



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Inpatient Hospital Services

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Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> • Updated the Reimbursement for Medical Educational Costs section and Qualification for Medical Education Payments subsection • Updated the cost-to-charge ratio information in the Outlier Payments section • Added a hospital to the list in the DRG Base Rate for Children's Hospitals section • Added a sentence about Medicare in the Change in Coverage during Inpatient Stay section • Updated the Reimbursement for Promoting Interoperability Program section • Added a reference to applicable code table in the Inpatient Blood Factor Claims section • Updated the Transfers section • Added a note about crossover claims in the Inpatient Stays Less Than 24 Hours section 	

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Inpatient Hospital Services

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise member services – providers must contact the member’s managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the [IHCP Quick Reference Guide](#), available at in.gov/medicaid/providers.*

For updates to information in this module, see [IHCP Banner Pages and Bulletins](#) at in.gov/medicaid/providers.

Introduction

Subject to the limitations described in this module, the Indiana Health Coverage Programs (IHCP) covers inpatient services (such as acute care, mental health, and rehabilitation care) when the services are both of the following:

- Provided or prescribed and documented by a physician
- Medically necessary for the diagnosis or treatment of the member’s condition

*Note: This module includes information about IHCP coverage, billing, and reimbursement for inpatient services. For additional information specific to inpatient **mental health** services, see the [Mental Health and Addiction Services](#) module.*

Prior Authorization for Hospital Inpatient Admissions

In accordance with *Indiana Administrative Code 405 IAC 5-17-2*, the IHCP requires prior authorization (PA) for all nonemergency inpatient hospital admissions, with the following exceptions:

- Routine vaginal and C-section deliveries
- Inpatient hospital admissions covered by Medicare

In all other cases, nonemergency inpatient hospital admissions – including all elective or planned admissions and admissions for which the patient’s condition permitted adequate time to schedule suitable accommodation – require PA. This requirement applies to medical and surgical inpatient admissions. Newborn stays do not require PA. Observation does not require PA.

PA is required for all Medicaid-covered rehabilitation, burn, and psychiatric inpatient stays reimbursed under the level-of-care (LOC) payment methodology, as well as substance abuse stays reimbursed under the diagnosis-related group (DRG) methodology. (Both reimbursement methodologies are described in *405 IAC 1-10.5* and the [Reimbursement Methodology for Inpatient Services](#) section of this module.) Emergency inpatient admissions for these diagnoses must be reported to the PA contractor within 48 hours of admission, not including Saturdays, Sundays, or legal holidays, to receive IHCP reimbursement. Days that are not prior authorized under the LOC methodology as required by *405 IAC 5-17-2* will not be covered by Medicaid. For all *other* emergency inpatient admissions, PA is not required.

Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient procedure, must be prior authorized. See the [Surgical Services](#) module for details.

All inpatient hospital PAs are requested via telephone. Providers are required to contact the PA contractor at least 2 business days prior to a nonemergency admission. For contact information, see the [IHCP Quick Reference Guide](#), available at in.gov/medicaid/providers.

To ensure a 48-hour turnaround, the PA request should be made by a clinical staff person. The facility must call prior to the admission and provide criteria for medical necessity.

When requesting PA for inpatient admission, providers must provide the following information:

- Member name and IHCP Member ID (also known as RID)
- Procedure requested, including revenue code, Current Procedural Terminology (CPT^{®1}), or Healthcare Common Procedure Coding System (HCPCS) code
- Location service is to be performed (facility)
- Medical condition being treated, including the International Classification of Diseases (ICD) code
- Medical necessity of the procedure
- Admitting physician or surgeon
- Date of admission
- Estimated length of stay (LOS)
- National Provider Identifier (NPI) of the requesting provider
- Documentation of the denial, if requesting retroactive PA for a dually eligible member who has had coverage denied by Medicare

See the [Prior Authorization](#) module for general information about requesting PA.

Note: All out-of-state services require PA, except as indicated in the [Out-of-State Providers](#) module.

PA Policy for Inpatient Stays for Burn Care

All inpatient stays for burn care are excluded from PA requirements when billed with an admit type 1 (emergency) or type 5 (trauma). If the member does not have PA, inpatient burn unit claims received with admit types other than 1 or 5 that group to a burn DRG will continue to deny for explanation of benefits (EOB) 3007 – No prior authorization segment on file for the level of care.

PA Policy for Inpatient Stays for Dually Eligible Members

A member who is dually eligible must obtain Medicaid PA for an inpatient stay that is not covered by Medicare. If a stay is covered by Medicare, in full or in part, the member does not require PA. Providers may request retroactive Medicaid PA for dually eligible members if Medicare will not cover the inpatient stay because the member has exhausted his or her Medicare benefit or if the stay is not a Medicare-covered service.

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Inpatient Admission Criteria

The IHCP follows Milliman guidelines for all nonemergency and urgent care inpatient admissions. If IHCP criteria already exist, those criteria are used first when determining whether admissions are appropriate. If criteria are not available within Milliman or IHCP policy, the IHCP relies on medical necessity determination of current evidence-based practice.

The following sections provide criteria for acute care hospital admissions for both adult and pediatric members (in accordance with 405 IAC 5-33), as well as admission criteria for hospital inpatient rehabilitation, dental admission, and inpatient burn admission.

For admission criteria for long-term acute care (LTAC) hospitals, see the [Long-Term Acute Care Hospital Services](#) section. For psychiatric admission criteria, including substance abuse admissions, see the [Mental Health and Addiction Services](#) module. For additional information about surgical admissions, see the [Surgical Services](#) module.

Acute Care Hospital Admission Criteria for Adults

The following sections provide criteria for acute care hospital admission for adults based on severity of illness or intensity of service, as well as criteria for appropriateness of day of care.

Severity-of-Illness Admission Criteria for Adults

For acute care hospital admission based on severity of illness, adults must meet at least one of the following criteria:

- Sudden onset of unconsciousness or disorientation (coma or unresponsiveness)
- Pulse rate less than 50 per minute or greater than 140 per minute
- Blood pressure (at least one of the following):
 - Systolic less than 90 or greater than 200 millimeters mercury
 - Diastolic less 60 or greater than 120 millimeters mercury
- Acute loss of sight or hearing
- Acute loss of ability to move body part
- Persistent fever equal to or greater than 100° (orally) or greater than 101° (rectally) for more than 5 days
- Active bleeding
- Severe electrolyte/blood gas abnormality, including any of the following:
 - Na < 123 mEq/L
 - Na > 156 mEq/L
 - K < 2.5 mEq/L
 - K > 6.0 mEq/L
 - CO₂ combining power (unless chronically abnormal) < 20 mEq/L
 - CO₂ combining power (unless chronically abnormal) > 36 mEq/L
 - Blood pH < 7.30
 - Blood pH > 7.45
- Acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, or breathe); must also meet intensity of service criterion simultaneously in order to certify; do not use for back pain

- Electrocardiogram (ECG) evidence of acute ischemia; must be suspicion of a new myocardial infarction (MI)
- Wound dehiscence of evisceration

Intensity-of-Service Admission Criteria for Adults

For acute care hospital admission based on intensity of service needed, adults must meet at least one of the following criteria:

- Intravenous medications and/or fluid replacement (does not include tube feedings)
- Surgery or procedure scheduled within 24 hours requiring either of the following:
 - General or regional anesthesia
 - Use of equipment, facilities, or procedure available only in a hospital
- Vital sign monitoring every 2 hours or more often (may include telemetry or bedside cardiac monitor)
- Chemotherapeutic agents that require continuous observation for life-threatening toxic reaction
- Treatment in an intensive care unit
- Intramuscular antibiotics at least every 8 hours
- Intermittent or continuous respirator use at least every 8 hours

Day-of-Care Criteria for Adults

Recertification for a continued stay in an acute care hospital requires documentation that the adult member meets the criteria for the appropriateness of day of care, based on medical services, nursing/life support services, or patient condition, as follows:

- Medical services (at least one of the following):
 - Procedure in operating room that day
 - Scheduled for procedure in operating room the next day, requiring preoperative consultation or evaluation
 - Cardiac catheterization that day
 - Angiography that day
 - Biopsy of internal organ that day
 - Thoracentesis or paracentesis that day
 - Invasive central nervous system (CNS) diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day
 - Any test requiring strict dietary control for the duration of the diet
 - New or experimental treatment requiring frequent dose adjustments under direct medical supervision
 - Close medical monitoring by a doctor at least three times daily (observations must be documented in record)
 - Postoperative day for any of the following procedures:
 - Procedure in operating room
 - Cardiac catheterization
 - Angiography
 - Biopsy of internal organ
 - Thoracentesis or paracentesis
 - Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography

- Nursing/life support services (any of the following):
 - Respiratory care—intermittent or continuous respirator use and/or inhalation therapy (with chest physiotherapy treatment [chest PT], intermittent positive pressure breathing [IPPB]) at least three times daily
 - Parenteral therapy—intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications)
 - Continuous vital sign monitoring, at least every 30 minutes, for at least 4 hours
 - Intramuscular and/or subcutaneous injections at least twice daily
 - Intake and output measurement
 - Major surgical wound and drainage care (chest tubes, T-tubes, hemovacs, Penrose drains)
 - Close medical monitoring by nurse at least three times daily, under doctor’s orders.
- Patient condition:
 - Within 24 hours before day of review – Inability to void or move bowels (past 24) not attributable to neurologic disorder
 - Within 48 hours before day of review – At least one of the following:
 - Transfusion due to blood loss
 - Ventricular fibrillation or ECG evidence of acute ischemia, as stated in progress note or in ECG report
 - Fever at least 101° rectally (at least 100° orally), if patient was admitted for reasons other than fever
 - Coma – unresponsiveness for at least 1 hour
 - Acute confusional state, not due to alcohol withdrawal
 - Acute hematologic disorders, significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis yielding signs or symptoms
 - Progressive acute neurologic difficulties
 - Within 14 days before day of review – Occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke)

Acute Care Hospital Admission Criteria for Pediatrics

The following sections provide criteria for acute care hospital admissions for pediatrics based on severity of illness or intensity of service, as well as criteria for appropriateness of day of care.

Severity-of-Illness Admission Criteria for Pediatrics

For acute care hospital admission based on severity of illness, pediatric members must meet at least one of the following criteria:

- Sudden onset of unconsciousness (coma or unresponsiveness) or disorientation
- Acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe, or urinate)
- Acute loss of sight or hearing
- Acute loss of ability to move body part
- Persistent fever (greater than 100° orally or greater than 101° rectally) for more than 10 days
- Active bleeding
- Wound dehiscence or evisceration

- Severe electrolyte/acid-base abnormality, including any of the following:
 - Na < 123 mEq/L
 - Na > 156 mEq/L
 - K < 2.5 mEq/L
 - K > 6.0 mEq/L
 - CO₂ combining power (unless chronically abnormal) < 20 mEq/L
 - CO₂ combining power (unless chronically abnormal) > 36 mEq/L
 - Arterial pH < 7.30
 - Arterial pH > 7.45
- Hematocrit greater than 30%
- Pulse rate outside following ranges (optimally, a sleeping pulse for members under 12 years old):
 - 2–6 years old: 70–200/minute
 - 7–11 years old: 60–180/minute
 - ≥ 12 years old: 50–140/minute
- Blood pressure outside following ranges (systolic/diastolic):
 - 2–6 years old: 75–125 mm Hg/40–90 mm Hg
 - 7–11 years old: 80–130 mm Hg/45–90 mm Hg
 - ≥ 12 years old: 90–200 mm Hg/60–120 mm Hg
- Need for lumbar puncture, where this procedure is not done routinely on an outpatient basis
- Any conditions not responding to outpatient, including emergency room:
 - Seizures
 - Cardiac arrhythmia
 - Bronchial asthma or croup
 - Dehydration
 - Encopresis (for clean-out)
 - Other physiologic problem (specify)
- Special pediatric problems (any of the following):
 - Child abuse
 - Noncompliance with necessary therapeutic regimen
 - Need for special observation or close monitoring of behavior, including calorie intake in cases of failure to thrive

Intensity-of-Service Admission Criteria for Pediatrics

For acute care hospital admission based on the intensity of care needed, pediatric members must meet at least one of the following criteria:

- Surgery or procedure scheduled within 24 hours requiring either of the following:
 - General or regional anesthesia
 - Use of equipment, facilities, or procedure available only in a hospital
- Treatment in an intensive care unit
- Vital sign monitoring every 2 hours or more often (may include telemetry or bedside cardiac monitor)
- Intravenous medications and/or fluid replacement (does not include tube feedings)
- Chemotherapeutic agents that require continuous observation for life-threatening toxic reaction
- Intramuscular antibiotics at least every 8 hours
- Intermittent or continuous respirator use at least 8 hours

Day-of-Care Criteria for Adults

Recertification of a continued pediatric inpatient stay requires documentation that the member has met criteria for the appropriateness of day of care, based on medical services, nursing/life support services, or patient condition, as follows:

- Medical services (at least one of the following):
 - Procedure in operating room that day
 - Procedure scheduled in operating room the next day, requiring preoperative consultation or evaluation
 - If the day being reviewed is the day of admission, any of the following procedures, scheduled for the day after admission (unless that procedure is usually done at that facility on a same-day basis):
 - Cardiac catheterization
 - Angiography
 - Biopsy of internal organ
 - Thoracentesis or paracentesis
 - Invasive CNS diagnostic procedure – for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography
 - Gastrointestinal endoscopy
 - Cardiac catheterization that day
 - Angiography that day
 - Biopsy of internal organ that day
 - Thoracentesis or paracentesis that day
 - Invasive CNS diagnostic procedure – for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day
 - Gastrointestinal endoscopy that day
 - Any test requiring strict dietary control for the duration of the diet
 - New or experimental treatment requiring frequent dose adjustments under direct medical supervision
 - Close medical monitoring by a doctor at least three times daily (observations must be documented in record)
 - Postoperative day for any of the following procedures:
 - Procedure in operating room
 - Cardiac catheterization
 - Angiography
 - Biopsy of internal organ
 - Thoracentesis or paracentesis
 - Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography
 - Gastrointestinal endoscopy
- Nursing/life support services (any of the following):
 - Respiratory care – intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB), at least three times daily; Bronkosol with oxygen, oxyhoods, or oxygen tents
 - Parenteral therapy – intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications)
 - Continuous vital sign monitoring, at least every 30 minutes for at least 4 hours
 - Intramuscular and/or subcutaneous injections at least twice daily
 - Intake and/or output measurement

- Major surgical wound and drainage care (for example, chest tubes, T-tubes, hemovacs, or Penrose drains)
- Traction for fractures, dislocations, or congenital deformities
- Close medical monitoring by nurse at least three times daily, under doctor's orders
- Patient condition:
 - Within 24 hours on or before day of review – Inability to void or move bowels, not attributable to neurologic disorder (usually postoperative)
 - Within 48 hours on or before day of review – At least one of the following:
 - Transfusion due to blood loss
 - Ventricular fibrillation or ECG evidence of acute ischemia as stated in progress note or in ECG report
 - Fever at least 101° rectally (at least 100° orally) if patient was admitted for reason other than fever
 - Coma – unresponsiveness for at least 1 hour
 - Acute confusional state, including withdrawal from drugs and alcohol
 - Acute hematologic disorders—significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis—yielding signs of symptoms
 - Progressive acute neurologic difficulties
 - Within 14 days before day of review – Occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke)

Inpatient Rehabilitation Admission and Discharge Criteria

The IHCP provides reimbursement for inpatient rehabilitation services when such services are prior authorized and determined to be medically necessary.

Prior authorization is required for all inpatient rehabilitation admissions. Before admission to a physical rehabilitation unit, an assessment of the patient's total rehabilitative potential must be completed and documented in the medical record. A written plan of care, cooperatively developed by the therapist or psychologist and the attending physician, is required for all rehabilitation services. Documentation in the medical record must include the member's condition, IHCP criteria, and level of care necessary in the rehabilitation unit.

The following conditions must be met for reimbursement for physical rehabilitation admission:

- The patient is medically stable.
- The patient is responsive to verbal or visual stimuli.
- The patient has sufficient mental alertness to participate in the program.
- The patient's premorbid condition indicates a potential for rehabilitation.
- The expectation for improvement is reasonable.
- The criteria listed in *405 IAC 5-32* are met.

Severity of Illness Criteria

Per *405 IAC 5-32-1*, the following criteria shall demonstrate the inability to function independently with demonstrated impairment:

- Cognitive function (attention span, memory, or intelligence)
- Communication (aphasia with major receptive or expressive dysfunction)
- Continence (bladder or bowel)

- Mobility (transfer, walk, climb stairs, or wheelchair)
- Pain management (pain behavior limits functional performance)
- Perceptual motor function (spatial orientation or depth or distance perception)
- Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis)

Intensity of Service Criteria

Intensity of service criteria for inpatient rehabilitation are as follows:

- Multidisciplinary team evaluation at least every 2 weeks
- Physical therapy and at least one of the following therapies (totaling a minimum of 3 hours daily):
 - Occupational therapy
 - Speech therapy
- Participation in a rehabilitation program under the direction of a qualified physician
- Skilled rehabilitative nursing care or supervision required at least daily

Discharge Criteria

Inpatient rehabilitation discharge criteria for consideration may include the following:

- There is evidence in the record that patient has achieved stated goals.
- Medical complications preclude intensive rehabilitative effort.
- Multidisciplinary therapy is no longer needed.
- No additional functional improvement is anticipated.
- The patient's functional status has remained unchanged for 14 days.

Dental Admissions

Any of the following is an inpatient dental admission indicator:

- Mental incapacitation such that the member's ability to cooperate with procedures is impaired, including intellectual disability, organic brain disease, and behavioral problems associated with uncooperative, but otherwise healthy children
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the member's ability to cooperate with procedures
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication
- The need for oral surgery, listed in *405 IAC 5-19-17*; or in extreme cases of facial trauma, pathology, or deformity
- Periodontal surgery only in cases of drug-induced periodontal hyperplasia
- Elective oral surgery when member is unable to cooperate with or tolerate the procedure

Prior authorization is required for all dental admissions.

Inpatient Burn Admissions

The following criteria for hospitalization for adults and children with burns are to be used as reference in determining IHCP-appropriate inpatient burn admissions.

Prior authorization is required for inpatient hospitalizations for the immediate treatment of burns, except those with an admit of type 1 (emergency) or type 5 (trauma).

Hospitalization for Members Age 10 and Over with Burns

A burn admission for a member age 10 or older may be approved without referral for physician review if any of the following conditions is present (recent onset):

- Loss or damage of skin \geq 15% of total body surface area (TBSA)
- High-voltage burn with devitalized skin, fat, or muscle
- Second- or third-degree burns of one of the following: face, hands, perineal region, encircling neck or extremities, anterior or posterior neck or limbs
- Temperature \geq 104.0° F
- Temperature \geq 102.0° F and one of the following:
 - White blood cells (WBC) \geq 18,000/cu.mm
 - WBC \geq 15,000/cu.mm with \geq 7% bands
- Temperature \geq 100.5° F and **one** of the following:
 - Absolute neutrophil count \leq 500/cu.mm
 - WBC \leq 1,500/cu.mm
- Admission for an invasive procedure which necessitates an inpatient setting **and** is scheduled for the same day as admission

Additionally, the admission requires that one of the following treatments is being provided:

- Post-surgery or procedure care \leq 3 days and at least **two** of the following (provided at least daily):
 - Intravenous (IV) fluids \geq 100 mL/h
 - IV or intramuscular (IM) analgesics
 - IV or IM anti-emetics
 - Graft or wound care
- Burn therapy with at least **three** of the following (provided at least daily):
 - IV electrolyte (K, Ca, Mg, P)
 - IV fluids \geq 100 mL/h
 - IV plasma expanders
 - O₂ \geq 28% (4L) or hyperbaric
 - Total parenteral nutrition
- A treatment that includes at least **three** of the following:
 - Blood or blood products
 - Complex burn, graft, or wound care
 - IV fluids \geq 100 mL/h
 - Total parenteral nutrition
 - Restorative physical therapy or occupational therapy at least two times per 24 hours
 - IV or IM corticosteroids at least three times per 24 hours
 - IV or IM diuretics at least two times per 24 hours
 - IV or IM analgesics at least four times per 24 hours

- IV or IM anti-emetics at least four times per 24 hours
- IV or IM anti-infectives at least three times per 24 hours

Hospitalization for Children Age 10 and Under with Burns

A burn admission for a member under age 10 may be approved without referral for physician review if any of the following conditions is present (recent onset):

- Electrical burns with devitalized skin, fat, or muscle
- First-degree burns covering 40% of TBSA
- Second-degree burns covering 15% of TBSA
- Second- or third-degree burns covering face, genitalia, hands, or feet
- Third-degree burns covering 5% or more of TBSA

Additionally, the admission requires that at least **one** of the following treatments is being provided at least daily (or more often, as indicated):

- Post-surgery or procedure care \leq 2 days
- IV electrolytes
- Burn therapy with at least **two** of the following:
 - IV fluids \geq 30 mL/kg/24h
 - IV plasma expanders
 - O₂ > 28% (4L)
- A treatment that includes at least **three** of the following:
 - Blood or blood products
 - Complex burn, graft, or wound care
 - Physical therapy
 - IV fluids \geq 30 mL/kg per 24 hours
 - IV plasma expanders
 - Total parenteral nutrition or enteral feeding
 - IV or IM corticosteroids at least three times per 24 hours
 - IV diuretics at least two times per 24 hours
 - IV or IM analgesics at least four times per 24 hours
 - IV or IM anti-emetics at least four times per 24 hours
 - IV or IM anti-infectives at least three times per 24 hours

General Inpatient Billing and Coding Procedures

Inpatient hospital services are billed using the *UB-04* paper claim form, or electronically through the 837I transaction or the Provider Healthcare Portal (Portal) institutional claim. For fee-for-service inpatient hospital paper claims, mail *UB-04* claim forms to DXC Technology at the following address:

DXC Inpatient Hospital Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

For general information about claim submission, see the [Claim Submission and Processing](#) module.

Revenue Code Itemization

The IHCP requires a complete itemization of services performed, using appropriate revenue codes on the claim. This itemization needs to occur even though the IHCP reimburses inpatient hospital services using a DRG/LOC methodology (see the [Reimbursement Methodology for Inpatient Services](#) section of this document).

The revenue code reveals crucial information about the type of service provided during the inpatient stay. Therefore, providers need to ensure that each claim properly identifies the appropriate revenue code. The revenue code that is used must reflect the setting in which the care was delivered. For example, providers must use revenue code 20X to submit a claim for services provided to patients admitted to an intensive care unit.

Principal Diagnosis

The *principal diagnosis* is defined as the condition established, after study, that is chiefly responsible for the admission of the patient to the hospital. When providers bill for inpatient services, a principal diagnosis is required. The principal diagnosis is the first diagnosis code entered on the claim (field 67 of the *UB-04* claim form).

Note: The IHCP prohibits use of ICD-10 diagnosis codes V00–Y99 as a principal diagnosis.

Other Diagnoses

Providers can enter additional diagnosis codes on the claim (fields 67A–Q of the *UB-04* claim form) to indicate all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or length of stay.

Providers must exclude diagnoses that relate to an earlier episode and have no bearing on the current hospital stay.

The IHCP defines *other diagnoses* as additional conditions that affect patient care in terms of requiring the following:

- Clinical evaluation
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care or monitoring
- Therapeutic treatment

Present on Admission Indicators

For all inpatient claims, hospitals are required to report whether each diagnosis on a Medicaid claim was present on admission (POA). POA is defined as a condition “present” at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA.

A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the *ICD Official Guidelines for Coding and Reporting* found on the [ICD-10](#) page at cms.gov). The IHCP does not require a POA indicator in the external cause of injury (ECI or E Code) field.

*Note: A list of diagnosis codes that are exempt from POA reporting can be accessed from the [Coding](#) page at [cms.gov](#). The POA indicator should be omitted only for codes on the list. Any inpatient claim without a POA indicator for a **nonexempt** diagnosis will be denied, and providers will need to correct and resubmit the claim for reimbursement.*

On the *UB-04* claim form, the appropriate POA indicator is entered in the shaded area after the diagnosis codes in field 67 and 67A–Q. On claims submitted via the Portal, the appropriate option is selected from the Present on Admission drop-down menu in the *Diagnosis Codes* panel.

Use the POA indicator options in Table 1 for all principal and secondary diagnoses on the inpatient claim.

Table 1 – POA Indicator Options

UB-04 Claim Form or 837I Transmission	Portal Institutional Claim	Definition
Y	Yes	Diagnosis was present at the time of inpatient admission.
N	No	Diagnosis was not present at the time of inpatient admission.
U	Unknown	The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
W	Not Applicable	The provider is unable to clinically determine whether the condition was present at the time of inpatient admission.
[Blank]	[Blank]	Diagnosis is exempt from POA reporting.

POA indicator reporting is mandatory for all Medicaid claims involving inpatient admission to any Medicaid-enrolled hospital. Inpatient and inpatient crossover claims submitted without a POA indicator for the principal diagnosis and secondary diagnoses (other than exempt diagnoses) are denied with the EOB code 4276 – *A POA must be entered. A POA of 1 or blank is not acceptable.* The provider needs to correct and resubmit the claim.

See the [Hospital-Acquired Conditions Policy](#) section for information about how POA indicators are factored into the IHCP reimbursement system.

Reimbursement Methodology for Inpatient Services

The IHCP reimburses for hospital inpatient claims on a hybrid system that consists of the following two distinct reimbursement methodologies:

- A diagnosis-related group (DRG) system that reimburses a per-case rate according to diagnoses, procedures, age, gender, and discharge status
- A level-of-care (LOC) system that reimburses psychiatric, burn, and rehabilitation cases on a per diem basis

The LOC portion of the methodology was developed in conjunction with the DRG reimbursement, due to wide variances in length of stay and costs associated with some care provided.

Reimbursement for inpatient hospital services under the hybrid system is composed of the following components:

- DRG rate per case or LOC per diem
- Capital rate
- Medical education rate, if applicable
- Outlier payment, if applicable
- Inpatient hospital adjustment factor or respective burn, psychiatric, rehabilitation LOC hospital adjustment factor for Hospital Assessment Fee (HAF)-participating hospitals (see the [Hospital Assessment Fee](#) module for details)

Note: Effective for dates of service from January 1, 2014, through June 30, 2021, the IHCP implemented a 3% reduction in reimbursement for inpatient and inpatient crossover claims. The rate reduction is not applicable for state-operated psychiatric hospitals. Disproportionate share hospital (DSH) payments are not subject to the reimbursement reduction. DRG payments, capital payments, medical education payments (if applicable), and outlier payments (if applicable) are calculated as usual. The total calculated payment amount is reduced by 3% before subtracting any applicable third-party liability (TPL) payments.

This reduction does not apply for HAF-participating hospitals.

Hospitals cannot bill IHCP members for the difference between payments and actual charges, except for conditions stated in the *Charging Members for Noncovered Services* section of the [Provider Enrollment](#) module.

Diagnosis-Related Group Reimbursement System

DRGs are the basis for payments to hospitals under a prospective payment system. DRGs group hospital inpatient cases that are clinically similar and relatively homogeneous with respect to resource use. The IHCP used claims data to base the DRG system. The system is a prospective cost-based method that contains no form of year-end settlement.

The DRG reimbursement rates are intended to cover all inpatient hospital costs, including the costs of inpatient routine care and ancillary services, with the exceptions of blood factor and certain other physician-administered drugs (as listed in *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable outside the Inpatient DRG*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers) as well as certain implantable durable medical equipment (as described in the [Surgical Services](#) module). Applicable codes must be billed separately on a professional claim for separate reimbursement.

Additional payments to hospitals are as follows:

- Capital-related costs
- Direct medical education costs, if applicable

The critical components of a DRG inpatient reimbursement system are as follows:

- Classification system, known as the *grouper*
- Calculation of the relative weights
- Calculation of the DRG base rate
- Length of stay
- Outlier payments (which use facility-specific cost-to-charge ratios), capital rates, and medical education rates, if applicable

Grouper

Groupers classify inpatient cases into categories that represent similar resource consumption during treatment. The categories are termed *DRGs*.

Each discharge is assigned to one DRG, regardless of the number of services furnished or the number of days of care provided. DRG assignment is based on the physician's record of the patient's principal diagnosis, any additional diagnoses, procedures performed, patient age, gender, and discharge status. The diagnoses and procedures information is grouped using ICD codes with the highest level of specificity possible. Providers must code to the highest level of specificity possible. Failure to properly specify this data may result in inaccurate payment for a submitted claim or in a suspended claim, which also may delay payment.

Indiana uses the 3M All-Patient Refined Diagnosis-Related Group (APR-DRG), version 30, as the grouper for the inpatient DRG assignment.

Note: The IHCP announced selection of the 3M APR-DRG, version 36, as the new grouper for inpatient DRG assignments, effective for inpatient stays with dates of discharge on or after August 1, 2020.

Relative Weights

Each DRG assigned by the grouper has a corresponding relative weight. Relative weights are numeric values that reflect the relative resource consumption for the DRGs to which they are assigned. Taking the average cost for a DRG and dividing by the average cost of all DRGs creates the weight.

DRG Base Rate

The DRG base rate is the payment rate used to reimburse hospitals for both routine and ancillary costs associated with inpatient care. The DRG base rate is determined by a fixed statewide base rate, which is the rate per IHCP stay multiplied by the relative weight:

$$\text{Statewide Base Rate} \times \text{Relative Weight} = \text{DRG Base Rate}$$

Statewide base rates change periodically, and providers must consider the date of service of claims when calculating payment using the formula. The statewide base rate is determined using hospital cost reports and was inflated using the Global Insight Hospital Market Basket Index. Providers can obtain current base rate information by checking the inpatient rates file on the [Hospital](#) page at mslc.com or contacting Customer Assistance toll-free at 1-800-457-4584.

For information about separate DRG base rates for designated children's hospitals, see the [DRG Base Rate for Children's Hospitals](#) section.

Length of Stay

A period of inpatient care that includes 24 hours or more in the hospital and is reimbursable under the IHCP is considered an *IHCP stay*. The length of the IHCP stay (known as *length of stay*) is one component of the DRG inpatient reimbursement system.

DRG Outlier, Medical Education Costs, and Capital Costs Payment

The state of Indiana defines a *DRG cost outlier case* as an IHCP stay that exceeds a predetermined threshold. The threshold is currently defined as the greater of twice the DRG or \$51,425. Day outliers that exceed a predetermined threshold are not reimbursed under the DRG outlier payment policy.

Under a DRG hybrid reimbursement system, the need for an outlier policy is significantly reduced, because cases that traditionally are classified as outliers – such as burn, psychiatric, and rehabilitative care – are reimbursed under the LOC component. The hybrid system, however, does not completely eliminate the need for appropriate outlier policies and reimbursement rates. Outlier payments are available for all qualifying cases reimbursed under the DRG system.

See the [Outlier Payments](#) section for information about the outlier payment as it pertains to the DRG and LOC methodologies.

The *capital costs payment* is a statewide per diem, and payment is based on the average length of stay for the assigned DRG. See the [Reimbursement for Capital Costs](#) section for information about the capital payment as it pertains to the DRG and LOC methodologies. Long-term acute care (LTAC) providers do not receive separate capital reimbursement.

The *medical education costs payment* is a provider-specific per diem rate based on the average length of stay for the assigned DRG. The medical education costs payment is outlined in the [Reimbursement for Medical Educational Costs](#) section of this document.

The IHCP allowed amount is calculated as follows:

DRG Base Rate + Capital Costs Payment + Medical Education Costs Payment (if applicable) + Outlier Payment (if applicable)

Note: For Hospital Assessment Fee (HAF)-participating hospitals, the IHCP-allowed amount is calculated as follows:

(DRG Base Rate × Inpatient Hospital Adjustment Factor) + Capital Costs Payment + Medical Education Costs Payment (if applicable) + Outlier Payment (if applicable)

The hospital adjustment factor is a multiplier used to increase the reimbursement rate for HAF-participating hospitals. For more information about HAF, see the [Hospital Assessment Fee](#) module.

Inpatient Level-of-Care Reimbursement System

Certain cases are excluded from the DRG rate methodology due to wide variances in length of stay and severity of resource consumption. Under the traditional DRG reimbursement systems, such cases are generally regarded as outliers. A hybrid system, however, incorporates a distinct reimbursement mechanism to accommodate these cases. This reimbursement mechanism is known as an LOC system, and it reimburses hospitals on a per diem basis. Three types of cases are reimbursed under the LOC system:

- Burn cases
- Psychiatric cases
- Rehabilitation cases

Claims are processed through the APR-DRG grouper to be classified into appropriate DRGs. Claims classified into the following DRGs are excluded from the DRG system and reimbursed under the LOC system as follows:

- APR-DRGs excluded for burn cases – 841–844
- APR-DRGs excluded for psychiatric cases – 740, 750–756, 758–760 (DRG 757 excludes ICD-10 diagnosis codes F70–F79)
- APR-DRGs excluded for rehabilitation cases – 860

The LOC reimbursement rates represent all payments, excluding any applicable disproportionate share payments, to a hospital for all inpatient costs, costs of routine inpatient care, and ancillary services (with the exception of blood factor and certain other physician-administered drugs (as listed in *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable outside the Inpatient DRG*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers). Additional payments to hospitals are provided for the following:

- Capital costs
- Burn outlier costs, if applicable
- Medical education costs, if applicable

Reimbursement under the LOC methodology will be made for the lesser of the following:

- Number of days actually used
- Number of days prior authorized by the office

Level-of-Care Payment Rates

LOC rates are established based on hospital costs and days for LOC services. A cost per diem is calculated for each hospital, and the LOC per diem rate is determined by calculating the weighted median per diem, weighted by the number of days. The four LOC payment rate types are as follows:

- Burn/1
- Burn/2
- Psychiatric
- Rehabilitation

Burn cases are divided into two groups, Burn/1 and Burn/2, based on the costs incurred by hospitals to treat burn patients. These rates handle severe burn cases that call for specialized facilities and procedures. The burn treatment rates are determined by Myers and Stauffer LC.

Burn/1 facilities have been identified based on the burn services provided in certified burn care facilities and the cost of those services. These facilities consistently provide more intensive burn care than other Indiana hospitals, and are the only hospitals eligible to bill and receive reimbursement at the Burn/1 rate. The certified Burn/1 facilities are the following:

- Sidney & Lois Eskenazi Hospital (Indianapolis)
- Indiana University Health (Indianapolis)
- University Medical Center (Louisville)
- University of Chicago Medical Center (Chicago)
- Loyola University Medical Center (Chicago area)
- St. Joseph Hospital (Fort Wayne)

All other hospitals are reimbursed at the Burn/2 rate.

Level-of-Care Outlier, Medical Education Costs, and Capital Costs Payment

Under the LOC system, the IHCP makes outlier payments for burn cases that exceed established thresholds. The state of Indiana defines an LOC cost outlier as an IHCP hospital stay with a cost per day that exceeds twice the burn rate.

The total payment is the sum of the LOC per diem rate; capital costs per diem rate; outlier payment, if applicable; and medical education costs per diem rate, if applicable.

The IHCP-allowed amount is calculated as follows:

**LOC Per Diem Rate + Capital Costs Per Diem + Outlier Payment (if applicable) +
Medical Education Costs Per Diem (if applicable)**

See the [Reimbursement for Capital Costs](#), [Reimbursement for Medical Educational Costs](#), and [Outlier Payments](#) sections of this document for more information about capital, educational cost, and outlier payments.

Note: For HAF-participating hospitals, the IHCP allowed amount is calculated as follows:

(LOC Per Diem Rate × Inpatient Hospital Adjustment Factor) + Capital Costs Per Diem + Medical Education Costs Per Diem (if applicable) + Outlier Payment (if applicable)

The inpatient hospital adjustment factor is a multiplier used to increase the reimbursement rate for HAF-participating hospitals. For more information about HAF, see the [Hospital Assessment Fee](#) module.

Reimbursement for Capital Costs

Facilities are reimbursed a flat, statewide per diem rate for capital costs. This payment rate is calculated by using facility documentation and the Global Insight, Inc. Hospital Market Basket Index. The capital payment rate for inpatient care reimbursed under the DRG methodology is the per diem capital rate, multiplied by the average length of stay for all cases within the particular DRG. For cases reimbursed under the LOC system, facilities are reimbursed the per diem capital rate for each covered day of care.

The IHCP does not determine a separate capital per diem rate for freestanding and acute care hospitals with distinct psychiatric units. All inpatient care, regardless of setting, receives the same capital per diem rate.

Reimbursement for Medical Educational Costs

The IHCP reimburses medical education costs on a hospital-specific, per diem basis. Medical education payment rates are based on medical education costs and patient days, adjusted by the number of residents. Medicaid education costs, patient days, and the number of residents are obtained from each facility's cost reports. The number of residents is based on the most recent cost report data.

Medical education payments are reimbursed under the DRG and LOC systems as follows:

- Medical education payments for IHCP stays under the DRG methodology are equal to the medical education per diem rate multiplied by the average length of stay for the DRG.
- IHCP stays under the LOC system are reimbursed using the medical education per diem rate for each covered day of care.

Qualification for Medical Education Payments

Payment for medical education is provided only to hospitals that operate medical education programs. Hospitals receiving a medical education rate must continue to submit current *CMS2552* cost reports.

Hospitals that discontinue or downsize the medical education programs must promptly notify the FSSA at the following address:

**MS07
Hospital Reimbursement Section
Indiana Office of Medicaid Policy and Planning
402 W. Washington Street, Room W374
Indianapolis, IN 46204**

Medical Education Reimbursement for Managed Care Claims

For managed care claims, all medical education payment calculations are made after the MCE submits the claim payment information to DXC and the encounter claim is posted to the Core Medicaid Management Information System (*CoreMMIS*). Based on encounter claim data received from the MCEs, DXC processes and issues medical education payments to the hospitals. Providers should allow 30–45 calendar days from the time the MCE has processed the claim for the medical education payment to be posted to the fee-for-service Remittance Advice (RA) from DXC. Providers can identify these payments by reviewing the *Medical Education Cost Expenditures* section of their RA.

Outlier Payments

Outlier payments are available for all qualifying cases reimbursed under the DRG system. Under the LOC system, the IHCP makes outlier payments for burn cases that exceed established thresholds (an IHCP hospital stay with a cost per day that exceeds twice the burn rate).

To determine the outlier payment amounts, costs per IHCP stay are calculated by multiplying a hospital-specific cost-to-charge ratio by allowed charges. The payment is a percentage of the difference between the prospective cost per stay (for DRG) or day (for LOC) and the established outlier threshold. The percentage, or marginal cost factor, has been determined at 60%.

Hospitals are notified individually of the specific cost-to-charge ratios that must be used to determine outlier payments for DRGs and the LOC system (burn only). Cost-to-charge ratios are calculated only during rebasing and recalibration periods. Each hospital that submits an Indiana Medicaid cost report will receive a cost-to-charge ratio. New hospitals and hospitals with fewer than 30 Medicaid claims annually are assigned the statewide average cost-to-charge ratio.

Hoosier Healthwise Package C Exceptions to DRG and LOC Reimbursement Systems

The following are exceptions to the DRG and LOC reimbursement systems for Hoosier Healthwise Package C members:

- Organ transplants are not covered for Hoosier Healthwise Package C members. Inpatient claims submitted to the IHCP that group to nonexperimental organ transplant DRGs are denied. APR-DRGs for nonexperimental organ transplants are 001, 002, 003, 006, and 440.

- Inpatient care rendered in an institution for mental diseases (IMD) having more than 16 beds is not covered for Hoosier Healthwise Package C members. This restriction does not apply to acute care hospitals that are not IMDs. The following providers systematically bypass this edit:
 - Four County Counseling Center
 - Grant-Blackford Mental Health – Grant County
 - Hamilton Center
 - Oaklawn Psychiatric Center – Elkhart County
 - Otis R. Bowen Center – Kosciusko County
 - Park Center – Allen County
 - Southlake Center for Mental Health – Lake County
 - Wabash Valley Hospital

DRG Base Rate for Children’s Hospitals

405 IAC 1-10.5-3 allows the Family and Social Services Administration (FSSA) to establish separate base rates for certain children’s hospitals to the extent necessary to reflect significant differences in cost. By definition, a children’s hospital is a freestanding, general, acute care hospital licensed under *Indiana Code IC 16-21* that meets the following criteria:

- Designated by the Medicare program as a children’s hospital
- Furnishes services to inpatients who are predominately members younger than 18 years old, as determined using the same criteria used by the Medicare program to determine whether a hospital’s services are furnished to inpatients who are predominately younger than 18 years old

Children’s hospitals incur significantly higher IHCP costs than other hospitals, even after accounting for differences in the case mix of patients. Each children’s hospital will be evaluated individually for eligibility for the separate base amount. Children’s hospitals with a case mix adjusted cost per discharge greater than one standard deviation above the mean cost per discharge for DRG services will be eligible to receive the increased DRG base rate. At this time, the IHCP-enrolled children’s hospitals are the following:

- Ann & Robert H. Lurie Children’s Hospital of Chicago
- Children’s Hospital Medical Center (Cincinnati)
- Riley Hospital for Children
- The University of Chicago Medicine Comer Children’s Hospital

Based on the review of costs for facilities meeting this definition, the DRG base rate for children’s hospitals is 120% of the standard DRG base rate. The DRG base rate for HAF-participating children’s hospitals is 120% of the standard DRG base rate multiplied by the inpatient hospital adjustment factor.

Change in Coverage during Inpatient Stay

In some cases, a member’s coverage can change during an inpatient stay from one plan to another; for example, from fee-for-service coverage to a managed care plan, or from one MCE to another MCE. The reimbursement in such cases depends on whether the reimbursement for the stay is based on a DRG or LOC methodology. If the reimbursement is based on a DRG methodology, the plan that was in effect on the day of admission is responsible for the entire stay. If the reimbursement is based on an LOC methodology, each plan is responsible for the days of the stay covered by that plan.

For members who become eligible for Medicare coverage during an inpatient stay, providers must bill Medicare first.

Inpatient Coverage for Presumptively Eligible Members

A member's presumptive eligibility coverage period begins on the date that his or her application for presumptive eligibility is submitted and the approval determination is made. For presumptive eligibility benefit packages that include inpatient hospital coverage:

- If a hospital admission date is before the presumptive eligibility start date, and the inpatient service is reimbursed using the DRG methodology, no portion of that member's inpatient stay will be considered a covered service.
- If a hospital admission date is before the presumptive eligibility start date and the inpatient service is reimbursed on an LOC per diem basis, dates of service on or after the member's presumptive eligibility start date will be covered; dates of service before the member's presumptive eligibility start date are not covered.

See the [Member Eligibility and Benefit Coverage](#) and the [Presumptive Eligibility](#) modules for more information about the presumptive eligibility process.

Inpatient Coverage for Inmates

The IHCP covers inpatient services for IHCP-eligible inmates admitted as inpatients to an acute care hospital, nursing facility, or intermediate care facility. Reimbursement is available only to facilities that are not primarily operated by law enforcement authorities. Facilities primarily operated by law enforcement authorities would be considered correctional facilities.

Eligibility for IHCP coverage requires the inmate to meet standard eligibility criteria, as determined by the Indiana FSSA Division of Family Resources (DFR). When an inmate is admitted to the inpatient facility, the correctional facility medical provider will assist the inmate in completing the *Indiana Application for Health Coverage*. Prior authorization is not required for an inmate's inpatient admission.

Eligible inmates receive IHCP coverage under the Medicaid Inpatient Hospital Services Only benefit plan. See the [Member Eligibility and Benefit Coverage](#) module for more information about services covered under this benefit plan. For billing information specific to this benefit plan, see the [Claim Submission and Processing](#) module.

Hospital-Acquired Conditions Policy

The IHCP does not pay the complicating condition (CC) or major complicating condition (MCC) for hospital-acquired conditions (HACs). The current list of HAC conditions is available from the [Hospital-Acquired Conditions](#) page at cms.gov.

Hospitals are required to report whether each diagnosis on a Medicaid inpatient claim was present on admission (POA), with the exception only of diagnosis codes specifically designated as exempt from POA/HAC reporting. Claims submitted without the required POA indicators for nonexempt codes are denied. (See the [Present on Admissions Indicators](#) section for more information.) The POA field should not be left blank for any codes on the HAC list. The IHCP follows determinations made by the CMS for additions and changes to the current list of HAC conditions, as well as changes to diagnosis codes exempted from POA reporting.

Table 2 shows how POA indicators affect DRG grouping for nonexempt HAC diagnosis codes.

Table 2 – Effect of POA Indicators on DRG Grouping for Nonexempt HAC Diagnosis Codes

POA Indicator	Description	Effect on DRG Grouping
Y (Yes)	Diagnosis was present at the time of inpatient admission.	Diagnosis is used for DRG grouping.
N (No)	Diagnosis was not present at the time of inpatient admission.	Diagnosis is suppressed from DRG grouping
U (Unknown)	The documentation is insufficient to determine if the condition was present at the time of inpatient admission.	Diagnosis is suppressed from DRG grouping
W (Not Applicable)	The provider is unable to clinically determine whether the condition was present at the time of inpatient admission	Diagnosis is used for DRG grouping.

For claims containing secondary diagnoses that are included in the list of HACs and for which the condition was not POA, the HAC secondary diagnosis will not be used for DRG grouping. The claim will be paid as though any secondary diagnoses included in the HAC list were not present on the claim.

The IHCP does not require a POA indicator in the external cause of injury (ECI or E Code) field. If a POA indicator is entered in the External Cause of Injury field, it is ignored and not used for DRG grouping.

An exemption for HAC/POA is deep vein thrombosis (DVT) and pulmonary embolism (PE) diagnoses following a total knee replacement or hip replacement for pediatric or obstetric patients. When all these conditions are present on the claim, the HAC/POA requirement is bypassed and *none* of the diagnosis codes included on the claim is suppressed. For applicable diagnosis codes, see *Inpatient Hospital Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Note: A pediatric patient is a patient younger than age 21.

An obstetric patient is a patient with an ICD-10 diagnosis code of O00.0–O9A or Z32.01 or Z34–Z37.9.

The IHCP does not cover surgical or other invasive procedures to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously. The IHCP also does not cover hospitalizations or other services related to these noncovered procedures. All services provided in the operating room when an error occurs, and all related services provided during the same hospitalization in which the error occurred, are not covered. See the *Provider Preventable Conditions* section in the [Surgical Services](#) module for more information.

Reimbursement for Promoting Interoperability Program

The Indiana Medicaid Promoting Interoperability Program provides incentives to eligible hospitals for adopting, implementing, upgrading, or demonstrating meaningful use of certified electronic health records (EHR) technology. To participate, eligible hospitals and critical access hospitals must have registered for the program with both the CMS and the IHCP no later than Program Year 2016.

Note: The Indiana Medicaid Promoting Interoperability Program is no longer accepting new registrations. Incentive payments for currently participating providers will continue through 2021. No incentive payments will be made after December 31, 2021.

Reimbursement for this program is made through the Medical Assistance Provider Incentive Repository (MAPIR) payment system, accessible via the IHCP Portal.

See the [Indiana Medicaid Promoting Interoperability Program](https://in.gov/medicaid/providers) page at in.gov/medicaid/providers for details about the Promoting Interoperability Program and MAPIR payment system.

Long-Term Acute Care Hospital Services

An IHCP long-term acute care (LTAC) hospital is a freestanding, general acute care hospital licensed under *IC 16-21*, meeting at least one of the following criteria:

- Is designated by the Medicare program as a long-term care hospital
- Has an average inpatient length of stay greater than 25 days, based on the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than 25 days

Prior authorization is required for all LTAC admissions.

Admission Criteria

Before admission to an LTAC hospital, assessment of the patient's current medical status and discharge goals must be provided to the appropriate PA vendor for PA purposes. This information should also be documented in the medical record. Each PA request is reviewed for medical necessity on an individual, case-by-case basis.

The patient must be admitted directly from an acute care facility or be readmitted from a nursing facility or rehabilitation facility. No PA will be approved for requests for initial admission directly from a nursing facility, a physician's office, or home.

The following documentation must be included with requests for admission to a LTAC hospital and must be available for review by the PA department or Surveillance and Utilization Review (SUR) department, as applicable:

- A signed statement from the referring physician indicating medical necessity for transfer to an LTAC hospital.
- The following information must accompany a request for approval and an evaluation by the requesting facility:
 - Diagnosis and premorbid conditions (If the patient is currently in an acute care hospital, the diagnosis at discharge should be included if it has changed from the time of admission.)
 - Information about where the patient is being admitted from, if not hospitalized
 - Neurological assessment
 - Complete listing of long- and short-term goals
 - Discharge plan with two options, depending on the member's condition
 - Potential date of admission
 - Projected date of discharge
 - History of any previous rehabilitation therapies
 - Prognosis and documentation that there is a reasonable expectation the member's functional and medical status will improve
 - History, physical, and discharge or case summary, if the member is currently hospitalized
 - Completed *IHCP Prior Authorization Request Form*, accessible from the [Forms](#) page at in.gov/medicaid/providers

All the following situations apply to the patient's status and current requirements before admission to the LTAC hospital:

- The patient is medically stable.
- The initial diagnostic workup is completed.
- There are no major surgical procedures planned.
- The patient has a prognosis requiring a prolonged stay in an acute setting, and there is a reasonable expectation for improvement in the status of his or her medical condition.
- The patient requires interactive physician direction with daily on-site assessment.
- The patient requires significant ancillary services dictated by complex, acute medical needs. Examples include but are not limited to full service and STAT laboratory, radiology, and respiratory care services.
- There is a patient-centered, outcome-focused, interdisciplinary approach requiring a physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care.
- Education for the patient and family must be provided to manage the patient's present and future healthcare needs.

During the PA process, the medical director may help determine whether the admission is medically necessary. Admissions requested for categories not specified in the following sections will be reviewed for medical necessity and intensity of service on a case-by-case basis.

Respiratory

The patient must meet two or more of the following requirements for admission and continued stay:

- Requires ventilator assistance and has failed attempts to be extubated or maintain adequate ventilation, oxygenation, or functional level after extubation
- Requires one or more of the following IV medications daily:
 - Antibiotics
 - Anticoagulation medications
 - Antifungal agents
 - Antiprotozoal agents
 - Antiviral agents
 - Anti-tuberculosis agents
 - Bronchodilators
 - Chemotherapy
 - Corticosteroids
 - Diuretics
- Requires frequent monitoring of tissue oxygenation (for example, pulse oximetry), frequent respiratory therapy treatments, or suctioning or inhalation medications

Impaired Skin Integrity

Impaired skin integrity means the patient has stage three or stage four decubitus wounds, infected necrotic skin conditions, surgical wounds, or burns. The patient must meet each of the following requirements for admission or continued stay:

- The patient has non-healing wounds that have failed to improve while receiving home care, skilled nursing facility (SNF), or acute hospital care.
- The patient requires complex dressing changes using daily whirlpool, debridement, frequent intramuscular or IV analgesics or antifungals, frequent positioning, or hyperbaric treatments.
- The patient requires more than one of the following IV medications at least daily:
 - Antibiotics
 - Antifungal agent
 - Antiviral agent
 - IV electrolytes
 - IV plasma expanders
 - Total parenteral nutrition

Cardiac

Cardiac care is required if the member is unable to maintain adequate circulation related to mechanical or electrical dysfunction of the cardiovascular system. The patient must meet each of the following requirements for admission or continued stay:

- The patient requires frequent monitoring of tissue oxygenation (for example, pulse oximetry) and continuous telemetry.
- The patient requires management of hemodynamic instability, cardioversion or Valsalva maneuver, temporary pacemaker, or monitoring of a functional permanent pacemaker, monitoring for drug toxicity, defibrillation, pulmonary artery catheterization and arterial monitoring, and monitoring of electrolyte imbalance.
- The patient requires two or more of the following medications intravenously to maintain cardiovascular integrity:
 - Alpha/beta-adrenoreceptor blocking agents
 - Anti-anginal agents
 - Anti-arrhythmics
 - Antibiotics
 - Anticoagulants
 - Antihypertensives
 - Beta blockers
 - Calcium channel blockers
 - Cardiac glycosides
 - Corticosteroids
 - Diuretics
 - Inotropic agents
 - Mucarinic receptor antagonists
 - Sodium channel blockers
 - Thrombolytic enzymes
 - Tissue plasminogen activators
 - Vasodilators
 - Vasopressors

Continued Stay Criteria

All the following are required to be documented for review of a continued stay in the LTAC hospital:

- Multidisciplinary team evaluation at least weekly
- Evidence of participation in a rehabilitation-therapy program
- Continued daily on-site direction of a qualified physician
- Continued skilled nursing care or supervision required
- Continued need for acute LOC, as evidenced by continuing to meet the admission criteria category requirements

Documentation Requirements for Continued Stay

Concurrent review for approval of additional days must be received by the PA department at least 48 hours before the last approved day, including:

- Completed *IHCP Prior Authorization Request Form*
- A summary of the current discharge plans
- Documentation of family or friend participation in the discharge planning process
- A neurological assessment update, if appropriate
- Documentation of the member's cooperation, participation, or progress

Discharge Criteria

Continued length of stay will not be authorized without the medical director's review when any of the following conditions occur:

- There is evidence in the patient record that the patient has achieved stated goals.
- Medical complications require readmission to an inpatient acute facility.
- Multidisciplinary services are no longer needed.
- No additional improvement is anticipated.
- Patient's progress toward goals has remained unchanged for 7 days.

LTAC Billing

LTAC facilities must submit charges on the institutional claim type (*UB-04* claim form or electronic equivalent). The billing provider must use revenue code 101 – *All-inclusive room and board* for the PA process and include that revenue code on the claim.

The discharging hospital must enter 63 as the patient status code (field 17 on the *UB-04* claim form). This code indicates the status of the patient as of the ending service date when the patient was discharged or transferred to a long-term care facility.

LTAC Reimbursement

Facilities meeting the definition of an LTAC hospital are paid a daily rate, or *per diem*, for each day of care provided. The per diem is all-inclusive. No other payments are permitted in addition to the LTAC per diem. Qualifying providers must be enrolled in the IHCP as an LTAC hospital (provider type 01, specialty 013) to receive the LTAC LOC per diem.

New LTAC hospitals receive the statewide median rate until sufficient claims are available to calculate a facility-specific rate. It is the provider's responsibility to request a facility-specific rate after sufficient discharges are submitted. When calculated, the facility-specific rate is retroactively effective on the date of the provider's request for a revised rate, unless sufficient discharges are still not available at the time of the request. In this case, a rate becomes effective on the date the provider reaches the rate-setting claims volume threshold.

Claims for as few as three discharges may be used to establish a per diem rate if the standard deviation of the rate is \$200 or less. Otherwise, a higher discharge threshold of eight or more discharges must be used. If a provider has an existing rate but does not meet the claims threshold or the standard deviation exception, the provider's current per diem rate applies the following year.

The rates for existing LTAC hospital providers are reviewed no more often than every second year and adjusted as necessary.

Inpatient Blood Factor Claims

The IHCP reimburses providers for claims for blood factor products administered during inpatient hospital stays at the lowest of the following:

- Estimated acquisition cost (84% of the average wholesale price)
- Inpatient blood factor – State maximum allowable cost (MAC)
- Submitted charge

Blood factor that is used during inpatient hospital stays should be billed separately from the inpatient hospital DRG or LOC claim. For applicable codes, see *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable outside the Inpatient DRG*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Hospitals are prohibited from submitting any charges for blood factor administered during inpatient hospital stays on their institutional claims. Instead, hospitals should submit their claims for blood factor used during inpatient hospital stays on the professional claim type (*CMS-1500* claim form or electronic equivalent) and should include both the NDC and the NDC quantity of the blood factor on the claims.

*Note: Paper claims with NDC quantities **greater** than 9,999.99 units must be special batched because the NDC code will be the same for each detail and will deny for duplicates. These claims must be sent to the following address for special handling:*

**DXC Provider Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263**

Hospitals should use their facility NPIs on their professional claims. The place of service (POS) code must be 21 – *Inpatient Hospital* for blood factor administered during an inpatient hospital stay.

When billing blood factor products for dually eligible members, if Medicare *covers* the blood factor product, the provider cannot bill it separately. If Medicare *does not cover* the blood factor product, the provider needs to attach documentation, such as an Explanation of Medicare Benefits (EOMB), to the claim to show where the factor charges are denied or not covered under Medicare.

Medicare Exhaust Claims and Inpatient Services

For dually eligible members, see the following sections for information about billing the IHCP when Medicare benefits are exhausted prior to or during an inpatient stay.

Benefits Exhausted Prior to Inpatient Admission

The IHCP reimburses acute care hospitals for dually eligible (Medicare and Medicaid) IHCP members who exhaust their inpatient hospital Medicare Part A benefits prior to admission to acute care hospitals.

When a Medicare Part A stay is exhausted by Medicare prior to admission, providers must bill the date of admission through the date of discharge on the institutional claim (*UB-04* claim form or electronic equivalent). **Do not bill the IHCP for partial inpatient stays.** The EOMB must be submitted with the claim to show that benefits were exhausted prior to the date of admission.

Providers must bill services payable to Medicare Part B before billing the exhaust claim to Medicaid. Because these claims are considered Medicaid primary claims, all IHCP filing limit and PA rules apply. See the [Claim Submission and Processing](#) module for information about waiving filing limit procedures and supplying appropriate documentation for claim adjudication.

When billing the IHCP for Medicare exhaust stays, enter the word “Exhaust” in place of the primary payer name (in field 50A of the *UB-04* claim form). Do not include the word “Medicare,” as doing so will cause the claim to process incorrectly. Also, do not enter any crossover information in the value code/amount fields (fields 39–41 on the *UB-04* claim form). Only Medicare crossover claims are billed with the A1 and A2 value code indicating the deductibles and coinsurance or copayment. Medicare exhaust claims are not considered crossover claims.

Benefits Exhausted During an Inpatient Stay

When a dually eligible member exhausts Medicare Part A benefits during an inpatient stay, the claim automatically crosses over from Medicare and adjudicates according to the IHCP inpatient crossover reimbursement methodology. After the coinsurance and deductible amounts are considered, no additional payment is made on the claim. This rule is also true for claims that do not automatically cross over but are submitted via the paper claim form or the Portal.

The IHCP will continue to reimburse Medicare Part B charges as long as the revenue codes billed on the Medicare Part A and B claims are not the same. If the same revenue codes appear on both claims, the claim will deny for duplicate billing.

Observation Billing

Providers can retain members for more than one 23-hour observation period when the member has not met criteria for admission but the treating physician believes that allowing the member to leave the facility would likely put the member at serious risk. This observation period can last *not more than 3 days or 72 hours and is billed as an outpatient claim*. See the [Outpatient Facility Services](#) module for details.

For general information about observation services, see the *Hospital Observation or Inpatient Care Services* section of the [Evaluation and Management Services](#) module.

Transfers

For dates of service on or after July 1, 2019, in the event of a transfer during an inpatient stay, both the *transferring hospital* and the *receiving (transferee) hospital* are reimbursed at a DRG-prorated daily rate, not to exceed the full DRG amount. The IHCP calculates the DRG daily rate by dividing the DRG base rate by the average length of stay (LOS).

It is important for providers to indicate the appropriate **patient status discharge code** to identify the *transferring hospital* on the institutional claim. To ensure accurate reimbursement, the applicable patient status discharge code in the appropriate field of the institutional claim:

- Patient Status field on the Portal institutional claim
- Field 17 of the *UB-04* claim form
- Loop 2300 CL102 on the 837I electronic transaction

Receiving hospitals are instructed to use **admission source code 4** in the appropriate field of the institutional claim:

- Admission Source Code field on the Portal institutional claim
- Field 15 on the *UB-04* claim form
- Loop 2300 CL102 on the 837I electronic transaction

The admission source code 4 is required only for the receiving hospital; however, if an invalid source code is submitted, providers will receive a claim denial with the following:

- Remark Code MA42 – *Admission Source Code is invalid*
- Explanation of benefits (EOB) 0029 – *Admission Source Code is invalid*

See instructions for completing the institutional claim in the [Claim Submission and Processing](#) module.

Providers are not to bill separately for two DRG-reimbursed inpatient stays when a member is transferred from one unit of the hospital to another unit within the same inpatient facility. Inpatient transfer claims from one inpatient unit of the hospital to another inpatient unit should be billed on one claim (a single paper or electronic claim submission), as they are considered part of the same episode of care. Exclusions to this policy are claims priced according to the LOC reimbursement methodology.

Note: In accordance with 405 IAC 5-17-1, all transfers are subject to retrospective review to ensure appropriate billing and payment.

Claims for patients that are transferred within 24 hours of admission are to be billed as outpatient claims. DRGs that include neonate transfer cases only are no longer exempt from the transfer reimbursement policies. For dates of service prior to July 1, 2019, APR-DRG 581 – *Neonate, transferred less than 5 days old, born here* and APR-DRG 580 – *Neonate, transferred less than 5 days old, not born here* were exempt from the transfer policy and were paid the full DRG rate. For dates of service on or after July 1, 2019, these DRGs will no longer be exempt and will be reimbursed at the daily DRG rate.

Providers do not receive separate DRG payments for IHCP patients that return from a *receiving (transferee) hospital*. Specifically, this policy applies when a patient returns to a hospital from which he or she was previously transferred out for the same illness. Providers must combine the original admission and subsequent return stay on one claim for billing purposes.

Readmissions

Readmission is the term used when a patient is admitted into the hospital or other inpatient facility following a previous admission and discharge **for the same or a related diagnosis**.

For payment purposes, readmissions within 3 days after discharge are treated as the *same admission*. Providers should bill one inpatient claim (that is, the stays should be consolidated into a single claim) when a patient is readmitted to their facility within 3 days of a previous inpatient discharge for the same or related diagnosis.

Note: “Same or related diagnosis” refers to the principal diagnosis code and is based on the first three digits of the ICD code. If a second inpatient claim is billed for the same member with the same or related principal diagnosis code within 3 days of a previous inpatient discharge, the second claim will be denied.

Readmissions more than 3 days after a previous hospital discharge are treated as separate stays for payment purposes, but are subject to medical review to determine if the previous discharge was premature. If it is determined that the discharge was premature, payment made as a result of the discharge or readmission may be subject to recoupment.

Inpatient Stays Less Than 24 Hours

Providers should bill inpatient stays that are less than 24 hours as an outpatient service.

Inpatient stays less than 24 hours that are billed as an inpatient service will be denied. For exceptions to this rule, see the following sections.

Note: Crossover claims must be submitted to Medicare first. Medicare claim information and claim documentation is then special batched to the IHCP.

Expiration within 1 Day of Birth

Providers can submit an inpatient claim for neonates that expire within 1 day of birth. These claims are assigned a neonatal APR-DRG grouper within the range of 580 through 640. Claims should indicate a patient status code of 20 – *Expired (died)*, and the member’s date of birth should be entered as the admit date. Claims meeting these criteria will be reimbursed appropriately through the DRG inpatient pricing methodology.

Inpatient-Only Codes

Inpatient claims with stays less than 24 hours that do not meet the neonatal DRG exception criteria will deny with EOB 0501 – *The discharge date is within 24 hours of the admit date/time* and will be required to be billed as outpatient claims. However, the IHCP will bypass this 24-hour rule to allow certain of the procedure codes designated by Medicare as “inpatient-only” to be reimbursed as inpatient services when the service is delivered in an inpatient setting to a patient discharged or expired within 24 hours of admission. For a list of the HCPCS and CPT codes to which this exception applies, see the *Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays of Less Than 24 Hours* table in *Inpatient Hospital Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. Only the affected codes are listed; these codes are not reimbursable when delivered in an outpatient setting.

*Note: The IHCP reminds providers that IHCP follows Medicare policy with respect to inpatient-only procedure codes. Accordingly, the codes on the Medicare Inpatient Only (IPO) list published by the CMS are covered by the IHCP in the inpatient setting only. The **Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays of Less Than 24 Hours** code table is not meant to be a full listing of inpatient-only codes recognized by IHCP. Rather, this code table is a subset of procedure codes from the Medicare IPO list that IHCP has determined to be billable as an inpatient procedure, even when the member is in the hospital for less than 24 hours.*

Interim Billing Instructions

The following billing instructions have been established as an interim solution until a permanent solution is developed in the CoreMMIS claim-processing system:

1. Claims for affected codes rendered in an inpatient setting to a patient discharged or expired within 24 hours of admission must first be submitted as an outpatient claim using the standard claim submission process.
2. When providers receive a claim denial for EOB 4183 – *Units of service on the claim exceed the medically unlikely edit (MUE) allowed per date of service* for these codes, they may submit a request for administrative review.
3. Requests for administrative review must be made using the secure correspondence feature on the Portal or the *IHCP Administrative Review Request* form, available on the [Forms](#) page at in.gov/medicaid/providers.
 - The administrative review request must include a new inpatient claim form for the services rendered, a copy of the original outpatient claim, the Remittance Advice (RA) page identifying the original claim denial, and documentation that the service was performed in the inpatient setting.
 - The administrative review request and documentation must be submitted within 60 days of the date of the claim denial.
 - The administrative review request and documentation may be submitted via the Portal as a secure correspondence message using the Administrative Review category, or the *IHCP Administrative Review Request* form and documentation should be mailed to the following address:

**Administrative Review Requests
DXC Provider Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263**

Note: Providers that follow this rule and bill for outpatient services when a patient has been admitted as an inpatient will not be viewed as being noncompliant with program policies concerning internal records and billing requirements. The FSSA will not take action against a provider for adhering to the agency's billing requirements for inpatient stays of less than 24 hours, because this policy is in compliance with the Indiana regulation and billing requirements.

Providers do not need to amend their medical recordkeeping to comply with these changes. Medical records that originally indicated an inpatient stay of less than 24 hours should not be amended.

Outpatient Service within 3 Days of an Inpatient Stay

Outpatient services that occur within 3 days preceding an inpatient admission to the same facility for the same or related diagnosis are considered part of the corresponding inpatient admission. Providers are required to submit an *inpatient claim only* in these situations. The *covered dates* for the claim should reflect the *from* and *through* dates of the inpatient stay, not the date the outpatient services were rendered.

If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will be denied with EOB 6516 – *Outpatient services performed three days prior to inpatient admission*. To resolve this denial, providers should void the outpatient claim in history, incorporate the outpatient services into the inpatient claim, and resubmit the corrected inpatient claim.

If an outpatient claim is submitted after the inpatient claim has been paid, the outpatient claim will be denied with an EOB indicating that the inpatient claim may be adjusted to reflect the outpatient services provided to the patient.

This policy is not applicable when the outpatient and inpatient services are provided by different facilities. Additionally, this policy is not applicable when the inpatient stay is less than 24 hours. Outpatient services provided within 3 days preceding a *less-than-24-hour* inpatient stay are billed as an outpatient service.

See the [Outpatient Facility Services](#) module for information about billing outpatient services.

Coding Claims for Newborns

Coding claims for newborns requires birth weight for the proper DRG assignment. When a newborn is transferred to another hospital for observation, not for treatment for a specific illness, the receiving provider must enter the ICD-10 diagnosis code Z03.89 – *Encounter for observation for other suspected diseases and conditions ruled out* as the principal diagnosis.

Unit and Age Limitations on Inpatient Neonatal and Pediatric Critical Care Services

Inpatient neonatal and pediatric critical care services are limited to one unit of service per day and are restricted by age as appropriate.

Providers rendering services under a managed care program should also follow IHCP policy and CPT coding guidelines when billing for these services.

For information about pediatric and neonatal critical care during interfacility transportation, see the [Transportation Services](#) module.

Newborn Screening

By law, newborn blood, pulse oximetry, and hearing screenings are conducted on all infants born in Indiana before they are discharged from the hospital. Babies born at home must have newborn screening within 1 week of birth. *IC 16-41-17-2(d)* identifies religious belief exceptions from the newborn screening requirement. See the [Newborn Screening](#) page at in.gov/isdh for general information about the newborn screening program.

The IHCP does not permit hospitals to bill separately for newborn screening. The IHCP pays the newborn hospitalization under the DRG that includes the newborn screening. The IHCP does not require Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch providers to report newborn screening on the professional claim (*CMS-1500* claim form or electronic equivalent).

Newborn Heelstick Screening – Dried Blood Spot Sample

Indiana law requires newborn blood screening tests for every infant before discharge from the hospital. Blood is taken from the infant using the heelstick method, and collected onto the newborn screening card, referred to as the dried blood spot (DBS) sample. The DBS sample card must contain information to identify the infant, the physician, the time of birth, the time of first feeding, and the time of the blood draw. The hospital sends the blood sample to the Indiana University (IU) Newborn Screening Laboratory.

The IU laboratory has a contract with the Indiana State Department of Health (ISDH) to perform laboratory analysis for newborn screening. Providers using laboratories other than the IU laboratory to perform newborn screening analysis must discontinue the practice. To ensure that the IU laboratory performs all newborn screening, the ISDH must coordinate all newborn screening:

- Primary care providers can access newborn screening results online through the Indiana Newborn Screening Tracking & Education Program (INSTEP). For more information, see the [Indiana Newborn Screening Tracking & Education Program \(INSTEP\)](#) page at in.gov/isdh.
- Other healthcare professionals who are not primary care providers can obtain newborn screening results by contacting the IU Newborn Screening Laboratory. A fax must be sent on office letterhead with the patient's name, date of birth, patient's mother's name, and birthing facility to (317) 491-6679. Healthcare professionals with questions may call 1-800-245-9137.
- Parents or other individuals requesting newborn screening results can contact the ISDH Genomics and Newborn Screening Program by calling 1-888-815-0006.

If the IU laboratory has obtained a valid test and the results are normal, the IHCP requires no further testing. If the laboratory needs to rescreen due to invalid or abnormal results, the provider must contact the ISDH to work out the best method of accomplishing the rescreening. Because hospitals are more frequently releasing newborns before the 48 hours needed to obtain valid newborn screen results, an increasing number of newborns require a second screen. Providers ask families to bring the newborn back to the birth hospital as an outpatient, or the hospital requests a nurse make a follow-up visit to obtain the sample for newborn screening. In either case, the possibility arises that the hospital could bill separately for newborn screening that is already included in the DRG that the IHCP pays for the newborn hospitalization.

Newborns should be screened at the birth hospital or the hospital of closest proximity. To avoid being charged by the IU laboratory for a second screen, a hospital screening a newborn who was born in another Indiana hospital must indicate the name of the birth hospital on the DBS sample card. If the newborn's name or birth date has been changed, the hospital must include the original name and date of birth in the information sent to the IU laboratory to facilitate a match and avoid a charge by the lab.

Newborn Screening for Critical Congenital Heart Disease – Pulse Oximetry

All babies born in Indiana receive a screening for critical congenital heart disease (CCHD) using pulse oximetry technology, which measures the blood oxygen level using a light-beam probe.

Newborn Hearing Screening – Early Hearing Detection and Intervention

Indiana legislation mandates that every infant must be given a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments. The IHCP includes the cost of this screening in the IHCP DRG reimbursement rate that includes the newborn's hospitalization. The IHCP does not allow hospitals to bill separately for initial newborn screening. Newborns must be screened at the birth hospital before the infant is discharged. Newborns requiring further evaluation should be referred to First Steps. See the [First Steps](#) page at in.gov/fssa for contact information. For more information about billing for newborn hearing screening, see the [Early and Periodic Screening, Diagnostic, and Treatment \(EPSDT\)/HealthWatch Services](#) module.