# Clinical Policy: Acute Inpatient Hospital Services

Reference Number: WNC.CP.252 Coding Implications
Last Review Date: 09/24 Revision Log

**See** Important Reminder **at the end of this policy for important regulatory and legal information.**

**Note:** When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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**Description**[1]

Inpatient Services are medical services provided to a member admitted to an acute inpatient hospital. The provider shall comply with 10A NCAC 25A .0201 (Medical Services).

WellCare of North Carolina utilizes InterQual (IQ) Care Guidelines to initially screen for medical necessity for Acute Inpatient Hospital Services. Medical Directors licensed in North Carolina review any inpatient cases that do not meet InterQual criteria for inpatient status or continued observation care beyond 30 hours, and apply individual clinical judgement to all cases prior to a final determination.

For the purposes of this policy, a member in outpatient hospital observation status for more than 30 hours shall either be discharged by the attending physician or converted to inpatient status by written order of the physician to receive continued Medicaid reimbursement beyond the 30 hours.

**Policy/Criteria**[1]

**I.** WellCare of North Carolina® **shall cover** the following services if medical necessity guidelines for the specific setting below are met:

**A.** ***Acute Inpatient Hospital Admission***

1. Covered for a member who:
   a. is admitted as an inpatient; **and**
   b. stays past midnight in an acute inpatient bed.
2. Services consist of **any** of the following:
   a. Bed and board in semiprivate room, except when private accommodations are medically necessary or when only private rooms are available;
   b. Nursing services and other related services that are ordinarily furnished by the hospital for the care and treatment of inpatients;
   c. Use of hospital facilities;
   d. Drugs and biologicals from the preferred drug list, for use in the hospital, excluding investigational or trial drugs or biological;
   e. Approved supplies, appliances, and equipment for use in the hospital; **and**
   f. Other diagnostic or therapeutic items or services not specifically listed but that are ordinarily furnished to inpatients.

**B.** ***Hospital Observation Status***

1. A member who is admitted to a hospital for observation by a physician order does not qualify as an inpatient, even if he or she stays past midnight. For the purposes of this policy, a member in hospital observation status for more than 30 hours shall either be discharged by the attending physician or converted to inpatient status by written order of the physician to receive continued Medicaid reimbursement beyond the 30 hours. Precertification and concurrent review from WellCare of North Carolina is required for inpatient admissions. Hospital observation stays under 30 hours do not require precertification but WellCare of North Carolina must be notified of the admission to observation status. Notification can occur via NC Notify (ADT from the NC Health Information Exchange) or via WellCare of North Carolina provider portal or fax.

**C.** ***Outpatient Hospital Services***

1. Services for members who are admitted and discharged on the same day, and who are discharged to home or to a non–acute care facility, must be billed as outpatient hospital services. Outpatient hospital services provided by a hospital to a member within the 24 hours immediately preceding an inpatient admission to the same hospital, and that are related to the inpatient admission, must be reported with the inpatient billing.

**Note**: The only exceptions to these requirements are members who are admitted as inpatients and either dies or are transferred to another acute care hospital on the day of admission. Acute hospital admissions prior to 72 hours after a previous acute inpatient hospital discharge for the same or related diagnosis are subject to review by WellCare of North Carolina.

**D.** ***Transfers***

1. A member who has medical or surgical needs that cannot be met at the admitting hospital may be transferred to a hospital that is able to provide the appropriate care. Hospital to hospital transfers must be approved by WellCare of North Carolina. When transfers occur emergently, authorization should be requested as soon as possible after the transfer occurs, but no later than 1 business day after transfer.

**II.** WellCare of North Carolina® **shall not** cover the services and items listed below:

**A.** Birth certificates, baby bracelets, layettes;
**B.** Shrouds, morgue boxes;
**C.** Sitters or attendants;
**D.** Private duty nurses;
**E.** Leave days (overnight leave of absence);
**F.** Late discharge for convenience of the member or physician; **and**
**G.** Private accommodations when the conditions listed in Section I are not applicable.

## Background[1]

For Services Out of State more than 40 miles beyond the North Carolina state border, refer to clinical coverage policy *WNC.CP.196 Out-of-State Services*.

## Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| Reviews, Revisions, and Approvals | Reviewed Date | Approval Date |
|---|---|---|
| Original Approval date. | 05/21 | 05/21 |
| Annual Review | 10/21 | 02/22 |
| Annual Review | 08/22 | 11/22 |
| Under Description, changed "MCG to InterQual (IQ)" | 12/22 | 12/22 |
| Annual Review. NCHC verbiage removed from NC Guidance Verbiage | 05/23 | 05/23 |
| Under Description added verbiage, "to initially screen for medical necessity for Acute Inpatient Hospital Services. Medical Directors licensed in North Carolina review any inpatient cases that do not meet InterQual criteria for inpatient status or continued observation care beyond 30 hours, and apply individual clinical judgement to all cases prior to a final determination. For the purposes of this policy, a member in outpatient hospital observation status for more than 30 hours shall either be discharged by the attending physician or converted to inpatient status by written order of the physician to receive continued Medicaid reimbursement beyond the 30 hours." | 05/23 | 05/23 |
| Annual Review. Criteria I.B. and I.B.1.Removed the word "outpatient." Removed ICD-10-CMS, CPT, HCPCS coding tables. | 05/24 | 05/24 |
| Criteria I.C.Note - Changed timeframe for readmission review from 72 hours to 30 days. Removed 'Medicaid and health choice" verbiage from References. | 08/24 | 08/24 |
| Criteria I.C.Note: Changed timeframe for readmission review from 30 days to 72 hours with an effective date of 06/01/2024 with an amended date of 09/24. | 09/24 | 09/24 |

**References**

1. State of North Carolina Medicaid Clinical Coverage Policy No: 2A-1 Acute Inpatient Hospital Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) Published September 23, 2024. Accessed September 25, 2024.

**North Carolina Guidance**

*Eligibility Requirements*

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

*EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age*

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure

meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   *NCTracks Provider Claims and Billing Assistance Guide*:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   *EPSDT provider page*: https://medicaid.ncdhhs.gov/

*Provider(s) Eligible to Bill for the Procedure, Product, or Service*
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

*Compliance*
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

*Claims-Related Information*
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10

edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   *Unlisted Procedure or Service*
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.