

Section 7

Inpatient & Outpatient Hospital Care

Acute Inpatient Admissions

All elective and emergent admissions require prior authorization and/or notification for all Health Choice Generations Members' admissions. Admissions must be called into the HC Generations Prior Authorization line at: 1-800-322-8670.

HC Generations Utilization Review staff will coordinate the admission plan of care with the attending physician, as well as hospital case management staff. Continued stay review will be conducted by HC Generations Utilization Review staff as determined by the medical necessity and intensity of service. HC Generations Utilization Review staff will assist in coordinating services identified for discharge planning, as well as required follow up post discharge.

If HC Generations Members need hospital care, providers must notify Health Choice Generations (HC Generations). Except in an emergency, the inpatient facility provider must obtain authorization from Health Choice Generations.

Authorization for inpatient service except in the case of emergency medical services, HC Generations Members may not be admitted to any hospital without the prior approval of the appropriate Primary Care Physician (PCP) and prior authorization by HC Generations.

Hospitals are required to notify HC Generations (via phone call or HC Generations web site once operational), **on the day of the admission**. Upon receipt of the information, HC Generations will provide an authorization number for the in-patient admission to the hospital.

Emergency medical services, hospitals must notify HC Generations prior to member admissions, if the condition of member permits. If admission is due to the severity of the emergency, and prior notification cannot be obtained, the hospital must provide notification, (via phone call or HC Generations web site (once operational) to HC Generations of the emergency no later than **twenty-four (24)** hours of the admission. Upon receipt of the information, HC Generations will provide written notification of the in-patient admission to the hospital.

The term "hospital" means a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

Members are covered for **90 days each benefit period**.

A benefit period begins the day the HC Generations Member is admitted into a hospital or skilled nursing facility.

The benefit period ends when the HC Generations Member has not received hospital or skilled nursing care for **60 days** in a row. If the HC Generations Member is admitted into the hospital after one benefit period has ended, a new benefit period begins.

There is no limit to the number of benefit periods a HC Generations Member can have.

If an HC Generations Member continues to receive inpatient care at a non-contracted hospital after the emergency condition is stabilized, the member cost is the cost sharing that would be paid at a plan hospital.

Inpatient Hospital Covered Services

Covered services include, but are not limited to, the following:

- Semiprivate room (or a private room if medically necessary).
- Meals including special diets.
- Regular nursing services.
- Costs of special care units (such as intensive or coronary care units).
- Drugs and medications.
- Lab tests.
- X-rays and other radiology services.
- Necessary surgical and medical supplies.
- Use of appliances, such as wheelchairs.
- Operating and recovery room costs.
- Physical therapy, occupational therapy, and speech therapy.
- Under certain conditions, the following types of transplants are covered: corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 11 for more information about transplants.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood needed – Medicaid (AHCCCS) will pay for the first 3 pints of un-replaced blood. All other components of blood are covered beginning with the first pint used.
- Physician Services.

Inpatient Services - Hospital or SNF days are not or are no longer covered

When the hospital or SNF days are not or are no longer covered (limits are used up), physician services and other medical services will still be covered. These services are:

- Physician services.
- Tests (like X-ray or lab tests).
- X-ray, radium, and isotope therapy including technician materials and services.
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.
- Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.

- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
- Physical therapy, speech therapy, and occupational therapy.

Hospitalist

HC Generations uses hospitalist to primarily take care of patients when they are in the hospital. Hospitalists are required to take over inpatient care for PCPs for their HC Generations Members that are in the hospital. Hospitalist must keep the primary doctor informed about the members progress, and will return the member's care to the primary doctor when the member is discharged from the hospital.

Health Choice Generations covers hospitalist care **except** in the following situations:

- _ If a child is receiving Medicare Advantage Special Needs benefits through Health Choice Generations, the plan does not require hospitalist care but will cover care received from their Primary Care Physician (PCP).
- _ If a pregnant woman is receiving Medicare benefits through Health Choice Generations, the plan will not cover hospitalist care, but will cover care received from their PCP or OB provider.

Skilled Nursing Facility Care (SNF)

If HC Generations Members need skilled nursing facility care, providers must notify HC Generations. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both.

Skilled nursing care includes: Services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include: Physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps members learn how to do usual daily activities such as eating and dressing by them self. It can be a separate facility, or part of a hospital or other healthcare facility. No prior hospital stay is required for Skilled Nursing Facility Care.

Authorization for SNF services, HC Generations Members may not be admitted to any hospital or skilled nursing facility without the prior approval of the appropriate Primary Care Physician (PCP) and prior authorization by HC Generations. SNFs are required to notify HC Generations (via phone call or HC Generations web site once operational), on the day of the admission. Upon receipt of the information, HC Generations will provide written notification of the SNF admission.

Members are covered for **100 days** each benefit period. As a member of Health Choice Generations the member qualifies for Medicaid (AHCCCS) benefits. If this remains true, then Medicaid will cover the HC Generations Member copay and deductible. These will be billed through our Health Choice (AHCCCS) plan if a member, or another AHCCCS plan.

A benefit period begins the day admitted into a hospital or skilled nursing facility.

The benefit period ends when the HC Generations Member has not received hospital or skilled nursing care for **60 days** in a row. If the member goes into the SNF after one benefit period has ended, a new benefit period begins.

There is no limit to the number of benefit periods HC Generations Members can have.

Skilled Nursing Facility Covered Services

Covered services include, but are not limited to, the following:

- Semiprivate room (or a private room if medically necessary).
- Meals, including special diets.
- Regular nursing services.
- Physical therapy, occupational therapy, and speech therapy.
- Drugs (this includes substances that are naturally present in the body, such as blood clotting factors).
- Blood - Including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood needed. Medicaid (AHCCCS) will pay for the first 3 pints of un-replaced blood.
- All other components of blood are covered beginning with the first pint used. Coverage begins with the third pint of blood needed including storage and administration Medical and surgical supplies.
- Laboratory tests.
- X-rays and other radiology services.
- Use of appliances such as wheelchairs.
- Physician services.

To be covered for care in a SNF, HC Generations Members must meet certain criteria:

To be covered, HC Generations Members must need daily skilled nursing or skilled rehabilitation care, or both. If the members do not need daily skilled care, other arrangements for care would need to be made.

Note: Medical services and other skilled care will still be covered when members start needing less than daily skilled care in the SNF.

Stays that provide Custodial Care only are Not Covered

“Custodial care” is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Health Choice Generations unless it is provided as

other care the HC Generations Member is getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

In some situations, HC Generations Members may be able to get care by a SNF that is not a plan provider.

Generally, HC Generations Members will get skilled nursing facility care from SNFs that are plan providers for Health Choice however, *if certain conditions are met*, HC Generations Members may be able to get skilled nursing facility care from a SNF that is not a plan provider. One of the conditions is that the SNF that is not a plan provider must be willing to accept Health Choice Generations rates for payment.

At the member's request, HC Generations may be able to arrange for members to get skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where the HC Generations Member was living right before they went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where the HC Generations Member and spouse are living at the time member leaves the hospital.

Observation Services

Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation until criteria for inpatient hospital admission or discharge/transfer have been met. Covered observation services include:

- Use of a bed
- Periodic monitoring by a hospital's nursing staff or, if appropriate, **other** staff necessary to evaluate, stabilize, or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis

Observation stays must be provided in a designated "observation area" of the hospital unless such an area does not exist.

It is not an observation stay when a recipient with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the recipient in the hospital for less than 24 hours. This is an outpatient procedure, regardless of the hour in which the recipient presented to the hospital, whether a bed was utilized, or whether services were rendered after midnight.

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation status *must* be ordered in writing by a physician or another individual authorized to admit patients to the hospital or to order outpatient diagnostic tests or treatments. The following factors must be taken into consideration by the physician or authorized individual in ordering observations status:

- Severity *of* the signs and symptoms *of* the recipient.
- Degree *of* medical uncertainty that the recipient may experience an adverse occurrence.
- Need *for* diagnostic studies that appropriately are outpatient stays (i.e., they *do not*

ordinarily require the recipient *to remain at the hospital for 24 hours or more*) *to assist in assessing whether the recipient should be admitted.*

- The availability *of* diagnostic procedures at the time and location where the recipient presents *for* medical treatment

The following services are *not* HC Generations-covered observation services:

- Substitution *of* outpatient services provided in lieu *of* observation status *for* physician ordered inpatient services.
- Services that are not reasonable, cost-effective, and necessary *for* diagnosis or treatment.
- Services provided for the convenience *of the* recipient or physician.
- Excessive time and/or amount *of* services medically required by the condition *of the* recipient.
- Services customarily provided in a hospital-based outpatient surgery center and *not* supported by medical documentation *of the* need *for* observation status.

In general, observation status should *not* exceed 24 *hours*. This time limit may be exceeded, if medically necessary, *to* evaluate the medical condition and/or treatment *of* a recipient. Extensions *to* the 24-hour limit must be prior authorized.

Observation services, without labor, billed on the UB claim *form* must be billed with a 762 revenue code (Treatment/Observation Room - Observation Room) and the appropriate observation HCPCS procedure code 99218, 99219 or 99220 (note that 99217 is *not* appropriate *for* hospital billing). Each *hour* or portion *of an hour* that a recipient is in observation status must be billed as one unit *of* service.

Observation services, with labor, billed on the UB claim *form* must be billed with a 721 revenue code (Labor Room Delivery - Labor) and the appropriate HCPCS procedure codes. Each *hour* or portion *of an hour* that a recipient is in observation status must be billed as one unit *of* service.

HC Generations will review the immediate and continuing observation status by assessing the severity of illness and intensity of services. Medical review for continued observation status will consider each case on an individual basis and include, at a minimum, the following documentation:

- Emergency room record, if applicable
- Progress notes
- Operative report, if applicable
- Diagnostic test results, if applicable
- Nursing notes, if applicable
- Labor and delivery records, if applicable 0 Physician orders

The following are required for documenting medical records:

- Orders for observation status must be written on the physician's order sheet, not the emergency room record, and must specify "admit to observation." Rubber stamped orders are not acceptable.
- Follow-up orders must be written at least every 24 hours.

- Changes Item "observation status to inpatient" or "inpatient to observation status" must be made by a physician or authorized individual.
- Inpatient to observation status must be made by a physician or authorized individual and occur within 12 hours after admission as an inpatient.
- Inpatient/outpatient status change must be supported by medical documentation.

Outpatient Hospital Services

HC Generations covers preventive, diagnostic, rehabilitative, and palliative items or services ordinarily provided in hospitals on an outpatient basis for all HC Generations Members.

If HC Generations Members are treated in the emergency room, observation area, or other outpatient department and are directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

Inpatient Mental Health Care

Mental healthcare services that require a hospital stay; Medicare beneficiaries may only receive **190 days** in a Psychiatric Hospital in a lifetime. Except in an emergency, providers must obtain authorization from Health Choice Generations.

Outpatient Mental Health Care (including Partial Hospitalization Services)

Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws.

“Partial hospitalization” is a structured program of active treatment that is more intense than the care received in at a doctor or therapist’s office and is an alternative to inpatient hospitalization.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by Health Choice Generations under certain conditions.

Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, HC Generations Members must have a medical condition that would allow them to receive inpatient hospital care or extended care services, or care in a home health agency.

HC Generations Members may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCI. In addition, members must sign a legal document that says they are conscientiously opposed to the acceptance of “non-excepted” medical treatment.

“Excepted” medical treatment is medical care or treatment that HC Generations Members receive involuntarily or that is required under federal, state, or local law.

“Non-excepted” medical treatment is any other medical care or treatment. Authorization is required (approval) in advance from Health Choice Generations, or member stay in the RNHCI may not be covered.

