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INPATIENT SERVICES

Louisiana Medicaid defines inpatient hospital as care needed for the treatment of an illness or injury which can only be provided safely and adequately in a hospital setting and includes those basic services that a hospital is expected to provide. Payment shall not be made for care that can be provided in the home or for which the primary purpose is of a convalescent or cosmetic nature.

Inpatient hospital services must be ordered by the attending physician, an emergency room physician or a dentist (if the patient has an existing condition which must be monitored during the performance of the authorized dental procedure).

The number of days of care charged to a recipient 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 to be used in counting days of care for Medicaid reporting purposes. A part of a day, including the day of admission, counts as a full day. However, the day of discharge or death is not counted as a day unless discharge or death occurs on the day of admission. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Pre-Admission Certification and Length of Stay Assignment

The Bureau of Health Services and Financing (BHSF)/Medicaid, requires registration and length of stay (LOS) assignment for all admissions to acute care and rehabilitation hospitals. Pre-admission certification and length of stay assignment is required for long-term hospitals and inpatient psychiatric/substance abuse services hospitals. Additional information regarding pre-admission certification and length of stay procedures can be found in Section 25.5 of this chapter.

NOTE: Inpatient admissions for dual **Medicare/Medicaid** recipients are not subject to these requirements except when Medicare Part A benefits have been exhausted or the recipient has Medicare Part B only.

Distinct Part Psychiatric Units

Medicaid recognizes Distinct Part Psychiatric Units within an acute care general hospital differently for reimbursement purposes if the unit meets Medicare's criteria for exclusion from Medicare's Prospective Payment System (PPS excluded unit). The unit must have the Health Standards Section verify that the Unit is in compliance with the PPS criteria and identify the number and location of beds in the psychiatric unit.

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A unit which qualifies for distinct part status must complete a separate provider enrollment packet and must be assigned a separate provider number from the rest of the hospital. Reimbursement for services provided in such a unit is a prospective per diem. This per diem includes all services provided to an inpatient of such a unit, except for physician services, which should be billed separately. All therapies (individual/group counseling or occupational therapy) shall be included in this per diem.

Providers bill on a UB-04 for these services. The hospital must set up the distinct part psychiatric unit as a separate cost center and be identified as a sub-provider on the hospital's cost report. The costs for this unit are not subject to cost settlement. Additional information regarding Distinct Part Psychiatric Units can be found in the section entitled Pre-Admission Certification/Length of Stay.

Obstetrical and Gynecological Services Requiring Special Procedures

Federal and state laws and regulations dictate strict guidelines for Medicaid reimbursement for sterilizations, abortions and hysterectomies. The information below provides more guidance.

Sterilizations

Sterilization is any medical procedure, treatment, or operation that is performed for the sole purpose of rendering an individual permanently incapable of reproducing. The physician is responsible for obtaining the signed Informed Consent to Sterilization form which can be downloaded from the U.S. Department of Health and Human Services (HHS) web site (see Appendix B).

Title XIX regulations require a 30-day waiting period after the consent form is signed. The procedure **cannot** be performed prior to the 31st day from the day the consent form is signed.

Sterilizations are reimbursable only if:

- The recipient is at least 21 years old at time the informed consent form is signed;
- The recipient is mentally competent. According to federal regulations an individual can be considered legally incompetent only if found to be so by a court of competent jurisdiction or so identified by virtue of a provision of state law; and
- The recipient voluntarily gave informed consent by signing the consent form not less than 30 days, but no more than 180 days prior to performing sterilization.

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Exceptions to Sterilization Policy

If the recipient has a premature delivery or requires emergency abdominal surgery within the 30 days of consent and at least 72 or more hours have passed since the consent form was signed, sterilization can be performed at the time of the delivery or emergency abdominal surgery.

In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery, or in the case of emergency abdominal surgery, the emergency must be described.

Informed Consent

An eligible recipient will be considered informed only if all the conditions described in this section are met.

The professional who obtains the consent for the sterilization procedure must offer to answer any questions the recipient may have concerning the procedure, provide a copy of the consent form, and orally give all of the following information or advice to the recipient:

- The recipient is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federal benefits to which the recipient might be otherwise entitled.
- The recipient is provided a description of available alternative methods of family planning and birth control. Recipient is informed that sterilization is considered irreversible.
- The recipient is provided a thorough explanation of the specific sterilization procedure to be performed.
- The recipient is given a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- The sterilization will not be performed for at least 30 days, except under the circumstances specified under the subtitle “Exceptions to Sterilization Policy”

Suitable arrangements were made to ensure that the information specified above was effectively communicated to any individual who is blind, deaf, or otherwise disabled.

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An interpreter was provided if the recipient did not understand the language used on the consent form or the language used by the person obtaining consent.

The recipient to be sterilized was permitted to have a witness of his or her choice present when consent was obtained.

Informed consent **must not be obtained** while the recipient is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the recipient's state of awareness.

The recipient must be given the consent form by the physician or clinic. All blanks on the form must be completed and the following individuals must sign the form:

- The recipient to be sterilized;
- The interpreter, if one was provided;
- The hospital professional who obtained the consent; and
- The physician who performed the sterilization procedure. (If the physician who performs the sterilization procedure is the one who also obtained the consent, the physician must sign both statements).

A copy of the consent form must be attached to all claims for sterilization, including attending physician, assistant surgeon, anesthesiologist, and hospital claims. The physician who signs the (Consent Form) must be the physician listed as the attending physician on the UB-04. Therefore, **only hard-copy claims will be processed.**

Abortions

Medicaid only covers an abortion performed by a physician and related hospital charges when it has been determined medically necessary to save the life of the mother or when the pregnancy is the result of rape or incest.

NOTE: All federal and state laws related to abortions must be adhered to.

Abortions claims will be reviewed by the fiscal intermediary (FI) and must meet the following criteria for one of the following circumstances:

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Life Endangerment

- A physician certifies in writing that on the basis of his/her professional judgment that the life of the woman would be endangered if the fetus were carried to term.
- The claim form must be submitted with the treating physician's certification statement including the complete name and address of the recipient and appropriate ICD-9 diagnosis that makes the pregnancy life endangering.
- The recipient's medical record must include the medical diagnosis and physician's documentation that made the abortion medically necessary to save the life of the mother.

Incest / Rape

- The recipient must report the act of incest or rape to law enforcement unless the treating physician's written certification statement documents that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the incident(s).
- The recipient must certify in writing that the pregnancy is a result of incest or rape and the treating physician must witness the recipient's certification by signature.
- The certification statements must be attached to the claim and include the complete name and address of the recipient and appropriate ICD-9 diagnosis.
- The recipient's medical record must include the medical diagnosis and physician's documentation to support the abortion and certification statements.

All claims associated with an abortion, including the attending physician, hospital, assistant surgeon, and anesthesiologist submitted for processing must be accompanied by a copy of the attending physician's written certification and statement of medical necessity. Therefore, **only hard-copy claims will be processed.**

Informed consent shall not be obtained while the individual to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness.

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Spontaneous / Missed Abortions

Must be coded with the appropriate ICD-9 code and the operative report must be attached to the claim.

Threatened Abortions

May be reimbursable except when surgery is performed. If surgery is performed, the claim will be denied with an error code message requesting a statement of medical necessity (as stated above) by the performing physician.

Dilation and Curettage

Claims for a Dilation and Curettage (D&C) for an incomplete or missed abortion will be denied until the following is submitted:

- The written sonogram results with operative report, pathology report and history must be submitted with the claim; and
- The documentation that substantiates that the fetus was not living at the time of the D&C and the documentation must indicate that this was not an abortion or pregnancy termination.

Listed below are examples of information and documentation necessary for proper claim review and to substantiate reimbursement.

- A sonogram report showing no fetal heart tones;
- A history showing passage of fetus at home, in the ambulance, or in the emergency room;
- A pathology report showing degeneration products of conception; or
- An operative report showing products of conception in the vagina.

Ectopic Pregnancies

To receive reimbursement for the termination of an ectopic pregnancy (tubal pregnancy), hospitals must submit billing on hardcopy with a copy of the operative report attached and an appropriate ICD-9 surgical procedure code that denotes the termination of an ectopic pregnancy.

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A sterilization procedure code cannot be used. Use of an improper ICD-9 surgical procedure may cause the claim to deny.

Molar Pregnancies

A molar pregnancy results from a missed abortion (i.e., the uterus retains the dead and organized products of conception). The Medicaid program covers the termination of molar pregnancies. To bill for the termination of a molar pregnancy, providers should use the appropriate procedure codes with a diagnosis of molar pregnancy.

Hysterectomies

Federal regulations prohibit Medicaid payment for a hysterectomy under any of the following circumstances:

The hysterectomy is performed solely for the purpose of terminating reproductive capability.

There was more than one purpose for performing the hysterectomy, but the procedure would not have been performed except for rendering the individual permanently incapable of reproducing.

Exceptions to the Hysterectomy Policy

The federal regulation applies to all hysterectomies regardless of the woman's age, fertility, or reason for the surgery except when the recipient:

- Was already sterile before the hysterectomy. The physician who performs the hysterectomy must certify in writing that the recipient was sterile at the time of the hysterectomy and state the cause of sterility.
- Required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible. The physician must certify in writing that the hysterectomy was performed under these conditions and include in his/her narrative a description of the nature of the emergency.
- Was certified retroactively for Medicaid benefits, and the physician who performed the hysterectomy certifies in writing that one of the following conditions were met:
 - The recipient was informed by the physician before the operation that the hysterectomy would make her permanently incapable of reproducing.

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- The recipient met one of the two other exceptions listed above. In this case, the statement must describe the cause of the sterility or the nature of the emergency.
- Payment can be made only if the recipient is informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing. The BHSF 96-A acknowledging consent must have been signed by the patient not less than 30 days, but no more than 180 days prior to performing the sterilization.
- If the recipient has a premature delivery or requires emergency abdominal surgery within the 30 days of consent and at least 72 or more hours have passed since the consent form was signed, sterilization can be performed at the time of delivery or emergency abdominal surgery.

Deliveries with Non-Payable Sterilizations

Payment of an inpatient hospital claim for a delivery/C-section is allowed when a non-payable sterilization is performed during the same hospital stay.

NOTE: A sterilization procedure is considered non-payable if the sterilization consent form is either missing or invalid.

When there is no valid sterilization form obtained, the procedure code for the sterilization and the diagnosis code associated with the sterilization should not be reported on the claim form, and charges related to the sterilization process should not be included on the claim form. In these cases, providers will continue to receive their per diem for covered charges. Claims for the covered charges will not require any prior or post-authorization (other than precertification) and may be billed via electronic media claims (EMC) or on paper.

Other Inpatient Services**Blood**

The Medicaid Program will pay for all necessary blood while the recipient is hospitalized if other provisions to obtain blood cannot be made. However, every effort must be made to have the blood replaced.

NOTE: See section 25.8 for specific information for billing blood.

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Hospital-Based Ambulance Services

If a recipient is transported to a hospital by a hospital-based ambulance (ground or air) and is admitted, the ambulance charges may be covered and are to be billed as part of inpatient services.

Air ambulance services are not covered unless the recipient is transported to the facility which owns the ambulance.

NOTE: Refer to section 25.8 for specific billing

Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Services (EMS). Hospitals must submit a copy of the EMS certification to Provider Enrollment for recognition to bill ambulance services.

Mother/Newborn/Nursery

Louisiana Medicaid requires that all Mother/Newborn claims be submitted separately. The National UB Manual contains information for specific type and source of admit codes when billing newborn claims.

A separate claim for the newborn must include only nursery and ancillary charges for the baby. The mother's precertification number is not required on this claim. The newborn claim will zero pay and receive an EOB code of 519.

NOTE: Refer to the fee schedule for the required billing procedures for newborn infant and mother (see Appendix B for fee schedule information).

Inpatient Hospital Definition of Discharge

An inpatient or outpatient is considered to be discharged from the hospital and paid under the prospective payment system (PPS) when:

- The recipient is formally discharged from the hospital; or
- The recipient dies in the hospital

NOTE: See other discharge criteria below.

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Non-medically necessary circumstances are not considered in determining the discharge time; therefore, hospitals will not be reimbursed under these circumstances (e.g., recipient does not have a ride home, does not want to leave, etc.).

If non-medical circumstances arise and the recipient does not leave the hospital when he/she is discharged and the hospital is not reimbursed, the recipient may be billed but only after hospital personnel have informed him/her that Medicaid will not cover that portion of the stay.

Discharge and Readmit on the Same Day

When a recipient is discharged and **readmitted to the same hospital** on the same day, the pre-administration certification length of stay process as described in Section 25.5 is applicable.

If the recipient is **readmitted to a different hospital** than the discharging hospital, the readmitting hospital should enter the name of the discharging hospital, as well as the discharge date, in the appropriate field on the UB-04 claim form.

Direct Transfers

When recipients must be transferred from one hospital to another including a transfer from an acute care unit to a distinct part psychiatric unit in the same hospital, for additional medical care, the pre-admission certification and length of stay assignment below must be followed.

Registration and length of stay assignment is required when transferring to acute care and rehabilitation hospitals.

Pre-admission certification and length of stay assignment is required when transferring to long-term hospitals and distinct part psychiatric/substance abuse units in acute care hospitals.

Date of Discharge or Death

The date of discharge or the date of death for an inpatient hospital stay is not reimbursed unless the date of discharge/death is the same date as the date of admission.

Out-of-State Acute Care Hospitals**Psychiatric and Substance Abuse**

Inpatient psychiatric or substance abuse treatment in out-of-state hospitals are covered for a maximum of two days in the case of a medical emergency. Outpatient psychiatric or substance abuse treatment is not covered.

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Rehabilitation Units in Acute Care Hospitals

Rehabilitation Units are considered part of the acute care hospital, and services are to be billed with the acute care provider number. Reimbursement rates are the same as for the acute care hospital. Separate provider numbers are not issued for rehabilitation units.

Psychiatric Diagnosis Within an Acute Care Hospital

When the primary diagnosis on the pre-certification file is in the 290-319 or 648.30-648.44 payment will be on the psychiatric per diem and not the long-term or acute care rate.

NOTE: Refer to Appendix B for website addresses and contacts mentioned in this section.