PRE-CERTIFICATION AND ADMISSION

The Louisiana Medicaid Program has performed hospital inpatient pre-certification reviews since 1994. This review process helps to control and monitor inpatient admissions, length of stay (LOS) and program expenditures and is an important adjunct to the hospital prospective payment methodology used by the Department of Health and Hospitals (DHH). The pre-certification and length of stay review/assignment impacts acute-care hospitals, rehabilitation facilities, private distinct-part psychiatric facilities, free-standing psychiatric hospitals and long-term acute care (LTAC) hospitals.

The major functions/procedures of the Hospital Pre-Certification/Length of Stay process are:

- Registration and LOS assignment for all acute care and rehabilitation hospitals admissions.

- Pre-admission certification and LOS assignment for admissions to long term acute care hospitals, private distinct part psychiatric/substance abuse units in acute care general hospitals and free-standing psychiatric hospitals.

- Reviews are conducted by nurses and physicians. Physicians are available to discuss any denied stay with the hospital designated physician.

- Hospitals submit all requests, including required forms and limited documentation when requested, via fax to the fiscal intermediary (FI). The **web** application e-pre-cert can be used for submission of **initial** acute care requests only or for **updating** an existing authorization.

- Hospitals are notified by written notification of approval, rejection and denial of requests. Hospitals can also obtain a copy of the pre-certification letter by accessing the Pre-Cert Inquiry application via the Louisiana Medicaid website.

- A reconsideration process is available for denied requests as well as a formal appeal process through DHH.

- Timely updating of clinical criteria and length of stay data bases occurs annually.

- Medical documentation submitted by the provider on required forms is utilized when the FI's pre-cert reviewer inputs data into the system to make a decision.

- All initial requests are assigned a designated pre-certification case number to enhance access and communication between the provider and the FI's pre-certification personnel.

The types of requests for inpatient hospital stays include:

- Acute Care: Adult and Pediatrics
- Rehabilitation
- Psychiatric/Substance Abuse
- Long-Term Acute Care

Length of Stay

Acute care and rehabilitation hospitals must register each Medicaid admission no later than one business day after admission. ***Length of stay (LOS)*** for each acute care/rehabilitation case will be determined by the FI using department specified criteria including Southern Region grand totals, customized criteria, and clinical information for the case provided by the hospital. The initial length of stay for acute care and psychiatric admissions will be assigned at the 50^{th} percentile of Thomson Reuters Southern Region averages based on the admitting diagnosis. The initial length of stay for rehabilitation will be assigned 14 days based on the lowest average length of stay from the American Hospital Association Average Study for Rehabilitation conditions.

Late submissions of an initial pre-cert case due to an incorrect response from a Medicaid Eligibility Verification System (MEVS) inquiry will be given consideration if a good faith effort is verified with the actual printout from the MEVS system that was accessed within the one business day of the admission. Submit to the Pre-Certification Department.

Admissions

Medicaid hospital admission/LOS reviews will reference current InterQual Adult and Pediatric intensity severity discharge (ISD) criteria sets (edition currently used by the Louisiana Medicaid program), current InterQual Procedures Guidelines, current Thomson Reuters LOS (grand total percentages based upon the admitting diagnosis) Southern Region data and customized criteria. Reviews will be conducted by the FI nurses and physicians. The FI review staff will be divided into specialty groups representing those services requiring pre-admission certification and LOS assignment.

Acute Care Adult or Pediatric Hospital Stays/Admissions Process

Acute Care admissions include the following levels of care: General, Burn, ICU, PICU, CCU and NICU (additional information on NICU and low-birth weight babies is in **Pre-certification for NICU Levels of Care** (see Pre-certification for NICU Levels of Care later in this section).

Initial requests whether approved, rejected or denied are assigned a pre-certification case number.

Medicaid recipients should be registered for admission by completing the Form PCF01 and faxing to the FI. No requests prior to the admission date are accepted for acute care facilities.

All initial admission requests must be submitted within 24 hours of admit except for weekends or the FI holidays. In these instances, submit the next business day.

Approved, denied, or rejected case decisions will be faxed to the facility within the required 24 hours from the date and time of receipt in pre-cert.

The hospital should only register a recipient and submit a PCF01 **if** there is medical necessity present for an inpatient admission, **if** the case meets InterQual Criteria and **if** there is a physician order for inpatient status.

Initial LOS for acute care is assigned according to the current Thomson-Reuters Recommended LOS Southern Region average. The assignment will be set at age appropriate. All Stays of the 50th percentile of the ICD-9 primary and/or admitting diagnosis code submitted.

Adult or Pediatric Extension Process

Acute care extensions include the following levels of care: General, Burn, ICU, PICU, CCU and NICU (additional information on NICU and low-birth weight babies is in **Pre-certification for NICU Levels of Care.**

Request for an extension must be submitted via fax no later than the expected discharge date. If the discharge date is a weekend or FI holiday, the extension request may be submitted on the next business day. The "expected discharge date" is shown on the provider notification received after each approved request.

Forms PCF01and PCF02 must be submitted for each acute care extension request. There are to be no attachments to the PCF02 unless requested by the nurse reviewer with a limit of no more than two additional pages of documentation. All pertinent information must be included on the form itself or on the accepted forms by the Provider Link system.

Extension LOS requests will be reviewed by a nurse to determine if the stay meets InterQual® criteria based on the recipient information submitted on the Form PCF02 for the appropriate Level of Care.

Extension LOS for acute care is assigned according to the current Thomson-Reuters recommended LOS Southern Region average. The first extension assignment will be set at the age appropriate ALL stays up to the 75th percentile of the ICD-9 diagnosis code submitted. Subsequent extensions will be assigned a LOS up to five days for a general level of care and up to seven days for the named levels of care. All approvals are based on criteria being met.

Approved, denied, or rejected case decisions will be faxed to the facility within the required 24 hours from the date and time of receipt in pre-cert.

For infants or children who move to a more intensive level of care, the nurse reviewer will use **both** Severity of Illness **and** Intensity of Service criteria reviews to determine if the stay meets criteria for NICU or PICU.

If an Intensity of Service criterion has limitations on appropriateness of hospitalization based on the specific criteria used then the nurse reviewer will shorten the approved number of days accordingly.

Rejections of Acute Care Pre-Certification Requests

All initial pre-cert requests that are rejected (no assignment of stay given) should be returned to pre-cert as an **Initial Resubmittal**. The PCF01 must be used for the **resubmittal request**. The resubmitted PCF01 must include the case number assigned on the initial pre-cert request and must be returned to pre-cert within 48 hours (two business days) from the date faxed from pre-cert. Exceeding 48 hours (two business days) will result in a denial for timeliness.

All extension requests that are rejected should be returned to pre-cert on a PCF02 as a **resubmittal**. The **resubmittal** should be returned to pre-cert within 48 hours (two business days) from the date faxed from pre-cert. Exceeding 48 hours (two business days) will result in a denial for timeliness.

Denials of Acute Care Pre-certification Requests

Only a physician can issue medical necessity denials. InterQual criteria are used by the registered nurse to determine approval of all LOS extension requests.

If submitted documentation does not meet current InterQual criteria, the request is sent for a physician review. A denial is issued when the physician determines (based on submitted documentation) that medical necessity for the requested length of stay is not supported.

The hospital provider has three options following a denial as listed below:

- Submit written reconsideration. Must be submitted the next business day following the denial.
- Request a scheduled physician to physician telephone conference.
- Submit to Division of Administrative (DOA) Law for appeal through the Administrative Court. The provider must schedule the appeal within 30 days of the first denial date.

A written **reconsideration** is submitted to pre-cert within one business day of the denial notification faxed by the FI. For denial of an initial admission, the PCF01 must be used for the reconsideration request and must include the case number assigned on the initial pre-certification request. For denial after an extension request, the PCF02 must be used for the reconsideration request.

The previously submitted documentation did not meet current InterQual criteria, thus it was denied. The provider should send documentation that does show InterQual criteria is met for the denied days.

The reconsideration documentation will be reviewed by a pre-cert physician. If an InterQual criterion is met; a LOS will be approved. The provider will then submit routine extension requests if the recipient remains inpatient. If InterQual is not met, the reconsideration will be denied.

Following a denial of a reconsideration request, the provider has two remaining options:

- Schedule physician to physician conference through the FI's Pre-certification Department.
- Submit to Division of Administrative (DOA) Law for appeal through the Administrative Court. The provider must schedule the within 30 days of the first denial date.

The physician to physician conference is an opportunity for the facility physician to discuss a denied case with a pre-cert physician. The hospital may "designate" a physician from their facility to participate in the conference.

The hospital will contact the telephone representative in pre-cert. The pre-cert representative will fax to the hospital, a schedule of conference date and time availability. The hospital will contact

their physician for his/her availability. The hospital will then contact the pre-cert telephone representative to set up the conference day and time based on the availability of the participating physicians.

The hospital contact person will be given specific instructions for what documentation will need to be sent to pre-cert and the deadline date for submitting that documentation. Documentation not faxed to pre-cert within the required time frame for pre-cert physician review, will not be accepted and the conference will be cancelled.

The Department allows a hospital up to two appointment cancellations per pre-cert denied case. If the conference is cancelled after two appointments, the hospital will need to submit an appeal for further action on the denial.

Outpatient Status vs. Inpatient Status

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

Medicaid will allow up to 30 hours for a recipient to be in an outpatient status. This time frame is for the physician to observe the patient and to determine the need for further treatment, admission to an inpatient status or for discharge. (Exception: Outpatient Ambulatory Surgeries).

The hospital should **ONLY** register a recipient and submit a PCF01 if there is **MEDICAL NECESSITY** present for an inpatient admission, if the case meets InterQual criteria and if there is a physician order for inpatient status. All claims submitted are subject to post payment review by Program Integrity.

Outpatient Status Changing to Inpatient Status

If the physician converts the recipient from an outpatient to an inpatient status, a PCF01 must be submitted within 24 hours of the admit order (next business day). When the inpatient order is written on a weekend or holiday, the PCF01 must be submitted the next business day after the inpatient order is written.

The physician must write the order to admit within 30 hours of the recipient being registered as an outpatient.

If the situation is where the recipient is an outpatient on hospital day one and converts to inpatient after hours on hospital day two, the PCF01 must be submitted the next business day. The hospital should indicate on the PCF01 by the admit date that hospital day one was an

outpatient day. This will prevent denials for timely submission. The outpatient "admit day" becomes the inpatient "admit day" for this type of case.

> **Case Example:** A recipient is referred to the hospital on 9/1 at 10:00am from the doctor's office with chest pain. Orders are to admit in an outpatient status and observe on a telemetry unit (EKG monitoring, cardiac enzymes q8hrs x3 sets). At 1:00 pm on 9/2 chest pain continues and enzymes are positive. The physician writes an order to convert the patient to inpatient. In this situation send a PCF01 with the admit date being 9/1.
>
> The hospital should indicate on the PCF01 that the patient came in as outpatient via emergency room or observation on 9/1. On 9/2, physician wrote orders to admit as inpatient. Admit date on the PCF-01 is 9/1. In the above example, all services performed on 9/1 are included in the inpatient stay and billed accordingly. The provider cannot bill an outpatient claim for 9/1.

NOTE: The FI reserves the right to request a copy of the inpatient order.

Outpatient Ambulatory Surgeries

Certain surgical procedures are covered by the Medicaid Program only when performed outpatient unless otherwise authorized. A list of these procedures is provided online (see Appendix A for web site).

Outpatient surgical cases that have a physician order for outpatient statuses do not need to be pre-certified. There are no time limitations for an outpatient surgery.

State operated hospitals that previously requested authorization for ambulatory outpatient surgeries from the FI's **Prior Authorization** Department will no longer do so effective 8/30/2010.

Outpatient Procedures Performed on Day of Admission or Day after Admission

In certain circumstances, recipients may require inpatient admission for surgical procedures normally covered by the Medicaid Program only when performed outpatient as referenced in **Outpatient Ambulatory Surgeries.**

Inpatient approval of these outpatient procedures will be granted when one or more of the following exception criteria exist:

- There is a physician order for inpatient status.

- Documented medical conditions exist that make prolonged pre-operative and post-operative observation by a nurse or skilled medical personnel a necessity.
- Procedure is likely to be time consuming or followed by complications.
- An unrelated procedure is being performed simultaneously that requires hospitalization.
- The procedure carries high patient risk.

Hospitals must submit both Forms PCF01 and PCF02 to request pre-cert approval for outpatient surgical procedure(s) performed on an inpatient basis on the day of or the day after admission within 24 hours of the admit order (or next business day).

The PCF02 information supports the medical necessity for the procedure being performed inpatient. If the PCF01 is received without the PCF02, the request will be rejected. If the initial authorization is submitted via the e-pre-cert application then the PCF02 is not required as there is space on the electronic form to include the medical necessity information.

The outpatient "admit day" becomes the inpatient "admit day" for this type of case.

> **Case example:** On 9/1 a 55 year old has an appendectomy with orders for outpatient status. He has a fever post op and stays overnight for observation. On 9/2 his fever continues and his WBC = 22.3. The physician starts IV antibiotics and writes an order to change to inpatient status. The hospital must submit a PCF01 and PCF02. The admit date will be 9/1.

In the above example, the hospital must submit the pre-cert request by 9/3 or the case will be denied for submission after allotted time.

The request will be reviewed by a nurse to determine if either InterQual® procedures criteria are met and/or InterQual admission criteria are met.

NOTE: We cannot approve an inpatient hospital stay for a planned outpatient surgical procedure provided on an inpatient basis for a recipient who has no medical reason to be admitted. It was never DHH's intention to give a blanket approval for the first 24 hours on any stay where medical necessity for inpatient care is not met, or when there is no length of stay for the diagnoses code.

Pre-certification of Newborns

Newborn Initial Admissions

Healthy babies born to Medicaid mothers are **not** pre-certed. They will be in the general nursery for up to 48 hours for vaginal delivery or up to 96 hours for C-section delivery.

Healthy babies, born to non-Medicaid eligible mothers **can** be pre-certed. You must submit a **completed** PCF01 with all "zeros" for the 13 digit Medicaid identification (ID) number.

In the "description" area on the PCF01 you must state "Mom not Medicaid Eligible" and include the mother's Social Security number.

The Admit and/or Primary ICD-9 diagnosis will be submitted as follows:

- V3000 will be used for baby "delivered vaginally."
- V3001 will be used for baby "delivered by C-section.

If mother does not have Medicaid, the baby will be pre-approved 48 hours for V3000 (vaginal delivery) or 96 hours for V3001 (C-section).

Ill newborns (with Medicaid eligible mothers) who remain after the mother's discharge date and are **not** admitted to NICU are pre-certed with the mother's discharge date as the ill newborn's admit date on form PCF-01.

The notification fax sent from the FI will note that the newborn case has been pre-approved pending eligibility since there is no Medicaid ID number. It is the hospital's responsibility to submit an "update" to pre-cert as soon as the Medicaid ID number is obtained. The following must be included or the update request will be rejected:

- Fully completed PCF01 checked as an update.
- The PCF01 must include the 13-digit Medicaid ID number, the baby's name **before** the Medicaid ID number was assigned, the baby's name **now** associated with the ID number and the **provider's signature**. The FI staff member is changing the name designation on the case and therefore must have signed authorization.

Newborn Extension Request

All extension requests for additional days, past the current assignment of days, for **newborns**, and/or **NICU Level of Care** (LOC) must be submitted on a completed PCF04.

All extension requests for newborns and/or NICU level of care that are **rejected**, must be returned to pre-cert on a completed PCF04 as a **Resubmittal**.

All extension requests for newborns and/or NICU level of care that are denied must be returned to pre-cert on a completed PCF04 as **Reconsideration**.

Pre-certification for NICU Levels of Care

Ill newborns (with Medicaid eligible mothers) who are admitted to NICU are pre-certed with an admit date of the day that they are admitted to NICU.

The pre-cert request is submitted on a fully completed PCF01 with all zeros for the 13 digit Medicaid ID number.

Initial NICU admissions for short gestation and low birth weight (less than 2500 gms)

- The length of stay assignment will be based on revisions to the Louisiana Medicaid defined LOS.
- The Initial requests that are submitted for low birth weight or short gestation require only the PCF01 for the Initial.
- The admission ICD-9 diagnosis code should be reported as the specific low birth weight or short gestational age.
- The initial LOS will be based on the ICD-9 diagnosis codes for specific low birth weight or short gestational age.

Initial NICU admissions for other than short gestation and low birth weight

- Initial LOS for NICU is assigned referencing the ICD-9 primary and/or admitting diagnosis code submitted by the hospital, and
- Current Thomson-Reuters 50th percentile of the Southern Region and/or Louisiana customized LOS.

- PCF01 will be required for initial admissions to NICU for diagnosis other than low birth weight/short gestation.

Extension requests for NICU for Short Gestation and Low Birth Weight (less than 2500 gms)

- Fully completed PCF04 will be required for all extension requests.
- Extension LOS assignment will be based on the Louisiana Medicaid defined Length of Stay.
- Current InterQual Intensity of Service (IS) criteria will be used for review of all extension requests for continued stay.
- The birth weight or short gestation ICD-9 diagnosis code used on the Initial admission should **always** be the first extension ICD-9 code entered in diagnosis block 1 on the PCF04 for all subsequent extension requests.
- Include additional diagnosis codes affecting intensity of service and supporting the continued stay.

Extensions Other Than Short Gestation and Low Birth Weight

- First extension assignment of stay will be based on current Thomson-Reuters up to the 75th percentile of the Southern Region and/or Louisiana customized LOS.
- Current InterQual Intensity of Service (IS) criteria will be used for the review of all extension requests for continued stay.

Pre-certification for OB Care and Delivery

Effective with the dates of service on or after August 30, 2010, deliveries are approved via the claims processing edit in accordance with the Newborn Protection Act when the following conditions are met:

- Three days are authorized for vaginal deliveries if the admission date is equal to the date of delivery.
- Four days are authorized for vaginal deliveries if the delivery occurs the day after admission.

- Five days are authorized for C-Sections if the admission date is equal to the date of delivery.

- Six days are authorized for C-sections if the delivery date occurs the day after admission.

The three days approved for a vaginal delivery and four days approved for a C-section are in accordance with federal guidelines pertaining to the Newborn Protection Act. Days beyond the three and four days that are approved in via the pre-certification edit are to account for admissions or deliveries late in the evening. Any days approved via the claims processing edit that are greater than the three and four days mandated by federal guidelines may be subject to medical necessity review retrospectively. Facility specific LOS reports are generated monthly to compare delivery LOS data pre and post implementation of this policy. Medical necessity should guide the physician decision-making process related to discharge and patients should be kept in the hospital for medical necessity only.

Additional information:

- Complete PCF01 and PCF02 with clinical information supporting stays beyond these periods of time.

- The PCF02 should include clinical information supporting stays beyond the periods of time listed above.

- The PCF01 and PCF02 must be submitted on the expected discharge date. If the expected discharge date falls on a weekend or FI holiday then submit the PCF01 and PCF02 the next business day following the expected discharge date.

- If an ambulatory surgical procedure is performed on the first or second day of the inpatient stay for a delivery, pre-certification is required. Refer to the Louisiana Medicaid web site for the list of ambulatory surgical procedures, sterilization procedures are excluded from this list starting June 7, 2011. Pre-certification is no longer required if performed on the first or second day of an inpatient hospitalization.

- When billing for the sterilization/delivery all required forms **must** be attached and correctly completed.

Vaginal Delivery Pre-certification Example:

If the vaginal delivery day is equal to the admission date to the hospital then the patient must discharge home by day four of the hospitalization in order to be excluded from pre-cert. If the mother does not discharge home on the fourth day of her hospitalization then the PCF01 & PCF02 must be submitted on the fourth day of hospitalization.

The fourth day is the expected discharge day. If the fourth day falls on a weekend then the PCF01 & PCF02 are due on the next business day.

C-Section Pre-certification Example:

If the C-Section delivery date is the day after the admission date to the hospital then the patient must discharge home by day seven of the hospitalization in order to be excluded from pre-cert. If the mother does not discharge home on day seven then pre-cert is required. Submit a PCF01 & PCF02 on day seven of the hospitalization. Day seven is the expected discharge date. If the seventh day falls on a weekend then the PCF01 & PCF02 are due on the next business day.

Short Cervical Length Guidelines – Length in Pregnancy

A shortened cervical length, as measured by transvaginal ultrasound, has been associated with increased risk of pre-term birth in some pregnancies. However, there is no clear published guidance on management of these pregnancies, or that intervention results in improved outcomes. Use of antenatal steroids has shown benefit in appropriately selected patients. The following protocol is suggested as a guide for selection of patients for inpatient evaluation / management. It is not intended to be a strict protocol and should be adapted as clinical conditions warrant, as provided by the patient's provider. Patients with cervical lengths of > 25 mm (20-37 weeks gestation) are generally considered to be at low risk for preterm birth and are not considered in this management protocol.

NOTE: See appendix A for information regarding Cervix Guide.

Rehabilitation Admission/Level of Care

Rehabilitation Admissions

Medicaid recipients may be registered for admission by completing the Form PCF01 and faxing it to the FI. No requests prior to the admission date are accepted for acute care facilities. If the recipient is transferred from an Acute Care to Rehab within the same facility, no new case number is needed. The acute care case number must be noted on the rehab PCF01.

Rehabilitation initial requests require a Form PCF01 and current DHH established criteria that will be reviewed by a nurse for the assignment of LOS up to 14 days.

Rehabilitation Extension

Request for an extension must be submitted via fax no later than the expected discharge date. If the discharge date is a weekend or holiday, the extension request may be submitted on the next business day. The "expected discharge date" is shown on the provider notification received after each approved request.

Rehab extension LOS requests will be reviewed by a nurse to determine if the stay meets the current DHH established criteria.

All of the following medical data must accompany the Rehab extension request:

- PCF01
- PCF03
- Established criteria
- Multidiscipline staffing report

The first extension approval for Rehab is given up to 14 days. Subsequent extensions are up to seven days.

Approved, denied, or returned cases will be faxed to the facility within the required 24 hours from the receipt in pre-cert.

Process for Rejected Extensions for Acute Care and Rehabilitation:

- The provider has 48 hours to "resubmit" with additional documentation that supports InterQual criteria.
- The provider will check the "resubmittal" box on the PFC01 and PCF03.
- If the case was rejected for not meeting criteria, you must submit with additional information. Do not submit the same PCF02 that was originally rejected.

Process for Denied Extensions for Acute Care and Rehabilitation:

- The provider has 24 hours to request a written reconsideration by submitting the requested supporting medical documentation and a Form PCF02 for the denied days.
- If the request is denied, the provider may contact the FI's Pre-certification Department to set up physician-to-physician conference.
- There is no reconsideration process for requests denied for lack of a timely submittal.
- If the request and the physician-to-physician review have been denied, providers may file an official appeal with the Division of Administrative Law-Health and Hospitals Section (see appendix B for contact information).

NOTE: Additional information can be found on the pre-cert notification letter or refer to Hospital Pre-certification Reconsideration/Appeal Process for additional information on the appeals process.

Long-Term Acute Care Hospital Stays

Long-Term Acute Care (LTAC) facilities are the only facilities that are allowed to submit for a pre-certification prior to the recipient's actual admit date.

All of the following medical data must accompany the preadmission/admission request for LTAC:

- Form PCF01,
- Established criteria,
- Either Discharge summary from transferring hospital **or** Form PCF06, **and**
- Long-Term Acute Care will be assigned an initial LOS of up to 14 days.

Long-Term Acute Care Extension

All of the following medical data must accompany the extension request for LTAC to determine if the stay meets criteria:

- Form PCF01,
- Established criteria, **and**
- Form PCF06.

Request for an extension must be submitted no later than the expected discharge day. If the discharge date falls on a weekend or FI holiday, the fax must be submitted the next business day. The expected discharge date is shown on the provider notification after each approved request.

The first extension approval for Long-Term Acute Care is given for up to 14 days. Subsequent extension is up to seven days.

Approved, denied, or returned cases will be faxed to the facility within the required 24 hours from the receipt in pre-cert.

Psychiatric/Substance Abuse Hospitals Stays - Admissions

All of the following medical data must accompany the admission request for Psychiatric/Substance Abuse: (SAU)

- Form PCF01,
- Appropriate criteria (psych/substance abuse),
- **Certificate of Need for Recipients under 21 years and**
- Form PCF05 or **all** of the following:
    - a, b, c,
    - Psychiatric physician evaluation (if available),
    - Initial assessment by registered nurse or licensed mental health professional, **and**
    - Psychiatric physician admit orders.

LOS for psych is assigned according to the Thomson-Reuters Recommended LOS Southern Region average. The assignment will be set at age appropriate all stays of the 50th percentile of the ICD-09 diagnosis code submitted.

NOTE: In compliance with Centers for Medicare and Medicaid Services (CMS) regulations, the Certificate of Need (CON) must be signed by the independent admit team unless it is

documented as an emergency psychiatric admission. Emergency admissions supported by appropriate documentation may have the CON signed by the hospital interdisciplinary team.

Psychiatric/Substance Abuse Extension

All of the following medical data must accompany the extension request for psych/substance abuse:

- Appropriate criteria (psych/substance abuse) **and**
- Form PCF05 **or all** of the following:
    - Psychiatric physician evaluation if not previously submitted with the initial admit request.
    - Medical documentation pertinent to the requested period includes:
        - Last (current) 48 hours of nurses notes
        - Last (current) 48 hours of psychiatric physician orders
        - Last (current) 48 hours of psychiatric physician progress notes

The first extension approval is assigned according to the current Thomson-Reuters recommended LOS Southern Region average. The assignment will be set up at the age appropriate **all stays** up to the 75th percentile of the ICD-9 diagnosis code submitted. Subsequent extensions are up to three days.

Late Requests for Initial Stay Due to Conflicting Medicaid Eligibility

Late submissions of an initial case due to an incorrect response from a Medicaid Eligibility Verification System (MEVS) inquiry will be given consideration if a good faith effort is verified with the actual printout from the MEVS system that was accessed within one business day of the admission. Such cases, along with supporting documentation, should be submitted to the FI's Pre-Certification Department.

Retrospective Review Based on Recipient Retroactive Eligibility

Only one situation is recognized for retrospective review based on recipient eligibility. This occurs when positive determination of Medicaid eligibility cannot be made during the admission period. This refers to the State's determination of eligibility.

If a recipient's stay exceeded the recommended LOS, an extension should be requested concurrently with the admission LOS review. All retrospective LOS must be supported by

criteria. Approval of the request will follow the procedures required for the type of admission/extended stay being requested.

The recipient's discharge date must be indicated on the PCF01.

If the approved LOS days are less than actual days of stay, only the number of approved LOS days will appear on the provider notification.

Cases denied will follow the same denial and appeal procedures described in **Outpatient Ambulatory Surgeries.**

Retrospective Review Based on Provider Retroactive Eligibility

If an in-state hospital is enrolled as a Louisiana Medicaid provider with a retroactive begin date of eligibility; the hospital may request retroactive review for Medicaid patient stays during the retroactive period.

If the recipient has been discharged, the request should be for the entire stay and must be supported by criteria.

If the approved LOS days are less than the actual days of stay, only the approved LOS will appear on the provider notification.

NOTE: Cases denied will follow same denial and appeal procedures described in Hospital Reconsideration/Appeal Process.

Pre-certification Requirements for Dual Recipients

Coverage	Pre-certification Required?
Medicare Part A only – benefits not exhausted	No
Medicare Part A only – benefits exhausted	Yes –Form PCF01 and Medicare EOMB (Explanation of Medical Benefits) to verify days are exhausted. EOMB should show the first date of Medicare exhausted benefits for denied days. (See **Submission of Hospital "Common Working File" (CWF) Screens for Pre-certification Documentation of Medicare Part A Benefits Exhausted, below.)**
Medicare Part B only	Yes

Medicare Parts A and B - Part A Benefits not exhausted	No
Medicare Parts A and B - Part A Benefits exhausted	Yes –Must submit Form PCF01 and Medicare EOMB (Explanation of Medical Benefits) to verify days are exhausted. EOMB should show the first date of Medicare Part A only exhausted benefits for denied days. (See **Submission of Hospital "Common Working File" (CWF) Screens for Pre-certification Documentation of Medicare Part A Benefits Exhausted, below.)**
Medicare Replacement Plans	No

NOTE: The provider has only 60 days from the notification date on the Medicare EOMB to submit a pre-cert request.

"Common Working File" Screens for Pre-Certification Documentation

The FI's Pre-Certification Department will accept the hospital Common Working File (CWF) screen printouts as documentation that Medicare Part A benefits are exhausted. However, they will only accept these screens if it is clearly indicated that Medicare was billed and a portion of the days were denied because **benefits were exhausted**, or that Medicare Part A benefits were exhausted as of the date of admission. Some of the screens submitted do not state clearly the information above in either form, so these have been rejected.

Denial of Extension Requests for Lack of Timely Submittal of Medical Information

In situations when a hospital is denied an extension request based on timely submittal of the medical information requested by the FI, and the recipient is still in the hospital, the DHH allows hospitals to request to re-open the pre-certification case under a new pre-certification number when the hospital submits current documentation to be reviewed as long as the patient continues to be an inpatient.

The hospital must submit an initial PCF01 with no pre-certification number. At the top of the PCF01, the provider must write "Attention: Pre-certification Supervisor." On the bottom of the PCF01 the provider should put "see old case # _____" (this will be the pre-cert # under which the case was denied for timeliness). This new request must have the current documentation which supports the continued LOS.

NOTE: This process can only be offered for **extension** requests when the recipient is still in-house – **not initial** requests or requests for recipients already discharged. If you have questions about the process described, please call the Pre-certification Department (see appendix B).

The hospital will be assigned a new pre-certification number, with the admit date being the date that the FI receives the current request. The days that were denied may be appealed through the DHH appeal process using the pre-certification number under which the days were denied.

Hospital Pre-certification Reconsideration/Appeal Process

All types of inpatient hospital stays must be approved through the FI's Pre-certification Department. In the event that an admission or extension is denied and the facility feels that there is a valid need for the admission or extension, the procedures as documented below should be followed.

Once the facility has received the denial from the Pre-certification Department, the facility may request a written reconsideration. The reconsideration must be submitted in writing to the Pre-certification Department within one business day from the date of the notification letter. The reconsideration will be reviewed by a physician, and a status determination will be faxed to the provider. If the reconsideration is approved, the facility will continue with extension requests if additional days are needed. If the reconsideration is denied, the facility will want to schedule a physician to physician review as the next step.

If the FI's physician upholds the denial and the facility still feels that a valid need exists to admit or extend the stay of a recipient, then a formal appeal may be initiated through the Division of Administrative Law.

When initiating a formal appeal, please include the following information in the letter to the Division of Administrative Law:

- The recipient's full name and Medicaid number.
- The first date which was not reimbursed through the actual discharge date.
- The total number of days under appeal (the discharge date is not reimbursable).
- The official name and address of the facility and the provider number.
- The name and telephone number of a contact person.

- The name, address, and telephone number of your attorney when one will be representing the facility.

- The last denial notification from the FI's Pre-certification Department.

Pre-certification Department General Information

Working Hours and Holidays of Current Fiscal Intermediary

The working hours are Monday through Friday 8:00 a.m. - 5:00 p.m. (except FI holidays).

Holidays are as follows:

- New Year's Day (observed)
- Martin Luther King Day
- Memorial Day
- July 4th
- Labor Day
- Thanksgiving and the day after
- Christmas

Pre-certification Department Fax System

The Pre-certification Department relies heavily on its fax machines to provide prompt service to providers. Sometimes, however, faxes get lost on their way from the provider to Pre-certification. The FI's fax server system addresses this issue with a mechanism to track or trace lost faxes.

The pre-certification fax system receives information from providers across the state, seven days a week, 24 hours a day. Therefore, you may fax a request from your facility at 10:00 a.m. but that fax may not arrive in print form to the Pre-certification Department until after noon on that same day.

Often information is difficult to read. This may be the result of copier quality or writing legibility. Colored pages DO NOT fax well.

This system works in a two-fold manner to retrieve faxes that are important in the FI's business dealings. For incoming faxes, the system can actually "visualize" faxes as they are received by the fax/computer. The benefit of this feature is that it is able to track a fax from the time it enters the system until the time it is printed in Pre-certification. If a provider has an ongoing problem with faxes sent, this tracking system can be utilized. The limitation of this mechanism is that it can track faxes for only six days after they've been sent and only if the provider has his CSID (Communication Sender Identification) number on each faxed page. The CSID number is a federal regulation, not an FI requirement.

The second unique feature of the Pre-certification fax server is its written reports, generated each hour, documenting failed faxes; these are faxes Pre-certification is sending to providers. This allows pre-certification staff to refax information listed as having failed. If groups of faxes sent to the same facility continue to fail in transmission, the Pre-certification staff contacts that facility to alert its staff to potential problems with the provider's fax machine. Every 24 hours, Pre-certification receives a written log of all faxes sent—those received by the providers as well as those which failed and were re-sent.

If, despite these features, providers have an ongoing fax problem with either sending data to or receiving data from Pre-certification, providers are encouraged to contact the FI's Pre-certification Department who will assist in identifying the problem and advising of its solution.

Helpful tips:

- Every fax to the Pre-cert Department should have a cover page.
- On your fax cover letters, the total number of pages submitted in that particular fax must be identified. This enables you to know if all the pages you intended to fax did go through.
- Check your fax transmittal receipt to verify that all pages were sent successfully.
- If your fax transmittal shows that some pages did not go through, please refax the entire submission.

Due to issues of recipient confidentiality, we are to send case information only to authorized fax numbers. If you are sending your fax from a different location or if your authorization fax number is discontinued or broken, you must contact the Pre-certification Department for instructions about how to have another fax destination authorized for pre-certification data.

NOTE: See appendix B for all contact information.

Pre-certification Turnaround Times

Maximum response time begins when all necessary information is received in the Pre-cert Department.

Acute Care	
LOS	24 Hours
Extension	24 Hours
Pre-certification	N/A
Retro Review	21 Days

Psych and Substance Abuse	
Initial LOS	24 Hours
Extension	24 Hours
Pre-certification	24 Hours
Retro Review	21 Days

Rehab	
Initial LOS	24 Hours
Extension	24 Hours
Pre-certification	N/A
Retro Review	21 Days

Long-Term Acute Care	
Initial LOS	24 Hours
Extension	24 Hours
Pre-certification	24 Hours
Retro Review	21 Days

Pre-certification Reference Guides

The following reference guides will be used as criteria:

- Most current McKesson InterQual® Level of Care Criteria
    - Acute Care Adult
    - Acute Care Pediatric
- Most current McKesson InterQual® Level of Care Criteria
    - Procedures Volume I Adult
    - Procedures Volume II Adult
    - Procedures – Pediatric

Most recent data from Thomson-Reuters recommended LOS Southern Region Average. These manuals may be obtained by contacting the InterQual® and Thomson-Reuters offices.

NOTE: Refer to appendix B for McKesson Health Solutions and Thomson Reuters contact information.

Pre-certification Reminders

- List an extension diagnosis for each extension request. This extension diagnosis should be the attending physician's diagnosis at the time of the extension request and may or may not be the same as the admitting and/or primary diagnosis.

- Reconsideration requests are only for denied cases that do not meet medical criteria on initial, extension, or retrospective requests. Cases denied for timely submittal do not have a reconsideration process.

- Write the description of the ICD-9 codes submitted.

- Include start and stop dates for medication, and date all lab values and vital signs. Per Interqual Criteria: "All PRN medication must be noted by the number of times administered and by what route."

- Transcribe the requested physician progress notes if they are not legible. Do not send additional documentation unless specifically requested for acute inpatient stays.

- Do not fax copies of photographs since they copy very poorly. Instead, please submit description or mail pictures of wounds/decubiti.

- In compliance with CMS regulations, the CON must be signed, as introduced in the CMS (Combined Medicare/Medicaid Service) required form, by the independent admit team unless this can be documented as an emergency psychiatric admission. Emergency admissions supported by appropriate documentation may have the CON signed by the hospital interdisciplinary team.

- The Pre-certification Department routinely announces changes in the *Provider Update* sent to all providers, and on remittance advice (RA) messages sent to all hospital billing departments. We strongly recommend that copies of the *Provider Update* and RA messages pertaining to pre-certification be sent to your Utilization Review Department.

NOTE: The Provider Update and RA messages can be found on the Louisiana Medicaid web site.

What Providers Can Do To Help the Process

The information below details things providers can do to help the FI's Pre-certification Department expedite the review and processing of your pre-certification requests.

The notification letter to the provider will contain the status of the request and, uses three-digit codes to inform the provider of any additional information needed. Providers need to respond by sending the requested information on the appropriate required Forms (PCFO1, PCFO2, PCF04 for acute inpatient and non general level of care) or by writing an explanation of why the information is not available.

Proofread the information being sent to the FI. Often providers send conflicting documentation among disciplines. These cases are reviewed based on the preponderance of information.

Often information is difficult to read. This may be the result of copier quality or writing legibility. Colored pages do not fax well.

Pre-certification staff always requires current, up-to-date information on medications and therapies supporting the criteria. Lack of current or time-sensitive information usually results in an unfavorable decision. Only that information pertinent to the request from the last request is required. Do not resubmit information previously submitted unless requested. Information must be on mandatory forms required.

Pre-certification Glossary

Approved: Admission and/or extension is approved.

Denied: Admission and/or extension is denied because documentation does not meet the **criteria** to warrant medical necessity after review by the consulting physician or psychiatrist.

Rejected: Admission and/or extension is rejected because **documentation** is insufficient and additional information is needed in order to process the case.

Resubmittal: Hospitals may send additional documentation/information for requests that have been **rejected**. If rejected, the provider is **resubmitting** the request, not reconsideration. A resubmittal must be submitted within 48 hours (two business days) from the date faxed from pre-cert.

Reconsideration: Hospitals may request reconsideration of cases **denied** for lack of medical necessity. Reconsideration must be submitted within 24 hours from the date faxed from pre-cert, except for weekends or FI holidays. In these instances, submit by the next business day.

Update: Hospitals may request the addition of newborn Medicaid ID numbers and/or outpatient procedures performed on an inpatient basis if it is the primary or only procedure performed within the first two days of the hospital stay. Indicate what items need to be updated by circling the item. All update requests should include the pre-certification case number.

Retrospective: Hospitals may request certification for cases where the Medicaid eligibility was not determined during the admission period. All retros should include a summary or abstract of entire stay – do not send the hospital chart, only what documents criteria.