

1. Inpatient Hospital Services

Payment for inpatient hospital services is limited to medically necessary days only. Medically necessary days are days of stay approved by the State agency responsible for utilization review, or its designee, i.e., the Quality Improvement Organization (QIO), which evaluates the quality, necessity, and appropriateness of care and renders length of stay determinations.

All accommodations and ancillary services are paid for each approved, medically necessary day. The day(s) of discharge does not count toward the limit. No payment is made for days of stay beyond the determination of medical necessity.

Coverage of organ transplantation is limited as per Attachment 3.1-E.

Prior authorization is required for inpatient hospitalizations at out of state hospitals, excluding border facilities and emergency hospitalizations.

2. Outpatient Hospital Services

a. Outpatient Hospital

Payment for outpatient hospital services is limited to twelve (12) visits per recipient per state fiscal year.

b. FOHC's

Payment for federally qualified health center services (FQHC's) is limited to federal requirements.

3. Other Laboratory and X-Ray Services

Payment is limited to fifteen (15) diagnostic x-ray procedures per recipient per state fiscal year. This limit includes x-ray procedures when performed by a physician or an independent laboratory.

Prior authorization is required for the following diagnostic x-ray services unless they are performed as part of a hospital emergency department visit, as part of an inpatient hospitalization, or performed concurrent with, or on the same day as, an urgent care facility visit:

- computerized tomography (CT)
- magnetic resonance imaging (MRI)
- magnetic resonance angiography (MRA)
- positive emission tomography (PET)
- nuclear cardiology

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4a. Nursing Facility Services

Payment for nursing facility care is available to both categorically and medically needy recipients in need of such care. Payment for nursing facility care must be prior authorized for a specified period of time based on the amount and length of care recommended by the recipient's physician. Payment is made for a non-private room. Determination of need for nursing facility care and authorization of payment for nursing facility care is made by the Office of Long Term Care.

Medicaid-only certified beds in which nursing facility services are provided shall be at or about 5,146 beds statewide. However, the Department of Health and Human Services does not intend to attain this number of beds unless there is a need for the beds to ensure access to services. Furthermore, the Commissioner or his/her designee shall approve certification of additional Medicaid-only nursing facility beds if needed to ensure access to nursing facility services.*

Nursing facility beds certified for both Medicare and Medicaid will be approved in accordance with He-Hea 904.

4b. Early and Periodic Screening and Diagnosis

Limited to federal requirements for the medically needy. Any limits to services provided in Attachment 3.1-B do not apply to individuals under EPSDT as long as medical necessity criteria as determined by the Medical Services Unit has been met.

4c. Family Planning Services

Payment for family planning services is subject to the limitations of each service category under which it falls. Family planning services provided by agencies under contract obligation with the Office of Community and Public Health shall include education and counseling services.

*The legislature has mandated that funding be made available for appropriate and effective alternatives to nursing facility services. This can be accomplished by providing funding only for the number of nursing facility beds that are necessary to achieve the purpose of providing nursing facility services. The number of beds available to Medicaid eligibles is currently significantly greater than the number of beds occupied.