

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 01/01/09
Section: Hospital Inpatient	Section: 25.25 Pages: 2	
Subject: Prior Authorization of Inpatient Hospital Services	Cross Reference: Utilization Management/Quality Improvement Organization 1.10	

Prior authorization serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit the Division of Medicaid (DOM) to require prior authorization for any service where it is anticipated or known that the service could either be abused by providers or beneficiaries, or easily result in excessive, uncontrollable Medicaid costs.

As a condition for reimbursement, DOM requires that all inpatient hospital admissions require prior authorization. Failure to obtain the prior authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician.

Note:

- When a beneficiary has third party insurance and Medicaid, prior authorization must be obtained from Medicaid.
- Prior authorizations are not required for Medicaid beneficiaries who are also covered by both Medicare Part A & B unless inpatient Medicare benefits are exhausted. Prior authorizations are are required for Medicaid beneficiaries who are also covered by Medicare Part A only or Medicare Part B only.

Submitting a Prior Authorization Request

Prior authorization is required for all inpatient hospital admissions except obstetrical deliveries. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight. Emergent and urgent admissions must be authorized on the next working day after admission.

Certification acknowledges only the medical necessity and appropriateness of the setting and does not guarantee payment.

To receive authorization for an inpatient request, the hospital must contact the UM/QIO as identified in Section 1.10.

Receiving Approval or Denial of a Request

Letters of approval will be sent to the provider indicating the approved treatment authorization number (TAN) and dates of service. This information should be used when filing the claim form.

Letters of denial will be sent to the provider and beneficiary. Letters to the provider will indicate the reason for denial.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s) to the UM/QIO.

Requests for administrative review by DOM must be made within 30 days from the final UM/QIO reconsideration decision letter.

Billing for Non-Approved Services

Medicaid beneficiaries in hospitals may be billed for inpatient care occurring after they have received written notification of Medicaid non-approval of hospital services. If the notice is issued prior to the beneficiary's admission, the beneficiary is liable for full payment if he/she enters the hospital. If the notice is issued at or after admission, the beneficiary is responsible for payment for all services provided after receipt of the notice.

In the event that the Utilization Management and Quality Improvement Organization's retrospective review determines that the admission did not meet the inpatient care criteria, Medicaid beneficiaries may not be billed for inpatient stay.

Medicaid beneficiaries may not be billed for inpatient care because the hospital failed to obtain the required admission and continued stay authorization.

This does not apply to Medicaid non-covered services such as geropsychiatric services.

Maternity-Related Services

Hospitals must report all admissions for deliveries, both vaginal and Cesarean section, to the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO). The hospitals must report the admissions in accordance with the requirements provided by the UM/QIO. A Treatment Authorization Number (TAN) will be issued to cover up to three (3) days for a vaginal delivery or up to five (5) days for a Cesarean section delivery.

For admissions exceeding three (3) days for a vaginal delivery or five (5) days for a Cesarean section delivery, providers must submit a request for a continued stay in accordance with the policies and procedures provided by the UM/QIO.

Newborns delivered in the hospital are covered under the mother's Medicaid number for the purposes of certification and billing. When the mother is discharged and the newborn remains hospitalized, the mother's discharge date becomes the newborn's beginning date for authorization purposes.

When seeking authorization for newborns, the infant's full name must be given to the UM/QIO. Baby Boy or Baby Girl is not acceptable. The infant's name given to the UM/QIO must be the same as the name on the claim submitted to Medicaid.

Newborns delivered outside the hospital, those remaining after the mother is discharged, and those admitted to accommodations other than well-baby must be authorized by the UM/QIO separately from the mother.

Newborns delivered to mothers eligible for Medicare are covered under the mother's Medicare claim and do not require certification unless they meet the requirements as noted above.

Unless the newborn infant needs medically necessary specialized care, no additional billings by the hospital for inpatient services are allowed while the mother is an inpatient.