INPATIENT SERVICES

Inpatient hospital care is defined 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 following:

1. Attending physician;

2. An emergency room physician; or

3. 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 beneficiary 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

Precertification of inpatient hospital services is no longer a requirement for Legacy/Fee-for-Service Medicaid. Each day of an inpatient stay must be medically necessary. All claims for inpatient services are subject to post payment medical necessity review and recoupment, if medical necessity is not met.

NOTE: Changes to precertification requirements are for Legacy/Fee-for-Service Medicaid beneficiaries only. Managed care organizations will continue to require precertification of inpatient hospital stays for their members.

Inpatient Status vs. Outpatient Status

Physicians responsible for a beneficiary's care at the hospital are responsible for deciding whether the beneficiary should be admitted as an inpatient. Place of treatment should be based on medical necessity.

Medicaid will allow up to 48 hours for a beneficiary to be in an outpatient status. This time frame is for the physician to observe the patient and to determine the need for further treatment, admission to an inpatient status, or for discharge. (Exception: outpatient ambulatory surgeries).

NOTE: Providers should refer to Section 25.3 – Outpatient Services for additional information.

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.

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 and must be billed using the Medicaid distinct part psychiatric number. 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.

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) website (see Appendix A).

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:

1. The beneficiary is at least 21 years old at time the informed consent form is signed;

2. The beneficiary is mentally competent. According to federal regulations, an individual may 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

3. The beneficiary voluntarily gave informed consent by signing the consent form not less than 30 days, but no more than 180 days prior to performing sterilization.

Exceptions to Sterilization Policy

If the beneficiary 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 beneficiary 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 beneficiary may have concerning the procedure, provide a copy of the consent form, and orally give all of the following information or advice to the beneficiary:

1. The beneficiary 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 beneficiary might be otherwise entitled;

2. The beneficiary is provided a description of available alternative methods of family planning and birth control. Beneficiary is informed that sterilization is considered irreversible;

3. The beneficiary is provided a thorough explanation of the specific sterilization procedure to be performed;

4. The beneficiary 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; and

5. 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 beneficiary who is blind, deaf, or otherwise disabled.

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

The beneficiary to be sterilized was permitted to have a witness of their choice present when consent was obtained.

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

The beneficiary 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:

1. The beneficiary to be sterilized;

2. The interpreter, if one was provided;

3. The hospital professional who obtained the consent; and

4. 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).

The primary surgeon's claim requires hard-copy submission with a valid consent form and the primary surgeon is expected to share copies of the completed consent forms to facilitate ancillary provider billing for sterilization services. Ancillary providers include the assistant surgeon, anesthesiologist, hospital, and/or ambulatory surgical center.

If an ancillary provider submits a claim for sterilization services without the appropriate consent form, the claim will be paid only if the primary surgeon's claim has been approved.

The ancillary provider's claim may be held 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, Medical Review will deny the ancillary provider's claim. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim hard-copy with the appropriate consent form.

Deleted: 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:

Life Endangerment

1. A physician certifies in writing that on the basis of their professional judgment that the life of the woman would be endangered if the fetus were carried to term;

2. The claim form must be submitted with the treating physician's certification statement including the complete name and address of the beneficiary and appropriate diagnosis code that makes the pregnancy life endangering; and

3. The beneficiary'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

1. The beneficiary 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);

2. The beneficiary must certify in writing that the pregnancy is a result of incest or rape and the treating physician must witness the beneficiary's certification by signature;

3. The certification statements must be attached to the claim and include the complete name and address of the beneficiary and appropriate diagnosis code; and

4. The beneficiary'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, when 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 beneficiary 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 beneficiary's state of awareness.

Spontaneous / Missed Abortions

Must be coded with the appropriate diagnosis 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:

1. The written sonogram results with operative report, pathology report and history must be submitted with the claim; and

2. 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.

1. A sonogram report showing no fetal heart tones;

2. A history showing passage of fetus at home, in the ambulance, or in the emergency room;

3. A pathology report showing degeneration products of conception; or

4. 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 surgical procedure code that denotes the termination of an ectopic pregnancy. A sterilization procedure code cannot be used. Use of an improper 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.

Hysterectomy

Federal regulations governing Medicaid payment of hysterectomies prohibit payment under the following circumstances:

1. If the hysterectomy is performed solely for the purpose of terminating reproductive capability; or

2. If there is more than one purpose for performing the hysterectomy, but the procedure would not be performed except for the purpose of rendering the beneficiary permanently incapable of reproducing.

Louisiana Medicaid guidelines only allow payment to be made for a hysterectomy when:

1. The person securing authorization to perform the hysterectomy has informed the beneficiary and her representative (if any), both orally and in writing, that the hysterectomy will make the beneficiary permanently incapable of reproducing; and

2. The beneficiary or their representative (if any) has signed a written acknowledgement of receipt of that information. (**Acknowledgement of Receipt of Hysterectomy Information** (BHSF Form 96-A) is available on the Louisiana Medicaid website under the “Forms/Files/User Manuals: link).

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These regulations apply to all hysterectomy procedures, regardless of the woman's age, fertility, or reason for surgery.

Consent for Hysterectomy

The hysterectomy consent form must be signed and dated by the beneficiary on or before the date of the hysterectomy.

The consent must include signed acknowledgement from the beneficiary stating they have been informed orally and in writing that the hysterectomy will make them permanently incapable of reproducing.

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The primary surgeon's claim requires hard-copy submission with a valid consent form and the primary surgeon is expected to share copies of the completed consent forms to facilitate ancillary provider billing for hysterectomy services. Ancillary providers include the assistant surgeon, anesthesiologist, hospital, and/or ambulatory surgical center.

If an ancillary provider submits a claim for hysterectomy services without the appropriate consent form, the claim will be paid only if the primary surgeon's claim has been approved.

The ancillary provider's claim may be held 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, Medical Review will deny the ancillary provider's claim. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim hard-copy with the appropriate consent form.

Deleted: The physician who obtains the consent should share the consent form with all providers involved in that beneficiary's care, (e.g., attending physician, hospital, anesthesiologist, and assistant surgeon) as each of these claims must have the valid consent form attached. To avoid a "system denial", **the consent must be attached to any claim submission related to a hysterectomy**. ¶

When billing for services that require a hysterectomy consent form, the name on the Medicaid file for the date of service in which the form was signed should be the same as the name signed at the time consent was obtained. If the beneficiary's name is different, the provider must attach a letter from the physician's office from which the consent was obtained. The letter should be signed by the physician and should state that the beneficiary's name has changed and should include the beneficiary's social security number and date of birth. This letter should be attached to all claims requiring consent upon submission for claims processing.

A witness signature is needed on the hysterectomy consent when the beneficiary meets one of the following criteria:

1. Beneficiary is unable to sign her name and must indicate "x" on the signature line; or

2. There is a diagnosis on the claim that indicates mental incapacity.

If a witness signs the consent form, the signature date **must** match the date of the beneficiary's signature. If the dates do not match, or the witness does not sign and date the form, claims related to the hysterectomy will be denied.

Exceptions

Obtaining consent for a hysterectomy is unnecessary under the following circumstances:

1. The beneficiary was already sterile before the hysterectomy, and the physician who performed the hysterectomy certifies in writing that the beneficiary was sterile at the time of the hysterectomy and states the cause of sterility;

2. The beneficiary required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician certifies in writing that the hysterectomy was performed under these conditions and includes in the narrative a description of the nature of the emergency; or

3. The beneficiary was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy certifies in writing that the beneficiary was informed before the operation that the hysterectomy would make her permanently incapable of reproducing. In addition, if the beneficiary was certified retroactively for benefits, the physician must certify in writing that the hysterectomy was performed under one of the above two conditions and that the beneficiary was informed, in advance, of the reproductive consequences of having a hysterectomy.

The written certification from the physician **must** be attached to the hard copy of the claim in order for the claim to be considered for payment.

Deliveries Prior to 39 Weeks

Louisiana Medicaid does not reimburse for deliveries prior to 39 weeks that are not medically necessary. In order for claims to process, the Department must validate that the delivery was not prior to 39 weeks or if prior to 39 weeks, that it was medically necessary.

Please see the following link for reporting instructions of deliveries: http://www.lamedicaid.com/provweb1/ProviderTraining/Packets/2014ProviderTraining/Performing_OB_Delivery_Services.pdf

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 and may be billed via electronic media claims (EMC) or on paper.

Donor Human Milk

Donor human milk provided in the inpatient hospital setting is covered for certain medically vulnerable infants.

Eligibility Criteria

Donor human milk is considered medically necessary when all of the following criteria are met:

1. The hospitalized infant is less than 12 months of age with one or more of the following conditions:

   a. Prematurity;

b. Malabsorption syndrome;

c. Feeding intolerance;

d. Immunologic deficiency;

e. Congenital heart disease or other congenital anomalies; and

f. Other congenital or acquired condition that places the infant at high risk of developing necrotizing enterocolitis (NEC) and/or infection.

2. The infant's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding;

3. The infant's caregiver has received education on donor human milk, including the risks and benefits, and agrees to the provision of donor human milk to their infant; and

4. The donor human milk is obtained from a milk bank accredited by, and in good standing with, the Human Milk Banking Association of North America.

Reimbursement

Reimbursement for donor human milk is made separately from the hospital payment for inpatient services. The payment for the donor human milk is equal to the fee on the Durable Medical Equipment (DME) fee schedule.

Hospitals shall bill the donor human milk using the HCPCS procedure code T2101 (1 unit per ounce) on a CMS 1500 claim form. If the hospital bills electronically, the 837P must be used with the DME file extension. If the hospital bills a hard copy claim, the claim must be submitted with the word "DME" written in bold, black print on the top of the form.

Long-Acting Reversible Contraceptives in the Inpatient Hospital Setting

Additional payment is allowed for the insertion of long-acting reversible contraceptives (LARCs) for women newly post-partum prior to discharge. The payment for the LARC is equal to the fee on the DME fee schedule in addition to the hospital's per diem payment. Providers should consult the DME fee schedule for covered LARCs and their reimbursement.

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Hospitals should bill the LARC claim using the appropriate J code to the FI on a CMS 1500 claim form. If the hospital bills electronically, the 837P must be used with the DME file extension. If the hospital bills a paper claim, the paper claim must be submitted with the word "DME" written in bold, black print on the top of the form.

Other Inpatient Services

Blood

The Medicaid Program will pay for all necessary blood while the beneficiary 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: Claims Related Information for specific information for billing blood.

Hospital-Based Ambulance Services

If a beneficiary 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 beneficiary is transported to the facility which owns the ambulance.

NOTE: See Section 25.8: Claims Related Information 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 Uniform Billing (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 newborn claim will zero pay and receive an explanation of benefits (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:

1. The beneficiary is formally discharged from the hospital; or

2. The beneficiary dies in the hospital.

NOTE: See other discharge criteria below.

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

If non-medical circumstances arise and the beneficiary does not leave the hospital when they are discharged and the hospital is not reimbursed, the beneficiary may be billed but only after hospital personnel have informed them that Medicaid will not cover that portion of the stay.

Discharge and Readmit on the Same Day

If the beneficiary is **readmitted to a different hospital** than the discharging hospital on the same day as discharge, 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.

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.

Trade Area

In-state acute care provider resources must be utilized prior to referring a beneficiary to out-of-state providers. Acute care out-of-state providers in "trade areas" are treated the same as in-state providers. Trade areas are defined as being counties located in Mississippi, Arkansas and Texas that border the State of Louisiana. Acute care out-of-state providers in the above states that are not located in counties that border Louisiana are required to obtain prior authorization for all inpatient services unless it is of an emergent nature.

A referral or transfer made by a 'trade area' hospital to another hospital does not constitute approval by Louisiana Medicaid unless it is to either a Louisiana hospital or another 'trade area' hospital. Prior authorization **is** required for all other referrals or transfers.

Below is list of counties located in the trade area:

Louisiana Trade Area		
Arkansas Counties	**Mississippi Counties**	**Texas Counties**
Chicot County	Hancock County	Cass County
Ashley County	Pearl River County	Marion County
Union County	Marion County	Harrison County
Columbia County	Walthall County	Panola County

Louisiana Trade Area		
Arkansas Counties	**Mississippi Counties**	**Texas Counties**
Lafayette County	Pike County	Shelby County
Miller County	Amite County	Sabine County
	Wilkerson County	Newton County
	Adams County	Orange County
	Jefferson County	Jefferson County
	Claiborne County	
	Washington County	
	Issaquena County	
	Warren County	

Rehabilitation Units in Acute Care Hospitals

Rehabilitation Units (Medicare designated) 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 Medicaid provider numbers are not issued for rehabilitation units.

Psychiatric Diagnosis within an Acute Care Hospital

When the beneficiary's primary diagnosis is psychiatric, payment will be on the psychiatric per diem and not the long-term or acute care rate.

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