A general care hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service (Category of Service 20) only on an emergency basis for a maximum period of three (3) days. During this period, the hospital must seek placement of the patient in a hospital enrolled to provide psychiatric services. Such services are subject to review by the department or its designated agent.

The department will not reimburse for psychiatric admissions for Department of Children and Family Services (DCFS) wards without a written consent from the DCFS Consent Unit or the Cook County Emergency Receptive Center. The DCFS Consent Unit and the Cook County Emergency Receptive Center are the only entities authorized to consent for psychiatric admissions of DCFS wards. The DCFS consent form must be placed in the patient's file to document that consent to admit the DCFS ward for inpatient psychiatric services was authorized. A faxed copy of the consent form is acceptable.

The DCFS Consent Unit may be reached during normal business hours, 8:30 a.m. - 4:30 p.m., Monday through Friday at 1-800-828-2179. The Consent Unit fax number is 312-814-4128. The Cook County Emergency Receptive Center (ERC) may be reached after regular business hours, on weekends and holidays at 773-538-8800.

Inpatient psychiatric services are not covered services for adult participants of the Family and Children Assistance program cases in the City of Chicago. Only children eighteen (18) years of age or younger on these cases are covered. Persons nineteen (19) years and older covered under the Family and Child Assistance program are not eligible.

H-262.5 Physical Rehabilitation Services

Physical rehabilitation inpatient services provided to patients during an acute stage of a disabling illness or injury are considered to be general inpatient services. When the acute stage ends and the patient no longer requires acute hospital care but does require comprehensive inpatient physical rehabilitation services, such services may be provided only by hospitals enrolled for Category of Service 22, Inpatient Hospital Services (Physical Rehabilitation).

Payment for inpatient physical rehabilitation services will be made only when provided by a general hospital or a rehabilitation hospital, enrolled with the department for Category of Service 22. **All physical rehabilitation services are exempt from DRG reimbursement and will be reimbursed at a per diem rate.**

The primary reason for hospitalization is to provide a structured program of comprehensive rehabilitation services, furnished by specialists, to a patient with a major disability for the purpose of habilitating or restoring that person to a realistic maximum level of functioning.

Inpatient physical rehabilitation services are not covered for adult participants of the Family and Children Assistance program cases in the City of Chicago. Only children eighteen (18) years of age or younger on these cases are covered. Persons nineteen (19) years and older covered under the Family and Child Assistance program are not eligible.

=H-262.6 Provider-Preventable Conditions (PPCs)

Effective July 1, 2012

Provider-preventable conditions are those conditions or events that are considered reasonably preventable through compliance with evidence-based guidelines. The department edits inpatient claims for two categories of PPCs. This policy applies to all hospitals, all inpatient claims (including Medicare/Medicaid combination claims), and both the DRG and per diem reimbursement methodologies:

1. PPCs defined as Hospital-Acquired Conditions (HACs): Beginning May 1, 2008, hospitals were required, for informational purposes only, to code inpatient claims with a Present on Admission (POA) indicator for principal and secondary diagnosis codes billed. Present on admission is defined as a condition that is present at the time the order for inpatient admission occurs. The POA indicator will identify if the condition was introduced after the inpatient admission. Effective with admissions on and after July 1, 2012, the department will deny the entire inpatient stay if a designated HAC presented during the inpatient admission. The department's designated list of diagnosis codes or diagnosis/procedure code combinations to be utilized as HACs are on the Web site.

2. PPCs defined as Other Provider Preventable Conditions (OPPCs): The department will deny payment for claims relating to a wrong surgical procedure performed on a patient; a surgical procedure performed on the wrong patient; or a surgical procedure performed on the wrong body part. Hospitals must submit claims to report these incidents and are instructed to populate the inpatient claims with the following specific supplementary diagnosis codes as appropriate:

    - E876.5 – Performance of wrong operation (procedure) on correct patient
    - E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
    - E876.7 – Performance of correct operation (procedure) on wrong side/body part

The above designated E codes may be reported in FL 72; however, they must also be identified in FL 67A-Q.

=H-262.61 Present on Admission Indicator Reporting

Effective July 1, 2012

Present on admission is defined as a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department services, observation, or outpatient surgery, are considered as present on admission.

The department requires hospitals to submit a POA indicator for the principal diagnosis code and every secondary diagnosis code on inpatient hospital claims. This requirement applies to all inpatient services and all hospitals.

Following are the POA reporting options and definitions:
Y – Yes (Present at the time of inpatient admission)
N – No (Not present at the time of inpatient admission)
U – Unknown (Documentation is insufficient to determine if condition is present at time of inpatient admission)
W – Clinically undetermined (Provider is unable to clinically determine whether condition was present at time of inpatient admission or not)
1 – Unreported/Not used – Exempt from POA reporting (This code is the equivalent of a blank on the UB-04, but blanks are not allowed in the 837I transaction). A list of these exempt diagnosis codes is identified in the ICD coding manual.

The POA indicator on a paper UB-04 is reported in the eighth digit (shaded area) of FL67 for the principal diagnosis and in the eighth digit (shaded area) of FL67A-Q for each secondary diagnosis. If the POA indicator is not placed in the shaded areas noted, it will be captured as part of the diagnosis code, which may cause the claim to be rejected.

The POA data element on an electronic claim (837I) must be in Loop 2300.

For additional coding information refer to the UB-04 Data Specifications Manual or 837I Implementation Guide.