NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services
Pre-Admission Certification
(LAC 50:V.301)

The Department of Health, Bureau of Health Services Financing proposes to repeal LAC 50:V.301 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Due to the implementation of managed care through the Healthy Louisiana program, pre-admission certification, concurrent review, and length of stay assignment are no longer required for admission of Medicaid recipients to non-state and state operated acute care general hospitals. The Department of Health, Bureau of Health Services Financing hereby amends the provisions governing inpatient hospital services in order to repeal provisions requiring pre-admission certification, concurrent review and length of stay assignment.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospitals

Chapter 3. Pre-Admission Certification

§301. General Provisions

~~A. Pre-admission certification, concurrent review and length of stay assignment shall be required for all admissions to non-state and state operated acute care general hospitals. Current InterQual® criteria, Thomson Reuters or Solucient data and Health Care Industries Association (HCIA) data shall be utilized by the fiscal intermediary to determine medical necessity and authorize admission, for initial length of stay (LOS) and continued stay assignment, and concurrent review.~~

~~1. Medical necessity for inpatient admission, concurrent review and length of stay assignment for acute care general hospitals will be determined by utilizing age-based guidelines for severity of illness and intensity of service as well as guidelines for surgery and procedures in the inpatient setting.~~

~~2. National and regional specific data elements such as age, multiple diagnoses and/or surgeries will also be utilized for initial length of stay and continued stay assignment.~~

~~B. Hospitals shall use current and updated InterQual® criteria and Thomson Reuter or Solucient data to determine appropriateness of admission and continued stays.~~

~~1. Providers must have the capability to submit requests and receive responses through a web-based system.~~

~~C. Registration and length of stay assignment are required for all admissions to rehabilitation hospitals.~~

~~1. The hospital is required to register each Medicaid admission no later than one business day after the date of admission.~~

~~2. Length of stay assignment for rehabilitation hospital admissions is determined by the fiscal intermediary staff using updated InterQual®, HCIA LOS Southern Region grand totals, and customized criteria as well as clinical information for the patient provided by the hospital.~~

~~3. The initial length of stay assigned for each rehabilitation hospital admission is 14 days based on the lowest average length of stay from the American Hospital Association Average Stay Study for rehabilitation conditions.~~

~~D. Pre-admission certification and length of stay assignment are required for all admissions for inpatient psychiatric services (free-standing psychiatric hospitals and distinct part psychiatric units in acute care general hospitals).~~

~~1. The pre-admission certification criteria for psychiatric admissions are formulated according to categories for adults and children and utilize the current revision of the *Diagnostic and Statistical Manual of Mental Disorders*.~~

~~2. The initial length of stay assigned for all~~

~~admissions to free-standing psychiatric hospitals and distinct part psychiatric units is at the fiftieth percentile based on the admitting diagnosis.~~

~~E. Pre-admission certification and length of stay assignment are required for all admissions to long term hospitals.~~

~~1. Admissions to long-term hospitals for acute care, psychiatric care, or rehabilitation will be assigned lengths of stay using the same criteria that is utilized for admissions to those respective hospital settings for these patients.~~

~~2. All other long-term hospital admissions will be assigned an initial length of stay of 14 days.~~

~~F. Extensions of the initial length of stay may be requested by the hospital when appropriate care of the recipient indicates the need for hospitalization in excess of the originally approved assignment.~~

~~1. An extension must be requested no later than the expected day of discharge. If the expected day of discharge is on a weekend or holiday, the extension must be requested by the next business day. Extensions are granted on a case-by-case basis and shall be based on clinical information provided by the hospital.~~

~~2. The initial approved extension is assigned up to the 75th percentile for acute care and up to the 75th percentile~~

~~for inpatient psychiatric services, regardless of the hospital setting.~~

~~a. Subsequent approved extensions may be submitted for consideration referencing customized data, southern regional and national length of stay data.~~

~~3. Initial approved extensions for acute care, psychiatric care and rehabilitation admissions to long term hospitals are assigned using the same criteria as that used in the other applicable hospital settings for these patients.~~

~~a. All other long term hospital initial approved extensions may be assigned up to 14 days.~~

~~b. Subsequent extension requests for long-term hospital admissions (other than admissions for acute care, psychiatric care or rehabilitation) may be assigned up to seven days.~~

~~4. Subsequent approved extension requests for rehabilitation cases may be assigned up to seven days.~~

~~5. There is no limit on the number of extensions that can be requested by a hospital.~~

~~G. The pre-admission certification requirement applies to acute care general hospitals (non-state and state operated), long term hospitals, free-standing psychiatric hospitals and distinct part psychiatric units in acute care general hospitals.~~

~~1. Pre-admission certifications must be obtained~~

~~prior to admission or on a concurrent basis, with provision for retrospective review only in exceptional circumstances. Medicaid reimbursement will not be authorized without completion of the pre-admission certification requirement.~~

~~a. Pre-admission certification for all emergency admissions to long term hospitals, free-standing psychiatric hospitals and distinct-part psychiatric units must be requested upon admission.~~

~~H. The pre-admission certification reviews are conducted by registered nurses (or licensed mental health professionals for psychiatric cases) in consultation with a physician. If the request for admission is denied, the hospital may request a reconsideration of the decision.~~

~~1. The reconsideration process involves a physician to physician consultation between the treating physician or his/her designee and the fiscal intermediary's physician consultant within one business day of receipt of the denial notification.~~

~~2. If the reconsideration process results in a denial of the admission, the hospital may appeal the decision by submitting a formal request for an appeal in writing to the Bureau of Appeals in accordance with the department's established appeal procedures.~~

~~I. Inpatient admissions for dually eligible~~

~~Medicare/Medicaid beneficiaries are not subject to pre-admission certification and length of stay assignment when Medicare Part A benefits are still in effect.~~

~~J. A hospital may request a retrospective review for Medicaid reimbursement of inpatient hospital services in only two situations: retroactive eligibility; and depletion of a dually eligible recipient's Medicare Part A benefits.~~

~~1. In the case of retroactive eligibility, hospitals have up to one year from the date that the recipient was added to the eligibility file to request a retrospective review.~~

~~2. In the case where Medicare Part A benefits have been exhausted, hospitals must request a retrospective review within 60 days from the date of the Medicare Explanation of Benefits that verifies that Medicare Part A benefits have been exhausted.~~

~~3. The two-year timely filing requirement for filing claims is applicable for retrospective reviews.~~Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:66 (January 2010), amended LR 38:824 (March 2012), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct cost or indirect cost to the provider to provide the same level of service, and will have no impact on the provider’s ability to provide the

same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, January 25, 2018 at 9:30 a.m. in Room 173, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary