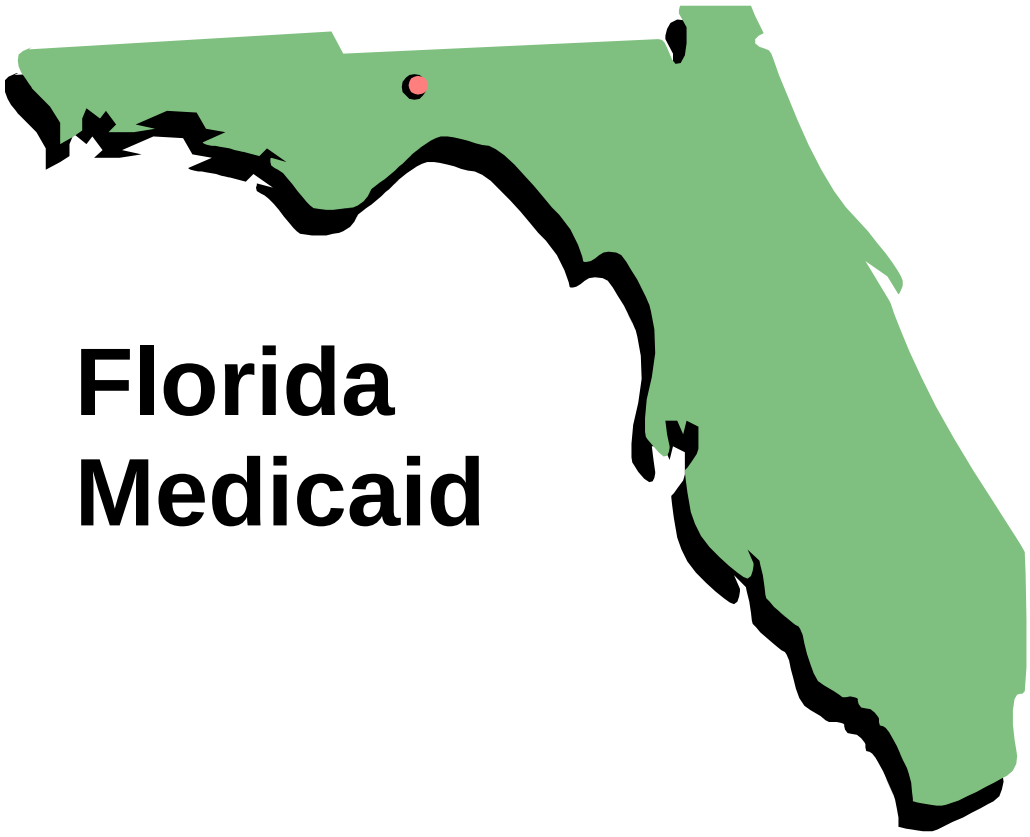

Florida Medicaid

Inpatient Hospital Services Coverage Policy

Agency for Health Care Administration

July 2016

Table of Contents

1.0 Introduction

1.1 Description

Florida Medicaid inpatient hospital services provide diagnostic, medical, and surgical services.

1.1.1 Florida Medicaid Policies

This policy is intended for use by inpatient hospital providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of inpatient hospital services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Inpatient hospital services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), section 440.10
- Sections 409.815, 409.9025, and 409.905, Florida Statutes (F.S.)
- Rule 59G-4.150, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.3 Diagnosis-Related Groups

A payment method which involves classifying inpatient stays and determining a price based on a combination of the classification and the hospital where the services were performed (also referred to as DRG).

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.6 Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary inpatient hospital services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, the service is covered for recipients of all ages.

2.3 Coinsurance, Copayment, or Deductible
There is no coinsurance, copayment, or deductible for this service.

3.0 Eligible Provider

3.1 General Criteria
Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide
Hospitals licensed as a general or specialty hospital in accordance with section 395.003, F.S.

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria
Florida Medicaid reimburses for inpatient hospital services when:

- The recipient is admitted to the hospital as an inpatient by a licensed physician or dentist with the expectation that the recipient will stay in excess of 24 hours and occupy an inpatient bed.
- The certification or recertification of need is completed in accordance with 42 CFR 456.60.

Inpatient hospital services are those items and services ordinarily furnished by the hospital for the care and treatment of inpatients, including:

- Bed and board in a semi-private room, except when private accommodations are medically necessary or only private rooms are available
- Drugs, biologicals, supplies, appliances, and equipment for use in the hospital
- Medical or surgical services
- Medical social services
- Nursing services and other related services
- Other diagnostic or therapeutic services
- Use of hospital facilities

4.2.1 Covered Days

Florida Medicaid reimburses for the following number of inpatient hospital days:

- Up to 365/6 days per year for recipients under the age of 21 years
- Up to 45 days per fiscal year for recipients age 21 years or older

Florida Medicaid reimburses for inpatient hospital days beyond the 45 day limit for emergency services, as defined in Rule 59G-1.010, F.A.C.

4.2.2 Emergency Services for Undocumented Aliens

Florida Medicaid reimburses for emergency services (including labor and delivery and dialysis services) provided to undocumented aliens who otherwise meet all eligibility requirements except citizenship status. Florida Medicaid will not pay for continuous or episodic services after the emergency has been alleviated.

4.2.3 Outpatient Hospital Services Status Change

Florida Medicaid reimburses for observation services provided to a recipient within the 48 hours immediately preceding an inpatient admission to the same hospital, and that are related to the inpatient admission, as part of the inpatient claim.

For more information on outpatient services, please refer to Florida Medicaid's outpatient hospital service coverage policy.

4.2.4 Psychiatric Services

Florida Medicaid reimburses for psychiatric services provided in a designated psychiatric bed in accordance with Rule 59A-3.278, F.A.C.

Florida Medicaid reimburses for psychiatric services in a medical bed when all psychiatric beds within a hospital are occupied and there are no psychiatric beds available in other vicinity hospitals.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0

- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Blood replacement fees
- Custodial care to assist a recipient with activities of daily living, unless the care provides continuous medical or paramedical attention
- Diabetic education for the self-management of diabetes
- Drugs and supplies for use outside of the hospital
- Durable medical equipment and supplies for use outside of the hospital
- Healthcare acquired conditions, in accordance with 42 CFR 447.26
- Laboratory, pathology, organ, and disease panels that contain duplicate components
- More than three pints of blood for dually eligible recipients
- Services for cosmetic purposes
- Services related to a recipient's terminal illness and related condition(s) when the recipient has elected hospice and the services are covered under the hospice benefit

Some services may be reimbursable through another Florida Medicaid-covered service. Please refer to the service-specific coverage policy for more information.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

6.2 Specific Criteria

Providers must submit the following AHCA forms, incorporated by reference in Rule 59G-1.045, F.A.C., with the claim, as applicable:

- State of Florida Abortion Certification Form - AHCA-Med Serv Form 011, June 2016
- State of Florida Exception to Hysterectomy Acknowledgement Requirement – ETA-5001, June 2016
- State of Florida Hysterectomy Acknowledgement Form – HAF-5000, June 2016

Providers must submit the U.S. Department of Health and Human Services' Consent for Sterilization Form - HHS-687, (10/12), incorporated by reference and available at http://www.hhs.gov/opa/pdfs/consent-for-sterilization-english-updated.pdf, with the claim, as applicable.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

7.2 Specific Criteria

The treating practitioner or hospital provider must obtain authorization from the quality improvement organization when:

- A recipient is admitted as an inpatient and Florida Medicaid is the primary payer.
- A recipient transfers between an acute care or rehabilitation bed and a psychiatric bed.

7.2.1 Retrospective Requests

Providers must submit a retrospective review request for the entire length of stay for inpatient hospital services provided to undocumented aliens.

Providers may submit a retrospective review request when a recipient is determined to be retroactively eligible for Florida Medicaid.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Specific Criteria

Florida Medicaid reimburses for inpatient hospital services using a DRG methodology, with the exception of:

- Infant and newborn hearing screening
- Intrathecal baclofen therapy pump
- Long-acting reversible contraception
- Transplant services
- Vagus nerve stimulator device

8.2.1 Labor and Delivery

Providers must submit separate claims as follows:

- Delivery - Using the mother's Florida Medicaid information (if eligible) and including all services provided to the mother.
- Birth - Using the infant's Florida Medicaid information and including all services related to the birth and the infant's care.

8.3 Claim Type

Institutional (837I/UB-04)

8.4 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.5 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.6 Rate

For DRG rates, see http://ahca.myflorida.com/medicaid/cost_reim/index.shtml

For global reimbursement transplant rates, see http://ahca.myflorida.com/Medicaid/organ_transplant/index.shtml

For rates for services reimbursed outside of the DRG methodology, see http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.6.1 Hospital to Hospital Transfer Claims

Florida Medicaid may reduce the total reimbursement to the transferring hospital if the length of stay is less than the DRG's average length of stay. The transfer pricing adjustment does not apply to the receiving hospital, unless it also transfers the patient to another acute care facility. The transfer payment adjustment affects only the DRG base payment.

8.6.2 Out-of-State Provider Reimbursement

Florida Medicaid reimburses for inpatient hospital services provided out-of-state at either:

- The Florida Medicaid all-inclusive DRG rate on the date(s) of service for emergency inpatient admissions

- A mutually agreed upon negotiated rate, that may not exceed 80% of the billed amount, for non-emergency or prescheduled services that cannot be performed in Florida