

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

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 LDH HSS verify that the Unit is in compliance with the PPS criteria and identify the number and location of beds in the psychiatric unit.

Hospital-Based Ambulance Services (Inpatient — Air and Ground)

If a hospital admits an inpatient that is transported by its own hospital-based ambulance (ground or air), the MCO shall cover the ambulance charges, which must be billed as part of inpatient hospital services.

It may be necessary to transport an inpatient temporarily to another hospital for specialized care while the enrollee maintains inpatient status. These services are not billable ambulance services.

If a hospital-based ambulance transports an enrollee for inpatient admission to any other hospital, the ambulance service is not part of the hospital service and may be covered under the independent ambulance provider number.

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.

Hysterectomies

For detailed requirements around coverage of hysterectomies, please see the corresponding section of the *Professional Services* section of this Manual.

Prior to providing payment to the provider performing the hysterectomy, the MCO shall ensure that the hysterectomy consent form or a physician's written certification is obtained. The MCO shall allow ancillary providers and hospitals to submit claims without the hard copy consent. The MCO shall reimburse these providers only if the provider performing the hysterectomy submitted a valid hysterectomy consent form and was reimbursed for the procedure.

The ancillary provider's claim may be pended for up to 30 days pending review of the primary surgeon's claim. If the primary surgeon's claim has not been approved during this timeframe, the MCO may deny the ancillary provider's claim. If the ancillary provider's claim is denied for this reason, the ancillary provider may resubmit the claim after allowing additional time for the primary surgeon's claim to be paid, however, timely filing requirements apply. Alternatively, the ancillary provider may resubmit the claim with the appropriate consent form.

The MCO shall retain all required documentation.