Title 23: Medicaid

Part 202: Hospital Services

Chapter 1: Inpatient Services

Rule 1.3: Prior Authorization of Inpatient Hospital Services

A. Requirement

1. Prior authorization is required from the appropriate Utilization Management/Quality Improvement Organization (UM/QIO) for all inpatient hospital admissions except for obstetrical deliveries and well newborns with a length of stay under six (6) days.

    a) Emergent admissions and urgent admissions must be authorized on the next working day after admission.

    b) Failure to obtain the prior authorization will result in denial of payment to all providers billing for services including, but not limited to, the hospital and the attending physician.

2. Prior authorization must be obtained from the appropriate UM/QIO when a Medicaid beneficiary:

    a) Has third party insurance, and/or

    b) Is also covered by Medicare Part A only or Medicare Part B only.

3. Prior authorizations are not required for Medicaid beneficiaries who are also covered by both Medicare Part A and Part B unless inpatient Medicare benefits are exhausted.

4. Inpatient hospital stays that exceed the Diagnostic Related Group (DRG) Long Stay Threshold require a Treatment Authorization Number (TAN) for inpatient days that exceed the threshold.

B. Non-Approved Services

1. Medicaid beneficiaries in hospitals shall be billed for inpatient care occurring after they have received written notification of Medicaid non-approval of hospital services. Notification prior to the beneficiary's admission shall be cause to bill the beneficiary for full payment if he/she enters the hospital. Notification at or after admission shall be cause to bill the beneficiary for all services provided after receipt of the notice.

2. The hospital cannot bill the Medicaid beneficiary for an inpatient stay when it is determined upon retrospective review by the appropriate UM/QIO that the admission did not meet inpatient care criteria.

C. Maternity-Related Services

1. Hospitals must report all admissions for deliveries to the Division of Medicaid and the appropriate UM/QIO. The hospitals must report the admissions in accordance with the requirements provided by the Division of Medicaid and the appropriate UM/QIO. A TAN is issued to cover up to nineteen (19) days, the DRG Long Stay Threshold, for a delivery.

2. For admissions exceeding nineteen (19) days for a delivery, providers must submit a request for a continued stay in accordance with the policies and procedures provided by the appropriate UM/QIO.

D. Newborns

1. Well newborn services provided in the hospital must be billed separately from the mother's hospital claim.

   a) The hospital must notify the Division of Medicaid within five (5) calendar days of a newborn's birth via the Newborn Enrollment Form located on the Division of Medicaid's website.

   b) The Division of Medicaid will notify the provider within five (5) business days of the newborn's permanent Medicaid identification (ID) number.

2. The hospital must obtain a TAN for sick newborns requiring hospitalization whose length of stay is six (6) days or more. The baby's date of birth is the sick newborn's beginning date for certification. A sick newborn whose length of stay exceeds nineteen (19) days requires a concurrent review by the appropriate UM/QIO.

3. The hospital must obtain authorization for newborns delivered outside the hospital and newborns admitted to accommodations other than well baby.

Source: 42 USC § 1395f; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2015; Revised eff. 10/01/2012.