

## Chapter 3

### Covered Services

This chapter covers the services for which hospitals may receive reimbursement through the Health Care Responsibility Act (HCRA). HCRA reimburses out-of-county hospitals for inpatient and outpatient emergency services. HCRA may also reimburse out-of-county hospitals for elective/non-emergency services, provided the services are not available in the county of residence and there is a prior agreement with the county of residence to treat the patient.

All counties must notify the Agency of its decision to provide in-county reimbursement starting with the county fiscal year 1999- 2000. Any changes to its decision must be filed with the Agency along with copies of notifications to the affected in-county hospitals no later than 45 days following the start of the new county fiscal year in which the change takes effect (on or around November 14).

All HCRA funds, whether in-county or out-of-county, are only to be used to reimburse hospitals for qualified indigent emergency or pre-approved non-emergency care. Please refer to Section 3-15, page 3-9, for services and care NOT covered by HCRA.

Additional information on non-emergency services is printed in Section 3-5. The policies regarding covered services used in HCRA are based on Rules 59G-4.150 and 59G-4.160, Florida Administrative Code (F.A.C.), and the Medicaid inpatient and outpatient covered services policy. Diagnoses or procedures not covered by Medicaid are also not covered through HCRA.

### Emergency Care

**3-1 Emergency Inpatient and Outpatient Services:** An “emergency medical” condition means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- A. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus;
- B. Serious impairment to bodily functions;
- C. Serious dysfunction of any bodily organ or part;
- D. With respect to a pregnant woman:
  - 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

***Or:***

The needed care and services were not available in the person's county of residence. Needed care and services are considered not available within the county of residence if a hospital within the county of residence transfers an indigent patient to an out-of- county hospital because the in-county hospital did not have the necessary treatment resources, such as diagnostic equipment or on- duty physicians, available.

**Note:** A physician must certify for each recipient that emergency services in a hospital are needed. The certification must be made at the time of admission. Upon request by the county of residence, the hospital will provide appropriate documentation to substantiate the emergency treatment.

**3-2 Emergency Services and Ability to Pay:** "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a participating or referral hospital. Emergency inpatient and outpatient services must be provided by the hospital without questioning the patient or any other person as to the ability to pay.

- A. In the emergency room admission process, the hospital may take financial information as long as the diagnosis and treatment has commenced.
- B. Likewise, in a patient transfer, a receiving hospital may not request a guarantee of payment from the transferring hospital as a condition of receiving the patient.
- C. Hospitals not having an organized emergency department must determine whether an emergency medical condition exists, provide treatment, and assist persons seeking emergency care in obtaining necessary services.

**3-3 Emergency Hysterectomies:** Emergency hysterectomies are covered through HCRA provided the physician who performs the hysterectomy certifies that it was performed under a life threatening emergency situation in which prior acknowledgement was not possible. The certification must include a description of the nature of the emergency and the hospital must attach the physician's certification to the UB-04 claim form.

**3-4 Abortions:** HCRA pays for abortions and related procedures only if the life of the mother would be endangered if the fetus were carried to term. In such cases the hospital must provide a written physician's certification to the county, that based on his professional judgment, the abortion was necessary because of danger to the life of the mother. Without this documentation, the county must deny the claim.

- A. The written statement must contain the name and address of the recipient.
- B. The statement must be signed by the physician.
- C. The hospital must attach this statement to the UB-92 claim form sent to the county for payment.

### **Non-Emergency Services**

**3-5 Elective and Non-Emergency Services:** No county shall be required to pay for elective or non-emergency admissions or services at an out-of-county hospital for a qualified indigent when one of the following conditions exist:

- A. If the county of residence provides funding for such services and the services are available at a hospital located within the resident county; or
- B. The out-of-county hospital has not obtained prior written authorization and approval for such hospital admission or service, provided that the resident county has established written procedures to authorize and approve such admissions or services.

Any such pre-authorization and pre-approval procedures must be filed with the Agency. Such procedures must include requirements for out-of-county hospitals to request and obtain written authorization and approval for elective and non-emergency services and admissions.

For in-county hospitals, the applicant must be a resident of the county where the hospital is located and services were provided and the county must have elected to reimburse its in-county hospitals. All in-county HCRA applicants must meet the same HCRA eligibility requirements used for out-of-county eligibility determination. If the county has established less restrictive requirements, the applicant would be required to meet the county's requirements on file with the Agency. The HCRA would not apply to persons active with a county medical assistance plan if the treating hospital is a participating facility under the county's medical assistance plan. The HCRA is the payor of last resort.

**3-6 Covered Oral Surgery:** Hospitals may receive reimbursement for inpatient hospital care for a medically necessary admission for an oral surgery procedure. Elective dental procedures are reimbursable only if there is a prior written approval made with the county of residence.

**3-7 Sterilization:** As an elective or non-emergency procedure, sterilization is voluntary on the part of the recipient and is covered through HCRA only if the procedure is not available in the county of residence, the county chooses to pay for such services, **and** ALL of the following circumstances are true:

- A. The patient was at least 21 years old at the time of signing a Florida Medicaid Sterilization Consent Form (see the Florida Medicaid Provider Reimbursement Handbook, UB-04, for a sample of the Sterilization Consent Form and the instructions on how to complete it);
- B. The patient was mentally competent and not institutionalized in a correctional, penal, or rehabilitative facility, including a mental hospital or any other facility for the care and treatment of mental illness;
- C. The Sterilization Consent Form was correctly completed at least 30 days prior to sterilization. The consent is valid for 180 days from the date the consent form was signed by the patient. Consent cannot be obtained during labor, childbirth, abortion, or under the influence of alcohol or other substances that affect the patient's state of awareness;
- D. When premature delivery is marked on the Sterilization Consent Form, the expected date of delivery must be entered. There must have been at least 30 days between the expected date of delivery and the date the Sterilization Consent Form is signed. If premature delivery or emergency abdominal surgery occurs between 72 hours and 30 days after the consent signature, an exception is allowed;
- E. The sterilization consent form must have been attached to the UB-04 claim form. HCRA will not pay for a sterilization without the completed consent form; and
- F. The physician's statement on the consent form must be signed and dated by the physician who performed the sterilization on the date of the sterilization or after the sterilization procedure was performed. The date of service on the sterilization claim form must be identical to the date and type of operation which are given in the physician's statement on the consent form.

**3-8 Organ Transplants:** HCRA covers specific organ transplants, such as kidney, heart, cornea, liver, lung, and bone marrow transplants that are medically necessary. Refer to the Medicaid Hospital Services Coverage and Limitations Handbook. Prior authorization is required for all transplants except cornea transplants. Transplants are not considered emergency procedures. All transplant procedures must be covered within the 45-day inpatient cap per recipient per fiscal year and are restricted to the hospital reimbursement rate. All transplants, except cornea, must be performed at approved Agency designated Organ Transplant Programs in Florida to be paid through HCRA.

- A. Approved Organ Transplant Programs may be found using Florida Health Finder at: <http://www.floridahealthfinder.gov/FacilityLocator/FacilitySearch.aspx>.
- B. Each approved transplant center has a Clinical Review Board, which may also be referred to as the evaluation team. This Board is responsible for the following:
  - 1. Evaluating the transplant candidate, and
  - 2. Determining whether or not a recipient is a suitable candidate for a transplant.
- C. To request prior authorization for an organ transplant procedure, the hospital must follow these steps:
  - 1. Verify that the county has chosen to establish procedures to authorize and approve admissions for such non-emergency services.
  - 2. Make sure the particular transplant is covered by HCRA.
  - 3. Attach a copy of the transplant evaluation performed by the Clinical Review Board.
  - 4. Send the prior authorization request to the county for medical review and approval.

If the county chooses to reimburse hospitals for transplant procedures, the county must review the request and verify medical necessity. The county must notify the hospital and patient if the reimbursement is approved or denied. If the county does not have access to medical staff to verify the necessity of the transplant, it may send the prior authorization request and documentation to the PDMM office at the address provided in Chapter 1, Section 1- 10, for review.

**3-9 Hysterectomies:** HCRA may pay for hysterectomies if they are not performed for the purpose of rendering a recipient permanently sterile, incapable of reproducing. These require prior authorization from the county. Other hysterectomy procedures are non- elective. HCRA may pay these if the county has established a procedure to authorize such admissions, if the procedure is not available in the county of residence, and if one of the following conditions is met:

- A. The person who obtained authorization to perform the hysterectomy has informed the recipient and her representative, if any, orally and in writing, that the procedure will make her incapable of reproducing. She or her representative, if any, must have signed a written acknowledgement of receipt of that information.

- B. The physician who performs the hysterectomy has certified that the individual was sterile at the time of the hysterectomy. On the same form, he must also state the cause of sterility.

## **Inpatient Care**

**3-10 Definition of Inpatient:** An inpatient is a person who has received inpatient hospital services for a period of 24 hours or longer or with the expectation that they will receive inpatient hospital services for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the hospital for 24 hours.

- A. Such a patient is considered an inpatient even if he can be discharged or transferred to another hospital within his county of residence in less than 24 hours and does not actually use a hospital bed overnight.
- B. HCRA inpatient reimbursement is limited to those eligible recipients who have been certified by a hospital utilization review committee as requiring inpatient hospital services.

**3-11 Inpatient Covered Services Included in the Inpatient Reimbursement Rate:** The following inpatient services are covered by HCRA within the reimbursement rate:

- A. Supplies, appliances, and equipment ordinarily furnished by the hospital for the care and treatment of the patient during his inpatient stay. The patient may take such items with him upon discharge only if they are attached to his body and are necessary to facilitate his release from the hospital.
- B. A bed in a semiprivate room (two to four beds in a room). Services shall be all inclusive. A private room shall be provided as part of the all inclusive service when ordered as a medical necessity by the attending physician.
- C. Drugs and biologicals for use in a hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients.
- D. Nursing and other related services, use of hospital facilities, and medical and social services ordinarily furnished by the hospital for inpatient treatment.
- E. The first three pints of blood, if provided within the inpatient setting, are included in the per diem rate.
- F. Diagnostic and therapeutic services as indicated in Rule 59G-4.150, F.A.C.

## **Outpatient Care**

**3-12 Outpatient Services:** Outpatient hospital services are medically necessary, preventative, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to an outpatient, by or under the direction of a physician or dentist, by an institution that is licensed as a hospital. Emergency outpatient services are covered under HCRA. Elective outpatient services are covered only if the county has established a procedure to reimburse such services as indicated in Section 3-5 of this Chapter.

**3-13 Definition of Outpatient:** An outpatient is a person who has not been formally admitted by the hospital for the purpose of receiving inpatient hospital services. If the hospital uses the category "day patient" to describe an individual who receives the hospital services during the day and is not expected to be lodged in the facility for more than 24 hours, then the individual is classified as an outpatient.

When a patient with a known diagnosis is admitted to a hospital for a specific minor surgical procedure or other treatment that is expected to keep the patient in the hospital for less than 24 hours, he is considered an outpatient regardless of the hour of admission, whether or not he used a bed, and whether or not he remained in the hospital past midnight.

**3-14 Outpatients Subsequently Admitted as Inpatients:** Sometimes a patient is admitted to the hospital as an inpatient after receiving outpatient services. In such situations, the hospital may be eligible for reimbursement of services as follows:

- A. If a patient is admitted to the hospital as an inpatient on the same day he received outpatient services, the hospital would bill the county for inpatient services, indicating the inpatient admit date as the date he received the outpatient services.
- B. If a patient is admitted as an inpatient before midnight of the day following the day he received outpatient services, the inpatient admit date is the date he is admitted as an inpatient. The outpatient services are then considered part of the inpatient hospital stay.

## **Limitations**

**3-15 Days of Care and Items Not Covered by HCRA:** The following items and days of care are not reimbursable through HCRA.

- A. All inpatient hospital days not certified as medically necessary.
- B. The patient's date of discharge from the hospital. The only exception is for an admission and discharge on the same day, which is reimbursable as one unit.

- C. Inpatient hospital days beyond the discharge checkout time for a patient who chooses to occupy hospital accommodations beyond that date.
- D. Administrative or grace days, or for leaves of absence by the hospital inpatient.
- E. Late discharge penalty charges.
- F. Physician services at the hospital (or elsewhere).
- G. Items not directly related to the treatment and care of an illness or injury, such as rental television, massage, haircuts, guest trays, and guest beds.
- H. Supplies, appliances and equipment furnished to an inpatient for use ONLY outside the hospital.
- I. Cosmetic surgery performed only for aesthetic purposes.
- J. Services of private duty nurses.
- K. Blood replacement fee.
- L. Items or services which are provided at no expense to the recipient.
- M. Revenue center codes NOT listed in Appendices O and P.

**3-16 Reimbursement Limitations:** The county must reimburse participating hospitals through HCRA for up to a maximum of 45 days of inpatient services and up to \$1,500 of emergency outpatient hospital services per eligible recipient per county fiscal year. Emergency outpatient services are reimbursable on a line-item Medicaid per diem rate. Reimbursement is covered further in Chapter 6.

The maximum amount of HCRA funds that a county can allocate for in-county reimbursement is up to ½ of its total HCRA funds, i.e., if a county must designate \$500,000 for the fiscal year, it can only use a maximum of \$250,000 for in-county hospital reimbursements. No county has the statutory authority to use out- of-county designated funds to supplement its in-county reimbursement amount above the aforementioned one half. Should a county exceed its designated in-county reimbursement limit, the additional funds must be provided through other funding sources from the county's budget and the amount exceeded shall not reduce the out-of-county obligation.

**3-17 Exceptions to the \$1,500 Reimbursement Limit:** The county may authorize exceptions to the \$1,500 outpatient reimbursement limit for certain surgical or medical procedures.