Acute Hospital Pre-Certification

McKesson's InterQual CareEnhance Review Manager Enterprise ® (CERMe) and the Thomson Reuters Length of Stay Data are used in determining current medical practice standards in the appropriateness of inpatient admissions and continued inpatient stays.

InterQual criteria clinical content is a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and/or primary care physicians. The criteria identifies the most appropriate level of care during the initial admission, validates the need for continued stay, directs care to the appropriate level of care (if needed), and is based on patient specific information.

Acute inpatient extension requests are reviewed utilizing the most recent criteria guidelines and length of stay data available at any given time.

Claims for physician inpatient services are edited to assure the inpatient hospitalization has been pre-certified/approved. When there is no approved pre-certification on file, the inpatient physician services claim will deny.

For further information related to submitting physician charges when hospital stays are not pre-certified, refer to "Physician Billing When Pre-Certification Is Not Authorized" in this section. For assistance with claims related to this topic, providers should contact the fiscal intermediary's Provider Relations Unit. (See Appendix A for contact information)

Medical Necessity

Admissions are not dependent solely upon the basis of the length of time the recipient actually spends in the hospital. Louisiana Medicaid allows reimbursement up to 30 medically necessary hours for a recipient to be in an outpatient status. This time frame is for the physician to observe the recipient and to determine the need for further treatment, admission to an inpatient status or for discharge.

The decision to admit a recipient is a complex medical judgment which can be made only after the physician has considered a number of factors. A recipient should not be "deemed" inpatient once outpatient services exceed 24 hours. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for recipients who are expected to need hospital care for 24 hours or more, and treat other recipients on an outpatient basis. Physicians who are responsible for a recipient's care at the hospital are likewise responsible for deciding whether the recipient should be admitted as an inpatient.

Upon the physician order in the medical record for inpatient status, the hospital should register a recipient using a "Request for Hospital Pre-Admission Certification and LOS Assignment" (PC-

F01) form for the inpatient stay when there is medical necessity per InterQual criteria. (See Appendix B for information on how to access this form)

OB Care and Delivery

Louisiana Medicaid complies with the federal Newborn Protection Act. Any days greater than the federal mandates are subject to medical necessity and retrospective review.

Precert Inquiry Application

Precert Inquiry is a web-based tool giving providers the ability to check and track the status of Medicaid inpatient hospital pre-certifications online. The Precert Inquiry tool is available to all Medicaid enrolled physician providers through the Louisiana Medicaid website. (See Appendix A for information on accessing user manual and website)

Physician Billing When Pre-Certification Is Not Authorized

A provider may bill the Medicaid recipient when the recipient presents to the hospital as a private-pay patient and does not inform the hospital of his/her Medicaid coverage.

The recipient cannot be billed when a pre-certification request is denied because medical necessity is not met. If medical necessity had been met, then the recipient would have received pre-certification. Since pre-certification was not received, the provider should not have admitted the recipient. This same logic is applicable to extensions. If it is not medically necessary for the recipient to be in the hospital, then discharge would be in order.

Providers shall not bill recipients simply because the pre-certification request was not timely. When a hospital's pre-certification request (initial or extension request) is denied due to the request not being submitted timely, or if the hospital fails to request initial pre-certification, the physician can request Medicaid payment for those services, but the claim must be submitted hard-copy to the fiscal intermediary's Provider Relations Unit and must include the following:

- An admit summary,
- A discharge summary, and
- A cover letter requesting pre-certification override.

NOTE: See Appendix A for contact information.

These hard copy claims may deny if they contain errors. Overriding the pre-certification requirement does not negate Medicaid policy regarding claim completion. Providers should ensure claims submitted for pre-certification overrides are correctly completed.

Retrospective Eligibility Pre-Certification

A retrospective eligibility pre-certification review may be considered filed timely if the request is submitted within a year from the date the eligibility decision was added to the recipient's eligibility file. If the retrospective review is received within a year of the eligibility decision and the date of service is already over one year old, the normal timely filing restriction may be overridden. Inquiries related to this condition should be addressed to the fiscal intermediary's Provider Relations Unit. (See Appendix A for contact information)

Outpatient Surgery Performed on an Inpatient Basis

Outpatient surgeries performed on an inpatient basis require prior authorization if the surgery is performed within the first two days of a hospital stay. The hospital's Utilization Review Department must complete a "Request for Hospitalization for Outpatient Procedures: Day of Admit or Day After Admit" (PCF-02) form and submit it to the fiscal intermediary's Pre-certification Department requesting the procedure be added to the pre-certification file. Clinical documentation on the PCF-02 form must indicate why the outpatient procedure was performed as an inpatient. (See Appendix A for contact information and Appendix B for information on accessing this form)

If the surgery is performed on or after the third day of a hospital stay, no prior authorization is required.