor Responsibilities (a):</b> How much notice will be allowed for the Contractor to coordinate physician advisor availability for a Fair Hearing?</p>	<p><b>Alabama Medicaid Agency Response:</b> All parties involved will be notified via e-mail within a reasonable time frame.</p>
<p><b>Page 18, Section 2.6 Informal Review and Fair Hearing (a):</b> How many informal reviews were requested in 2012, and how many are anticipated in 2014?</p>	<p><b>Alabama Medicaid Agency Response:</b> There were 30 Informal Reviews (reconsiderations) in the last 12 months. Unable to predict the number of these for 2014.</p>
<p><b>Page 18, Section 2.6 Informal Review and Fair Hearing (b):</b> Will the Contractor's personnel need to attend a Fair Hearing in person or can participation be telephonic? Please explain the role of the Contractor with Fair Hearings.</p>	<p><b>Alabama Medicaid Agency Response:</b> Fair Hearings require the Contractor's consulting physician advisor and other appropriate personnel who were involved in the denial to attend in person. The Contractor participation role is to act as subject matter expert and provide justification for the denial.</p>

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<p><b>Page, 19, Section 2.7 Monitoring, Performance Standards and Corrective Action Plans:</b> How frequently will performance audits be conducted?</p>	<p><b>Alabama Medicaid Agency Response:</b> This will be done via review of monthly and quarterly reports provided the Agency, quarterly audit of sample of Contractor reviews and during the monthly conference call with the Contractor.</p>
<p><b>Page, 19, Section 2.7 Monitoring, Performance Standards and Corrective Action Plans:</b> Please describe where the performance reviews will be conducted.</p>	<p><b>Alabama Medicaid Agency Response:</b> At the Medicaid Agency central office in Montgomery, AL</p>
<p><b>Page 19, Section 2.8 Operational Requirements:</b> Please clarify what data will be required to be entered into the DSS and the interfacing requirement with DSS.</p>	<p><b>Alabama Medicaid Agency Response:</b> Access to DSS/BO will be given to the Contractor in order to access claims history data. The DSS/BO query should only require the Contractor to refresh dates of service in order to generate the necessary report.</p>
<p><b>Page 19, Section 2.8 Operational Requirements:</b> Please confirm that entry of review determinations will occur in the state system.</p>	<p><b>Alabama Medicaid Agency Response:</b> No state system is used for entry of review determinations.</p>
<p><b>Page 19, Section 2.8 Operational Requirements:</b> Please describe any associated costs to the Contractor for accessing any state systems for this contract.</p>	<p><b>Alabama Medicaid Agency Response:</b> None.</p>
<p><b>Page 21, Section 3.0 General:</b> How many inpatient retrospective admission and continued stay reviews were conducted in the past year?</p>	<p><b>Alabama Medicaid Agency Response:</b> The average number of selected cases for review ranges from 900-1,400/quarter.</p>
<p><b>Page 21, Section 3.1 Key Personnel:</b> Since the registered nurse reviewers and physician advisors must be licensed in the State of Alabama, is the Contractor expected to have an office location in the State of Alabama?</p>	<p><b>Alabama Medicaid Agency Response:</b> No.</p>

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<p><b>Page 22, Section 3.2 Admission and Continued Stay Criteria:</b> What is the average time it takes to complete a single retrospective review inclusive of entry into the state system?</p>	<p><b>Alabama Medicaid Agency Response:</b> That would depend on the complexity of the review, if additional records were requested, if physician review was needed etc. The goal is to complete 80-90% of selected cases per quarter. There is no entry of information into the state system.</p>
<p><b>Page 21, Section Admission and Continued Stay Criteria, Requirement 3.2(a):</b> If the Contractor determines there is a need for additional information to complete the medical review, how much time will be allowed for the hospital to submit additional information? Once additional information is received, how much time will the Contractor have to complete the medical review?</p>	<p><b>Alabama Medicaid Agency Response:</b> This time frame will be discussed between Contractor and Medicaid. The goal is to complete 80-90% of selected cases for each quarter.</p>
<p><b>Page 21, Section 3.2 Admission and Continued Stay Criteria, Requirement (a):</b> If the state approved criteria do not exist for a particular review diagnosis or procedure, what is the process to be followed? For example, does the Contractor use alternative criteria, or is there another process the Contractor should follow?</p>	<p><b>Alabama Medicaid Agency Response:</b> This will be determined and discussed between Medicaid and the Contractor on a case by case basis.</p>
<p><b>Page 21, Section 3.2 Admission and Continued Stay Criteria, Requirement (a):</b> Are patient's medical records received by HP fiscal agent, scanned and stored in the agent FEITH system for access to complete the review? If not, how will the Contractor obtain the copies of medical records for review?</p>	<p><b>Alabama Medicaid Agency Response:</b> The Contractor is responsible for correspondence to hospital providers and the request of records from them. This can be done via mail, fax or electronically. The records can then be sent to the Contractor via mail, electronically, or on a password protected CD.</p>
<p><b>Page 21, Section 3.2 Admission and Continued Stay Criteria, Sampling (b):</b> Please clarify how the 5% sampling is produced and by whom.</p>	<p><b>Alabama Medicaid Agency Response:</b> Via the VPN connection the Contractor will have access to a DSS/BO query from which they will generate a report that contains hospital paid claims for the timeframe selected. The Contractor will then do a random selection of 5% sample from all hospitals that appear on the report. If a hospital provider only has one paid claim, that provider must be included in the review as the goal is to review all hospitals with paid claims per quarter reviewed.</p>
<p><b>Page 21, Section 3.2 Admission and Continued Stay Criteria, Sampling (b):</b> Please confirm that the sampling expected to be 5% of each hospital's Medicaid admissions during the previous quarter.</p>	<p><b>Alabama Medicaid Agency Response:</b> See response above.</p>

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<p><b>Page 21, Section 3.2 Admission and Continued Stay Criteria, Requirement (a):</b> Will this Contractor be required to reimburse hospitals for copying and/or postage costs? If so, please describe what the reimbursements are expected to be.</p>	<p><b>Alabama Medicaid Agency Response:</b> No</p>
<p><b>Page 22, Section 3.2 Admission and Continued Stay Criteria, Timeframes(c):</b> Can retrospective reviews be staggered in order to be completed monthly instead of quarterly?</p>	<p><b>Alabama Medicaid Agency Response:</b> No</p>
<p><b>Page 22, Section 3.2 Admission and Continued Stay Criteria, Timeframes (c):</b> Please confirm that hospitals have one month to provide requested records as shown in the schedule. What is the process if the requested records are not received at all or not received timely from the hospital?</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes, hospitals have 30 days to provide requested records as shown in the schedule on page 22. The process to address timeliness of records not received will be determined between Medicaid and the Contractor.</p>
<p><b>Page 22, Section 3.2 Admission and Continued Stay Criteria, Timeframes (c):</b> How many days does the contractor have overall to complete the review from receipt of all information required to make a determination?</p>	<p><b>Alabama Medicaid Agency Response:</b> The goal is to complete 80-90% of selected cases per quarter to avoid large number of cases to carry over to the next quarterly review. The 1<sup>st</sup> level review shall be done within 15-30 days of receipt of the records. Completion of a review depends on the complexity of the review, if additional records were requested, if physician review was needed etc.</p>
<p><b>Page 22, Section 3.2 Admission and Continued Stay Criteria, Timeframes (c):</b> The RFP says the first chart review will be performed January 2014 based on dates of services April 1, 2013 through September 30, 2013. January 2014 is prior to the program start date provided in Section 1.3. Please clarify which start date bidders should assume for their pricing. Also, please advise if January 1, 2014 is the date the case selection requests are to be sent by the Contractor to the hospitals for the six month review or if it is the date the records are due to the Contractor to start performing reviews.</p>	<p><b>Alabama Medicaid Agency Response:</b> This ITB section will be amended to remove 'performed' and add 'selected'. The contract start date is November 1, 2013.</p>

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<p><b>Page 22, 3.2 Admission and Continued Stay Criteria, Timeframes (c):</b> Please describe how the Contractor should handle those cases where the hospital does not provide the requested additional information within the specified timeframes.</p>	<p><b>Alabama Medicaid Agency Response:</b> Hospitals have 30 days to provide requested records as shown in the schedule on page 22. The process to address timeliness of records not received will be determined between Medicaid and the Contractor.</p>
<p><b>Page 22, 3.2 Admission and Continued Stay Criteria, Report of Findings (d):</b> Please confirm that the State system can produce the required reports that are described in this Section.</p>	<p><b>Alabama Medicaid Agency Response:</b> Reports are generated by the Contractor. No state system is involved in the production of reports.</p>
<p><b>Page 23, Section 3.2 Admission and Continued Stay Criteria, Claim Recoupment/Adjustment, (e)(3):</b> How does the State categorize billing errors for recoupment purposes?</p>	<p><b>Alabama Medicaid Agency Response:</b> Billing errors are identified by the Contractor. These are determined on a case by case basis. For example: When an outpatient surgery has been billed as an inpatient day.</p>
<p><b>Page 23, Section 3.3 Provider Preventable Conditions (PPCs):</b> Will the review for Provider Preventable Conditions be performed using the 5% sample described in Section 3.2.(a), or are they to be identified for all claims through a DSS query or through some other method?</p> <p>Also, please clarify that the Contractor is only identifying and reporting on hospital acquired conditions (HACs) and not on Other Provider Preventable Conditions (OPPCs).</p>	<p><b>Alabama Medicaid Agency Response:</b> A separate report is generated through DSS and 100% of patients that appear on the report must be reviewed and included in the CMS HAC report. Medical record requests for review will be required on a 10% sample for each quarter. An amendment will be made in this section. If the Contractor identifies questionable POA indicators on the report (e.g., recipient with fracture and POA indicator of N) medical record review may then be indicated as well in those instances.</p> <p>Yes, the Contractor is only identifying and reporting on HAC's and not OPPCs.</p>
<p><b>Page 23, Section 3.4 Internal Utilization Review Plans (a):</b> Is there a tool currently being used for evaluation of the appropriateness of the Internal UR Plans? If so, we would like to request a copy of that tool.</p>	<p><b>Alabama Medicaid Agency Response:</b> The Contractor will develop and use a tool approved by the Agency.</p>
<p><b>Page 23, Section 3.4 (c)(2):</b> What timelines are allowed between request for the UR plan and when the hospital is required to send the plan? Will the Contractor be advised which hospitals are due in the coming year for review?</p>	<p><b>Alabama Medicaid Agency Response:</b> What timelines are allowed between request for the UR plan and when the hospital is required to send the plan? This will be determined between Medicaid and the Contractor.</p> <p>Will the Contractor be advised which hospitals are due in the coming year for review? Yes</p>

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<p><b>Page 23, Section 3.4 Internal Utilization Review Plans (d):</b> Please describe the responsibility of the contractor in follow-up of unsatisfactory plans. Does the contractor work directly with the facility? Is there a timeline upon which the facility must respond to a finding of an unsatisfactory plan once the notification is sent to the facility?</p>	<p><b>Alabama Medicaid Agency Response:</b> This will be determined between Medicaid and the Contractor.</p>
<p><b>Page 24, Section 3.5 Medical Care Evaluation (MCE) Studies, Requirement (a):</b> Is there a tool currently being used for evaluation of the appropriateness of the MCE Studies? If so, we would like to request that tool.</p>	<p><b>Alabama Medicaid Agency Response:</b> The Contractor will develop and use a tool approved by the Agency.</p>
<p><b>Page 25, Section 3.8 InterQual® Criteria:</b> When does the State anticipate converting to InterQual criteria?</p>	<p><b>Alabama Medicaid Agency Response:</b> Unknown at this time.</p>
<p><b>Page 25, Section 3.8 InterQual® Criteria:</b> When the State begins using InterQual criteria, will the contract use InterQual criteria for admission and continued stay reviews instead of the Medicaid-approved Adult and Pediatric Inpatient Care Criteria (Attachment D)?</p>	<p><b>Alabama Medicaid Agency Response:</b> Medicaid and the Contractor will work together to implement InterQual® and Local Medicaid policy.</p>
<p><b>Page 26, Section 3.8 InterQual® Criteria:</b> Who are you referring to as InterQual staff? Will the InterQual pass-through cost be a separate cost in view of the need to contract with McKesson for the ability to share criteria in this manner? Is InterQual training of Agency staff for use of the criteria to be included in the pass-through cost as well?</p>	<p><b>Alabama Medicaid Agency Response:</b> Who are you referring to as InterQual® staff? An amendment will be made to this section to change 'InterQual®' to 'Contractor'. Will the InterQual® pass-through cost be a separate cost in view of the need to contract with McKesson for the ability to share criteria in this manner? Yes. Is InterQual® training of Agency staff for use of the criteria to be included in the pass-through cost as well? No.</p>
<p><b>Page 26, Section 3.8 InterQual® Criteria (1):</b> In stating "to compare existing Medicaid policies to InterQual criteria and make recommendations for changes to avoid conflicts".....is it the intent of the Agency to maintain the rigor of the current policy, when changing to InterQual as the nationally recognized criteria set?</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes.</p>

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<p><b>Page 26, Section 3.9 Medicaid’s Responsibilities (b):</b> Does “referred charts” in this context of audits mean those that have gone to physician advisors? If not, please explain.</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes.</p>
<p><b>Page 28, Section 4.4 Contract Term:</b> The ITB states, “Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended at the <b>same rate</b> paid by Medicaid for the initial contract term.” The Alabama Medicaid Agency is migrating to Regional Care Organizations and there is the potential for expansion of the Medicaid program. This could result in significantly fewer or significantly more Medicaid recipients, and therefore fewer significantly fewer or significantly more hospital admissions in future years. How will the State make adjustments to the Contractor’s future pricing in light of the potential impact on the number of Medicaid recipients and hospital admissions?</p>	<p><b>Alabama Medicaid Agency Response:</b> Unknown.</p>
<p><b>Page 38, Section 4.35 Guarantees, Warranties, and Certifications:</b> Will the State agree that the Contractor will not be liable to indemnify the State for claims to the extent that those claims arose from the negligence or willful acts or omissions of the State or its employees or agents?</p>	<p><b>Alabama Medicaid Agency Response:</b> The referenced ITB section will remain as written.</p>
<p><b>Page 39, Section 4.35 Guarantees, Warranties, Certifications, Performance Guarantee (e):</b> If the Contractor’s performance has been satisfactory, will the performance guarantee be refunded to the Contractor at the end of the contract/applicable optional renewal period? Please describe.</p>	<p><b>Alabama Medicaid Agency Response:</b> No.</p>

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<p><b>Page 40, Section 4.36 Contract Sanctions-Liquidated Damages:</b> Please describe how liquidated damages are determined?</p>	<p><b>Alabama Medicaid Agency Response:</b> Refer to Page 40, 4.36 (a-k).</p>
<p><b>General Questions:</b> Please describe any changes in the SOW compared to the previous RFP?</p>	<p><b>Alabama Medicaid Agency Response:</b> Addition of: review of PPCs (HAC/POA); four full time RN's; requirement to complete 80-90% of selected cases each quarter; addition of the schedule of review table; more specificity to Report of Findings and Claims adjustment/Recoupment sections; change to UR Plan and MCE Study timeframes and report of findings.</p>
<p><b>General Questions:</b> Are there any anticipated changes to the Medicaid population to be served under this RFP? For example, moving to managed care, etc.</p>	<p><b>Alabama Medicaid Agency Response:</b> Unknown.</p>
<p><b>Section 1, 1.0 Purpose Page 5, Paragraph 1:</b> When does the agency anticipate the implementation of InterQual® criteria?</p>	<p><b>Alabama Medicaid Agency Response:</b> Unknown at this time.</p>
<p><b>Section 1, 1.6 Amendments to BID Page 8, Paragraph 1:</b> Please clarify that just the copy of the signed signature page is required not if the entire Amendment?</p>	<p><b>Alabama Medicaid Agency Response:</b> Please review page 2 of the Invitation to Bid provided to you from State Purchasing. This document has specific instructions on how to submit the proposal.</p>
<p><b>Section 1, 1.12 Specifications Format Page 12 Paragraph 1:</b> Please clarify where the bid pricing information should be placed within our response? Should technical and bid price be within the same binder or separate? Please clarify format/layout?</p>	<p><b>Alabama Medicaid Agency Response:</b> Please review page 2 of the Invitation to Bid provided to you from State Purchasing. This document has specific instructions on how to submit the proposal.</p>
<p><b>Section 2, 2.5 Additional Contractor Responsibilities Page 18, Paragraph 2.a:</b>          "...physician advisors should be available during normal business hours of 8:00am-5:00pm, Monday through Friday, Central Time." When physicians participate in informal hearings resulting from appeals/denied reviews, is this done telephonically? Please provide the</p>	<p><b>Alabama Medicaid Agency Response:</b> Please refer to page 18 of the ITB section 2.6 (a).           Please provide the number of reconsiderations, informal hearings and appeals per year: In the last 12 months there were 30 reconsiderations/informal hearings. If by appeal you mean Fair Hearing, there were none in the last 12 months.</p>

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<p>number of reconsiderations, informal hearings and appeals per year.</p>	
<p><b>Section 2, 2.6. Informal Review and Fair Hearing Page 18, Paragraph 3.b:</b> Is it the vendors responsibility to notify all parties via a letter of final decision (appeal, informal hearing, fair hearing, etc.?)</p>	<p><b>Alabama Medicaid Agency Response:</b> The Contractor is responsible to notify related to reconsideration (informal review). Fair Hearing decision notification would come from the Agency.</p>
<p><b>Section 2, 2.8 - Operational Requirements Page 19, Paragraph 2:</b> Is a leased line required for the site-to-site VPN connection between the Contractor and the Fiscal Agent? As an alternative, may the Contractor utilize a <u>secure</u> site-to-site VPN, utilizing the public internet, without incurring the cost of a leased line?</p>	<p><b>Alabama Medicaid Agency Response:</b> No, a leased line is not required for the site-to site VPN connection between the Contractor and the Fiscal Agent.</p> <p>Yes, the Contractor may utilize a secure site-to-site VPN utilizing the public internet. However, the Fiscal Agent charges a one-time setup fee (currently \$1,600) and a quarterly charge currently \$1,350 for this connection.</p> <p>The Fiscal Agent does not support client based VPN connection from external agencies or contractors.</p>
<p><b>Section 2, 2.8 - Operational Requirements Page 19, Paragraph 2:</b> As an alternative to the desktop configuration identified, may the Contractor employ Windows 7 embedded thin-client virtual desktops to access the State's Medicaid system?</p>	<p><b>Alabama Medicaid Agency Response:</b> No.</p>
<p><b>Section 3, 3.1 Key Personnel Page 21, Paragraph 2:</b> Can the project manager and the clinical director be serviced by the same individual? Must these individuals serve as a FTE?</p>	<p><b>Alabama Medicaid Agency Response:</b> Can the project manager and the clinical director be serviced by the same individual? No. Must these individuals serve as a FTE? Yes.</p>
<p><b>Section 3, 3.1 Key Personnel Page 21, Paragraph 2:</b> The previous RFP did not require a specific number of Nurse Reviewer FTE's. How has the agency determined that 4 FTE's are needed?</p>	<p><b>Alabama Medicaid Agency Response:</b> Based on the volume of reviews and the goal to complete 80-90% of selected cases per quarter.</p>

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<p><b>Section 3, 3.2.b – Sampling Page 21, Paragraph 3:</b> Does each day of the hospitalization need to be validated with criteria? If so, what is the average length of stay for?</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes admission through discharge must meet the current Adult or Pediatric Severity of Illness and Intensity of Illness Criteria. Average length of stay varies.</p>
<p><b>Section 3, 3.2.b – Sampling Page 21, Paragraph 4:</b> Which party is responsible for the sample selection?</p> <p>If not the Contractor, how will the information be communicated to the Contractor?</p>	<p><b>Alabama Medicaid Agency Response:</b> The Contractor.</p>
<p><b>Section 3, 3.2.b – Sampling Page 21, Paragraph 4:</b> If a provider fails to submit a medical record are we to deny the services?</p>	<p><b>Alabama Medicaid Agency Response:</b> If the hospital fails to provide the documents the Contractor should notify the hospital of this and the possibility that the Agency may recoup payment for the admission. The Contractor should keep a running spreadsheet that details providers who have failed to provide requested documentation and include in the quarterly report and have available at Agency request.</p>
<p><b>Section 3, 3.2.b – Sampling Page 21, Paragraph 4:</b> Is an oversample necessary to ensure the proper amount of records are reviewed each month in the event a provider fails to produce a record?</p>	<p><b>Alabama Medicaid Agency Response:</b> No.</p>
<p><b>Section 3, 3.3 Provider Preventable Conditions (PPC)s Page 23, Paragraph 1.1:</b> What does DSS query stand for?</p>	<p><b>Alabama Medicaid Agency Response:</b> DSS stands for Decision Support System also known as BO, Business Objects. This is a program that is capable of generating custom reports which contain claims information among other things.</p>
<p><b>Section 3, 3.7 Reconsiderations Page 25, Paragraph 1 Page 25, Paragraph 1:</b> How does a reconsideration differ from an informal hearing?</p> <p><b>Page 25, Paragraph 1.d:</b> Is it the vendors responsibility to send the final decision notification letter to the provider?</p>	<p><b>Alabama Medicaid Agency Response:</b></p> <p>They are one in the same.</p> <p>Yes.</p>
<p><b>Section 4, 4.36 Contract Sanctions Page 40, Paragraph 1:</b> What is the history of this contract regarding sanctions and liquidated damages?</p>	<p><b>Alabama Medicaid Agency Response:</b> There have been none during the current contract period.</p>

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<p><b>Attachment B, 3 (f) Page 45, Paragraph 6:</b> Can the State further clarify the method/means by which business associate must provide access to PHI and to whom this access should be given?</p>	<p><b>Alabama Medicaid Agency Response:</b> Alabama Medicaid has an obligation as a Covered Entity under HIPAA to provide Medicaid recipients access to their information that is part of our designated record set (DRS) upon request. If the Business Associate maintains any Medicaid Recipient records that are part of the DRS, Alabama Medicaid will send a request to the Business Associate in writing to request copies of the those records needed to comply with any HIPAA obligations. The method and means of access could vary from paper copies of information, electronic copies, or physical inspection on-site. The method and means of access will be specified in the request for access.</p>
<p><b>Attachment B, 3 (g) Page 46, Paragraph 1:</b> Can the State clarify by what means a "written request" from Covered Entity will be delivered to business associate?</p>	<p><b>Alabama Medicaid Agency Response:</b> The Alabama Medicaid Privacy Officer will send written request to amend a recipient's record containing PHI on official Agency letterhead and send to the original request via US Mail to the Business Associate.</p>
<p><b>Attachment B, 3 (l) Page 46, Paragraph 6:</b> Can the State clarify the means by which business associate is expected to notify Covered Entity of a breach and to whom the notification should made?</p>	<p><b>Alabama Medicaid Agency Response:</b> The Business Associate can provide notice of a breach via phone, email (by secure method if PHI is included), or regular mail. Notice can be provided to the Alabama Medicaid office responsible for this contract or the Agency's Privacy or Legal Offices.</p>
<p><b>Attachment B, 3 (n) and (o) Page 46, Paragraph 8-9:</b> Did the State intend to require notification to Covered Entity prior to providing necessary notices, as opposed to approval?</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes. Any breach must be reported to Alabama Medicaid before notifications are provided.</p>
<p><b>Section 1.3; ITB page 6 Schedule of Activities:</b> Requesting clarification of Program start date. Schedule on page 6 indicates February 1, 2014; 3.2 Admission and Continued Stay Criteria-Timeframes, ITB page 22 indicates that "first chart review will be performed January 2014."</p>	<p><b>Alabama Medicaid Agency Response:</b> This time frame allows the vendor a startup time-frame for obtaining VPN access, running queries for data, data connectivity, to request selected records for review, policy and procedure manual development, etc. The Contractor will be performing services as described in the ITB (reviews, etc.) no later than February 1, 2014. Section 3.2 (c) will be amended to remove 'performed' and add 'selected'. The contract start date is November 1, 2013.</p>
<p><b>Section 3.4; ITB page 24 Internal Utilization Review Plans-Report of Findings-d. (2):</b> ITB indicates that "Contractor will be expected to send Medicaid a spreadsheet by January 15<sup>th</sup> of the following year. Requesting clarification: January 15<sup>th</sup> of 2014 or January 15<sup>th</sup> of 2015</p>	<p><b>Alabama Medicaid Agency Response:</b> Upon start of work the Contractor will request UR Plans for CY 2013 and provide a completed report by January 15, 2015.</p>

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<p><b>Section 3.5; ITB page 24 Medical Care Evaluation (MCE) Studies-d. (2):</b> ITB indicates that “Contractor will be expected to send Medicaid a spreadsheet by January 15<sup>th</sup> of the following year.” Requesting clarification: January 15<sup>th</sup> of 2014 or January 15<sup>th</sup> of 2015</p>	<p><b>Alabama Medicaid Agency Response:</b> Upon start of work the Contractor will request Medical Care Evaluations (MCD) for CY 2013 and provide a completed report by January 15, 2015.</p>
<p><b>Section 3.6; ITB page 25 Procedure Manual-b. Timeframes:</b> ITB indicates that “Upon Medicaid approval, the manual will be made available to all hospitals and posted to the Contractor’s and Medicaid’s website. Question: Can the contractor produce two procedure manuals, one for the AL Agency (AMA) and one for posting in order to safeguard proprietary internal processes.</p>	<p><b>Alabama Medicaid Agency Response:</b> Any material and manuals produced for Medicaid should be suitable for posting without the need for an additional manual.</p>
<p><b>Section 3.6; ITB page 25 Procedure Manual-b. Timeframes:</b> ITB indicates, “Contractor’s and Medicaid’s website”. Question: Is contractor required to develop and maintain a separate Alabama Inpatient Hospital Quality Assurance website or use their existing website and provide a link to the Alabama Inpatient Hospital Quality information?</p>	<p><b>Alabama Medicaid Agency Response:</b> This can be discussed between Medicaid and the Contractor.</p>
<p><b>Section 1.8.h, Page 9:</b> Should the offeror include the business and technical components in the same three-ring notebook or should the business proposal be separate and sealed from the technical component?</p>	<p><b>Alabama Medicaid Agency Response:</b> Please review page 2 of the Invitation to Bid provided to you from State Purchasing. This document has specific instructions on how to submit the proposal.</p>
<p><b>Section 1.8.i., Page 10:</b> Will the Alabama Medicaid Agency provide the template for the bid pricing?</p>	<p><b>Alabama Medicaid Agency Response:</b> No</p>
<p><b>Section 1.8.i., Page 10:</b> In addition to the Division of Purchasing Pricing page, what additional information should accompany the bid price?</p>	<p><b>Alabama Medicaid Agency Response:</b> Please review page 2 of the Invitation to Bid provided to you from State Purchasing. This document has specific instructions on how to submit the proposal.</p>

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<p><b>Section 1.8. c (2), Page 9:</b> Please clarify the number and content for the electronic copies of the Bid response. The first sentence calls for three but the second sentence only describes two copies.</p>	<p><b>Alabama Medicaid Agency Response:</b> Section 1.8 c. (2) specifies that three electronic copies should be provided on CD, jump drive, or disc clearly labeled with the Bidder's name. An amendment will be made to this section to change "three" to "two".</p>
<p><b>Section 2.6, Page 18:</b> In this section, the ITB refers to an aggrieved party as the requesting provider or recipient. Are recipients to be notified of adverse determinations by the contractor or is it the hospital's responsibility to notify the recipient?</p>	<p><b>Alabama Medicaid Agency Response:</b> The Contractor only has to notify the hospital.</p>
<p><b>Section 3.2, Page 21:</b> Does the contractor conduct the sampling for the admission and continued stay retrospective reviews or does the State or HP select the sample</p>	<p><b>Alabama Medicaid Agency Response:</b> Via the VPN connection the Contractor will have access to a DSS/BO query from which they will generate a report that contains hospital paid claims for the timeframe selected. The Contractor will then do a random selection of 5% sample from all hospitals that appear on the report. If a hospital provider only has one paid claim, that provider must be included in the review as the goal is to review all hospitals with paid claims per quarter reviewed.</p>
<p><b>Section 3.3, Page 23:</b> What is the current annual volume of Provider Preventable Conditions cases subject to review?</p>	<p><b>Alabama Medicaid Agency Response:</b> Approximately 110</p>

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<p><b>Section 3.1 Page 21:</b> In the response to the previous question “Must these individuals serve as a FTE?” the response from Medicaid was “Yes”. Does the Alabama Medicaid Agency require that these two individuals (Project Manager and Clinical Director) serve as 100% dedicated full time employees (40 hours/week) on this contract?</p>	<p><b>Alabama Medicaid Agency Response:</b> After further review by Medicaid, the Project Manager and the Clinical Director may serve as one FTE, it is expected that the Project Manager would manage day to day operations and would spend more time than the Clinical Director on this contract. The FTE percentage of time allocated for the Clinical Director will be determined by the contractor.</p>
<p><b>Section 3.1 Page 21:</b> Is the Clinical Director required to be a physician, i.e., a licensed Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) or are other healthcare related professionals (i.e., nurses) appropriate for this position?</p>	<p><b>Alabama Medicaid Agency Response:</b> Other healthcare related professionals are appropriate for this position.</p>
<p><b>Section 3.1 Page 21:</b> Are all four (4) registered nurses listed in this section expected to serve as 100% dedicated full time employees (40 hours/week) on this contract?</p>	<p><b>Alabama Medicaid Agency Response:</b> Yes.</p>
<p><b>Section 3.8 Page 25:</b> In what form is the contractor required to provide the Agency with a complete set of InterQual® criteria annually, i.e., hardcopy notebook or electronic? If hardcopy, how many copies of the InterQual® criteria will be required to be provided to the Agency?</p>	<p><b>Alabama Medicaid Agency Response:</b> One hard copy each of the Acute Care Pediatric and Acute Care Adult Criteria.</p>
<p><b>Section 3.8 Page 25 and Bid Form Page 6:</b> Should the offeror include the InterQual® criteria pass-through costs in its Bid Total? If not, where should InterQual® criteria pass-through costs be shown? Should this be a line item by itself on Page 6 of the bid form and then included in the bid total?</p>	<p><b>Alabama Medicaid Agency Response:</b> See section 1.8, (j), page 10, “the firm and fixed annual bid price submission shall exclude the cost of InterQual® criteria, which shall be a pass-through expense.” This expense should not be included in the bid total.</p>
<p><b>Bid Form Page 6:</b> Should the offeror consider the Unit Price as the initial 24 month contract amount and the Extended Amount be the total of the three (3) one-year extensions? If not, please provide guidance on what number should be placed in the Unit Price and Extended Amount column?</p>	<p><b>Alabama Medicaid Agency Response:</b> Please review page 2, #4 of the Invitation to Bid provided to you from State Purchasing. This document has specific instructions on how to submit the proposal. Per the instructions on page 2, the only column that must be filled is the unit price column. See section 1.8 (i), Bid Submission Requirements, page 10 which indicates the bid is a firm and fixed price for <b>each year</b> of the contract, including any extensions. The amount listed on page 6 of the ITB Bid form should be the annual fixed price and listed under the unit price column only.</p>

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<p><b>3.1; ITB page 21 and Pre-Bid Q&amp;A page 16 Key Personnel:</b> Requesting clarification from the pre-bid questions and answers. "Can the project manager and the clinical director be serviced by the same individual? No. Must these individuals serve as a FTE? Yes." Please clarify the expected allocation for the Project Manager to be dedicated for this project. Please clarify the expected allocation of time for the Clinical Director to be dedicated for this project</p>	<p><b>Alabama Medicaid Agency Response:</b> After further review by Medicaid, the Project Manager and the Clinical Director may serve as one FTE, it is expected that the Project Manager would manage day to day operations and would spend more time than the Clinical Director on this contract. The FTE percentage of time allocated for the Clinical Director will be determined by the contractor.</p>
<p><b>3.2; ITB page 22 Admission and Continued Stay Criteria-c. Timeframes:</b> Should the last quarterly report be submitted July 2015 to include the full quarter of data or should a partial quarter report be submitted September 2015 before the contract ends?</p>	<p><b>Alabama Medicaid Agency Response:</b> Section 3.2, page 22-c timeline table would indicate a final quarterly report would need to be provided October 1, 2015 to cover the cases selected for 1<sup>st</sup> quarter of 2015 (January – March).</p>