Health, Department of

Medicaid

Chapter 8: Inpatient Hospital Admission Certification

Effective Date: 01/06/2015 to 10/28/2019

Rule Type: Repealed Rules & Regulations

Reference Number: 048.0037.8.01062015

CHAPTER 8

Rules and Regulations for Medicaid

Inpatient Hospital Admission Certification

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-104 and the Wyoming Administrative Procedure Act at W.S. § 16-3-102.

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to establish the standards and procedures for admission certification to be followed by attending physicians and hospitals seeking Medicaid payment for inpatient hospital services provided to clients. This Chapter shall apply to all admissions which occur after its effective date.

(b) The requirements of the Medicaid State Plan Amendment, Attachment 4.19a, Part 1, also apply to Medicaid and are incorporated by this reference as of the effective date of this Chapter, and may be cross-referenced throughout this Chapter where applicable. This incorporation by reference does not include any later amendments or editions of the incorporated matter. The incorporated State Plan Amendment may be viewed at http://www.health.wyo.gov or may be obtained at cost from the Department.

Section 3. Definitions. Except as otherwise specified in Chapter 1, the terminology used in this Chapter is the standard terminology and has the standard meaning used in healthcare, Medicaid, and Medicare.

Section 4. General Provisions.

(a) General methodology. The Department shall review designated admissions and proposed admissions for inpatient hospital services to ensure the appropriateness and medical necessity of such services.

(b) The failure to comply with this Chapter shall result in the denial of certification and, if appropriate, recovery of Medicaid payments. A provider may not bill a client if there has been a denial of certification or recovery of Medicaid payments.

Section 5. Non-emergent Admissions.

(a) Designated non-emergent admissions shall receive admission certification before the client's admission.

(b) The Department may, from time to time, designate those non-emergent admissions which require the admission certification procedures set forth in Section 6.

(i) The Department's designation of admission certification procedures shall be based on:

(A) Clinical consultation with health care professionals;

(B) Applicable Centers for Medicare & Medicaid Services guidelines; and

(C) The potential for over-utilization.

(ii) The Department shall disseminate a current list of non-emergent admission surgeries and procedures to providers through manuals or bulletins.

Section 6. Procedure for Admission Certification.

(a) The hospital or its designee shall notify the Department at least three (3) working days prior to the proposed admission and provide the information required by Sections 9(b) and (c) of this Chapter.

(b) Notice from the hospital or its designee shall be given in writing as required by the Department.

(c) Upon receipt of the information required by Sections 9(b) and (c) of this Chapter, a clinical evaluator shall review the information and determine whether the admission meets the medical necessity criteria.

(i) If the clinical evaluator determines the admission meets the medical necessity criteria, the Department shall issue a Prior Authorization (PA) number, which shall be communicated by an admission certification letter to the attending physician or the hospital as required by the Department, by the end of the next working day after the determination.

(ii) An inpatient hospital service which is not a covered service shall not receive a PA number.

(iii) If the clinical evaluator is unable to determine that the admission meets the medical necessity criteria, the evaluator shall refer the matter to a physician adviser.

(d) If the physician adviser determines that the admission meets the medical necessity criteria, the Department shall issue a PA number. In determining whether the admission is medically necessary, the physician adviser may consult with the attending physician or other physician advisers.

(e) The physician adviser's determination shall be communicated to the attending physician or, in the case of a continued stay review, the hospital, in writing as required by the Department, by the end of the next working day after the referral to the physician adviser.

(i) If the admission is certified, the Department shall issue an admission certification letter and PA number to the attending physician and the hospital, in writing as required by the Department.

(ii) If the admission is not certified, the Department shall send written denial of admission certification to the attending physician and the hospital by the end of the next working day after the physician adviser's decision.

(iii) Appeal of denial. The attending physician or the hospital may appeal the denial of admission certification by submitting a written request to the Department's designee within twenty (20) working days after the date of receipt of the notice of denial. The denial shall be reviewed within three (3) working days of the Department's receipt, by a physician adviser who has not previously been consulted about the admission. The physician advisor may review the medical record, consult with the clinical evaluator and the physician adviser who were previously involved in the case or another physician adviser, and request other information from the attending physician and the hospital.

(A) If the appeal results in admission certification, the Department shall issue an admission certification letter and PA number to the attending physician and the hospital.

(B) If the appeal results in upholding the denial of admission certification, the Department shall send written denial to the attending physician and hospital. Either the attending physician or the hospital may ask for a hearing on the denial pursuant to Chapter 4.

(f) The issuance of an admission certification and PA number is not a guarantee of Medicaid reimbursement or a guarantee that the individual is a client at the time of admission. Reimbursement is subject to benefit coverage changes or aging out. Admissions are subject to continued stay and/or post-payment review pursuant to Section 13 of this Chapter. An admission certification and PA number may be withdrawn as a result of such reviews.

(g) Continued stay review of Non-emergent Admissions.

(i) Required continued stay review. A hospital shall request continued stay review of any client who is expected to remain hospitalized after the period, if any, specified in the admission certification.

(ii) Discretionary continued stay review. The Department may conduct a continued stay review of any non-emergent admission which results in the provision of inpatient hospital services to a client.

(iii) Medicaid payments. There shall be no Medicaid payments to any provider of inpatient hospital services except to the extent that the continued stay review results in admission certification.

Section 7. Continued Stay Review for Emergency Admissions.

(a) Notice to Department. A hospital shall request a continued stay review of an emergency admission which results in the provision of inpatient hospital services which require an admission certification.

(b) Review by Department. The Department shall conduct a continued stay review of any emergency admission which results in the provision of inpatient hospital services to a client.

(c) Medicaid payments. There shall be no Medicaid payments to any provider of inpatient hospital services except to the extent that the continued stay review results in an admission certification. Medicaid payments for inpatient hospital services shall be pursuant to State Plan Amendment, Attachment 4.19a, Part 1.

(d) Procedures for continued stay review. The hospital shall:

(i) Notify the Department of the admission and provide the information required in Sections 9(b) and (c) of this Chapter by the end of the next working day after the admission. Notification shall be in writing as required by the Department.

(ii) Failure to timely request a continued stay review shall result in the denial of Medicaid payment for inpatient services furnished to the client before the date of the request.

Section 8. Medical Necessity Criteria.

(a) The Department shall, in consultation with appropriate medical and other health care professionals, develop criteria to determine the medical necessity and appropriateness of inpatient hospital services. The criteria shall reflect prevailing norms of medical practice.

(b) Admission certification shall be denied unless the request meets the medical necessity criteria.

(c) The medical necessity criteria may be obtained from the Department by written request.

Section 9. Hospital Responsibilities. A hospital which seeks Medicaid payment for inpatient hospital service provided to a client shall:

(a) Obtain an admission certification pursuant to this Chapter, if required.

(b) Request a written admission form to provide certification by contacting the Department in writing as required by the Department and provide the following information:

(i) The attending physician's name and National Provider Identifier (NPI) number;

(ii) The client's name, Medicaid identification number and date of birth;

(iii) The name of the hospital;

(iv) The principal diagnosis by narrative description or diagnostic code according to the International Classification of Disease (ICD), as specified by the Department;

(v) The primary procedure by narrative description or procedure code according to the Current Procedural Terminology (CPT), as specified by the Department;

(vi) Whether the admission is a readmission;

(vii) The expected date of admission; and

(viii) Information from the plan of care and information concerning the reason for admission as requested by the Department to determine if admission meets the medical necessity criteria.

(c) Provide the following information when applicable:

(i) Surgeon's name and NPI number;

(ii) Expected date of surgery; and

(iii) Affirmation that any required prior authorization has been received.

(d) Enter the admission certification and any required prior authorization number on all claims submitted to the Department.

Section 10. Department Responsibilities. The Department shall:

(a) Obtain and review the information required by Sections 9(b) and (c) of this Chapter;

(b) Determine whether the admission met or meets the medical necessity criteria.

(c) Inform the attending physician and the hospital of the determination, in writing as required by the Department, by the end of the next working day after the determination;

(d) Mail a written notice of the admission certification determination to the attending physician and the hospital;

(e) Determine that all diagnosis and procedure coding satisfies ICD and CPT;

(f) Determine if the admission of a retroactively eligible client met the medical necessity criteria;

(g) Provide for an appeal of denial of certification;

(h) Recruit and coordinate the work of the physician advisers;

(i) Notify the attending physician and the person responsible for the hospital's utilization review in writing or as required by the Department, of an appeal decision by the end of the next working day after the decision; and

(j) Mail a written notice of the appeal decision to the attending physician and the hospital.

Section 11. Retroactive Eligibility.

(a) A hospital may seek admission certification for a client found retroactively eligible for Medicaid benefits after the date of admission for services which require admission certification. An attending physician and a hospital shall not seek admission certification for a person whose application for Medicaid is pending at the time of admission.

(b) Procedure. The hospital shall request admission certification within thirty (30) calendar days after the hospital receives notice of eligibility. The request for certification shall be in writing and shall include the information required by Sections 9(b) and (c) of this Chapter. The request shall also include:

(i) A statement of the date and method of notice of eligibility; and

(ii) A copy of the client's complete medical record, submitted at the hospital's expense, which can be mailed or scanned to the Department.

(c) Failure to request certification in a timely manner or to submit the complete medical record with the request shall result in the denial of admission certification.

(d) The hospital shall inform the attending physician of the admission certification of a retroactively eligible client.

Section 12. Medicare Admissions.

(a) An admission which has been approved under Medicare is exempt from this Chapter.

(b) The denial of reimbursement for an inpatient hospital service under Medicare because the service is not medically necessary shall also preclude Medicaid payment for the service, and the provider(s) of such services may not request an appeal or an administrative hearing pursuant to this rule or other rules of the Department.

Section 13. Post-payment Reviews.

(a) The Department may conduct a post-payment review to determine whether:

(i) All procedural requirements of this Chapter were met;

(ii) The admission met the medical necessity criteria;

(iii) All appropriate services were provided;

(iv) All services provided were medically necessary and appropriate;

(v) All services were provided in conformance with prevailing norms of medical practice;

(vi) Diagnosis and procedure coding meets ICD and CPT; and

(vii) Revenue coding is appropriate.

(b) The procedure for post-payment reviews shall be as follows:

(i) Once the records have been requested from the provider and received, a clinical evaluator shall review the medical record and shall review the claims involving such client.

(ii) If the clinical evaluator is unable to determine that the client's admission met the medical necessity criteria, that the client's continued stay met the medical necessity criteria, or that all medically necessary services were provided, the clinical evaluator may request additional information from the attending physician or the hospital as necessary to clarify the medical record. If the clinical evaluator determines that the procedural requirements of this Chapter were not met, the clinical evaluator shall follow Department policy.

(iii) If, after additional information is submitted, the clinical evaluator is unable to determine that the client's admission met the medical necessity criteria, or that all medically necessary services were provided, a physician adviser shall be consulted.

(iv) If a physician adviser determines that the client's admission was not medically necessary, or that all medically necessary services were not provided, the Department shall, if admission certification was previously granted, withdraw the admission PA.

(v) The Department shall notify the attending physician and hospital in writing that the admission certification is withdrawn, that no Medicaid payment will be made for inpatient hospital services, and that payments previously made for services which were not medically necessary shall be recovered.

(c) Consequences of withdrawal of admission certification. If admission certification is withdrawn, the Department shall withhold or recover Medicaid payments for inpatient hospital services which were not medically necessary or otherwise in violation of this Chapter or the other rules of the Department. The Department may take such other action as may be permitted by law.

Section 14. Information Used For Determination. At any stage of the admission certification process, including an appeal, the reviewer may make a decision based on the information provided by the attending physician or hospital, or, in the reviewer's sole discretion, the reviewer may request and refer to additional facts submitted by the attending physician or hospital. Such information shall be submitted at the expense of the provider.

Section 15. Ineligibility to Serve as Physician Adviser. A physician shall not be eligible to serve as a physician adviser if:

(a) The physician is the attending physician;

(b) During the previous twelve (12) months, the physician issued treatment orders or participated in the formulation or execution of the treatment plan for the client for whom admission certification is requested;

(c) The physician or the physician's spouse, child, grandchild, parent, or grandparent, has an ownership interest of five percent (5%) or more in the hospital for which admission certification is being requested; or

(d) The physician can obtain a financial benefit from the admission of the client.

Section 16. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

Section 17. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and bulletins, which are inconsistent with this Chapter.

Section 18. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.