

Marketplace National Regional Benefit Interpretation Document

Benefit Name	INPATIENT HOSPITAL SERVICES
Applicable State	California, Florida, Idaho, Illinois, Kentucky, Michigan, Mississippi, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, Wisconsin
Benefit Definition	<p>This policy addresses acute inpatient hospital services and supplies.</p> <p>Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member’s Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member’s EOC/SOB, the member’s EOC/SOB provision will govern.</p> <p>Essential Health Benefits for Individual and Small Group</p> <p>For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>A. FEDERAL/STATE MANDATED REGULATIONS</p> </div> <p>Note: The most current federal/state mandated regulations for each state can be found in the links below.</p> <p>CALIFORNIA:</p> <p style="padding-left: 40px;">28 CCR §1300.67 (b) (Effective date: October 16, 2003) Scope of Basic Health Care Services:</p>

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any copayment, deductible, or limitation.

FLORIDA:

[Fla. Admin. Code 690-191.024\(15\)\(b\)](#): Inpatient Hospital Services

ILLINOIS:

[Text of Section from P.A. 101-371; Sec. 356z.33](#)- Long-term antibiotic therapy for tick-borne diseases

KENTUCKY:

[Ky. Rev. Stat. § 304.17-317](#): Coverage for treatment rendered by an ambulatory surgical center

MICHIGAN:

[MCL500.3406e](#)- Antineoplastic surgery drugs

[Chapter 550](#) - General Insurance Laws

NEW MEXICO:

[TITLE 7 CHAPTER 7 PART 2](#)- SPECIAL HEALTH HOSPITALS REQUIREMENTS FOR ACUTE CARE, LIMITED SERVICE AND HOSPITAL

OHIO:

[Ohio Rev. Code § 3727.01](#)- Health Maintenance Organization - Hospital Defined

TEXAS:

[28 TAC Section 11.508](#): **Basic Health Services and Mandatory Benefit Standards: Group, Group, Individual and Conversion Agreements:**

Each evidence of coverage providing basic health care services must provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set out in §11.506(9) (b) or §11.506(b)(14) of this title; (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate)

WASHINGTON:

[WAC 284-44-500](#)- Alternative care - General rules as to minimum standards.

WISCONSIN:

[632.895 \(12\)](#)- Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care

B. STATE MARKET PLAN ENHANCEMENTS

The member may have additional mental health coverage as required by State Law or designee. Refer to the Benefit Interpretation Policy titled **Mental Health (Inpatient and Outpatient)**

TEXAS:

Private duty and special duty nursing care is covered when medically necessary and the member is inpatient in an acute care hospital.

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

INPATIENT HOSPITAL SERVICES

CALIFORNIA:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered hospital services, except in the case of an Emergency or out-of-area Urgent Care Services. Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services or out-of-area Urgent Care Services will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided in a Non-Participating Provider hospital are not Covered Services, the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or OOPM.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-covered services

include, but are not limited to, private duty nursing, guest trays and patient convenience items

FLORIDA:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered hospital services, except in the case of an Emergency. Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or OOPM.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-covered services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

IDAHO:

Inpatient Hospital Services: Members must have a Prior Authorization to receiving covered Hospital services, except in the case of an Emergency Services. If coverage with Molina terminates during a Hospital stay, the services received after the Member's termination date are not Covered Services. Medically Necessary inpatient services are generally and customarily provided by acute care general Hospitals inside the Service Area. Non-Covered Services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

ILLINOIS:

Inpatient Hospital Services: Members must have a Prior Authorization to receiving covered hospital services, except in the case of an Emergency or Urgent Care Services.

Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the

Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum.

Prior Authorization for covered post-stabilization services is required, Molina will provide access 24 hours a day, 7 days a week to persons designated by Molina to make Prior Authorization determinations. Molina will reimburse for covered post-stabilization medical services if Prior Authorization is approved or after two documented good faith efforts, the treating health care provider has attempted to contact the Molina and neither Molina nor designated persons were accessible, or the authorization was not denied within 60 minutes of the request.

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

- Bed, Board and General Nursing Care when you are in:
 - a semi-private room
 - a private room
 - an intensive care unit
- Ancillary Services (such as operating rooms, drugs, surgical dressings, and lab work) Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the surgery. These tests are considered part of your Inpatient Hospital surgical stay.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-Covered services include, but are not limited to, guest trays and patient convenience items.

Tick-borne disease Services: Molina covers a Tick-borne a disease caused when an infected tick bites a person and the tick's saliva transmits an infectious agent

(bacteria, viruses, or parasites) that can cause illness, including, but not limited to, the following:

- A severe infection with borrelia burgdorferi;
- A late stage, persistent, or chronic infection or complications related to such an infection;
- An infection with other strains of borrelia or a tick-borne disease that is recognized by the United States Centers for Disease Control and Prevention; and
- The presence of signs or symptoms compatible with acute infection of borrelia or other tick-borne diseases.

Coverage is as follows:

- long-term antibiotic therapy, including necessary office visits and ongoing testing, for a person with a tick-borne disease when determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches after making a thorough evaluation of the person's symptoms, diagnostic test results, or response to treatment.
- An experimental drug shall be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a tick-borne disease if the drug has been approved by the United States Food and Drug Administration

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)/Pediatric Acute Onset Neuropsychiatric Syndrome (PANS) Treatment: Molina provides Medically Necessary covered services for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including coverage for Medically Necessary covered services for intravenous immunoglobulin therapy. Immunoglobulin therapy is also known as immune gamma globulin therapy.

KENTUCKY:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered hospital services, except in the case of an Emergency. Services received in a Non-Participating hospital after admission to the hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Passport has not terminated. Passport will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Passport terminates during a hospital stay, the services received after the Member's termination date are not Covered Services.

After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-Covered services include private duty nursing, guest trays and patient convenience items.

MICHIGAN:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered Hospital services, except in the case of an Emergency. Services received in a Non-Participating Provider Hospital after admission to the Hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a Hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider Hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum.

Medically Necessary inpatient services are generally and customarily provided by acute care general Hospitals inside the Service Area. Molina covers long-term acute care. Non-Covered Services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

MISSISSIPPI:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered hospital services, except in the case of an Emergency. Services received in a Non-Participating Provider Hospital after admission to the hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a

Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-Covered services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

Alternative to Hospitalization or Inpatient Care: To the extent mandated by State Law, home healthcare furnished by duly licensed home health, hospice and home care agencies covered by this Agreement may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home healthcare:

- Can be provided at equal or lesser cost;
- Is the most appropriate and cost-effective setting; and
- Is substituted with the consent of the Member and upon the recommendation of the Member's attending Physician or licensed health care Provider that such care will adequately meet the Member's needs.

The decision to substitute less expensive or less intensive services shall be made based on the medical needs of the Member. Molina may require a written treatment plan that has been approved by the Member's attending Provider. Coverage of substituted home healthcare is limited to the maximum benefits available for Hospital or other inpatient care under this Agreement and is subject to any applicable Cost Sharing and limitations in this Agreement.

NEW MEXICO:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered hospital services, except in the case of an Emergency. Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out of-

area or Non-Participating Provider hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum. For exceptions, Members should review the Access to Care section of the Agreement.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Inpatient hospital services shall include, but not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by the member's primary care provider or treating health care professional, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary. Non-Covered services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

OHIO:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered hospital services, except in the case of an Emergency. Services received in a Non-Participating Provider Hospital after admission to the Hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a Member's inpatient Hospital stay, Molina will continue coverage until the earliest occurrence of any of the following:

- The Member's discharge from the hospital;
- The determination by the Member's attending physician that inpatient care is no longer medically indicated for the enrollee. Molina may still conduct utilization review;
- The Member's reaching the limit for Agreement benefits;
- The effective date of any new coverage

After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider Hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum.

Medically Necessary inpatient services are generally and customarily provided by acute care general Hospitals inside the Service Area. Non-Covered Services include, but are not limited to, guest trays and patient convenience items.

SOUTH CAROLINA:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered hospital services, except in the case of an Emergency. Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided in an out-of-area or Non-Participating Provider hospital are not Covered Services, the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or OOPM.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-covered services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

TEXAS:

Inpatient Hospital Services: Members must have a Prior Authorization to receiving covered hospital services, except in the case of an Emergency [or Urgent Care Services. Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-Covered services include but are not limited to guest trays and patient convenience items.

Alternative to Hospitalization or Inpatient Care: To the extent mandated by State Law, home healthcare furnished by duly licensed home health, hospice and home care agencies covered by this Agreement may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home healthcare:

- Can be provided at equal or lesser cost;
- Is the most appropriate and cost-effective setting; and
- Is substituted with the consent of the Member and upon the recommendation of the Member's attending Physician or licensed health care Provider that such care will adequately meet the Member's needs.

The decision to substitute less expensive or less intensive services shall be made based on the medical needs of the Member. Molina may require a written treatment plan that has been approved by the Member's attending Provider. Coverage of substituted home healthcare is limited to the maximum benefits available for Hospital or other inpatient care under this Agreement and is subject to any applicable Cost Sharing and limitations in this Agreement.

UTAH:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered Hospital services, except in the case of an Emergency Services received in a Non-Participating Provider hospital after admission to the Hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a Hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum.

Medically Necessary inpatient services are generally and customarily provided by acute care general Hospitals inside the Service Area. Non-Covered Services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

WASHINGTON:

Inpatient Hospital Services: Members must have a Prior Authorization to receiving covered hospital services, except in the case of an Emergency Services and Behavioral Health Emergency Services. Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services or Behavioral Health Emergency Services, will be covered without Prior Authorization provided the Member's coverage with Molina has not terminated and the services are otherwise Covered Services. Molina may work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-Covered services include, but are not limited to, private duty nursing, guest trays, and patient convenience items.

Alternative to Hospitalization or Inpatient Care: To the extent mandated by State Law, home healthcare furnished by duly licensed home health, hospice and home care agencies (including skilled nursing care) covered by this Agreement may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home healthcare:

- Can be provided at equal or lesser cost
- Is the most appropriate and cost-effective setting, and
- Is substituted with the consent of the Member and upon the recommendation of the Member's attending Provider or licensed healthcare Provider that such care will adequately meet the Member's needs.

The decision to substitute less expensive or less intensive services shall be made based on the medical needs of the Member. Molina may require a written treatment plan that has been approved by the Member's attending Provider. Coverage of substituted home healthcare is limited to the maximum benefits available for Hospital or other inpatient care under this Agreement and is subject to any applicable Cost Sharing and limitations in this Agreement. Expenses may include coverage for durable medical equipment which permits the Member to stay in the less expensive or less restrictive environment.

WISCONSIN:

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered hospital services, except in the case of an Emergency. Services received

in a Non-Participating Provider hospital after admission to the hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated.

Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-Covered services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

INPATIENT SURGERY

CALIFORNIA:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required.

Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Discharge planning
- Operating and recovery rooms

Separate Cost Sharing may apply for professional services and facility services. Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

FLORIDA:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required.

Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Discharge planning

- Operating and recovery rooms

Please consult the Schedule of Benefits for Outpatient Services or Inpatient Services to determine applicable Member Cost Sharing.

IDAHO:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a licensed facility. Prior Authorization is required. Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Discharge planning
- Operating and recovery rooms

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost Sharing

ILLINOIS:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below including Bariatric Surgery when provided at a Participating Provider facility. Prior Authorization is required.

Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Assistant surgeon
- Discharge planning
- Operating and recovery rooms
- Blood transfusion services, processing and the administration of whole blood and blood components and derivatives

Please consult the [Schedule of Benefits] for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost Sharing.

KENTUCKY:

Surgery (Inpatient): Passport covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required.

Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Discharge planning
- Operating and recovery rooms

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

MICHIGAN:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required. Inpatient surgical services include:

- Anesthesia
- Anti-Cancer drugs
- Discharge planning
- Operating and recovery rooms

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost Sharing.

MISSISSIPPI:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required, Inpatient surgical services include

- Anesthesia
- Anti-Cancer surgical drugs
- Discharge planning
- Operating and recovery rooms

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

NEW MEXICO:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required.

Inpatient surgical services include:

- Anesthesia and the administration of anesthesia. Anesthesia may include coverage of hypnotherapy. General anesthesia may be provided where local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
- Antineoplastic surgical drugs
- Discharge planning
- Operating and recovery rooms

Please consult the SBC for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

OHIO:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required.

Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Discharge planning
- Operating and recovery rooms

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost Sharing.

SOUTH CAROLINA:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required.

Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Discharge planning
- Operating and recovery rooms

Please consult the Schedule of Benefits for Outpatient Services or Inpatient Services to determine applicable Member Cost Sharing.

TEXAS:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required, Inpatient surgical services include:

- Anesthesia and oxygen services
- Antineoplastic surgical drugs
- Diagnostic testing
- Discharge planning
- General nursing care
- Inhalation therapy
- Inpatient drugs, medications, biologicals, anesthesia and oxygen services
- Meals and special diets when medically necessary
- Operating and related facilities (which includes room and board)
- Private Duty Nursing when medically necessary
- Radiation therapy

- Short-term rehabilitation therapy services in the acute hospital setting
- Use of intensive care unit and services
- Whole blood and blood, including the cost of blood, blood plasma, blood plasma expanders, and administration of whole blood and blood plasma
- X-ray services

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

UTAH:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required. Inpatient surgical services include:

- Outpatient or ambulatory surgery center (including physician surgical charges, outpatient surgery)
- Hospital operating room
- Clinic
- Physician's office

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

WASHINGTON, WISCONSIN:

Surgery (Inpatient): Molina covers the inpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required. Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Discharge planning
- Operating and recovery rooms

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

MORE INFORMATION

Reimbursement for services of a non-par hospital-based providers at a PAR facility is paid at a percentage of Medicare allowed. The member's cost share is the same as if rendered by a PAR provider.

Refer to Benefit Interpretation Policy titled **Outpatient Hospital Services**

Refer to the Benefit Interpretation Policy titled **Mental Health (Inpatient and Outpatient)**

D. NOT COVERED

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

NON-COVERED SERVICES

CALIFORNIA, FLORIDA, IDAHO, ILLINOIS, MICHIGAN, MISSISSIPPI, NEW MEXICO, SOUTH CAROLINA, UTAH, WASHINGTON, WISCONSIN:

Non-covered services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

(KENTUCKY, OHIO and TEXAS only cover Private Duty Nursing under Home Health Benefit. In other states, Private Duty Nursing is not covered)

KENTUCKY:

Non-Covered services include private duty nursing, guest trays and patient convenience items.

OHIO, TEXAS:

Non-Covered services include but are not limited to guest trays and patient convenience items.

SERVICES PROVIDED OUTSIDE THE SERVICE AREA

ALL STATES:

Services Provided Outside the Service Area: Any services and supplies provided to a Member outside the Service Area where the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialty care, and inpatient services are not covered when furnished outside the Service Area. Only Emergency Services outside the Service Area are covered to treat an Emergency Medical Condition. When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered. Please contact Member Services for more information.

SERVICES PERFORMED BY UNLICENSED PEOPLE

ALL STATES:

Services Performed by Unlicensed People: Services performed by people who are not required by State Law to possess valid licenses or certificates to provide healthcare services are not covered, except otherwise covered by this Agreement.

	<p>E. DEFINITIONS</p> <p>See Glossary</p> <p>F. POLICY HISTORY/REVISION INFORMATION</p> <table border="1"> <thead> <tr> <th data-bbox="456 489 902 525">Date</th> <th data-bbox="902 489 1346 525">Action/Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="456 525 902 632">4/15/2021</td> <td data-bbox="902 525 1346 632"> <ul style="list-style-type: none"> Added KY 2022 Drafted Language </td> </tr> <tr> <td data-bbox="456 632 902 741">5/14/2021</td> <td data-bbox="902 632 1346 741"> <ul style="list-style-type: none"> Added IL 2022 EOC Language </td> </tr> <tr> <td data-bbox="456 741 902 806">6/29/2021</td> <td data-bbox="902 741 1346 806"> <ul style="list-style-type: none"> Added ID 2022 EOC </td> </tr> </tbody> </table>	Date	Action/Description	4/15/2021	<ul style="list-style-type: none"> Added KY 2022 Drafted Language 	5/14/2021	<ul style="list-style-type: none"> Added IL 2022 EOC Language 	6/29/2021	<ul style="list-style-type: none"> Added ID 2022 EOC
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Procedure Codes (Internal Use Only)	<p>BI Policy Configuration Inpatient Hospital (Facility)</p> <p>Coding Disclaimer: Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT[®]), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.</p>								
Prior Authorization	<p>For the MHI PA Matrix, if a code is NOT listed, it could EITHER be:</p> <ol style="list-style-type: none"> Covered and No PA Required Not Covered <p>You cannot use the MHI PA Matrix to make coverage determinations.</p> <p>PA Lookup Tool</p>								

Approval	Departments	Product	CIM	Clinical Management
	Date	2/18/2021	4/8/2021	4/7/2021
	Revised (for 1/1/2022)	11/9/2021	3/30/2022	11/9/2021
	Revised (for 1/1/2023)	11/18/2022		11/10/2022