TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #10-791(F)

DIGEST

Amends 405 IAC 5-17-2 to modify the prior authorization requirements for all nonemergent inpatient hospital admissions that are not covered by Medicare. Effective 30 days after filing with the Publisher.

405 IAC 5-17-2

SECTION 1. 405 IAC 5-17-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-17-2 Prior authorization; generally

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3

Sec. 2. **(a) Prior authorization is required for all nonemergent inpatient hospital admissions of Medicaid eligible recipients. Nonemergent inpatient hospital admissions include all elective or planned inpatient hospital admissions and inpatient hospital admissions for which the patient's condition permitted adequate time to schedule the availability of a suitable accommodation. The following are exempt from this requirement:**

(1) Inpatient hospital admissions when covered by Medicare.

(2) Routine vaginal and cesarean section deliveries.

~~(a)~~ **(b)** Prior authorization is required for all Medicaid covered rehabilitation, burn, and psychiatric inpatient stays that are reimbursed under the level of care methodology described in 405 IAC 1-10.5 as well as substance abuse stays that are reimbursed under the DRG methodology described at 405 IAC 1-10.5.

~~(b)~~ **(c)** Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient procedure, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate DRG, but will be subject to retrospective review for medical necessity.

~~(c)~~ **(d)** Criteria for determining the medical necessity for inpatient admission shall include the following:

(1) Technical or medical difficulties during the outpatient procedure as documented in the medical record.

(2) Presence of physical or mental conditions that make prolonged preoperative or postoperative observations by a nurse or skilled medical personnel a necessity.

(3) Performance of another procedure simultaneously, which itself requires hospitalization.

(4) Likelihood of another procedure following the initial procedure, which would require hospitalization.

~~(d)~~ **(e)** Days that are not prior authorized under the level of care methodology as required by this rule will not be covered by Medicaid.

~~(e)~~ **(f) In addition to the prior authorization requirements set forth in this section,** prior authorization is **also** required for the procedures listed in 405 IAC 5-3-13.

(Office of the Secretary of Family and Social Services; 405 IAC 5-17-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 3:58 p.m.: 20110608-IR-405100791FRA)

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