Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospital Services Rule, Section 8.300
Rule Number: MSB 23-05-17-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule change clarifies covered hospital services by moving from time based standards to medical necessity standards. The changes simplify inpatient, outpatient, and observation stay definitions and move the standards from those definitions to the covered services section of the rule. Criteria for medical necessity for inpatient, outpatient, and observation stays were also added to the covered services section. Technical changes were also addressed in this rule change such as changing in-network and out-of-network to in state and out of state. Temporal standards were also removed in the inpatient psychiatric covered services section. Corrective action was defined in rule and clarifying language was added to the utilization management section. This revision provides more clarity to hospitals and providers on medical necessity criteria and determining the appropriate level of care for members. The community clinic, including freestanding emergency departments, rule is also being revised to align with the proposed changes to the hospital services rule.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   Social Security Act, Section §§ 1905(a)(1-2) [42 U.S.C. 1396d(a)(1-2)] (2022); 42 C.F.R. §§ 440.10-.20 (2023)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Sections 25.5-5-102(1)(a-b), C.R.S. (2021)

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospital Services Rule, Section 8.300
Rule Number: MSB 23-05-17-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Hospitals that serve Health First Colorado members will benefit from clarified definitions and standards including medical necessity criteria. Members that utilize hospital services will benefit from being placed in appropriate levels of care as determined medically necessary.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Removing temporal standards from rule and clarifying medical necessity criteria will improve the clarity of the rule for providers and improve billing guidance. Members will be treated in a level of care that addresses their medical needs by medical necessity standards and not primarily by time-based standards2 The quantitative impact of the rule changes is that it will provide clarity regarding hospital admission standards and therefore reduce inappropriate admission and billing.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department anticipates that this rule change will be budget neutral. No new services are being provided just updating guidance. The updated guidance may result in paying for more observation stays in the outpatient setting; this is projected to be offset by a shift of claims billed for the inpatient setting to the outpatient setting.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The benefits of the proposed rule are improved clarity in the billing guidance for providers. Inaction will result in continued unclear standards in the hospital services rule. Not updating the rule could potentially discourage providers from enrolling and not provide care to Health First Colorado members. Also, needed technical changes would not be completed.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no other methods to implement this policy change.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There is no alternative method for achieving the purpose of the proposed rule2

8.300 HOSPITAL SERVICES

8.300.1 Definitions

8.300.1.A. Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.

8.300.1.B. Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.

8.300.1.C. Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.

8.300.1.D. Corrective Action is a step-by-step plan approved by the Department to achieve targeted outcomes and address patterns of inappropriate behavior, including, but not limited to, improper billing, unwarranted utilization, or questionable quality of care. Corrective action may include, but is not limited to, Concurrent Review, Continued Stay Review, Prospective Review, Retrospective Review, requirement to self-audit, or any other action as determined appropriate by the Department.

8.300.1.~~D~~E. Department means the Department of Health Care Policy and Financing.

8.300.1.~~E~~F. Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.

8.300.1.~~F~~G. DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals.

8.300.1.~~G~~H. Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury or other health condition in a client.

8.300.1.~~H~~I. Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.

8.300.1.~~I~~J. Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, 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: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

8.300.1.~~J~~K. Enhanced Ambulatory Patient Group (EAPG) means a cluster of similar procedures within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of services performed during Outpatient visits that utilize similar amounts of Hospital resources.

8.300.1.~~K~~L. Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment

(CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

1. A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

2. A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical services and/or obstetrical services including a delivery room and nursery.

3. A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.

4. A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.

5. A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital which primarily serves an inpatient population requiring longterm care services including but not limited to respiratory therapy, head trauma treatment, complex wound care, IV antibiotic treatment and pain management.

6. A Spine/Brain Injury Treatment Specialty Hospital licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital OR CMS-certified as a Rehabilitation Hospital is a Not-for Profit Hospital as determined by the CMS Cost Report for the most recent fiscal year. A Spine/Brain Injury Treatment Specialty Hospital primarily serves an inpatient population requiring long term acute care and extensive rehabilitation for recent spine/brain injuries. To qualify as a Spine/Brain Injury Treatment Specialty Hospital, for at least 50% of Medicaid members discharged in the preceding calendar year the hospital must have submitted Medicaid claims including spine/brain injury treatment codes (previously grouped to APR-DRG 40, 44, 55, 56, and 57). The Department shall revoke the designation if the percentage of Medicaid members discharged falls below the 50% requirement for a calendar year. Designation is removed the calendar year following the disqualifying year.

7. A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.

8. A Medicare Dependent Hospital is defined as set forth at 42 C.F.R § 412.103 (2022). 42 C.F.R. § 412.108(1) (~~2019~~2018) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S § 24-4-410(12.5)(V)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

9. A Non-independent Urban Hospital is a hospital which reports a name of the home office of the chain with which they are affiliated on the CMS-2552-10 Cost Report in Worksheet S-2 Part 1, Line 141, Column 1, with the exception of individual hospitals reporting an affiliation not reported amongst other hospitals located in Colorado.

8.300.1.~~L~~M. Inpatient is a person who has been admitted to a Hospital for purposes of receiving Inpatient Hospital Services~~means a person who is receiving professional services at a Hospital; the services include a room and are provided on a continuous 24-hour-a-day basis. Generally, a person is considered an Inpatient by a physician's order if formally admitted as an Inpatient with the expectation that the client will remain at least overnight and occupy a bed even though it later develops that the client can be discharged or transferred to another Hospital and does not actually use a bed overnight~~.

8.300.1.~~M~~N. Inpatient Hospital Services means services that are furnished by a Hospital for the care and treatment of an Inpatient and are provided in the Hospital by or under the direction of a physician~~preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by a Hospital for the care and treatment of Inpatients and are provided in the Hospital by or under the direction of a physician~~.

8.300.1.~~N~~O. Medical Necessity is defined at Section 8.076.1 and, for members ages 20 and under receiving Early and Periodic Screening, Diagnosis, and Treatment services, at Section 8.280.4.E.2.

8.300.1.~~O~~P. Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals, Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital are considered NonDRG Hospitals since their reimbursement is based on a per diem rate.

8.300.1.~~P~~Q. Observation Stay means Outpatient Hospital Services provided in a Hospital for the purposes of evaluating a person for Inpatient admission, stabilization, or extended recovery ~~a stay in the Hospital for no more than forty-eight hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed twenty-four hours in length~~.

8.300.1.~~Q~~R. Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.

8.300.1.~~R~~S. Outpatient means a person who is receiving professional services at a Hospital or an off campus location of a Hospital but is not admitted as an Inpatient~~client who is receiving professional services at a Hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-aday basis~~.

8.300.1.~~S~~T. Outpatient Hospital Services means services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist~~preventive, diagnostic, therapeutic,~~

~~rehabilitative, or palliative services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist~~.

8.300.1.~~T~~U. Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service prior to treatment.

8.300.1.~~U~~V. Rehabilitative Services means any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his/her best possible functional level.

8.300.1.~~V~~W. Relative Weight (DRG weight or EAPG weight) means a numerical value which reflects the relative resource consumption for the DRG or EAPG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost for each DRG or EAPG. Relative Weights are intended to be cost effective, and based upon Colorado data as available.

8.300.1.~~W~~X. Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.

8.300.1.~~X~~Y. Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by the United States Office of Management & Budget.

8.300.1.~~Y~~Z. State University Teaching Hospital means a Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education; and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

8.300.1.~~Z~~AA. Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called “swing beds.”

8.300.1.~~AA~~BB. Trim Point Day (Outlier Threshold Day) means the day during an inpatient stay after which Outlier Days are counted. The Trim Point Day occurs 2.58 standard deviations above the average length of stay for each DRG. Beginning July 1, 2020, the Trim Point Day for delivery and neonate DRGs is equal to the Trim Point Day as calculated in the applicable Hospital-Specific Relative Value National File for Delivery and Neonate DRGs.

8.300.1.~~BB~~CC. Urban Hospital means a Hospital located within a MSA as designated by the United States Office of Management & Budget.

8.300.1.~~CC~~DD. Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

8.300.2 Requirements for Participation

8.300.2.A In-Network In-State Hospitals

1. In order to qualify as an in-state-network Hospital, a Hospital must:

   a. be located in Colorado

   b. be certified for participation as a Hospital in the Medicare Program;

   c. have an approved Application for Participation with the Department; and

   d. have a fully executed contract with the Department.

2. A border-state Hospital (located outside of Colorado) which is more accessible to clients who require Hospital services than a Hospital located within the state may be an in-state-network Hospital by meeting the requirements of 10 CCR 2505-10 Section 8.300.2.A.1.b – c. The Department shall make the proximity determination for Hospitals to enroll as a border-state Hospital.

3. In-state Hospitals located in Colorado hospitals network and out-of-network Hospitals located in Colorado shall be surveyed by the CDPHE. Failure to satisfy the requirements of CDPHE may cause the Department to institute corrective action as it deems necessary.

8.300.2.B Out-of-State-of-Network Hospitals

An out-of-state-of-network Hospital, including out-of-state Hospitals, may receive payment for emergency Hospital services if:

1. the services meet the definition of Emergency Care;

2. the services are covered benefits;

3. the Hospital agrees on an individual case basis not to charge the client, or the client's relatives, for items and services which are covered Medicaid benefits, and to return any monies improperly collected for such covered items and services; and

4. the Hospital has an approved Application for Participation with the Department.

~~**8.300.2.C Out-of-State Hospitals**~~

Out-of-sState Hospitals may receive reimbursement for Outpatient Hospital Services if they meet the conditions specified in 10 CCR 2505-10 Section 8.300.2.B.2 – 4.

Out-of-state Hospitals may receive reimbursement for non-emergent Inpatient Hospital Services ~~Hospital services~~ if they meet the conditions specified in 10 CCR 2505-10 Section 8.300.2.B.2 – 4, and the Department has issued a ~~written~~ prior authorization.

8.300.2.CD Hospitals with Swing-Bed Designation

1. Hospitals which intend to designate beds as swing beds shall apply to CDPHE for certification of swing beds and to the Department for participation as a Medicaid provider of nursing facility services. The criteria in 10 CCR 2505-10 Section 8.430 must be met in order to become a Medicaid provider.

2. Hospitals providing nursing facility services in swing beds shall furnish within the per diem rate the same services, supplies and equipment which nursing facilities are required to provide.

3. Clients and/or their responsible parties shall not be charged for any of these required items or services as specified in 10 CCR 2505-10 Sections 8.440 and 8.482.

4. Hospitals providing nursing facility services to swing-bed clients shall be in compliance with the following nursing facility requirements.

   a. Client rights: 42 C.F.R. Section 483.10(b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (l), and (m).

   b. Client Admission, transfer and discharge rights: 42 C.F.R. Section 483.12 (a)(1) through (a)(7).

   c. Client behavior and facility practices: 42 C.F.R. Section 483.13.

   d. Client activities: 42 C.F.R. Section 483.15(f).

   e. Social Services: 42. C.F.R. Section 483.15(g).

   f. Discharge planning: 42 C.F.R. Section 483.20(e)

   g. Specialized rehabilitative services: 42 C.F.R. Section 483.45.

   h. Dental services: 42 C.F.R. Section 483.55.

5. Personal Needs Funds and Patient Payments

   Swing-bed Hospitals shall maintain personal needs accounts, submit AP-5615 forms, and be responsible for collecting patient payment amounts in accordance with the requirements established for nursing facilities in 10 CCR 2505-10 Section 8.482.

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

Inpatient Hospital Services are a covered Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. ~~1.~~ To support the Medical Necessity of an Inpatient admission, the provider must adequately document in the member's medical record that a provider with applicable expertise expressly determined that, based on the client's severity of illness, the client required services involving the intensity of services that cannot be provided safely and effectively in an ~~n~~ Outpatient setting. Such determination may take into account the amount of time the client is expected to require Inpatient Hospital Services. However, the decision to admit a client to Inpatient may not be based solely on the expected length of stay. The decision to admit a client to Inpatient is a medical determination that is based on a multitude of clinical factors, including, but not limited to the:

   a. Client's current medical needs;

   b. Client's medical history;

c. Severity of the signs and symptoms exhibited by the client at the time of presentation to the hospital, and at the point of admission decision;

d. Medical predictability of an adverse clinical event occurring with the client;

e. Results of diagnostic studies, laboratory tests, and other clinical tests and examinations; and

f. Types of services available to Inpatients and Outpatients at the specific hospital of admission

~~1.~~2. Inpatient Hospital services include:

a. bed and board, including special dietary service, in a semi-private room to the extent available;

b. professional services of H~~h~~ospital staff;

c. laboratory services provided within the Hospital, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;

d. related outpatient services, including but not limited to emergency department services, provided prior to Inpatient admission;~~emergency room services;~~

e. drugs, blood products; and

f. medical supplies, equipment and appliances as related to care and treatment~~; and~~

~~g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.~~

3~~2~~. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.

4~~3~~. Prior to July 1, 2020, Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

Beginning July 1, 2020, reimbursement for a mother's hospitalization for delivery does not include reimbursement for the newborn's hospitalization. Services shall be reimbursed under the identification number of each client.

5~~4.~~ Psychiatric Hospital Services

Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-~~-~~state ~~network~~ Hospital.

a. Inpatient care in a Psychiatric Hospital may require ~~is limited to forty-five (45) days per state fiscal year, unless additional services are~~ prior-authorization~~ed as~~

~~medically necessary~~ by the Department's utilization review vendor or other Department representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.

b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:

i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and

ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.

c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

6~~5.~~ Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in~~-~~state ~~network~~ DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

a. an acute medical condition for which dialysis treatments are required; or

b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or

c. placement or repair of the dialysis route ~~("shunt", "cannula")~~.

7~~6.~~ Inpatient Subacute Care

Administration of subacute care by an enrolled hospital in its inpatient hospital or alternate care facilities is covered for the duration of the Coronavirus Disease 2019 (COVID-19) public health emergency. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Members may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital.

8.300.3.B Covered Hospital Services – Outpatient

Outpatient Hospital Services are a Medicaid benefit when determined Medically Necessary and provided by or under the direction of a physician. Outpatient Hospital Services are limited to the

scope of Outpatient Hospital Services as defined in 42 C.F.R. Section 440.20. Outpatient Hospital Services include:

1. Observation Stays

Observation Stays are a covered Medicaid benefit when provided by or under the direction of a physician, for as many days as determined Medically Necessary. The physician must adequately document in the client's medical records that Observation Stay is Medically Necessary for the purposes of evaluating a client for possible Inpatient admission, treating a client expected to be stabilized and released without the need for Inpatient admission, or allowing extended recovery following a complication of an Outpatient procedure. In a majority of cases, the decision whether to admit a client to Inpatient admission or discharge from the hospital can be made in less than twenty-four hours. Only rarely shall Observation Stay exceed forty-eight hours in length.

Observation Stays end when a physician orders either Inpatient admission or discharge from the hospital. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged unless for purposes of rebilling after an audit finding as specified in 10 CCR 2505-10 8.043.

The decision to admit a client to Observation Stay is a medical determination that is based on a multitude of factors, including, but not limited to the:

a. Client's current medical needs;

b. Client's medical history;

c. Severity of the signs and symptoms exhibited by the client at the time of presentation to the hospital, and at the point of the admission to observation status;

d. Medical predictability of an adverse clinical event occurring with the client;

e. Results of diagnostic studies, laboratory tests, and other clinical tests and examinations; and

f. Types of services available to Inpatient and Outpatients at the specific hospital of admission

~~Observation stays are a covered benefit as follows:~~

~~a. Clients may be admitted as Outpatients to Observation Stay status.~~

~~b. With appropriate documentation, clients may stay in observation more than 24 hours, but an Observation Stay shall not exceed forty-eight hours in length.~~

~~c. A physician's order must be written prior to initiation of the Observation Stay.~~

~~d. Observation Stays end when the physician orders either Inpatient admission or discharge from observation.~~

~~e. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged.~~

2. Outpatient Hospital Psychiatric Services

Outpatient psychiatric services, including prevention, diagnosis and treatment of emotional or mental disorders, are Medicaid benefits at non-~~-~~Psychiatric Hospitals.~~DRG Hospitals.~~

a. Psychiatric outpatient services are not a Medicaid benefit in ~~freestanding~~ P~~p~~sychiatric H~~h~~ospitals.

3. Emergency Care

a. Emergency Care Services are a Medicaid benefit, and are exempt from primary care provider referral.

b. An appropriate medical screening examination and ancillary services such as laboratory and radiology shall be available to any individual who comes to the emergency treatment facility for examination or treatment of an emergent or apparently emergent medical condition and on whose behalf the examination or treatment is requested.

[SECTION 8.300.3.C. UNAFFECTED BY THIS RULE CHANGE, REMAINS AS-IS]

8.300.12 Utilization Management and Reviews ~~Activities~~

All participating ~~in-network~~ Hospitals are required to comply with utilization management and review, prior authorization requirements, audit and/or program integrity, and quality improvement activities administered by the Department's utilization review vendor, external quality review organization or other representative.

8.300.12.A Conduct of Reviews

1. All reviews will be conducted in compliance with 10 CCR 2505-10, Sections 8.058 Request for Prior Authorization, 8.076, Program Integrity, and 8.079, Quality Improvement.

2. Reviews will be conducted relying on the professional expertise of health professionals, prior experience and professional literature; and nationally accepted evidence-based utilization review screening criteria whenever possible. These criteria shall be used to determine the quality, Medical Necessity and appropriateness of a health care procedure, treatment or service under review.

3. The types of reviews conducted may include, but are not limited to the following:

a. Prospective Reviews;

b. Concurrent Reviews;

c. Reviews for continued stays and transfers;

d. Retrospective Reviews.

4. These reviews, for selected Inpatient or Outpatient procedures and/or services, shall include but are not limited to:

   a. Medical Necessity;

   b. Appropriateness of care;

   c. Service authorizations;

   d. Payment reviews;

   e. DRG validations;

   f. Outlier reviews;

   g. Second opinion reviews; and

   h. Quality of care reviews.

5. If criteria for Inpatient hospitalization or outpatient Hospital services are not met at any point in a hospitalization (i.e., at the point-of-admission review, Continued Stay Review or Retrospective Review) the provider will be notified of the finding.

   a. When appropriate, payment may be adjusted, denied or recouped.

6. When the justification for services is not found, a written notice of denial shall be issued to the client, attending physician and Hospital. Clients and providers may follow the Department's procedures for appeal. See 10 CCR 2505-10 Sections 8.050, Provider Appeals, and 8.057, Recipient Appeals.

8.300.12.B Corrective Action

1. The Department may require or recommend Corrective Action when documentation indicates a pattern of inappropriate behavior, including, but not limited to, improper billing, unwarranted utilization, or questionable quality of care. ~~Corrective action may be recommended when documentation indicates a pattern of inappropriate utilization, or questionable quality of care.~~

2. The Department may initiate sanctions, as set forth in 10 CCR 2505-10, Section 8.076 and Section 8.130 if the required Corrective Action is not implemented or the implemented Corrective Action fails to resolve the pattern of inappropriate behavior. ~~If corrective action does not resolve the problem, T~~the Department shall initiate sanctions, ~~as set forth in 10 CCR 2505-10, Section 8.076 and Section 8.130 if corrective action fails to resolve the problem.~~

3. ~~Retrospective Review may be performed as a type of corrective action for an identified Hospital or client.~~Requirement to self-audit, Retrospective Reviews, and other actions as determined appropriate by the Department may be required or performed as a type of Corrective Action for an identified Hospital or client.

[SECTION 8.300.12.C UNAFFACTED BY THIS RULE CHANGE, REMAINS AS-IS]

8.320 COMMUNITY CLINIC, INCLUDING FREESTANDING EMERGENCY DEPARTMENTS

8.320.1 Definitions

A. Community Clinic (CC) means a hospital-owned health care facility, licensed as a Community Clinic under 6 CCR 1011-1, Chapter IX or as a Freestanding Emergency Department (FSED) under 6 CCR 1011-1, Chapter XIII and enrolled as a CC provider type, that provides health care services on an ambulatory basis.

B. CMS means the Centers for Medicare and Medicaid Services.

C. Department means the Department of Health Care Policy and Financing.

D. Emergency Care Services, for the purposes of this rule, has the same meaning as Section 8.300.1.I.

E. Observation Stay, for the purposes of this rule, has the same meaning as Section 8.300.1.Q. ~~means a stay in the CC for no more than 48 hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed 24 hours.~~

[SECTIONS 8.320.2-4 UNAFFECTED BY THIS RULE CHANGE, REMAIN AS-IS]