Chapter 7:

Inpatient & Outpatient Hospital Care

Review/Revised: 01/18, 01/19, 01/20, 06/20, 01/21, 01/22, 2/23, 2/24, 5/25, 11/25

7.0 ACUTE INPATIENT ADMISSIONS

All elective and emergent admissions require prior authorization and/or notification.

Admission notification must be faxed to the Inpatient Admissions line at (480) 760-4732 on the day of admission. Upon receipt of the information, we will review clinical documentation and render a decision to the hospital or skilled nursing facility based on medical necessity.

Continued stay reviews are conducted by Utilization Review staff and communicated to the hospital case management staff. Utilization Review staff also assist in coordinating services identified for discharge planning.

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

Members are covered 90 days for an inpatient stay with 60 lifetime reserve days per benefit period.

7.1 INPATIENT HOSPITAL COVERED SERVICES

Covered services include, but are not limited to:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical therapy, occupational therapy, and speech therapy
- Inpatient substance abuse services
- Blood - including storage and administration
- Physician Services

- Under certain conditions, the following types of transplants are covered:
- Corneal, kidney, pancreas, heart, liver, lung, bone marrow, intestinal/multivisceral. See Chapter 11 for more information about transplants.

7.2 INPATIENT SERVICES – WHEN HOSPITAL OR SNF DAYS ARE NOT COVERED OR LIMITS ARE EXHAUSTED

When the hospital or SNF days are no longer covered (limits are exhausted), physician services and other medical services will still be covered.

These services are:

- Physician services
- Tests (like X-ray or lab tests)
- X-ray, radium, and isotope therapy including technician materials and service
- Surgical dressings, splints, casts, and other devices used to reduce fractures and dislocations
- Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Physical therapy, speech therapy, and occupational therapy

7.3 HOSPITALIST

Hospitalists are required to manage inpatient care on behalf of PCPs whose Health Choice Pathway members are in the hospital. The hospitalist must keep the primary provider informed about the member's progress and will return the member's care to the primary provider when the member is discharged from the hospital.

7.4 SKILLED NURSING FACILITY CARE (SNF)

Providers must notify us if members require skilled nursing facility care. The term "skilled nursing facility" does not include facilities that mainly provide custodial care, such as convalescent nursing homes or rest homes.

By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

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

- Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include Physical therapy, speech therapy, and occupational therapy. No prior hospital stay is required for Skilled Nursing Facility Care.

7.5 AUTHORIZATION FOR SNF SERVICES

Members may not be admitted to any skilled nursing facility without prior authorization. Our Utilization Review nurse managing member care at the acute facility will review for medical necessity and provide admission and continued stay determinations. To be covered, members must need daily skilled nursing or skilled rehabilitation care, or both. If the member does not need daily skilled care, other arrangements for care would need to be made. The UR nurse will assist with transition to the right level of care.

Enrollees are covered for 100 days each benefit period. As a dual eligible member, the enrollee also qualifies for Medicaid (AHCCCS) benefits. If this remains true, then Medicaid will cover the enrollee copay and deductible. These will be billed to their AHCCCS plan which may be Health Choice or another AHCCCS plan.

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

The benefit period ends when the member has not received hospital or skilled nursing care for 60 days in a row. If the member is admitted to the SNF after one benefit period has ended, a new benefit period begins.

There is no limit to the number of benefit periods members can have in a lifetime.

7.6 SKILLED NURSING FACILITY COVERED SERVICES

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

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

7.7 CUSTODIAL CARE STAYS ONLY ARE NOT COVERED

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered unless it is provided as other care the beneficiary is receiving *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

7.8 OBSERVATION SERVICES

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

Covered observation services include:

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

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

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

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

Observation status *must* be ordered in writing by a physician or another individual authorized *to* admit patients *to* the hospital or *to* order outpatient diagnostic tests or treatments.

The following factors must be taken into consideration by the physician or authorized individual in ordering observations status:

- Severity of the signs and symptoms of the recipient and the degree of medical uncertainty the recipient may experience an adverse occurrence
- Need for diagnostic studies which appropriately are outpatient stays (i.e., they do not ordinarily require the recipient to remain at the hospital for 24 hours or more) to assist in assessing whether the recipient should be admitted
- The availability of diagnostic procedures at the time and location where the recipient presents for medical treatment

The following services are *not* covered observation services:

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

In general, observation status should not exceed 24 hours. This time limit may be exceeded, if medically necessary, *to* evaluate the medical condition and/or treatment of a recipient. Extensions to the 24-hour limit must be prior authorized. A physician or another individual authorized to admit patients to the hospital or to order outpatient tests or treatments must sign an order for further observation each day.

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

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

We will review the immediate and continuing observation status by assessing the medical criteria for that level of care. Medical review for continued observation status will consider each case on an individual basis. At a minimum, the following documentation is required:

- Emergency department record, if applicable
- Progress notes
- Operative report, if applicable diagnostic test results, nursing notes
- Labor and delivery records, if applicable
- Physician orders
- Orders for observation status must be written on the physician's order sheet, not the emergency department record, and must specify "admit to observation."
- Changes in status such as "observation status to inpatient" or "inpatient to observation status" must be made by a physician or authorized individual
- Inpatient to observation status must be made by a physician or authorized individual and occur within 12 hours after admission as a inpatient
- Inpatient/outpatient status change must be supported by medical documentation

7.9 OUTPATIENT HOSPITAL SERVICES

We cover preventive, diagnostic, rehabilitative, and palliative services ordinarily provided in hospitals on an outpatient basis for all enrollees.

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

7.10 INPATIENT BEHAVIORAL HEALTH CARE

Inpatient Admission and Continued Stay Review Process

We must be notified within 24 hours of admission or the next business day.

For all pre-certifications, initial review, and continued stay requests, the hospital is required to submit the completed Certificate of Need (CON), Health Choice Prior Authorization/ Continued Stay Request Form for Psychiatric Hospitals and Sub-Acute Facilities and supporting documentation, within one business day of admission. For request forms, visit our website request form page. All requests are submitted by fax to **(480) 760-4732.**

- Medicare beneficiaries may only receive 190 days in a free-standing psychiatric hospital in a lifetime.

A behavioral health professional is required to apply the designated authorization and continued stay criteria to approve the provision of the covered service. [NCQA HPA 2024, UM 4A-2]. Submitted clinical information and documentation relevant to the authorization request are reviewed by a behavioral health professional to determine medical necessity. If adequate clinical information relevant to the medical necessity criteria is not provided with the request, we will request the clinical information needed to make a decision. [NCQA HPA 2025, UM 6-B]. A decision to deny is made by the Plan BH Medical Director. [NCQA HPA 2025, UM 4-D] When appropriate, we will provide a consultation with the requesting provider to obtain additional information to make a determination. [NCQA HPA 2025, UM4-1, 4D] Before a final decision to deny is made, the person's attending behavioral health medical practitioner can ask for reconsideration and present additional information. [NCQA HPA 2025, UM 7-A]

We apply objective and evidenced-based national, and state-recognized medical necessity criteria applied explicitly to the request. All requests consider individual enrollee circumstances and consider the local delivery system into account when making medical necessity. [NCQA 2025 HPA, UM 2A-1, 2 and 3].

Upon request, individual criteria used in the medical necessity decision is available. [NCQA HPA 2025 UM 2]

Discharge Planning and Coordination of Care

Discharge planning is an essential component of inpatient care that starts with an early assessment of the beneficiary's potential discharge needs to facilitate the transition to another

level of care or community placement. Medical Management Specialists and Care Managers will coordinate closely with the hospital and outpatient teams to establish a safe and effective discharge plan.

We have Transition of Care Coordinators who call members post-discharge for up to thirty (30) days to ensure the member's discharge needs are addressed.