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 October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: September 20, 2016	Semiannual update: • Changed references to the prior authorization contractor from ADVANTAGE Health Services to Cooperative Managed Care Services (CMCS) throughout • Added a notation for the blood factor exception in the *Diagnosis-Related Group Reimbursement System* and *Inpatient Level-of-Care Reimbursement System* sections • Clarified information about rate reduction in the *Reimbursement Methodology for Inpatient Services* section • Updated the list of excluded DRGs in the *Inpatient Level of Care Reimbursement System* section • Removed references to Corizon Health from the *Inpatient Coverage for Department of Correction Inmates* section • Added the *Inpatient Coverage for Presumptively Eligible Members* section • Removed the HAF note box from the *Long-Term Acute Care Facility Services* section • Expanded the *Outpatient Service within Three Days of an Inpatient Stay* section	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: May 16, 2017	*Core*MMIS update: • Reorganized text and made edits as needed for clarity • Changed RID references to IHCP Member ID • Changed Indiana*AIM* references to *Core*MMIS	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
		• Changed Web interChange references to Provider Healthcare Portal (Portal), and added Portal instructions for billing as needed • Removed ICD-9 information • Updated EOB description in the *PA Policy for Inpatient Stays for Burn Care* section • Added information for MCE contacts in the *General Inpatient Billing and Coding Procedures* section • Updated the *Present on Admission Indicators* section • Included reference to implantable DME in the *Diagnosis-Related Group Reimbursement System* section • Updated the Customer Assistance telephone number • Updated the AP-DRGs excluded for psychiatric cases in the *Inpatient Level-of-Care Reimbursement System* section • Updated the section of the RA in which medical education payment information appears in the *Medical Education Reimbursement for Encounter Claims* section • Updated the list of IHCP-enrolled children's hospitals in the *DRG Base Rate for Children's Hospitals* section • Updated the *Hospital-Acquired Conditions Policy* section • Updated EVS information in the *Inpatient Coverage for Department of Correction Inmates* section • Changed Medicare Remittance Notice (MRN) references to Explanation of Medicare Benefits (EOMB) • Clarified "same or related" in the *Readmissions* section • Updated the *Inpatient Stays Less Than 24 Hours* section and *Inpatient-Only Codes* subsection	

Table of Contents

Note:	*For policy information regarding coverage of inpatient hospital services, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

The Indiana Health Coverage Programs (IHCP) covers inpatient services, such as acute care, mental health, and rehabilitation care, when the services are provided or prescribed by a physician, and when the services are medically necessary for the diagnosis or treatment of the member's condition.

This document includes information about IHCP coverage, billing, and reimbursement for inpatient services. For information specific to inpatient mental health services, see the *Mental Health and Addiction Services* module.

Prior Authorization for Hospital Inpatient Admissions

Prior authorization (PA) is required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This requirement applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-section deliveries, and newborn stays do not require PA. Observation does not require PA. The PA requirement applies to members of all ages served by Traditional Medicaid and, in some cases, dually eligible members (members who are eligible for Medicaid and Medicare).

Providers are required to contact Cooperative Managed Care Services (CMCS), 1-800-269-5720, at least two business days prior to a nonemergent admission. All inpatient hospital PAs are requested via telephone. The facility must call prior to the admission and provide criteria for medical necessity.

The IHCP follows Milliman guidelines for all nonemergent and urgent care inpatient admissions. If IHCP criteria already exist, those criteria are used first when determining whether admissions are appropriate. If criteria are not available within Milliman or IHCP policy, the IHCP relies on medical necessity determination of current evidence-based practice. To ensure a 48-hour turnaround, the PA request should be made by a clinical staff person. For nonemergent and urgent care admissions that occur outside normal business hours, including weekends and holidays, providers have 48 hours from the time of admission to request PA.

Inpatient services for diagnoses reimbursed under the level-of-care (LOC) payment methodology and emergency substance abuse require PA. Emergency inpatient admissions for these diagnoses must be reported to PA within 48 hours of admission, not including Saturdays, Sundays, or legal holidays, to receive IHCP reimbursement.

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

- Member name and IHCP Member ID (also known as RID)
- Procedure requested, including revenue code, Current Procedural Terminology (CPT®[1]), or Healthcare Common Procedure Coding System (HCPCS) code
- Location service is to be performed (facility)
- Medical condition being treated, including the International Classification of Diseases (ICD) code
- Medical necessity of the procedure
- Admitting physician or surgeon
- Date of admission
- The estimated length of stay (LOS)
- National Provider Identifier (NPI)
- Documentation of the denial, if requesting retroactive PA for a dually eligible member who has had coverage denied by Medicare

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 diagnosis-related group (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 has exhausted his or her Medicare benefit or if the stay is not a Medicare-covered service.

General Inpatient Billing and Coding Procedures

Inpatient hospital services are billed using the *UB-04* paper claim form, or electronically through the 837I transaction or the Provider Healthcare Portal (Portal) institutional claim. For fee-for-service (FFS) inpatient hospital claims, mail *UB-04* claim forms to Hewlett Packard Enterprise at the following address:

HPE Inpatient Hospital Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

Note:	*For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific billing procedures. MCE contact information is included in the IHCP Quick Reference Guide, available at indianamedicaid.com.*

For general information about claim submission, see the *Claim Submission and Processing* module.

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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.

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 67 A–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.

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

Present on Admission Indicators

For all inpatient claims, hospitals are required to report whether each diagnosis on a Medicaid claim 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 *Official Guidelines for Coding and Reporting*). The Centers for Medicare & Medicaid Services (CMS) does not require a POA indicator for an external cause of injury code unless it is being reported as an "other diagnosis." Therefore, the IHCP does not require a POA indicator in the external cause of injury (ECI or E Code) field.

> *Note: The ICD Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting. 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 explanation of benefits (EOB) code 4276 – *A POA must be entered. A POA of 1 or blank is not acceptable*. 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.

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 participating hospitals

> *Note:* *Effective for dates of service from January 1, 2014, through June 30, 2017, the IHCP implemented a 3% reduction in reimbursement for inpatient and inpatient crossover claims. The rate reduction is not applicable for state-operated psychiatric hospitals. Disproportionate share hospital (DSH) payments are not subject to the reimbursement reduction. DRG payments, capital payments, medical education payments (if applicable), and outlier payments (if applicable) are calculated as usual. The total calculated payment amount is reduced by 3% before subtracting any applicable third-party liability (TPL) payments.*
>
> *This reduction does not apply for HAF-participating hospitals.*

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, as described in the *Inpatient Blood Factor Claims* section of this module, and of certain implantable durable medical equipment (DME) as described in the *Surgical Services* module.). Additional payments to hospitals are as follows:

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

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.

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

- The classification system, known as the *grouper*
- The calculation of the relative weights
- The calculation of the DRG/DRG + Severity of Illness base rate
- Length of inpatient stay
- 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 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, patient age, gender, and discharge status. The diagnoses and procedures information is grouped using ICD codes with the highest level of specificity possible. Providers must code to the highest level of specificity possible. 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.

For *from* dates of service October 1, 2003, through September 30, 2015, Indiana used the All Patient Diagnosis-Related Group (AP-DRG), version 18, as the grouper for the DRG system. For *through* dates of service on or after October 1, 2015, Indiana uses the All-Patient Refined Diagnosis-Related Group (APR-DRG), version 30, for the DRG system. The AP-DRG and APR-DRG are used because they more appropriately address the resource consumption of the IHCP, such as the non-Medicare population.

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 Rate

The DRG base rate is the payment rate used to reimburse hospitals for both routine and ancillary costs associated with inpatient care. The DRG base rate is determined by a fixed statewide base rate, which is the rate per IHCP stay multiplied by the relative weight:

Statewide Base Rate × Relative Weight = DRG Base Rate

Statewide base rates change 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 contacting Customer Assistance toll-free at 1-800-457-4584.

Length of Inpatient 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 inpatient stay*. The length of the IHCP stay is one component of the DRG inpatient reimbursement system.

DRG Outlier, Medical Education Costs, and Capital Costs Payment

The state of Indiana defines a *DRG cost outlier case* as an IHCP stay that exceeds a predetermined threshold. For the dates of service before on or before September 30, 2015, the threshold was defined as the greater of twice the DRG or $34,425. For dates of service on or after October 1, 2015, the threshold is defined as the greater of twice the DRG or $51,425. Day outliers (IHCP days 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.

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 and the outlier threshold indicated previously. 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, except for new providers.

The IHCP allowed amount is calculated as follows:

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

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.

Hospital Adjustment Factor

For Hospital Assessment Fee (HAF)-participating hospitals, the IHCP-allowed amount is calculated as follows:

(DRG Base Rate × 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 AP- or 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:

- AP-DRGs excluded for burn cases – 821 through 828
- APR-DRGs excluded for burn cases – 841 through 844
- AP-DRGs excluded for psychiatric cases – 424 through 432
- APR-DRGs excluded for psychiatric cases – 740, 750–756, 758, 759, and 760 (DRG 757 excludes ICD-10 diagnosis codes F70 through F79)
- AP-DRGs excluded for rehabilitation cases – 462
- 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, as described in the *Inpatient Blood Factor Claims* section). Additional payments to hospitals are provided for the following:

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

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

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:

- Psychiatric
- Burn/1
- Burn/2
- 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:

- Eskenazi Health (formerly Wishard Memorial Hospital)
- Indiana University Health
- Saint Joseph's Hospital of Fort Wayne
- University Medical Center (Louisville)

- University of Chicago Medical Center
- Loyola University Medical Center

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

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

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.

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 outlier payment is a percentage of the difference between the prospective cost per day and the outlier threshold for each covered day of care. The percentage, or marginal cost factor, is 60%.

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

The IHCP-allowed amount is calculated as follows:

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

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

Hospital Adjustment Factor

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

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

Inpatient hospital stays are reimbursed using the DRG or LOC rate, the capital rates, and the medical education rates and outlier payments, if applicable. This subsection describes the methodology for calculation of capital (*per diem*) rates under the DRG and LOC systems.

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 the daily cost per resident, multiplied by the number of residents. The resident cost per day is calculated using each facility's cost reports. The number of residents is based on the most recent cost report data. The most recent data is used to indicate the number of residents to ensure that the payment rate established is most indicative of the number of residents at each hospital.

Medical Education under the DRG System

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.

Medical Education under the Level-of-Care System

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

Institutional providers must continue to submit current *CMS-2552* cost reports. For providers receiving medical education payments, adjustments in the payment rate are made based on changes in the full-time equivalent (FTE) count of interns and residents. Payment for medical education is provided only to hospitals that operate medical education programs. Hospitals that discontinue or downsize the medical education programs must promptly notify the FSSA at the following address:

MS07
Hospital Reimbursement Section
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204

Medical Education Reimbursement for Encounter Claims

All medical education payment calculations are made after the MCE posts the claim payment information and the encounter claim is posted to the Core Medicaid Management Information System (*Core*MMIS). Based on encounter claims data received from the MCEs, Hewlett Packard Enterprise 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 Hewlett Packard Enterprise. Providers can identify these payments by reviewing the *Medical Education Cost Expenditures* section of their RA.

DRG Base Rate for Children's Hospitals

Indiana Administrative Code 405 IAC 1-10.5-3 allows the Family and Social Services Administration (FSSA) to establish separate base rates for certain children's hospitals to the extent necessary to reflect significant differences in cost. By definition, a children's hospital is a freestanding, general, acute care hospital licensed under *Indiana Code IC 16-21* that meets 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 amount. 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 DRG base rate. At this time, the IHCP-enrolled children's hospitals are the following:

- Ann & Robert H. Lurie Children's Hospital of Chicago
- Riley Hospital for Children
- The University of Chicago Medicine Comer Children's Hospital

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

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 CMS does not require a POA indicator for an external cause of injury code unless it is being reported as an "other diagnosis." Therefore, 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. See *Inpatient Hospital Services Codes* on the *Code Sets* page at indianamedicaid.com for applicable diagnosis codes.

Note:	*A pediatric patient is a patient younger than age 21.* *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.

Hoosier Healthwise Package C Exceptions to DRG and LOC Reimbursement Systems

The following are exceptions to the DRG and LOC reimbursement systems for Hoosier Healthwise Package C members:

- Organ transplants are not covered for Hoosier Healthwise Package C members. Inpatient claims submitted to the IHCP that group to nonexperimental organ transplant DRGs are denied. DRGs for nonexperimental organ transplants are:
  - APR: 001, 002, 003, 006, and 440
  - AP: 103, 302, 480, 481, 795, 803, 804, and 805
- Inpatient care rendered in an institution for mental diseases (IMD) having more than 16 beds is not covered for Hoosier Healthwise Package C members. This restriction does not apply to acute care hospitals that are not IMDs. The following providers systematically bypass this edit:
  - Four County Counseling Center
  - Grant-Blackford Mental Health – Grant County
  - Hamilton Center
  - Oaklawn Psychiatric Center – Elkhart County
  - Otis R. Bowen Center – Kosciusko County
  - Park Center – Allen County
  - Southlake Center for Mental Health – Lake County
  - Wabash Valley Hospital

Inpatient Coverage for Department of Correction Inmates

The IHCP covers inpatient services for IHCP-eligible Indiana Department of Correction (DOC) inmates admitted as inpatients to an acute care hospital, nursing facility, or intermediate care facility. Covered inpatient services exclude transportation services, per *Section 1905 (a)(A*) of the *Social Security Act*. Eligibility for IHCP coverage requires the inmate to meet standard eligibility criteria, as determined by the Indiana FSSA Division of Family Resources (DFR).When a DOC inmate is admitted to the inpatient

facility, the DOC medical provider will assist the inmate in completing the *Indiana Application for Health Coverage*.

Billing providers should follow current procedures for submitting claims to the DOC medical provider for adjudication. The DOC medical provider will notify providers on the RA if an inmate is eligible for IHCP coverage, indicating that the claim should be billed to the IHCP. In instances where eligibility is determined after the DOC medical provider has made payment, an adjusted RA will be issued, indicating IHCP eligibility and recouping payment for the eligible inmate.

On notification, providers must verify member eligibility and submit claims to the IHCP using their standard transaction method. The IHCP Eligibility Verification System (EVS) indicates a benefit plan of *Medicaid Inpatient Hospital Services Only* for DOC inmates with this coverage. The DOC medical provider will retroactively review claims submitted to the IHCP and will initiate adjustments for unapproved services. If unapproved services were paid by the IHCP, the current IHCP recoupment process will be followed.

Inpatient Coverage for Presumptively Eligible Members

A member's presumptive eligibility coverage period begins on the date that his or her 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* module for more information about the presumptive eligibility processes.

Long-Term Acute Care Facility Services

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

- Is designated by the Medicare program as a long-term 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

The FSSA conducts eligibility reviews once each year.

Prior authorization is required for all LTAC admissions.

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

Hospitals 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 as an IHCP LTAC hospital 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 providers are reviewed no more often than every second year and adjusted as necessary.

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.

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: Paper claims 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 for duplicates. These claims must be sent to the following address for special handling:*
>
> **HPE Provider 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

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 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 Hospital and Ambulatory Surgical Center 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

Special payment policies apply to transfer cases paid using the DRG methodology. The receiving hospital, or transferee hospital, is reimbursed according to the DRG or LOC methodology, whichever is applicable. Transferring hospitals are reimbursed a DRG-prorated daily rate for each day, not to exceed the full DRG amount. The IHCP calculates the DRG daily rate by dividing the DRG base rate by the average length of stay (LOS). The full payment to the transferring hospital is the sum of the DRG daily rate, the capital *per diem* rate (up to the DRG average LOS), and the medical education *per diem* rate (up to the DRG average LOS). Transferring hospitals are eligible for outlier payments.

Because special payment policies apply to certain transfer cases that are to be reimbursed using the DRG payment methodology, it is important for providers to identify the transferring hospital on the institutional claim. To ensure accurate reimbursement, the appropriate patient status discharge code must be placed in the patient status field (field 17 of the *UB-04* claim form). 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 form (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.

Providers must combine the original admission and subsequent return stay on one claim for billing purposes. Transfer claims continue to be 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. However, certain DRGs include neonate transfer cases only, and are exempt from the transfer reimbursement policies. The DRGs that include only transfer cases are as follows:

- APR 581 (all severity levels)/AP 639 – *Neonate, transferred less than 5 days old, born here*
- APR 580 (all severity levels)/AP 640 – *Neonate, transferred less than 5 days old, not born here*

Reimbursement for the preceding DRGs is equal to the specified DRG rate.

Providers do not receive separate DRG payments for IHCP patients that return from a transferee hospital. Specifically, this policy applies when a patient returns to a hospital from which he or she was previously transferred out for the same illness.

Readmissions

A readmission is defined as a hospital admission within three days following a previous hospital admission and discharge for the same or related condition. Providers should bill one inpatient claim when a patient is readmitted to their facility within three days of a previous inpatient discharge (the stays should be consolidated on one claim) for the same or related diagnosis.

> *Note:* *"Same or related" 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 greater than three days following a previous hospital discharge are treated as separate stays for payment purposes, but are subject to medical review. If it is determined that a discharge is 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 *Inpatient-Only Codes* section. Outpatient services within three days preceding a less-than-24-hour inpatient stay are billed as an outpatient service.

Under the AP-DRG grouper, version 18, the following DRGs were exempt from the inpatient 24-hour policy because they were specific to one-day stays:

- DRG 637 – *Neonate, died w/in one day of birth, born here*
- DRG 638 – *Neonate, died w/in one day of birth, not born here*

There is no direct crosswalk between these two AP-DRGs and the new APR-DRG system. A neonate that expires within one day of birth could be linked to any of the neonate APR-DRGs 580–640 (all severity levels). The IHCP policy regarding the expiration of a neonate within one day of birth has not changed with the introduction of the APR-DRG. Providers are advised to continue to submit claims for this scenario as an outpatient claim. When the claim denies, to receive payment, providers should then submit a request for administrative review of the claim, attaching a copy of the original outpatient claim, a new inpatient claim for the services, and additional documentation as described in the *Inpatient-Only Codes* section.

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.*

Inpatient-Only Codes

The IHCP will bypass this 24-hour rule to allow procedure codes determined by Medicare as "inpatient-only" 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. A list of the applicable HCPCS and CPT procedure codes to which this change applies is available in *Inpatient Hospital Services Codes* on the *Code Sets* page at indianamedicaid.com. Only the codes affected by this change are listed; the codes listed are not reimbursable when delivered in an outpatient setting.

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 for dates of service on or after July 1, 2014, 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 must be made using the secure correspondence feature on the Portal or the *IHCP Administrative Review Request* form, available on the *Forms* page at indianamedicaid.com.
   - The administrative review request must include 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, and 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 Portal as a secure correspondence message using the Administrative Review category, or the *IHCP Administrative Review Request* form and documentation should be mailed to the following address:

     Administrative Review Requests
     HPE Provider Written Correspondence
     P.O. Box 7263
     Indianapolis, IN 46207-7263

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* when the services, outpatient and inpatient, occur at their facility. Inpatient claims billed with outpatient charges for services rendered at the same facility within three days of admission should reflect the *from* and *through* dates of the inpatient stay, not the date the outpatient services were rendered.

If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will be denied with an 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. Outpatient services provided within three days preceding a *less-than-24-hour* inpatient stay are billed as an outpatient service.

See the *Outpatient Hospital and Ambulatory Surgical Center Services* module for information about billing outpatient services.

Coding Claims for Newborns

Coding claims for newborns requires birth weight for the proper DRG assignment. See the *Inpatient Hospital Services Codes* on the *Code Sets* page at indianamedicaid.com for diagnosis codes corresponding to birth weight. Do not use these codes as principal diagnosis codes.

When a newborn transfers 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.

Providers rendering services under a managed care program should also follow IHCP policy and CPT coding guidelines when billing for these services.

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

Newborn Screening

By law, newborn blood 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.

Note:	*A child born to a woman eligible for pregnancy care and urgent care only is categorically eligible, at birth, for **full** IHCP coverage, at least for the month of birth. The child's claims must have the child's IHCP Member ID.*

Newborn Blood Screening

Indiana law requires newborn blood screening tests for every infant before discharge from the hospital. The newborn blood screening tests for a specific group of conditions, including the following:

- Congenital adrenal hyperplasia
- Hypothyroidism
- Hemoglobinopathies, including sickle cell anemia
- Biotinidase deficiency
- Cystic fibrosis
- Galactosemia
- Homocystinuria
- Maple syrup urine disease
- Phenylketonuria (PKU)
- Medium chain acyl-coenzyme A dehydrogenase (MCAD) deficiency
- 35 other amino acid defects, fatty acid oxidation defects and/or organic acidemias
- Congenital heart disease (CCHD)
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
  - Tandem mass spectrometry (MS/MS)
  - High volume radioimmunoassay
  - Hemoglobin electrophoresis

- Isoelectric focusing
- Bacterial inhibition assays
- Immunoreactive trypsin (IRT)
- DNA testing

The hospital collects all blood samples on a filter paper card that must also 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 State Department of Health (ISDH) 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 ISDH 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 and contact information, see the *Genomics and Newborn Screening – Contact Us* page at in.gov/isdh.
- Other healthcare professionals who are not primary care providers can obtain newborn screening results by contacting the IU Newborn Screening Laboratory. A fax must be sent on office letterhead with the patient's name, date of birth, patient's mother's name, and birthing facility to (317) 491-6679. Healthcare professionals with questions may call 1-800-245-9137.
- Parents or other individuals requesting newborn screening results can contact the ISDH Genomics and Newborn Screening Program by calling 1-888-815-0006.

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 ISDH 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.

The IHCP does not require Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch providers to report newborn screening on the professional claim (*CMS-1500* claim form or electronic equivalent). 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. 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 filter paper 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 Hearing Screening

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* page at in.gov/fssa for contact information.

Providers that deliver newborns not hospitalized at birth, at locations *other than in the hospital*, may use the appropriate CPT codes to bill for the newborn hearing screening. Use CPT code 92585 for auditory evoked potentials for evoked response audiometry and testing of the central nervous system, or evoked auditory brainstem responses (ABR). Use CPT code 92587 for evoked otoacoustic emissions (OAE); limited, single stimulus level, either transient or distortion products, or OAE.

For any follow-up diagnostic testing resulting from detection of possible audiological impairment via the newborn screening process, providers should bill the same way they bill other audiological testing. Providers should obtain PA, if applicable.