

Chapter 13

Inpatient Hospital Notification and Authorization

An inpatient authorization is required for out of network facilities. All inpatient admissions for MinnesotaCare members will require an Authorization. Eligibility should be verified on admission, and routinely thereafter.

All (contracted and non-contracted) hospitals shall comply with the following requirements:

1. Notify IMCare of all emergency and non-emergency hospital inpatient admissions within 24 hours of the admission, or for admissions occurring during a weekend or holiday, by the end of the following business day.
 - a. Failure to notify IMCare may result in denial or delay in payment of claims
2. Make information related to the admission available to IMCare during the course of a member's hospitalization. This information must be provided in the form of an update and will be requested by IMCare's Utilization Management department in order to conduct concurrent and continued stay review. The medical records of the patient covered under IMCare are subject to retrospective review to determine the medical necessity of inpatient services. Inability to satisfy medical necessity will result in denial or delay in payment of claims.
3. Make information regarding the time and date of discharge and information regarding the treatment provided to the member available to IMCare within the next working day following a member's discharge
4. Make specific medical criteria and information from the plan of care, available to IMCare, to determine whether or not admission is necessary. The suggested information would initially be limited to an admission history and physical, full admission orders from the medical record, and laboratory data from admission date.

You will find the link to our Service Authorization form [here](#). Providers must fill out authorization form or at a minimum include all of the required documentation and components.

Requests for authorization after the service has been provided are subject to the same review criteria as those that are received prior to providing the service. The inability to satisfy medical necessity will result in denial or delay in payment of claims.

Receiving approval for a Service Authorization request does not guarantee payment. Providers must follow IMCare billing policy guidelines, and the IMCare member must be eligible at the time the service is rendered.

Submission of an explanation of benefits (EOB) from the primary insurance with the claim will help ensure accurate and timely reimbursement. In the event primary insurance denies the inpatient stay, IMCare would pay the entire claim if medical necessity is met using our criteria.

Providers may not seek payment from members for inpatient hospital services for which a Service Authorization is required but not issued.

Definitions

Admission: The time of birth at a hospital or other act that allows the member to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Admitting Physician: The physician who orders the member's admission to the hospital.

Authorization Number: The number IMCare issues that establishes that all or part of the inpatient hospital services are medically necessary.

Certification of Need for Care: Admitting physician or hospital providing services certifies the admission to the hospital in the medical record; it is dated and signed by a physician, physician assistant, or nurse practitioner.

Concurrent Review: A medical record review completed to determine medical necessity of inpatient hospital services while the member is in the hospital. The review consists of admission review, continued stay review, and, when appropriate, procedure review.

Continued Stay Review: A review and determination of the medical necessity of continuing inpatient hospital service to the member.

Diagnostic Categories: The diagnostic classifications established under [MN Stat. sec. 256.969, subd. 2](#), containing one or more Diagnosis Related Groups (DRGs) under Medicare.

Diagnostic Category Validation: The process of comparing documentation in the medical record to the information submitted on the inpatient hospital billing claim to ascertain the accuracy of the information upon which the diagnostic category was assigned.

Inpatient Hospital Service: A service furnished in the hospital and provided by or under the supervision of a physician after admission to a hospital and outpatient services provided by the same hospital that immediately preceded the admission.

Inpatient Service Authorization: The certification number indicating that, upon initial review, the member seems to qualify for an inpatient stay.

Medical Necessity: A health service that is consistent with the member's diagnosis or condition and is:

1. Recognized as the prevailing medical community standard or current practice by the provider's peer group; and
2. Rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve community standards for diagnosis or condition; or
3. Is a preventive health service as defined in [MN Rules part 9505.0355](#).

Out-of-Area Hospital: A hospital located outside of IMCare's network of providers.

Principal Diagnosis: The condition established, after study, to be responsible for causing the admission to the hospital for inpatient hospital services.

Principal Procedure: A procedure performed for definitive treatment of the principal diagnosis rather than one performed for diagnostic exploratory purposes or a procedure necessary to take care of a complication. When multiple procedures are performed for definitive treatment, the principal procedure is the procedure most closely related to the principal diagnosis.

Readmission: An admission that occurs within 15 days of a discharge, not including the day of discharge or the day of readmission. Retrospective review may be completed to determine if the admission and readmission are considered separate admissions, transfer admissions, or a readmission that is a continuation of the previous admission.

Retrospective Review: A review conducted after inpatient hospital services are provided to a member. The

review is focused on validating the diagnostic category, verifying recertification (where applicable), and determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, and if all medically necessary inpatient hospital services were provided.

Transfer: The movement of a member after admission from one facility directly to another facility with a different provider number, or to or from a unit of a hospital to another unit recognized as a rehabilitation distinct part by Medicare. Transfer also includes members who move to or from extended inpatient psychiatric services capacity under contract with the Minnesota Department of Human Services (DHS). Moving a member from a medical or surgical service to the acute psychiatric unit within the same hospital is not considered a transfer and must be billed as one continuous hospitalization.

Admissions Requiring Service Authorization

All inpatient stays requiring authorization will be subject to concurrent review and continued stay review.

The medical records of patients covered under IMCare are subject to retrospective review to determine the medical necessity of inpatient services.

Obtaining Inpatient Service Authorizations

An admitting physician or hospital must obtain a Service Authorization from IMCare when a MinnesotaCare member is admitted, readmitted, or transferred to acute inpatient care, or a member's stay is at an out of network facility.

Service Authorizations can be requested in writing, by telephone, or fax. In the event that the notification is attempted outside of normal business hours, IMCare is able to accept facsimile or confidential voicemail 24 hours per day, 365 days per year. A clinical administration staff member will return the call as soon as possible if requested. Telephone and fax numbers are included at the end of this chapter.

Service Authorization requests must include the following information:

1. Caller/requester name and contact information
2. Member's name, IMCare identification (ID) number, DOB, and gender
3. Date of admission, or expected date of admission
4. Expected date of discharge
5. Admitting physician's name and National Provider Identifier (NPI)
6. Hospital's name, NPI, and city (and state when appropriate)
7. Admitting or principal diagnosis and a secondary diagnosis descriptor with codes, according to the most recent *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)*
8. Primary or principal procedure descriptor with code, when applicable, according to the most recent *ICD-10-CM* and anticipated date of surgery
9. Whether the member is a transfer from another hospital
10. Reason and source of the admission
11. Classification of request – prospective, concurrent, or retrospective

If the physician determines that the admission is not medically necessary, or is unable to determine if the admission is medically necessary, IMCare will deny the Service Authorization request. IMCare Utilization Management staff will notify providers if additional medical information is needed to make a determination.

Failure to provide legible or complete records will result in a denial of the request.

All requests will be acted upon within 10 business days of receipt. If the attending health care provider determines that waiting may harm the member, an urgent request can be requested and a decision will be given within 72 hours. Care related to emergency cases does not require authorization; once the member's condition is stabilized, authorization will be needed to continue services.

If the inpatient admission is denied, a written notice of the denial, with the reason for the denial clearly stated, is sent to the admitting physician, the hospital, and the member. The member is also informed of his/her Appeal rights. The physician and hospital are notified of their right to an Appeal.

Only a physician can deny inpatient hospital services for medical necessity not being met.

Concurrent, Continued Stay, and Retrospective Reviews

IMCare performs concurrent, continued stay for all MinnesotaCare and out of network member's admissions. All admissions may have a retrospective review done. A physician (secondary medical reviewer) is consulted if the medical record and other supporting information do not clearly demonstrate the medical necessity of the admission, continued stay, services provided, or the reasons for the member's discharge and readmission.

IMCare reserves the right to review all inpatient admissions to determine medical necessity, even if an inpatient Service Authorization is not required or has already been granted. If this review (using InterQual™ criteria) determines that the admission did not meet medical necessity criteria, the review will be forwarded for secondary medical review.

If the secondary medical reviewer (physician) determines medical necessity was not established, IMCare will notify the admitting physician and the hospital of the withdrawal. A denial letter will also be provided along with Appeal rights.

Denial, Withdrawal, or Retrospective Denial of Coverage for Not Meeting Inpatient Criteria

If the medical record does not adequately document that the admission was medically necessary, IMCare may deny or recover all or part of the IMCare payment made to the attending physician, hospital, and other providers of inpatient hospital services.

If the Service Authorization number is denied or withdrawn, the services may be billed as outpatient observation hospital services only if the following apply: an inpatient claim has been submitted and denied, inpatient charges have not been submitted, and the total time the member was in the hospital was less than 48 hours. For additional information, review the *Outpatient Observation Services* section in Chapter 14, Hospital Services.

Criteria to Determine Medical Necessity

IMCare's review staff uses InterQual™ to determine medical necessity. InterQual™ is a multi-specialty clinically-based application that utilizes clinical literature, community standards of practice, and national practice guidelines to help determine medical need and intensity of services to manage certain conditions. The IMCare Utilization Management department uses the most current InterQual™ criteria, adopted clinical practice guidelines. Minnesota Department of Human Services (DHS) and State of Minnesota coverage policies, Centers for Medicare & Medicaid Services (CMS) national coverage determinations (dual eligible members only), local

Medicare coverage determinations published by National Government Services (NGS) (dual eligible members only), and other IMCare-approved medical policies in its authorization decisions. Criteria are available upon request of the practitioner. The practitioner may request the criteria either by phone, fax, email, or by a written request sent via the United States Post Office. The criteria will be provided to the practitioner upon request.

Readmission

The medical records of inpatients readmitted to the hospital within 15 days may be reviewed retrospectively as indicated by IMCare. The initial admission, discharge, and the readmission are reviewed to monitor quality of care (e.g., underutilization of services, fragmented care, premature discharge) to determine if payment should be made for one or both hospitalizations, or if payment should be made according to transfer payment established by Minnesota Rules. If the decision is that the readmission is continuous with the previous admission, reconsideration may be requested through the provider Appeal process.

Medical records with clearly documented situations of patient preference, leaving the hospital against medical advice (AMA), patient noncompliance, physician/hospital convenience, or scheduling conflicts will not be sent through physician review. Situations of episodic illness (same or different episode) or prevailing medical standards, practice, and usage will be sent to physician review (secondary medical review) if the Utilization Management (UM) Care Coordinator cannot make a determination based on criteria and the information submitted for review. If the provider does not agree with it, reconsideration may be requested through the provider Appeal process.

Medical records of an admission must clearly state the following:

1. The reason the member was discharged from the hospital
2. The member's status upon discharge

Medical records of a readmission must clearly state the following:

1. The reason the member was readmitted
2. The member's medical status at readmission

Readmission Criteria

Criteria used to determine whether a readmission is considered a second admission, continuous with the first admission, or eligible for transfer payment are shown below.

Criteria: A **second admission** is a readmission that resulted from one of the following circumstances:

1. During the first admission, the member left the hospital AMA once the member understood the hospital course (usually within the initial hours of hospitalization). This "admission" should be billed as outpatient services.
2. During the first admission, the member was noncompliant with medical advice (i.e., the member was informed of his/her medical condition and fully understood the need for treatment and follow-up, yet refused to adhere to medical recommendations). The information provided to the member is documented in the medical record at the hospital of the first admission.
3. A new episode of the same diagnosis of an episodic illness or condition
4. The member was discharged and readmission was medically necessary according to prevailing medical standards, practice, and usage

Criteria: An **admission continuous with the initial admission** is a readmission that resulted from one of the following circumstances:

1. The member was discharged from the admitting hospital without receiving the procedure or treatment for the condition diagnosed during the admission because of the physician's or hospital's preference or because of a scheduling conflict. If the admitting and readmitting hospitals are the same, the second admission is a continuation of the first, and only one Service Authorization number is to be provided to the provider. If the

- admitting and readmitting hospitals are not the same, the second hospital is given a new Service Authorization number. Both hospitals need to know that they are going to receive **transfer payment** (applies to DRG hospitals only).
2. The member's discharge was not appropriate according to prevailing medical standards, practice, and usage. InterQual™ discharge criteria and, if necessary, secondary medical review, will be used to determine if discharge was appropriate. If the discharge was not appropriate and the admitting and readmitting hospitals are the same, IMCare will authorize only one admission (the readmission is a continuation of the admission). If the admitting and readmitting hospitals are different, IMCare may withdraw the Service Authorization number for the initial admission and a new Service Authorization number will be generated for the second hospital. If IMCare provides both hospitals with a Service Authorization number, both hospitals need to know that they are going to receive **transfer payment** (applies to DRG hospitals only).
 3. The preference of the member or his/her family that the treatment be delayed, the member be discharged without receiving the **necessary** procedure or treatment, and then the member be readmitted to the same hospital for the necessary procedure or treatment. In this situation, "preference" differs from AMA discharge because the choice is compatible with prevailing medical standards. If the admitting and readmitting hospitals are the same, the initial admission Service Authorization number will be given to the provider (the readmission becomes a continuation of the initial admission). If the admitting and readmitting hospitals are not the same, then a new Service Authorization number is entered for the second hospital, and *both* hospitals need to know that they are going to receive **transfer payment**. Transfer payment applies if the readmission to the new hospital is within hours of the discharge from the first hospital.
 4. The readmission results from the same episode of the same diagnosis/disease of an episodic illness or condition. For readmissions to physical rehabilitation after transfer to acute care, it is necessary to determine if the member's treatment can resume at or near the pre-transfer stage. If so, combine the admission and readmission. If the patient physically regressed or the functional level deteriorated during the acute care hospitalization and the treatment program must be repeated, the readmission is considered a second admission. Although the decision is not based on the LOS in rehabilitation or an acute hospitalization, LOS must be considered.

Criteria: An admission **eligible for transfer payment** is an inpatient discharge followed by a readmission that resulted from the circumstances noted above (an admission continuous with the initial admission) and the following:

1. The readmission results from a referral from one hospital to a different hospital because the member's medically necessary treatment is outside the scope of the admitting hospital's available services. In this case, both hospitals will have their own Service Authorization numbers if any of the following apply:
 - a. The admitting hospital admitted the member as an emergency
 - b. At the time of admission, the admitting hospital was unaware and had no reason to believe that the member's treatment was outside the scope of the hospital's available services
 - c. There is a physician or hospital scheduling conflict at the admitting hospital and the readmission is at a different hospital

If the first admission did not meet any of the criteria listed above, the admission event for the first hospital is void and the hospital is asked to bill for outpatient services.

IMCare Contact Information

IMCare Utilization Management
1219 SE 2nd Ave
Grand Rapids, MN 55744

Fax: 1-218-327-5545

Phone: **1-800-843-9536** (toll free); Monday – Friday, 8 a.m. – 4:30 p.m.

IMCare Service Authorization forms can be found on the [IMCare](#) website.

Legal References

[MN Stat. sec. 256.969, subd. 2](#) – Payment Rates: Diagnostic categories

[MN Stat. sec. 256B.04](#) – Duties of State Agency

[MN Stat. sec. 256D.03](#) – Responsibility to Provide General Assistance

[MN Stat. sec. 256L.03, subd. 3\(b\)](#) – Covered Health Services: Inpatient hospital services

[MN Rules parts 9505.0501 – 9505.0540](#) – Hospital Admissions Certification

[Title 42 Code of Federal Regulations \(CFR\) Part 456, Subpart C](#) – Utilization Control: Hospitals

[42 CFR 456, subp. D](#) – Utilization Control: Mental Hospitals

[42 CFR 482.30](#) – Condition of participation: Utilization review