INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Inpatient Hospital Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: Sept. 20, 2016	Scheduled update	FSSA and HPE
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6.0	Policies and procedures as of July 1, 2022 Published: Jan. 24, 2023	Scheduled update • Edited text as needed for clarity • Updated Indiana State Department of Health to Indiana Department of Health • Updated the *Prior Authorization for Hospital Inpatient Admissions* section • Updated the *Inpatient Admission Criteria* section and removed the *Dental Admissions* and *Inpatient Burn Admissions* subsections • Updated the EOB in the *Present-on-Admission Indicators* section • Updated the note box in the *Reimbursement Methodology for Inpatient Services* section • Updated the *Length of Stay* section • Updated the list of certified Burn/1 facilities in the *Level-of-Care Payment Rates* section	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Updated the *Base Rate for Children's Hospitals* section • Removed the *Reimbursement for Promoting Interoperability Program* section • Updated the *LTAC Admission Criteria* section and removed the *Respiratory*, *Impaired Skin Integrity* and *Cardiac* subsections • Updated the *LTAC Continued Stay Criteria* section and removed the *LTAC Discharge Criteria* subsection • Added the *Physician-Administered Drugs Reimbursed Outside the Inpatient DRG* section • Updated the *Inpatient-Only Codes* section	

Table of Contents

> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise member services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide, available at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Banner Pages and IHCP Bulletins at in.gov/medicaid/providers.*

Introduction

Subject to the limitations described in this module, the Indiana Health Coverage Programs (IHCP) covers inpatient services (such as acute care, behavioral health and rehabilitation care) when the services are both of the following:

- Provided or prescribed and documented by a physician
- Medically necessary for the diagnosis or treatment of the member's condition

> *Note: This module includes information about IHCP coverage, billing and reimbursement for inpatient services. For additional information specific to **inpatient behavioral health** services, see the Behavioral Health Services module.*

Prior Authorization for Hospital Inpatient Admissions

In accordance with *Indiana Administrative Code 405 IAC 5-17-2*, the IHCP requires prior authorization (PA) for all nonemergency inpatient hospital admissions, with the following exceptions:

- Routine vaginal and C-section deliveries
- Inpatient hospital admissions covered by Medicare

In all other cases, nonemergency inpatient hospital admissions – including all elective or planned admissions and admissions for which the patient's condition permitted adequate time to schedule suitable accommodation – require PA. This requirement applies to medical and surgical inpatient admissions. Observation does not require PA.

PA is required for all Medicaid-covered rehabilitation, burn and psychiatric inpatient stays reimbursed under the level-of-care (LOC) payment methodology, as well as substance abuse stays reimbursed under the diagnosis-related group (DRG) methodology. (Both reimbursement methodologies are described in *405 IAC 1-10.5* and the Reimbursement Methodology for Inpatient Services section of this module.) **Emergency inpatient admissions for these diagnoses must be reported to the PA contractor within 48 hours of admission**, not including Saturdays, Sundays or legal holidays, to receive IHCP reimbursement. Days that are not prior authorized under the LOC methodology as required by *405 IAC 5-17-2* will not be covered by Medicaid. For all *other* emergency inpatient admissions, PA is not required.

Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient procedure, must be prior authorized. See the *Surgical Services* module for details.

> *Note: All out-of-state services require PA, except as indicated in the Out-of-State Providers module.*

Inpatient hospital PAs are generally requested via telephone. **Providers are required to contact the PA contractor at least three calendar days prior to a nonemergency admission.** For contact information, see the *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers.

To ensure a 72-hour turnaround, the PA request should be made by a clinical staff person. The facility must call (or submit the request by other means) **prior to** the admission and provide criteria for medical necessity. An *IHCP Prior Authorization Request Form* is not necessary for inpatient PA requests submitted by telephone; however, written documentation may be required in addition to the information provided by phone.

When requesting PA for inpatient admission, providers must provide the following information:

- Member name, address, date of birth and IHCP Member ID
- Requesting provider name, address, telephone number, and National Provider Identifier (NPI)
- Rendering provider name, address, telephone number, and NPI
- Procedure requested, including revenue code, Current Procedural Terminology (CPT®[1]) or Healthcare Common Procedure Coding System (HCPCS) code
- Medical condition being treated, including the International Classification of Diseases (ICD) diagnosis code
- Member-specific clinical information that establishes the medical necessity of the procedure
- Location where service is to be performed (facility)
- Date of admission
- Estimated length of stay (LOS)

If requesting retroactive PA for a dually eligible member who has had coverage denied by Medicare or a Medicare Advantage Plan, documentation of the denial is also required. See the *PA Policy for Inpatient Stays for Dually Eligible Members* section for details.

See the *Prior Authorization* module for general information about requesting PA.

PA Policy for Inpatient Stays for Burn Care

All inpatient stays for burn care are excluded from PA requirements when billed with an admit type 1 (emergency) or type 5 (trauma). If the member does not have PA, inpatient burn unit claims received with admit types other than 1 or 5 that group to a burn DRG will continue to deny for explanation of benefits (EOB) 3007 – *No prior authorization segment on file for the level of care*.

PA Policy for Inpatient Stays for Dually Eligible Members

A member who is dually eligible must obtain Medicaid PA for an inpatient stay that is not covered by Medicare. If a stay is covered by Medicare, in full or in part, the member does not require PA. Providers may request retroactive Medicaid PA for dually eligible members if Medicare will not cover the inpatient stay because the member's Medicare benefit has been exhausted or if the stay is not a Medicare-covered service.

[1] *CPT copyright 2022 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Inpatient Admission Criteria

The IHCP follows national clinical guidelines for all nonemergency and urgent inpatient admissions. If IHCP criteria already exist, those criteria are used first when determining whether admissions are appropriate. If criteria are not available within the national clinical guidelines or IHCP policy, the IHCP relies on medical necessity determination of current evidence-based practice.

The following sections provide criteria for acute care hospital admissions for both adult and pediatric members (in accordance with *405 IAC 5-33*), as well as admission criteria for hospital inpatient rehabilitation (in accordance with *405 IAC 5-17-4*).

For admission criteria for long-term acute care (LTAC) hospitals, see the *Long-Term Acute Care Hospital Services* section. For psychiatric admission criteria, including substance abuse admissions, see the *Behavioral Health Services* module. For additional information about surgical admissions, see the *Surgical Services* module.

Acute Care Hospital Admission and Continued Stay Criteria for Adults

The following sections provide criteria for acute care hospital admission for adults based on severity of illness or intensity of service, as well as criteria for appropriateness of "day of care" for a continued stay.

Severity-of-Illness Admission Criteria for Adults

For acute care hospital admission based on severity of illness, adults must meet at least one of the following criteria:

- Sudden onset of unconsciousness or disorientation (coma or unresponsiveness)
- Pulse rate less than 50 per minute or greater than 140 per minute
- Blood pressure (at least one of the following):
  - Systolic less than 90 or greater than 200 millimeters mercury
  - Diastolic less than 60 or greater than 120 millimeters mercury
- Acute loss of sight or hearing
- Acute loss of ability to move body part
- Persistent fever equal to or greater than 100 degrees Fahrenheit (orally) or greater than 101 degrees Fahrenheit (rectally) for more than five days
- Active bleeding
- Severe electrolyte/blood gas abnormality, including any of the following:
  - Na less than 123 mEq/L
  - Na greater than 156 mEq/L
  - K less than 2.5 mEq/L
  - K greater than 6.0 mEq/L
  - CO_2 combining power (unless chronically abnormal) less than 20 mEq/L
  - CO_2 combining power (unless chronically abnormal) greater than 36 mEq/L
  - Blood pH less than 7.30
  - Blood pH greater than 7.45
- Acute or progressive sensory, motor, circulatory or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed or breathe); must also meet intensity of service criterion simultaneously in order to certify; do not use for back pain

- Electrocardiogram (ECG) evidence of acute ischemia; must be suspicion of a new myocardial infarction (MI)
- Wound dehiscence of evisceration

Intensity-of-Service Admission Criteria for Adults

For acute care hospital admission based on intensity of service needed, adults must meet at least one of the following criteria:

- Intravenous medications and/or fluid replacement (does not include tube feedings)
- Surgery or procedure scheduled within 24 hours requiring either of the following:
  - General or regional anesthesia
  - Use of equipment, facilities or procedure available only in a hospital
- Vital sign monitoring every two hours or more often (may include telemetry or bedside cardiac monitor)
- Chemotherapeutic agents that require continuous observation for life-threatening toxic reaction
- Treatment in an intensive care unit
- Intramuscular antibiotics at least every eight hours
- Intermittent or continuous respirator use at least every eight hours

Continued Stay (Day-of-Care) Criteria for Adults

Recertification for a continued stay in an acute care hospital requires documentation that the adult member meets the criteria for the appropriateness of day of care, based on medical services, nursing/life support services or patient condition, as follows:

- Medical services (at least one of the following):
  - Procedure in operating room that day
  - Scheduled for procedure in operating room the next day, requiring preoperative consultation or evaluation
  - Cardiac catheterization that day
  - Angiography that day
  - Biopsy of internal organ that day
  - Thoracentesis or paracentesis that day
  - Invasive central nervous system (CNS) diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap or pneumoencephalography, that day
  - Any test requiring strict dietary control for the duration of the diet
  - New or experimental treatment requiring frequent dose adjustments under direct medical supervision
  - Close medical monitoring by a doctor at least three times daily (observations must be documented in record)
  - Postoperative day for any of the following procedures:
    - Procedure in operating room
    - Cardiac catheterization
    - Angiography
    - Biopsy of internal organ
    - Thoracentesis or paracentesis
    - Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap or pneumoencephalography

- Nursing/life support services (any of the following):
  - Respiratory care – Intermittent or continuous respirator use and/or inhalation therapy (with chest physiotherapy treatment [chest PT], intermittent positive pressure breathing [IPPB]) at least three times daily
  - Parenteral therapy – Intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein or medications)
  - Continuous vital sign monitoring, at least every 30 minutes, for at least four hours
  - Intramuscular and/or subcutaneous injections at least twice daily
  - Intake and output measurement
  - Major surgical wound and drainage care (chest tubes, T-tubes, hemovacs, Penrose drains)
  - Close medical monitoring by nurse at least three times daily, under doctor's orders.
- Patient condition:
  - Within 24 hours before day of review – Inability to void or move bowels (past 24) not attributable to neurologic disorder
  - Within 48 hours before day of review – At least one of the following:
    - Transfusion due to blood loss
    - Ventricular fibrillation or ECG evidence of acute ischemia, as stated in progress note or in ECG report
    - Fever at least 101 degrees Fahrenheit rectally (at least 100 degrees Fahrenheit orally), if patient was admitted for reasons other than fever
    - Coma – Unresponsiveness for at least one hour
    - Acute confusional state, not due to alcohol withdrawal
    - Acute hematologic disorders, significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis or thrombocytosis yielding signs or symptoms
    - Progressive acute neurologic difficulties
  - Within 14 days before day of review – Occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke)

Acute Care Hospital Admission and Continued Stay Criteria for Pediatrics

The following sections provide criteria for acute care hospital admissions for pediatrics based on severity of illness or intensity of service, as well as criteria for appropriateness of "day of care" for a continued stay.

Severity-of-Illness Admission Criteria for Pediatrics

For acute care hospital admission based on severity of illness, pediatric members must meet at least one of the following criteria:

- Sudden onset of unconsciousness (coma or unresponsiveness) or disorientation
- Acute or progressive sensory, motor, circulatory or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe or urinate)
- Acute loss of sight or hearing
- Acute loss of ability to move body part
- Persistent fever (greater than 100 degrees Fahrenheit orally or greater than 101 degrees Fahrenheit rectally) for more than 10 days
- Active bleeding
- Wound dehiscence or evisceration

- Severe electrolyte/acid-base abnormality, including any of the following:
  - Na less than 123 mEq/L
  - Na greater than 156 mEq/L
  - K less than 2.5 mEq/L
  - K greater than 6.0 mEq/L
  - CO_2 combining power (unless chronically abnormal) less than 20 mEq/L
  - CO_2 combining power (unless chronically abnormal) greater than 36 mEq/L
  - Arterial pH less than 7.30
  - Arterial pH greater than 7.45
- Hematocrit greater than 30%
- Pulse rate outside following ranges (optimally, a sleeping pulse for members under 12 years old):
  - 2–6 years old: 70–200/minute
  - 7–11 years old: 60–180/minute
  - 12 years old or older: 50–140/minute
- Blood pressure outside following ranges (systolic/diastolic):
  - 2–6 years old: 75–125 mm Hg/40–90 mm Hg
  - 7–11 years old: 80–130 mm Hg/45–90 mm Hg
  - 12 years old or older: 90–200 mm Hg/60–120 mm Hg
- Need for lumbar puncture, where this procedure is not done routinely on an outpatient basis
- Any conditions not responding to outpatient, including emergency room:
  - Seizures
  - Cardiac arrhythmia
  - Bronchial asthma or croup
  - Dehydration
  - Encopresis (for clean-out)
  - Other physiologic problem (specify)
- Special pediatric problems (any of the following):
  - Child abuse
  - Noncompliance with necessary therapeutic regimen
  - Need for special observation or close monitoring of behavior, including calorie intake in cases of failure to thrive

Intensity-of-Service Admission Criteria for Pediatrics

For acute care hospital admission based on the intensity of care needed, pediatric members must meet at least one of the following criteria:

- Surgery or procedure scheduled within 24 hours requiring either of the following:
  - General or regional anesthesia
  - Use of equipment, facilities or procedure available only in a hospital
- Treatment in an intensive care unit
- Vital sign monitoring every two hours or more often (may include telemetry or bedside cardiac monitor)
- Intravenous medications and/or fluid replacement (does not include tube feedings)
- Chemotherapeutic agents that require continuous observation for life-threatening toxic reaction

- Intramuscular antibiotics at least every eight hours
- Intermittent or continuous respirator use at least eight hours

Continued Stay (Day-of-Care) Criteria for Pediatrics

Recertification of a continued pediatric inpatient stay requires documentation that the member has met criteria for the appropriateness of day of care, based on medical services, nursing/life support services or patient condition, as follows:

- Medical services (at least one of the following):
  - Procedure in operating room that day
  - Procedure scheduled in operating room the next day, requiring preoperative consultation or evaluation
  - If the day being reviewed is the day of admission, any of the following procedures, scheduled for the day after admission (unless that procedure is usually done at that facility on a same-day basis):
    - Cardiac catheterization
    - Angiography
    - Biopsy of internal organ
    - Thoracentesis or paracentesis
    - Invasive CNS diagnostic procedure – for example, lumbar puncture, cisternal tap, ventricular tap or pneumoencephalography
    - Gastrointestinal endoscopy
  - Cardiac catheterization that day
  - Angiography that day
  - Biopsy of internal organ that day
  - Thoracentesis or paracentesis that day
  - Invasive CNS diagnostic procedure (for example, lumbar puncture, cisternal tap, ventricular tap or pneumoencephalography) that day
  - Gastrointestinal endoscopy that day
  - Any test requiring strict dietary control for the duration of the diet
  - New or experimental treatment requiring frequent dose adjustments under direct medical supervision
  - Close medical monitoring by a doctor at least three times daily (observations must be documented in record)
  - Postoperative day for any of the following procedures:
    - Procedure in operating room
    - Cardiac catheterization
    - Angiography
    - Biopsy of internal organ
    - Thoracentesis or paracentesis
    - Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap or pneumoencephalography
    - Gastrointestinal endoscopy
- Nursing/life support services (any of the following):
  - Respiratory care – Intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB), at least three times daily; Bronkosol with oxygen, oxyhoods or oxygen tents
  - Parenteral therapy – Intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein or medications)
  - Continuous vital sign monitoring, at least every 30 minutes for at least four hours

  - Intramuscular and/or subcutaneous injections at least twice daily
  - Intake and/or output measurement
  - Major surgical wound and drainage care (for example, chest tubes, T-tubes, hemovacs or Penrose drains)
  - Traction for fractures, dislocations or congenital deformities
  - Close medical monitoring by nurse at least three times daily, under doctor's orders
- Patient condition:
  - Within 24 hours on or before day of review – Inability to void or move bowels, not attributable to neurologic disorder (usually postoperative)
  - Within 48 hours on or before day of review – At least one of the following:
    - Transfusion due to blood loss
    - Ventricular fibrillation or ECG evidence of acute ischemia as stated in progress note or in ECG report
    - Fever at least 101 degrees Fahrenheit rectally (at least 100 degrees Fahrenheit orally) if patient was admitted for reason other than fever
    - Coma – Unresponsiveness for at least one hour
    - Acute confusional state, including withdrawal from drugs and alcohol
    - Acute hematologic disorders – Significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis or thrombocytosis – yielding signs of symptoms
    - Progressive acute neurologic difficulties
  - Within 14 days before day of review – Occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke)

Inpatient Rehabilitation Admission and Discharge Criteria

The IHCP provides reimbursement for inpatient rehabilitation services when such services are prior authorized and determined to be medically necessary.

Prior authorization is required for all inpatient rehabilitation admissions. Before admission to a physical rehabilitation unit, an assessment of the patient's total rehabilitative potential must be completed and documented in the medical record. A written plan of care, cooperatively developed by the therapist or psychologist and the attending physician, is required for all rehabilitation services. Documentation in the medical record must include the member's condition, IHCP criteria and level of care necessary in the rehabilitation unit.

The following conditions must be met for reimbursement for physical rehabilitation admission:

- The patient is medically stable.
- The patient is responsive to verbal or visual stimuli.
- The patient has sufficient mental alertness to participate in the program.
- The patient's premorbid condition indicates a potential for rehabilitation.
- The expectation for improvement is reasonable.
- The criteria listed in *405 IAC 5-32* are met.

Severity-of-Illness Criteria

Per *405 IAC 5-32-1*, the following criteria shall demonstrate the inability to function independently with demonstrated impairment:

- Cognitive function (attention span, memory or intelligence)
- Communication (aphasia with major receptive or expressive dysfunction)
- Continence (bladder or bowel)
- Mobility (transfer, walk, climb stairs or wheelchair)
- Pain management (pain behavior limits functional performance)
- Perceptual motor function (spatial orientation or depth or distance perception)
- Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis)

Intensity-of-Service Criteria

Intensity-of-service criteria for inpatient rehabilitation are as follows:

- Multidisciplinary team evaluation at least every two weeks
- Physical therapy and at least one of the following therapies (totaling a minimum of three hours daily):
  - Occupational therapy
  - Speech therapy
- Participation in a rehabilitation program under the direction of a qualified physician
- Skilled rehabilitative nursing care or supervision required at least daily

Discharge Criteria

Inpatient rehabilitation discharge criteria for consideration may include the following:

- There is evidence in the record that patient has achieved stated goals.
- Medical complications preclude intensive rehabilitative effort.
- Multidisciplinary therapy is no longer needed.
- No additional functional improvement is anticipated.
- The patient's functional status has remained unchanged for 14 days.

General Inpatient Billing and Coding Procedures

Inpatient hospital services are billed using the *UB-04* paper claim form or electronically using the 837I transaction or (for fee-for-service claims) the Provider Healthcare Portal (Portal) institutional claim.

Paper claim forms for fee-for-service inpatient stays should be mailed to Gainwell Technologies at the following address:

Gainwell – UB-04 Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

For general IHCP billing information and guidelines for completing the *UB-04* claim form and Portal institutional claim, see the *Claim Submission and Processing* module. For guidance on the 837I electronic transaction, see *837I Health Care Claim: Institutional Transaction*, accessible from the *IHCP Companion Guides* page at in.gov/medicaid/providers.

The following sections provide additional information specific to inpatient billing procedures.

Revenue Code Itemization

The IHCP requires a complete itemization of services performed, using appropriate revenue codes on the claim. This itemization needs to occur even though the IHCP reimburses inpatient hospital services using a DRG/LOC methodology (see the *Reimbursement Methodology for Inpatient Services* section of this document).

The revenue code reveals crucial information about the type of service provided during the inpatient stay. Therefore, providers need to ensure that each claim properly identifies the appropriate revenue code. The revenue code that is used must reflect the setting in which the care was delivered. For example, providers must use revenue code 20X to submit a claim for services provided to patients admitted to an intensive care unit.

Diagnosis Codes

ICD diagnosis codes are required on inpatient claims as described in the *Claim Submission and Processing* module. The following sections include additional information about principal and secondary (other) diagnoses for inpatient billing.

Principal Diagnosis

The *principal diagnosis* is defined as the condition established, after study, that is chiefly responsible for the admission of the patient to the hospital. When providers bill for inpatient services, a principal diagnosis is required. The principal diagnosis is the first diagnosis code entered on the claim (field 67 of the *UB-04* claim form).

Note: The IHCP prohibits use of ICD-10 diagnosis codes V00–Y99 as a principal diagnosis.

Other Diagnoses

Providers can enter additional diagnosis codes on the claim (fields 67A–Q of the *UB-04* claim form) to indicate all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or length of stay.

The IHCP defines *other diagnoses* as additional conditions that affect patient care in terms of requiring the following:

- Clinical evaluation
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care or monitoring
- Therapeutic treatment

Providers must exclude diagnoses that relate to an earlier episode and have no bearing on the current hospital stay.

Present-on-Admission Indicators

For all inpatient Medicaid claims, hospitals are required to report whether the principal diagnosis and each secondary diagnosis was present on admission (POA). POA is defined as a condition "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter – including emergency department, observation or outpatient surgery – are considered POA.

A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the *ICD-10-CM Official Guidelines for Coding and Reporting,* accessible from the *ICD-10* page at cms.gov). The IHCP does not require a POA indicator in the external cause of injury (ECI or E Code) field.

> *Note: A list of diagnosis codes that are **exempt** from POA reporting can be accessed from the Coding page at cms.gov. The POA indicator should be omitted only for codes on the list. Any inpatient claim without a POA indicator for a **nonexempt** diagnosis will be denied, and providers will need to correct and resubmit the claim for reimbursement.*

On the *UB-04* claim form, the appropriate POA indicator is entered in the shaded area after the diagnosis codes in field 67 and 67A–Q. On claims submitted via the Portal, the appropriate option is selected from the Present on Admission drop-down menu in the *Diagnosis Codes* panel.

Use the POA indicator options in Table 1 for all principal and secondary diagnoses on the inpatient claim.

Table 1 – POA Indicator Options

***UB-04* Claim Form or 837I Transmission**	**Portal Institutional Claim**	**Definition**
Y	Yes	Diagnosis was present at the time of inpatient admission.
N	No	Diagnosis was not present at the time of inpatient admission.
U	Unknown	The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
W	Not Applicable	The provider is unable to clinically determine whether the condition was present at the time of inpatient admission.
[Blank]	[Blank]	Diagnosis is exempt from POA reporting.

POA indicator reporting is mandatory for all Medicaid claims involving inpatient admission to any Medicaid-enrolled hospital. Inpatient and inpatient crossover claims submitted without a POA indicator for the principal diagnosis and secondary diagnoses (other than exempt diagnoses) are denied with the EOB code 851 – *POA code is invalid.* The provider needs to correct and resubmit the claim.

See the *Hospital-Acquired Conditions Policy* section for information about how POA indicators are factored into the IHCP reimbursement system.

Occurrence Codes

Health Insurance Portability and Accountability Act (HIPAA)-compliant occurrence codes are required on claims for facility services, including all inpatient and inpatient crossover claims. Accordingly, for all live discharges of IHCP members, providers must include occurrence code 42 – *Date of discharge*. Claims for members with a discharge due to death should be billed with occurrence code 55 – *Date of death*.

On the *UB-04* claim form, occurrence codes and the associated dates are entered in fields 31a–34b (35a–36b may be used for occurrence codes that span multiple dates).

Reimbursement Methodology for Inpatient Services

The IHCP reimburses for hospital inpatient claims on a hybrid system that consists of the following two distinct reimbursement methodologies:

- A diagnosis-related group (DRG) system that reimburses a per-case rate according to diagnoses, procedures, age, gender and discharge status
- A level-of-care (LOC) system that reimburses psychiatric, burn and rehabilitation cases on a per diem basis

The LOC portion of the methodology was developed in conjunction with the DRG reimbursement, due to wide variances in length of stay and costs associated with some care provided.

Reimbursement for inpatient hospital services under the hybrid system is composed of the following components:

- DRG rate per case or LOC per diem
- Capital rate
- Medical education rate, if applicable
- Outlier payment, if applicable
- Inpatient hospital adjustment factor or respective burn, psychiatric, rehabilitation LOC hospital adjustment factor for Hospital Assessment Fee (HAF)-participating hospitals (see the *Hospital Assessment Fee* module for details)

> *Note: Effective for dates of service from Jan. 1, 2014, through June 30, 2021, the IHCP implemented a 3% reduction in reimbursement for inpatient claims, including inpatient crossover claims. The rate reduction was not applicable for HAF-participating hospitals or state-operated psychiatric hospitals. Additionally, disproportionate share hospital (DSH) payments were not subject to the reimbursement reduction.*
>
> *Effective for dates of services on or after July 1, 2021, the 3% reduction for hospital services was eliminated.*

Hospitals cannot bill IHCP members for the difference between payments and actual charges, except for conditions stated in the *Charging Members for Noncovered Services* section of the *Provider Enrollment* module.

Diagnosis-Related Group Reimbursement System

DRGs are the basis for payments to hospitals under a prospective payment system. DRGs group hospital inpatient cases that are clinically similar and relatively homogeneous with respect to resource use. The IHCP used claims data to base the DRG system. The system is a prospective cost-based method that contains no form of year-end settlement.

The DRG reimbursement rates are intended to cover all inpatient hospital costs, including the costs of inpatient routine care and ancillary services, with the exceptions of blood factor and certain other physician-administered drugs (as listed in *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient DRG*, accessible from the *Code Sets* page at in.gov/medicaid/providers) as well as certain implantable durable medical equipment (as described in the *Surgical Services* module). Applicable codes must be billed separately on a professional claim for separate reimbursement.

Additional payments to hospitals are as follows:

- Capital-related costs
- Direct medical education costs, if applicable

The critical components of a DRG inpatient reimbursement system are as follows:

- Classification system, known as the *grouper*
- Length of stay
- Calculation of the relative weights
- Calculation of the DRG base payment
- Outlier payments (which use facility-specific cost-to-charge ratios), capital rates, and medical education rates, if applicable

Grouper

Groupers classify inpatient cases into categories that represent similar resource consumption during treatment. The categories are termed *Diagnosis-Related Groups* (*DRGs)*.

Each discharge is assigned to one DRG, regardless of the number of services furnished or the number of days of care provided. DRG assignment is based on the physician's record of the patient's principal diagnosis, any additional diagnoses, procedures performed, age, gender and discharge status. Failure to properly specify this data may result in inaccurate payment for a submitted claim or in a suspended claim, which also may delay payment.

The diagnoses and procedures information is grouped using ICD codes. Providers must code to the highest level of specificity possible.

The IHCP uses the 3M All-Patient Refined Diagnosis-Related Group (APR-DRG) as the grouper for the inpatient DRG assignment. Each APR-DRG has four severity levels (1 – Minor, 2 – Moderate, 3 – Major and 4 – Extreme), which allow for more-detailed coding of the patient's status. Version 36 of the APR-DRG is used for inpatient stays with dates of discharge on or after Aug. 1, 2020.

Length of Stay

A period of inpatient care that includes 24 hours or more in the hospital and is reimbursable under the IHCP is considered an *IHCP stay*.

The *average* length of stay (ALOS) is one component of the DRG inpatient reimbursement system. Each DRG has an ALOS based on the severity of illness from national data.

The *actual* length of stay is considered in the case of transfer claims, where both the transferring and receiving hospitals are reimbursed at a DRG-prorated daily rate, as described in the *Transfers* section.

DRG Relative Weights

Each DRG assigned by the grouper has a corresponding relative weight. Relative weights are numeric values that reflect the relative resource consumption for the DRGs to which they are assigned. Taking the average cost for a DRG and dividing by the average cost of all DRGs creates the weight.

DRG Base Payment

The DRG base payment is the amount used to reimburse hospitals for both routine and ancillary costs associated with inpatient care. The DRG base payment is determined by multiplying a fixed statewide base rate (which is the overall rate per IHCP stay) by the relative weight of the applicable DRG:

Statewide Base Rate × DRG Relative Weight = DRG Base Payment

The statewide base rate changes periodically, and providers must consider the date of service of claims when calculating payment using the formula. The statewide base rate is determined using hospital cost reports and was inflated using the Global Insight Hospital Market Basket Index. Providers can obtain current base rate information by checking the inpatient rates file on the *Hospital* page at mslc.com/Indiana or contacting Customer Assistance toll-free at 800-457-4584.

For information about a separate statewide base rate for designated children's hospitals, see the *Base Rate for Children's Hospitals* section.

DRG Outlier, Capital Costs and Medical Education Costs Payments

The state of Indiana defines a *DRG cost outlier case* as an IHCP stay that exceeds a predetermined threshold. The threshold used to determine outlier payments is currently defined as the greater of twice the DRG base payment or $56,350. Day outliers that exceed a predetermined threshold are not reimbursed under the DRG outlier payment policy.

Under a DRG hybrid reimbursement system, the need for an outlier policy is significantly reduced, because cases that traditionally are classified as outliers – such as burn, psychiatric and rehabilitative care – are reimbursed under the LOC component. The hybrid system, however, does not completely eliminate the need for appropriate outlier policies and reimbursement rates. Outlier payments are available for all qualifying cases reimbursed under the DRG system.

See the *Outlier Payments* section for information about the outlier payment as it pertains to the DRG and LOC methodologies.

The *capital costs payment* is a statewide per diem, and payment is based on the average length of stay for the assigned DRG. See the *Reimbursement for Capital Costs* section for information about the capital payment as it pertains to the DRG and LOC methodologies. Long-term acute care (LTAC) providers do not receive separate capital reimbursement.

The *medical education costs payment* is a provider-specific per diem rate based on the average length of stay for the assigned DRG. The medical education costs payment is outlined in the *Reimbursement for Medical Educational Costs* section of this document.

The IHCP allowed amount is calculated as follows:

DRG Base Payment + Capital Costs Payment + Medical Education Costs Payment (if applicable) + Outlier Payment (if applicable)

Note: *For Hospital Assessment Fee (HAF)-participating hospitals, the IHCP-allowed amount is calculated as follows:*
(DRG Base Payment × Inpatient Hospital Adjustment Factor) + Capital Costs Payment + Medical Education Costs Payment (if applicable) + Outlier Payment (if applicable)

The hospital adjustment factor is a multiplier used to increase the reimbursement rate for HAF-participating hospitals. For more information about HAF, see the Hospital Assessment Fee module.

Inpatient Level-of-Care Reimbursement System

Certain cases are excluded from the DRG rate methodology due to wide variances in length of stay and severity of resource consumption. Under the traditional DRG reimbursement systems, such cases are generally regarded as outliers. A hybrid system, however, incorporates a distinct reimbursement mechanism to accommodate these cases. This reimbursement mechanism is known as an LOC system, and it reimburses hospitals on a per diem basis. Three types of cases are reimbursed under the LOC system:

- Burn cases
- Psychiatric cases
- Rehabilitation cases

Claims are processed through the APR-DRG grouper to be classified into appropriate DRGs. Claims classified into the following DRGs are excluded from the DRG system and reimbursed under the LOC system as follows:

- APR-DRGs excluded for burn cases – 841–844
- APR-DRGs excluded for psychiatric cases – 740, 750–756, 758–760 (DRG 757 excludes ICD-10 diagnosis codes F70–F79)
- APR-DRGs excluded for rehabilitation cases – 860

The LOC reimbursement rates represent all payments (excluding any applicable disproportionate share payments) to a hospital for all inpatient costs, costs of routine inpatient care, and ancillary services – with the exception of blood factor and certain other physician-administered drugs that are separately reimbursable when billed on a professional claim; as indicated in *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient DRG*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Additional payments to hospitals are provided for the following:

- Capital costs
- Burn outlier costs, if applicable
- Medical education costs, if applicable

Reimbursement under the LOC methodology will be made for the lesser of the following:

- Number of days actually used
- Number of days prior authorized by the office

Level-of-Care Payment Rates

LOC rates are established based on hospital costs and days for LOC services. A cost per diem is calculated for each hospital, and the LOC per diem rate is determined by calculating the weighted median per diem, weighted by the number of days. The four LOC payment rate types are as follows:

- Burn/1
- Burn/2
- Psychiatric
- Rehabilitation

Burn cases are divided into two groups, Burn/1 and Burn/2, based on the costs incurred by hospitals to treat burn patients. These rates handle severe burn cases that call for specialized facilities and procedures. The burn treatment rates are determined by Myers and Stauffer LC.

Burn/1 facilities have been identified based on the burn services provided in certified burn care facilities and the cost of those services. These facilities consistently provide more intensive burn care than other Indiana hospitals and are the only hospitals eligible to bill and receive reimbursement at the Burn/1 rate. The certified Burn/1 facilities are the following:

- Sidney & Lois Eskenazi Hospital (Indianapolis)
- Indiana University Health – Methodist Hospital (Indianapolis)
- Riley Hospital for Children
- University Medical Center (Louisville)
- University of Chicago Medical Center (Chicago)
- Loyola University Medical Center (Chicago area)
- Lutheran Hospital of Indiana
- Ascension St. Vincent Hospital

All other hospitals are reimbursed at the Burn/2 rate.

Level-of-Care Outlier, Capital Costs and Medical Education Costs Payments

Under the LOC system, the IHCP makes outlier payments for burn cases that exceed established thresholds. The state of Indiana defines an LOC cost outlier as an IHCP hospital stay with a cost per day that exceeds twice the burn rate.

The total payment is the sum of the LOC per diem rate; capital costs per diem rate; outlier payment, if applicable; and medical education costs per diem rate, if applicable.

The IHCP-allowed amount is calculated as follows:

LOC Per Diem Rate + Capital Costs Per Diem + Medical Education Costs Per Diem (if applicable) + Outlier Payment (if applicable)

See the *Reimbursement for Capital Costs*, *Reimbursement for Medical Educational Costs* and *Outlier Payments* sections of this document for more information about capital cost, educational cost and outlier payments.

Note: For HAF-participating hospitals, the IHCP allowed amount is calculated as follows:

(LOC Per Diem Rate × Inpatient Hospital Adjustment Factor) + Capital Costs Per Diem + Medical Education Costs Per Diem (if applicable) + Outlier Payment (if applicable)

The inpatient hospital adjustment factor is a multiplier used to increase the reimbursement rate for HAF-participating hospitals. For more information about HAF, see the Hospital Assessment Fee module.

Reimbursement for Capital Costs

Facilities are reimbursed a flat, statewide per diem rate for capital costs. This payment rate is calculated by using facility documentation and the Global Insight, Inc. Hospital Market Basket Index. The capital payment rate for inpatient care reimbursed under the DRG methodology is the per diem capital rate, multiplied by the average length of stay for all cases within the particular DRG. For cases reimbursed under the LOC system, facilities are reimbursed the per diem capital rate for each covered day of care.

The IHCP does not determine a separate capital per diem rate for freestanding and acute care hospitals with distinct psychiatric units. All inpatient care, regardless of setting, receives the same capital per diem rate.

Reimbursement for Medical Educational Costs

The IHCP reimburses medical education costs on a hospital-specific, per diem basis. Medical education payment rates are based on medical education costs and patient days, adjusted by the number of residents. Medicaid education costs, patient days and the number of residents are obtained from each hospital's cost reports. The number of residents is based on the most recent cost report data.

Medical education payments are reimbursed under the DRG and LOC systems as follows:

- Medical education payments for IHCP stays under the DRG methodology are equal to the medical education per diem rate multiplied by the average length of stay for the DRG.
- IHCP stays under the LOC system are reimbursed using the medical education per diem rate for each covered day of care.

Qualification for Medical Education Payments

Payment for medical education is provided only to hospitals that operate medical education programs. Hospitals receiving a medical education rate must continue to submit current hospital cost reports (*Form CMS 2552-10*).

Hospitals that discontinue or downsize the medical education programs must promptly notify the Family and Social Services Administration (FSSA) at the following address:

MS07
Hospital Reimbursement Section
Indiana Office of Medicaid Policy and Planning
402 W. Washington Street, Room W374
Indianapolis, IN 46204

Medical Education Reimbursement for Managed Care Claims

For managed care claims, all medical education payment calculations are made after the MCE submits the claim payment information to Gainwell and the encounter claim is posted to the Core Medicaid Management Information System (*Core*MMIS). Based on encounter claim data received from the MCEs, Gainwell processes and issues medical education payments to the hospitals. Providers should allow 30–45 calendar days from the time the MCE has processed the claim for the medical education payment to be posted to the fee-for-service Remittance Advice (RA) from Gainwell. Providers can identify these payments by reviewing the *Medical Education Cost Expenditures* section of their RA.

Outlier Payments

Outlier payments are available for all qualifying cases reimbursed under the DRG system. Under the LOC system, the IHCP makes outlier payments for burn cases that exceed established thresholds (an IHCP hospital stay with a cost per day that exceeds twice the burn rate).

To determine the outlier payment amounts, costs per IHCP stay are calculated by multiplying a hospital-specific cost-to-charge ratio by allowed charges. The payment is a percentage of the difference between the prospective cost per stay (for DRG) or day (for LOC) and the established outlier threshold. The percentage, or marginal cost factor, has been determined at 60%.

Hospitals are notified individually of the specific cost-to-charge ratios that must be used to determine outlier payments for DRGs and the LOC system (burn only). Cost-to-charge ratios are calculated only during rebasing and recalibration periods. Each hospital that submits a hospital cost report (*Form CMS 2552-10*) will receive a cost-to-charge ratio. New hospitals and hospitals with fewer than 30 Medicaid claims annually are assigned the statewide average cost-to-charge ratio.

Base Rate for Children's Hospitals

405 IAC 1-10.5-3 allows the FSSA to establish a separate base rate for certain children's hospitals to the extent necessary to reflect significant differences in cost. The IHCP defines a children's hospital as a freestanding, general, acute care hospital licensed under *Indiana Code IC 16-21* that meets one of the following criteria:

- Designated by the Medicare program as a children's hospital
- Furnishes services to inpatients who are predominately members younger than 18 years old, as determined using the same criteria used by the Medicare program to determine whether a hospital's services are furnished to inpatients who are predominately younger than 18 years old

Children's hospitals incur significantly higher IHCP costs than other hospitals, even after accounting for differences in the case mix of patients. Each children's hospital will be evaluated individually for eligibility for the separate base rate. Children's hospitals with a case mix adjusted cost per discharge greater than one standard deviation above the mean cost per discharge for DRG services will be eligible to receive the increased base rate for DRG payments.

Based on the review of costs for facilities meeting this definition, the IHCP base rate for these children's hospitals is 120% of the standard IHCP base rate. The IHCP base rate for HAF-participating children's hospitals is 120% of the standard IHCP base rate multiplied by the inpatient hospital adjustment factor.

At this time, the IHCP-enrolled children's hospitals that receive this adjusted base rate are the following:

- Children's Hospital Medical Center (Cincinnati)
- Riley Hospital for Children
- University of Chicago Medicine – Comer Children's Hospital

For dates of discharge from July 1, 2021, through June 30, 2023, **out-of-state** children's hospitals that meet qualifying criteria in *House Enrolled Act (HEA) 1305* will receive 130% of the Medicaid reimbursement rate. See the *Out-of-State Providers* module for more information.

Change in Coverage During Inpatient Stay

In some cases, a member's coverage can change during an inpatient stay from one plan to another; for example, from fee-for-service coverage to a managed care plan, or from one MCE to another MCE. The reimbursement in such cases depends on whether the reimbursement for the stay is based on a DRG or LOC methodology. If the reimbursement is based on a DRG methodology, the plan that was in effect on the day of admission is responsible for the entire stay. If the reimbursement is based on an LOC methodology, each plan is responsible for the days of the stay covered by that plan.

For members who become eligible for Medicare coverage during an inpatient stay, providers must bill Medicare first.

Inpatient Coverage for Presumptively Eligible Members

A member's presumptive eligibility coverage period begins on the date that the member's application for presumptive eligibility is submitted and the approval determination is made. For presumptive eligibility benefit packages that include inpatient hospital coverage:

- If a hospital admission date is before the presumptive eligibility start date and the inpatient service is reimbursed using the DRG methodology, no portion of that member's inpatient stay will be considered a covered service.
- If a hospital admission date is before the presumptive eligibility start date and the inpatient service is reimbursed on an LOC per diem basis, dates of service on or after the member's presumptive eligibility start date will be covered; dates of service before the member's presumptive eligibility start date are not covered.

See the *Member Eligibility and Benefit Coverage* and the *Presumptive Eligibility* modules for more information about the presumptive eligibility process.

Inpatient Coverage for Inmates

The IHCP covers inpatient services for IHCP-eligible inmates admitted as inpatients to an acute care hospital, nursing facility or intermediate care facility. Reimbursement is available only to facilities that are not primarily operated by law enforcement authorities. Facilities primarily operated by law enforcement authorities would be considered correctional facilities.

Eligibility for IHCP coverage requires the inmate to meet standard eligibility criteria, as determined by the Indiana FSSA Division of Family Resources (DFR).When an inmate is admitted to the inpatient facility, the correctional facility medical provider will assist the inmate in completing the *Indiana Application for Health Coverage*. Prior authorization is not required for an inmate's inpatient admission.

Eligible inmates receive IHCP coverage under the Medicaid Inpatient Hospital Services Only benefit plan. See the *Member Eligibility and Benefit Coverage* module for more information about services covered under this benefit plan. For billing information specific to this benefit plan, see the *Claim Submission and Processing* module.

Hospital-Acquired Conditions Policy

The IHCP does not pay the complicating condition (CC) or major complicating condition (MCC) for hospital-acquired conditions (HACs). The current list of HAC conditions is available from the *Hospital-Acquired Conditions* page at cms.gov.

Hospitals are required to report whether each diagnosis on a Medicaid inpatient claim was present on admission (POA), with the exception only of diagnosis codes specifically designated as exempt from POA/HAC reporting. Claims submitted without the required POA indicators for nonexempt codes are denied. (See the *Present on Admissions Indicators* section for more information.) The POA field should not be left blank for any codes on the HAC list. The IHCP follows determinations made by the CMS for additions and changes to the current list of HAC conditions, as well as changes to diagnosis codes exempted from POA reporting.

Table 2 shows how POA indicators affect DRG grouping for nonexempt HAC diagnosis codes.

Table 2 – Effect of POA Indicators on DRG Grouping for Nonexempt HAC Diagnosis Codes

POA Indicator	Description	Effect on DRG Grouping
Y (Yes)	Diagnosis was present at the time of inpatient admission.	Diagnosis is used for DRG grouping.
N (No)	Diagnosis was not present at the time of inpatient admission.	Diagnosis is suppressed from DRG grouping
U (Unknown)	The documentation is insufficient to determine if the condition was present at the time of inpatient admission.	Diagnosis is suppressed from DRG grouping
W (Not Applicable)	The provider is unable to clinically determine whether the condition was present at the time of inpatient admission	Diagnosis is used for DRG grouping.

For claims containing secondary diagnoses that are included in the list of HACs and for which the condition was not POA, the HAC secondary diagnosis will not be used for DRG grouping. The claim will be paid as though any secondary diagnoses included in the HAC list were not present on the claim.

The IHCP does not require a POA indicator in the external cause of injury (ECI or E Code) field. If a POA indicator is entered in the External Cause of Injury field, it is ignored and not used for DRG grouping.

An exemption for HAC/POA is deep vein thrombosis (DVT) and pulmonary embolism (PE) diagnoses following a total knee replacement or hip replacement for pediatric or obstetric patients*. When all these conditions are present on the claim, the HAC/POA requirement is bypassed and *none* of the diagnosis codes included on the claim is suppressed. For applicable diagnosis codes, see *Inpatient Hospital Services Codes,* accessible from the *Code Sets* page at in.gov/medicaid/providers.

> **Note:* *A pediatric patient is a patient younger than age 20.*
>
> *An obstetric patient is a patient with an ICD-10 diagnosis code of O00.0–O9A or Z32.01 or Z34–Z37.9.*

The IHCP does not cover surgical or other invasive procedures to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously. The IHCP also does not cover hospitalizations or other services related to these noncovered procedures. All services provided in the operating room when an error occurs, and all related services provided during the same hospitalization in which the error occurred, are not covered. See the *Provider Preventable Conditions* section in the *Surgical Services* module for more information.

Long-Term Acute Care Hospital Services

An IHCP long-term acute care (LTAC) hospital is a freestanding, general acute care hospital licensed under *IC 16-21,* meeting at least one of the following criteria:

- Is designated by the Medicare program as a long-term care hospital
- Has an average inpatient length of stay greater than 25 days, based on the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than 25 days

Prior authorization is required for all LTAC admissions.

LTAC Admission Criteria

Before admission to an LTAC hospital, assessment of the patient's current medical status and discharge goals must be provided to the appropriate PA vendor for PA purposes. This information should also be documented in the medical record. Each PA request is reviewed for medical necessity on an individual, case-by-case basis.

The patient must be admitted to the LTAC hospital directly from an acute care facility, or be readmitted to the LTAC hospital from a nursing facility or rehabilitation facility. No PA will be approved for requests for initial admission directly from a nursing facility, physician's office, or home.

The following documentation must be included with requests for admission to an LTAC hospital and must be available for review by the PA department or utilization management department, as applicable:

- A signed statement from the referring physician indicating medical necessity for transfer to an LTAC hospital.
- A completed *IHCP Prior Authorization Request Form*, available from the *Forms* page at in.gov/medicaid/providers (not required if the PA requested online via the Portal)
- The following information must accompany a request for approval and an evaluation by the requesting facility:
  - Diagnosis and premorbid conditions (If the patient is currently in an acute care hospital, the diagnosis at discharge should be included if it has changed from the time of admission.)
  - Information about where the patient is being admitted from, if not hospitalized
  - Neurological assessment
  - Complete listing of long- and short-term goals
  - Discharge plan with two options, depending on the member's condition
  - Potential date of admission
  - Projected date of discharge
  - History of any previous rehabilitation therapies
  - Prognosis and documentation that there is a reasonable expectation the member's functional and medical status will improve
  - History, physical, and discharge or case summary, if the member is currently hospitalized

All the following situations apply to the patient's status and current requirements before admission to the LTAC hospital:

- The patient is medically stable.
- The initial diagnostic workup is completed.
- There are no major surgical procedures planned.
- The patient has a prognosis requiring a prolonged stay in an acute setting, and there is a reasonable expectation for improvement in the status of the patient's medical condition.
- The patient requires interactive physician direction with daily on-site assessment.
- The patient requires significant ancillary services dictated by complex, acute medical needs. Examples include but are not limited to full service and STAT laboratory, radiology and respiratory care services.
- There is a patient-centered, outcome-focused, interdisciplinary approach requiring a physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care.
- Education for the patient and family must be provided to manage the patient's present and future healthcare needs.

During the PA process, the medical director may help determine whether the admission is medically necessary. Admissions requested for specific medical conditions such as respiratory, cardiac or impaired skin integrity should follow national clinical guidelines. These admissions will be reviewed for medical necessity and intensity of service on a case-by-case basis.

LTAC Continued Stay Criteria

When reviewing requests for a continued stay in the LTAC hospital, the IHCP follows national clinical guidelines.

Concurrent review for approval of additional days must be received by the PA department at least 48 hours before the last approved day, including:

- Completed *IHCP Prior Authorization – System Update Request Form* (not required if the PA update is requested online via the Portal)
- A summary of the current discharge plans
- Documentation of family or friend participation in the discharge planning process
- A neurological assessment update, if appropriate
- Documentation of the member's cooperation, participation or progress

LTAC Billing

LTAC facilities must submit charges on the institutional claim type (*UB-04* claim form or electronic equivalent). The billing provider must use revenue code 101 – *All-inclusive room and board* for the PA process and include that revenue code on the claim.

The discharging hospital must enter 63 as the patient status code (field 17 on the *UB-04* claim form). This code indicates the status of the patient as of the ending service date when the patient was discharged or transferred to a long-term care facility.

LTAC Reimbursement

Facilities meeting the definition of an LTAC hospital are paid a daily rate, or *per diem*, for each day of care provided. The per diem is all-inclusive. No other payments are permitted in addition to the LTAC per diem. Qualifying providers must be enrolled in the IHCP as an LTAC hospital (provider type 01, specialty 013) to receive the LTAC LOC per diem.

New LTAC hospitals receive the statewide median rate until sufficient claims are available to calculate a facility-specific rate. It is the provider's responsibility to request a facility-specific rate after sufficient discharges are submitted. When calculated, the facility-specific rate is retroactively effective on the date of the provider's request for a revised rate, unless sufficient discharges are still not available at the time of the request. In this case, a rate becomes effective on the date the provider reaches the rate-setting claims volume threshold.

Claims for as few as three discharges may be used to establish a per diem rate if the standard deviation of the rate is $200 or less. Otherwise, a higher discharge threshold of eight or more discharges must be used. If a provider has an existing rate but does not meet the claims threshold or the standard deviation exception, the provider's current per diem rate applies the following year.

The rates for existing LTAC hospital providers are reviewed no more often than every second year and adjusted as necessary.

Physician-Administered Drugs Reimbursed Outside the Inpatient DRG

The IHCP reimburses select physician-administered drugs separate from the inpatient admission. These drugs should be billed separately from the inpatient hospital DRG or LOC claim. For applicable codes, see *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient DRG*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Inpatient Blood Factor Claims

The IHCP reimburses providers for claims for blood factor products administered during inpatient hospital stays at the lowest of the following:

- Estimated acquisition cost (84% of the average wholesale price)
- Inpatient blood factor – State maximum allowable cost (MAC)
- Submitted charge

Blood factor that is used during inpatient hospital stays should be billed separately from the inpatient hospital DRG or LOC claim. For applicable codes, see *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient DRG*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Hospitals are prohibited from submitting any charges for blood factor administered during inpatient hospital stays on their institutional claims. Instead, hospitals should submit their claims for blood factor used during inpatient hospital stays on the **professional** claim type (*CMS-1500* claim form or electronic equivalent) and should include both the NDC and the NDC quantity of the blood factor on the claims.

> *Note: The IHCP Provider Healthcare Portal is the preferred method of submitting claims and supporting documentation.*
>
> *However, if providers choose to submit a claim by mail, note that paper CMS-1500 claim forms with NDC quantities **greater** than 9,999.99 units must be special batched because the NDC code will be the same for each detail and will deny as duplicates. Therefore, such claims must be sent to the following address for special handling:*
>
> **Gainwell – Written Correspondence**
> **P.O. Box 7263**
> **Indianapolis, IN 46207-7263**

Hospitals should use their facility NPIs on their professional claims. The place of service (POS) code must be 21 – *Inpatient Hospital* for blood factor administered during an inpatient hospital stay.

When billing blood factor products for dually eligible members, if Medicare *covers* the blood factor product, the provider cannot bill it separately. If Medicare *does not cover* the blood factor product, the provider needs to attach documentation, such as an Explanation of Medicare Benefits (EOMB), to the claim to show where the factor charges are denied or not covered under Medicare.

Medicare Exhaust Claims and Inpatient Services

For dually eligible members, see the following sections for information about billing the IHCP when Medicare benefits are exhausted prior to or during an inpatient stay.

Benefits Exhausted Prior to Inpatient Admission

The IHCP reimburses acute care hospitals for dually eligible (Medicare and Medicaid) IHCP members who exhaust their inpatient hospital Medicare Part A benefits prior to admission to acute care hospitals.

When a Medicare Part A stay is exhausted by Medicare prior to admission, providers must bill the date of admission through the date of discharge on the institutional claim (*UB-04* claim form or electronic equivalent). **Do not bill the IHCP for partial inpatient stays**. The EOMB must be submitted with the claim to show that benefits were exhausted prior to the date of admission.

Providers must bill services payable to Medicare Part B before billing the exhaust claim to Medicaid. Because these claims are considered Medicaid primary claims, all IHCP filing limit and PA rules apply. See the *Claim Submission and Processing* module for information about waiving filing limit procedures and supplying appropriate documentation for claim adjudication.

When billing the IHCP for Medicare exhaust stays, enter the word "Exhaust" in place of the primary payer name (in field 50A of the *UB-04* claim form). Do not include the word "Medicare," as doing so will cause the claim to process incorrectly. Also, do not enter any crossover information in the value code/amount fields (fields 39–41 on the *UB-04* claim form). Only Medicare crossover claims are billed with the A1 and A2 value code indicating the deductibles and coinsurance or copayment. Medicare exhaust claims are not considered crossover claims.

Benefits Exhausted During an Inpatient Stay

When a dually eligible member exhausts Medicare Part A benefits during an inpatient stay, the claim automatically crosses over from Medicare and adjudicates according to the IHCP inpatient crossover reimbursement methodology. After the coinsurance and deductible amounts are considered, no additional payment is made on the claim. This rule is also true for claims that do not automatically cross over but are submitted via the paper claim form or the Portal.

The IHCP will continue to reimburse Medicare Part B charges as long as the revenue codes billed on the Medicare Part A and B claims are not the same. If the same revenue codes appear on both claims, the claim will deny for duplicate billing.

Observation Billing

Providers can retain members for more than one 23-hour observation period when the member has not met criteria for admission but the treating physician believes that allowing the member to leave the facility would likely put the member at serious risk. This observation period can last *not more than three days or 72 hours and is billed as an outpatient claim*. See the *Outpatient Facility Services* module for details.

For general information about observation services, see the *Hospital Observation or Inpatient Care Services* section of the *Evaluation and Management Services* module.

Transfers

In the event of a transfer during a DRG-reimbursed inpatient stay, both the *transferring* hospital and the *receiving* (*transferee*) hospital are reimbursed at a **DRG-prorated daily rate**, not to exceed the full DRG amount. The IHCP calculates the DRG daily rate by dividing the DRG base payment (statewide base rate × DRG relative weight) by the average length of stay (ALOS).

To identify themselves as a *transferring hospital*, it is important for providers to enter the appropriate **patient status code** on the institutional claim to indicate that the patient was discharged or transferred to another hospital. To ensure accurate reimbursement, the applicable patient status discharge code must be entered in the appropriate field of the institutional claim:

- Patient Status field on the Portal institutional claim
- Field 17 of the *UB-04* claim form
- Loop 2300 CL102 on the 837I electronic transaction

Receiving hospitals are instructed to use **admission source code 4** in the appropriate field of the institutional claim:

- Admission Source Code field on the Portal institutional claim
- Field 15 on the *UB-04* claim form
- Loop 2300 CL102 on the 837I electronic transaction

The admission source code 4 is required only for the receiving hospital; however, if an invalid source code is submitted, providers will receive a claim denial with the following:

- Remark Code MA42 – *Admission Source Code is invalid*
- Explanation of benefits (EOB) 0029 – *Admission Source Code is invalid*

See instructions for completing the institutional claim in the *Claim Submission and Processing* module.

Providers are not to bill separately for two DRG-reimbursed inpatient stays when a member is transferred from one unit of the hospital to another unit within the same inpatient facility. Inpatient transfer claims from one inpatient unit of the hospital to another inpatient unit should be billed on one claim (a single paper or electronic claim submission), as they are considered part of the same episode of care. Exclusions to this policy are claims priced according to the LOC reimbursement methodology.

> *Note: In accordance with 405 IAC 5-17-1, all transfers are subject to retrospective review to ensure appropriate billing and payment.*

Claims for patients that are transferred within 24 hours of admission are to be billed as outpatient claims. DRGs that include neonate transfer cases only are not exempt from the transfer reimbursement policies and are reimbursed at the daily DRG rate.

Providers do not receive separate DRG payments for IHCP patients that return from a *receiving* (*transferee*) hospital. Specifically, this policy applies when a patient returns to a hospital from which the patient was previously transferred out for the same illness. Providers must combine the original admission and subsequent return stay on one claim for billing purposes.

Readmissions

Readmission is the term used when a patient is admitted into the hospital or other inpatient facility following a previous admission and discharge **for the same or a related diagnosis**.

For payment purposes, readmissions within three days after discharge are treated as the *same admission*. Providers should bill one inpatient claim (that is, the stays should be consolidated into a single claim) when a patient is readmitted to their facility within three days of a previous inpatient discharge for the same or related diagnosis.

> *Note: "Same or related diagnosis" refers to the principal diagnosis code and is based on the first three digits of the ICD code. If a second inpatient claim is billed for the same member with the same or related principal diagnosis code within three days of a previous inpatient discharge, the second claim will be denied.*

Readmissions more than three days after a previous hospital discharge are treated as separate stays for payment purposes, but are subject to medical review to determine if the previous discharge was premature. If it is determined that the discharge was premature, payment made as a result of the discharge or readmission may be subject to recoupment.

Inpatient Stays Less Than 24 Hours

Providers should bill inpatient stays that are less than 24 hours as an outpatient service.

Inpatient stays less than 24 hours that are billed as an inpatient service will be denied. For exceptions to this rule, see the following sections.

> *Note: Crossover claims must be submitted to Medicare first. Medicare claim information and claim documentation is then special batched to the IHCP.*

Expiration Within One Day of Birth

Providers can submit an inpatient claim for neonates that expire within one day of birth. These claims are assigned a neonatal APR-DRG grouper within the range of 580 through 640. Claims should indicate a patient status code of 20 – *Expired (died)*, and the member's date of birth should be entered as the admit date. Claims meeting these criteria will be reimbursed appropriately through the DRG inpatient pricing methodology.

Inpatient-Only Codes

Inpatient claims with stays less than 24 hours that do not meet the neonatal DRG exception criteria will deny with EOB 0501 – *The discharge date is within 24 hours of the admit date/time* and will be required to be billed as outpatient claims. However, the IHCP will bypass this 24-hour rule to allow certain of the procedure codes designated by Medicaid as "inpatient-only" (IPO) to be reimbursed as inpatient services when the service is delivered in an inpatient setting to a patient discharged or expired within 24 hours of admission.

For a list of the HCPCS and CPT codes to which this exception applies, see the *Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays of Less Than 24 Hours* table in *Inpatient Hospital Services Codes,* accessible from the *Code Sets* page at in.gov/medicaid/providers. Only the affected codes are listed. Any IPO code that is not on the table is not reimbursable in instances when the member has a hospital stay of less than 24 hours.

Procedure codes with a Medicaid Outpatient Hospital Services medically unlikely edit (MUE) of "0" are considered inpatient only (IPO) by the IHCP and are not separately reimbursable in the outpatient setting.

> *Note: For FFS claims with dates of service on or after Jan. 1, 2021, the IHCP applies National Correct Coding Initiative (NCCI) MUEs to IPO procedure codes to better align IHCP reimbursement of Medicaid services with nationwide standards.*

Interim Billing Instructions

The following billing instructions have been established as an interim solution until a permanent solution is developed in the *Core*MMIS claim-processing system:

1. Claims for affected codes rendered in an inpatient setting to a patient discharged or expired within 24 hours of admission must first be submitted as an **outpatient claim** using the standard claim submission process.
2. When providers receive a claim denial for EOB 4183 – *Units of service on the claim exceed the medically unlikely edit (MUE) allowed per date of service* for these codes, they may submit a request for administrative review.
3. Requests for administrative review of a claim must be made using the secure correspondence feature on the Portal or the *IHCP Administrative Review Request* form, available on the *Forms* page at in.gov/medicaid/providers.
   - The administrative review request must include the following:
     - A new inpatient claim form for the services rendered
     - A copy of the original outpatient claim
     - The Remittance Advice (RA) page identifying the original claim denial
     - Documentation that the service was performed in the inpatient setting
   - The administrative review request and documentation must be submitted within 60 days of the date of the claim denial.
   - The administrative review request and documentation may be submitted via the IHCP Provider Healthcare Portal as a secure correspondence message using the Administrative Review category. Alternatively, the *IHCP Administrative Review Request* form and documentation could be mailed to the following address:

     Claim Administrative Review Requests
     Gainwell – Written Correspondence
     P.O. Box 7263
     Indianapolis, IN 46207-7263

> *Note: Providers that follow this rule and bill for outpatient services when a patient has been admitted as an inpatient will not be viewed as being noncompliant with program policies concerning internal records and billing requirements. The FSSA will not take action against a provider for adhering to the agency's billing requirements for inpatient stays of less than 24 hours, because this policy is in compliance with the Indiana regulation and billing requirements.*
>
> *Providers do not need to amend their medical recordkeeping to comply with these changes. Medical records that originally indicated an inpatient stay of less than 24 hours should not be amended.*

Outpatient Service Within Three Days of an Inpatient Stay

Outpatient services that occur within three days preceding an inpatient admission to the same facility for the same or related diagnosis are considered part of the corresponding inpatient admission. Providers are required to submit an *inpatient claim only* in these situations. For the *covered dates* on these claims, the *from* date should reflect the earliest outpatient service detail on the claim, not the subsequent inpatient admission date.

If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will be denied with EOB 6516 – *Outpatient services performed three days prior to inpatient admission.* To resolve this denial, providers should void the outpatient claim in history, incorporate the outpatient services into the inpatient claim and resubmit the corrected inpatient claim.

If an outpatient claim is submitted after the inpatient claim has been paid, the outpatient claim will be denied with an EOB indicating that the inpatient claim may be adjusted to reflect the outpatient services provided to the patient.

This policy is not applicable when the outpatient and inpatient services are provided by different facilities. Additionally, this policy is not applicable when the inpatient stay is less than 24 hours. Outpatient services provided within three days preceding a *less-than-24-hour* inpatient stay are billed as an outpatient service.

See the *Outpatient Facility Services* module for information about billing outpatient services.

Coding Claims for Newborns

Coding claims for newborns requires birth weight for the proper DRG assignment. When a newborn is transferred to another hospital for observation, not for treatment for a specific illness, the receiving provider must enter the ICD-10 diagnosis code Z03.89 – *Encounter for observation for other suspected diseases and conditions ruled out* as the principal diagnosis.

Unit and Age Limitations on Inpatient Neonatal and Pediatric Critical Care Services

Inpatient neonatal and pediatric critical care services are limited to one unit of service per day and are restricted by age as appropriate.

When billing for these services, all providers, including those rendering services under a managed care program, should follow IHCP policy, CPT coding guidelines administered by the American Medical Association, and National Billing Committee (NUBC) guidelines.

For information about pediatric and neonatal critical care during interfacility transportation, see the *Transportation Services* module.

Newborn Screening

By law, newborn blood, pulse oximetry and hearing screenings are conducted on all infants born in Indiana before they are discharged from the hospital. Babies born at home must have newborn screening within one week of birth. *IC 16-41-17-2(d)* identifies religious belief exceptions from the newborn screening requirement. See the *Newborn Screening* page at in.gov/health for general information about the newborn screening program.

The IHCP does not permit hospitals to bill separately for newborn screening. The IHCP pays the newborn hospitalization under the DRG that includes the newborn screening. The IHCP does not require Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/HealthWatch providers to report newborn screening on the professional claim (*CMS-1500* claim form or electronic equivalent).

Newborn Heelstick Screening – Dried Blood Spot Sample

Indiana law requires newborn blood screening tests for every infant before discharge from the hospital. Blood is taken from the infant using the heelstick method and collected onto the newborn screening card, referred to as the dried blood spot (DBS) sample. The DBS sample card must contain information to identify the infant, the physician, the time of birth, the time of first feeding and the time of the blood draw. The hospital sends the blood sample to the Indiana University (IU) Newborn Screening Laboratory.

The IU laboratory has a contract with the Indiana Department of Health (IDOH) to perform laboratory analysis for newborn screening. Providers using laboratories other than the IU laboratory to perform newborn screening analysis must discontinue the practice. To ensure that the IU laboratory performs all newborn screening, the IDOH must coordinate all newborn screening:

- Primary care providers can access newborn screening results online through the Indiana Newborn Screening Tracking & Education Program (INSTEP). For more information, see the *Indiana Newborn Screening Tracking & Education Program (INSTEP)* page at in.gov/health.
- Other healthcare professionals who are not primary care providers can obtain newborn screening results by contacting the IU Newborn Screening Laboratory. A fax with the patient's name and date of birth, patient's mother's name, and birthing facility must be sent on office letterhead to 317-491-6679. Healthcare professionals with questions may call 800-245-9137.
- Parents or other individuals requesting newborn screening results can contact the IDOH Genomics and Newborn Screening Program by calling 888-815-0006.

If the IU laboratory has obtained a valid test and the results are normal, the IHCP requires no further testing. If the laboratory needs to rescreen due to invalid or abnormal results, the provider must contact the IDOH to work out the best method of accomplishing the rescreening. Because hospitals are more frequently releasing newborns before the 48 hours needed to obtain valid newborn screen results, an increasing number of newborns require a second screen. Providers ask families to bring the newborn back to the birth hospital as an outpatient, or the hospital requests a nurse make a follow-up visit to obtain the sample for newborn screening. In either case, the possibility arises that the hospital could bill separately for newborn screening that is already included in the DRG that the IHCP pays for the newborn hospitalization.

Newborns should be screened at the birth hospital or the hospital of closest proximity. To avoid being charged by the IU laboratory for a second screen, a hospital screening a newborn who was born in another Indiana hospital must indicate the name of the birth hospital on the DBS sample card. If the newborn's name or birth date has been changed, the hospital must include the original name and date of birth in the information sent to the IU laboratory to facilitate a match and avoid a charge by the lab.

Newborn Screening for Critical Congenital Heart Disease – Pulse Oximetry

All babies born in Indiana receive a screening for critical congenital heart disease (CCHD) using pulse oximetry technology, which measures the blood oxygen level using a light-beam probe.

Newborn Hearing Screening – Early Hearing Detection and Intervention

Indiana legislation mandates that every infant must be given a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments. The IHCP includes the cost of this screening in the IHCP DRG reimbursement rate that includes the newborn's hospitalization. The IHCP does not allow hospitals to bill separately for initial newborn screening. Newborns must be screened at the birth hospital before the infant is discharged. Newborns requiring further evaluation should be referred to First Steps. See the First Steps website at in.gov/fssa/firststeps for contact information. For more information about billing for newborn hearing screening, see the *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services* module.