51327 Inpatient Hospital Services

(a)

Inpatient hospital services are covered as specified below: (1) Hospital care for newborns and hospitalization for delivery services are covered as follows: (A) Inpatient delivery services in hospitals designated as contract hospitals in closed areas or contract/non-contract hospitals in open areas are covered without authorization up to a maximum of two consecutive days prior to delivery, beginning at midnight at the beginning of the day the mother is admitted, if delivery occurs within that two-day period, and without authorization up to a maximum of two consecutive days following vaginal delivery, or four consecutive days following delivery by Cesarean section, beginning at midnight at the end of the day the mother delivers. Continued medically necessary hospitalization beyond two days prior to delivery, beyond two days following vaginal delivery, or beyond four days following delivery by Cesarean section, requires timely submission of a request for authorization, as defined in Section 51003(b)(3), for Medi-Cal field office review. Authorization is required for all days of hospitalization when delivery does not occur within two consecutive days of admission. Hospitals under the onsite authorization procedure shall obtain authorizations not later than the first regularly scheduled review day following admission. Authorizations may be granted for up to a maximum of 30 days. For the purposes of this section, the following definitions shall apply: 1. "Closed areas" means areas in which the

proportion of bed capacity under contract between the Department and the contracting hospitals exceeds the hospital bed needs of the Medi-Cal population in that area. 2. "Open areas" means areas in which the proportion of bed capacity under contract between the Department and the contracting hospitals does not exceed the hospital bed needs of the Medi-Cal population in that area. (B) Hospital care for newborns is covered, subject to the following:1. Nursery care for well newborns during the same hospital admission associated with the delivery is not separately reimbursable. 2. Nursery care for sick newborns, who do not require neonatal intensive care, but who require an acute level of care during the same hospital admission associated with the delivery, is separately reimbursable under the following circumstances:a. For contract hospitals reimbursed on a per diem basis, timely submission of a request for authorization for Medi-Cal field office review, as specified in subsection (a)(1)(A), is required for services provided to the newborn beginning with the day of the mother's discharge, or as dictated by the terms of the hospital's contract. b. For non-contract hospitals, a separate authorization is required commencing with the onset of the newborn's illness, whether or not the mother has been discharged. 3. Nursery care for a newborn whose mother is ineligible for Medi-Cal and has no other medical insurance, or whose mother's health coverage does not include coverage for the newborn, or whose mother is incarcerated, is covered subject to timely submission of a request for authorization for Medi-Cal field office review, as specified in Section 51003(b)(3). Authorization is required for each day of the newborn's hospital stay. 4. Neonatal intensive care is covered, commencing with the onset of the newborn's illness and admission to the Neonatal Intensive Care Unit (NICU), subject to timely submission of a request for authorization for Medi-Cal field office review, as specified in Section 51003(b)(3), or as dictated by the terms of the hospital's

contract. (C) When delivery occurs prior to admission of the mother to the hospital, inpatient care for both the mother and newborn is covered without authorization up to a maximum of 48 hours beginning at midnight at the end of the day the mother delivered. The actual time of vaginal delivery shall be established based upon the mother's statement, records of auxiliary personnel involved in the care/transport of the mother, and clinical assessment by the attending physician. (D) Emergency inpatient services in hospitals designated as noncontract hospitals in closed areas are covered as specified in section 51327(a)(2). (2) Emergency hospital services shall not require authorization prior to admission, if hospitalization is for services that meet the definition of emergency services as defined in section 51541(c)(6)(A) and are justified as required in section 51056(c). However, all hospitalization resulting from emergency admissions requires approval by the Medi-Cal Consultant. Approval shall be obtained by the hospital on the day of admission or, when the day of admission is not a State working day, the first State working day thereafter. For those hospitals under the onsite authorization procedure, the first State working day shall mean the first regularly scheduled review day. Authorizations may be granted for up to a maximum of 30 days.(A) A Medi-Cal beneficiary who is admitted to a noncontract hospital in a closed area for emergency inpatient delivery services shall be transported when stable to a contracting facility for all, or the remainder of, the post-delivery inpatient length of stay specified in subsection (a)(1)(A), unless: 1. A contract facility is unable to accept the transfer. 2. The mother's condition fails to meet the Stable for Transport Guidelines in Section 5.4 of the Manual of Criteria for Medi-Cal Authorization. If the mother's condition does not stabilize during the two consecutive days following vaginal delivery, or four consecutive days following delivery by Cesarean section, the post delivery length of stay at the noncontract

hospital shall be covered, without authorization. 3. A decision for early discharge is made by the treating physician, in consultation with the mother, as specified in subsection (b). (3) All other hospitalization is covered only if prior authorization is obtained from the Medi-Cal Consultant before the hospital admission is effected. The Medi-Cal Consultant's authorization shall be for a specified number of days of hospital care for the diagnosis specified or the operative procedure contemplated in the authorization request. Nonemergency services for other unrelated diagnoses or operative procedures shall not be covered without additional prior authorization by a Medi-Cal Consultant. Continued necessary hospitalization beyond the specified number of days shall be covered after approval by the Medi-Cal Consultant has been obtained by the hospital on or before the last day of the previously approved period of hospitalization. Hospitals under the onsite authorization procedure shall obtain authorization not later than the first regularly scheduled review day thereafter. Days not prior authorized for admission or for extension of stay are not covered unless otherwise provided for in these regulations. (A) As a minimum, the authorization request shall contain the admitting diagnosis or operative procedure contemplated and acceptable justification of the hospital admission and the estimated length of hospital stay. The beneficiary's physician, podiatrist or dentist shall certify to the Department at the time of admission, and recertify not less often than every two calendar months where such services are furnished over a period of time, that the beneficiary requires inpatient hospital services. (B) If a request is approved, the number of days of hospitalization shall be authorized as determined by the Medi-Cal Consultant on the basis of medical information submitted. (C) Under no circumstances shall any one request for authorization of extensions be approved for more than one month for acute or one year for long-term care. (D) Claims for

nonemergency hospitalization shall be accompanied by an approved preadmission authorization request and an approved extension of hospital stay if the stay extends beyond the period previously authorized. (4) For long-term care, the attending physician must recertify, at 30, 60, and 90 days after initial certification and every 60 days thereafter, the patient's need for continued care in accordance with the procedures specified by the Director. (5) Inpatient hospital services, in an institution for mental illness or in the psychiatric service of a general hospital, are covered for persons 65 years of age and over and for persons under 21 years of age. If the person was receiving such services prior to his twenty-first birthday and he continues without interruption to require and receive such services, the services are covered to his twenty-second birthday. Such inpatient services are subject to the limitations specified in (2) and (3) above. (6) Inpatient hospital services, in an institution for tuberculosis or in the tuberculosis service of a general hospital, are covered for persons 65 years of age or older. (7) Inpatient general hospital services for persons under 65 years of age with a primary diagnosis of mental illness or tuberculosis are covered. Such inpatient services are subject to the limitations specified in (2), 3, 5 and (6) above.

(1)

Hospital care for newborns and hospitalization for delivery services are covered as follows: (A) Inpatient delivery services in hospitals designated as contract hospitals in closed areas or contract/non-contract hospitals in open areas are covered without authorization up to a maximum of two consecutive days prior to delivery, beginning at midnight at the beginning of the day the mother is admitted, if delivery occurs within that two-day period, and without authorization up to a maximum of two consecutive days following vaginal delivery, or four consecutive days following delivery by Cesarean section, beginning at midnight at the end of the day the mother delivers. Continued

medically necessary hospitalization beyond two days prior to delivery, beyond two days following vaginal delivery, or beyond four days following delivery by Cesarean section, requires timely submission of a request for authorization, as defined in Section 51003(b)(3), for Medi-Cal field office review. Authorization is required for all days of hospitalization when delivery does not occur within two consecutive days of admission. Hospitals under the onsite authorization procedure shall obtain authorizations not later than the first regularly scheduled review day following admission. Authorizations may be granted for up to a maximum of 30 days. For the purposes of this section, the following definitions shall apply: 1. "Closed areas" means areas in which the proportion of bed capacity under contract between the Department and the contracting hospitals exceeds the hospital bed needs of the Medi-Cal population in that area. 2. "Open areas" means areas in which the proportion of bed capacity under contract between the Department and the contracting hospitals does not exceed the hospital bed needs of the Medi-Cal population in that area. (B) Hospital care for newborns is covered, subject to the following:1. Nursery care for well newborns during the same hospital admission associated with the delivery is not separately reimbursable. 2. Nursery care for sick newborns, who do not require neonatal intensive care, but who require an acute level of care during the same hospital admission associated with the delivery, is separately reimbursable under the following circumstances:a. For contract hospitals reimbursed on a per diem basis, timely submission of a request for authorization for Medi-Cal field office review, as specified in subsection (a)(1)(A), is required for services provided to the newborn beginning with the day of the mother's discharge, or as dictated by the terms of the hospital's contract. b. For non-contract hospitals, a separate authorization is required commencing with the onset of the newborn's illness, whether or not the mother has been discharged. 3. Nursery care for a newborn whose mother is ineligible for Medi-Cal and has no other medical insurance, or whose mother's health coverage

does not include coverage for the newborn, or whose mother is incarcerated, is covered subject to timely submission of a request for authorization for Medi-Cal field office review, as specified in Section 51003(b)(3). Authorization is required for each day of the newborn's hospital stay. 4. Neonatal intensive care is covered, commencing with the onset of the newborn's illness and admission to the Neonatal Intensive Care Unit (NICU), subject to timely submission of a request for authorization for Medi-Cal field office review, as specified in Section 51003(b)(3), or as dictated by the terms of the hospital's contract. (C) When delivery occurs prior to admission of the mother to the hospital, inpatient care for both the mother and newborn is covered without authorization up to a maximum of 48 hours beginning at midnight at the end of the day the mother delivered. The actual time of vaginal delivery shall be established based upon the mother's statement, records of auxiliary personnel involved in the care/transport of the mother, and clinical assessment by the attending physician. (D) Emergency inpatient services in hospitals designated as noncontract hospitals in closed areas are covered as specified in section 51327(a)(2).

(A)

Inpatient delivery services in hospitals designated as contract hospitals in closed areas or contract/non-contract hospitals in open areas are covered without authorization up to a maximum of two consecutive days prior to delivery, beginning at midnight at the beginning of the day the mother is admitted, if delivery occurs within that two-day period, and without authorization up to a maximum of two consecutive days following vaginal delivery, or four consecutive days following delivery by Cesarean section, beginning at midnight at the end of the day the mother delivers. Continued medically necessary hospitalization beyond two days prior to delivery, beyond two days following vaginal delivery, or beyond four days following delivery by Cesarean section, requires timely submission of a request for authorization, as defined in Section 51003(b)(3), for Medi-Cal field office review. Authorization is required for

all days of hospitalization when delivery does not occur within two consecutive days of admission. Hospitals under the onsite authorization procedure shall obtain authorizations not later than the first regularly scheduled review day following admission. Authorizations may be granted for up to a maximum of 30 days. For the purposes of this section, the following definitions shall apply: 1. "Closed areas" means areas in which the proportion of bed capacity under contract between the Department and the contracting hospitals exceeds the hospital bed needs of the Medi-Cal population in that area. 2. "Open areas" means areas in which the proportion of bed capacity under contract between the Department and the contracting hospitals does not exceed the hospital bed needs of the Medi-Cal population in that area.

1.

"Closed areas" means areas in which the proportion of bed capacity under contract between the Department and the contracting hospitals exceeds the hospital bed needs of the Medi-Cal population in that area.

2.

"Open areas" means areas in which the proportion of bed capacity under contract between the Department and the contracting hospitals does not exceed the hospital bed needs of the Medi-Cal population in that area.

(B)

Hospital care for newborns is covered, subject to the following:1. Nursery care for well newborns during the same hospital admission associated with the delivery is not separately reimbursable. 2. Nursery care for sick newborns, who do not require neonatal intensive care, but who require an acute level of care during the same hospital admission associated with the delivery, is separately reimbursable under the following circumstances:a. For contract hospitals reimbursed on a per diem basis, timely submission of a request for authorization for Medi-Cal field office review, as specified in subsection (a)(1)(A), is required for services

provided to the newborn beginning with the day of the mother's discharge, or as dictated by the terms of the hospital's contract. b. For non-contract hospitals, a separate authorization is required commencing with the onset of the newborn's illness, whether or not the mother has been discharged. 3. Nursery care for a newborn whose mother is ineligible for Medi-Cal and has no other medical insurance, or whose mother's health coverage does not include coverage for the newborn, or whose mother is incarcerated, is covered subject to timely submission of a request for authorization for Medi-Cal field office review, as specified in Section 51003(b)(3). Authorization is required for each day of the newborn's hospital stay. 4. Neonatal intensive care is covered, commencing with the onset of the newborn's illness and admission to the Neonatal Intensive Care Unit (NICU), subject to timely submission of a request for authorization for Medi-Cal field office review, as specified in Section 51003(b)(3), or as dictated by the terms of the hospital's contract.

1.

Nursery care for well newborns during the same hospital admission associated with the delivery is not separately reimbursable.

2.

Nursery care for sick newborns, who do not require neonatal intensive care, but who require an acute level of care during the same hospital admission associated with the delivery, is separately reimbursable under the following circumstances:a. For contract hospitals reimbursed on a per diem basis, timely submission of a request for authorization for Medi-Cal field office review, as specified in subsection (a)(1)(A), is required for services provided to the newborn beginning with the day of the mother's discharge, or as dictated by the terms of the hospital's contract. b. For non-contract hospitals, a separate authorization is required commencing with the onset of the newborn's illness, whether or not the mother has been discharged.

a.

For contract hospitals reimbursed on a per diem basis, timely submission of a request for authorization for

Medi-Cal field office review, as specified in subsection (a)(1)(A), is required for services provided to the newborn beginning with the day of the mother's discharge, or as dictated by the terms of the hospital's contract.

b.

For non-contract hospitals, a separate authorization is required commencing with the onset of the newborn's illness, whether or not the mother has been discharged.

3.

Nursery care for a newborn whose mother is ineligible for Medi-Cal and has no other medical insurance, or whose mother's health coverage does not include coverage for the newborn, or whose mother is incarcerated, is covered subject to timely submission of a request for authorization for Medi-Cal field office review, as specified in Section 51003(b)(3). Authorization is required for each day of the newborn's hospital stay.

4.

Neonatal intensive care is covered, commencing with the onset of the newborn's illness and admission to the Neonatal Intensive Care Unit (NICU), subject to timely submission of a request for authorization for Medi-Cal field office review, as specified in Section 51003(b)(3), or as dictated by the terms of the hospital's contract.

(C)

When delivery occurs prior to admission of the mother to the hospital, inpatient care for both the mother and newborn is covered without authorization up to a maximum of 48 hours beginning at midnight at the end of the day the mother delivered. The actual time of vaginal delivery shall be established based upon the mother's statement, records of auxiliary personnel involved in the care/transport of the mother, and clinical assessment by the attending physician.

(D)

Emergency inpatient services in hospitals designated as noncontract hospitals in closed areas

are covered as specified in section 51327(a)(2).

(2)

Emergency hospital services shall not require authorization prior to admission, if hospitalization is for services that meet the definition of emergency services as defined in section 51541(c)(6)(A) and are justified as required in section 51056(c). However, all hospitalization resulting from emergency admissions requires approval by the Medi-Cal Consultant. Approval shall be obtained by the hospital on the day of admission or, when the day of admission is not a State working day, the first State working day thereafter. For those hospitals under the onsite authorization procedure, the first State working day shall mean the first regularly scheduled review day. Authorizations may be granted for up to a maximum of 30 days.(A) A Medi-Cal beneficiary who is admitted to a noncontract hospital in a closed area for emergency inpatient delivery services shall be transported when stable to a contracting facility for all, or the remainder of, the post-delivery inpatient length of stay specified in subsection (a)(1)(A), unless: 1. A contract facility is unable to accept the transfer. 2. The mother's condition fails to meet the Stable for Transport Guidelines in Section 5.4 of the Manual of Criteria for Medi-Cal Authorization. If the mother's condition does not stabilize during the two consecutive days following vaginal delivery, or four consecutive days following delivery by Cesarean section, the post delivery length of stay at the noncontract hospital shall be covered, without authorization. 3. A decision for early discharge is made by the treating physician, in consultation with the mother, as specified in subsection (b).

(A)

A Medi-Cal beneficiary who is admitted to a noncontract hospital in a closed area for emergency inpatient delivery services shall be transported when stable to a contracting facility for all, or the remainder of, the post-delivery inpatient length of stay specified in subsection (a)(1)(A), unless: 1. A contract facility is unable to accept the transfer. 2. The

mother's condition fails to meet the Stable for Transport Guidelines in Section 5.4 of the Manual of Criteria for Medi-Cal Authorization. If the mother's condition does not stabilize during the two consecutive days following vaginal delivery, or four consecutive days following delivery by Cesarean section, the post delivery length of stay at the noncontract hospital shall be covered, without authorization. 3. A decision for early discharge is made by the treating physician, in consultation with the mother, as specified in subsection (b).

1.

A contract facility is unable to accept the transfer.

2.

The mother's condition fails to meet the Stable for Transport Guidelines in Section 5.4 of the Manual of Criteria for Medi-Cal Authorization. If the mother's condition does not stabilize during the two consecutive days following vaginal delivery, or four consecutive days following delivery by Cesarean section, the post delivery length of stay at the noncontract hospital shall be covered, without authorization.

3.

A decision for early discharge is made by the treating physician, in consultation with the mother, as specified in subsection (b).

(3)

All other hospitalization is covered only if prior authorization is obtained from the Medi-Cal Consultant before the hospital admission is effected. The Medi-Cal Consultant's authorization shall be for a specified number of days of hospital care for the diagnosis specified or the operative procedure contemplated in the authorization request. Nonemergency services for other unrelated diagnoses or operative procedures shall not be covered without additional prior authorization by a Medi-Cal Consultant. Continued necessary hospitalization beyond the specified number of days shall be covered after approval by the Medi-Cal Consultant has been obtained by the hospital on or before the

last day of the previously approved period of hospitalization. Hospitals under the onsite authorization procedure shall obtain authorization not later than the first regularly scheduled review day thereafter. Days not prior authorized for admission or for extension of stay are not covered unless otherwise provided for in these regulations. (A) As a minimum, the authorization request shall contain the admitting diagnosis or operative procedure contemplated and acceptable justification of the hospital admission and the estimated length of hospital stay. The beneficiary's physician, podiatrist or dentist shall certify to the Department at the time of admission, and recertify not less often than every two calendar months where such services are furnished over a period of time, that the beneficiary requires inpatient hospital services. (B) If a request is approved, the number of days of hospitalization shall be authorized as determined by the Medi-Cal Consultant on the basis of medical information submitted. (C) Under no circumstances shall any one request for authorization of extensions be approved for more than one month for acute or one year for long-term care. (D) Claims for nonemergency hospitalization shall be accompanied by an approved preadmission authorization request and an approved extension of hospital stay if the stay extends beyond the period previously authorized.

(A)

As a minimum, the authorization request shall contain the admitting diagnosis or operative procedure contemplated and acceptable justification of the hospital admission and the estimated length of hospital stay. The beneficiary's physician, podiatrist or dentist shall certify to the Department at the time of admission, and recertify not less often than every two calendar months where such services are furnished over a period of time, that the beneficiary requires inpatient hospital services.

(B)

If a request is approved, the number of days of hospitalization shall be authorized as

determined by the Medi-Cal Consultant on the basis of medical information submitted.

(C)

Under no circumstances shall any one request for authorization of extensions be approved for more than one month for acute or one year for long-term care.

(D)

Claims for nonemergency hospitalization shall be accompanied by an approved preadmission authorization request and an approved extension of hospital stay if the stay extends beyond the period previously authorized.

(4)

For long-term care, the attending physician must recertify, at 30, 60, and 90 days after initial certification and every 60 days thereafter, the patient's need for continued care in accordance with the procedures specified by the Director.

(5)

Inpatient hospital services, in an institution for mental illness or in the psychiatric service of a general hospital, are covered for persons 65 years of age and over and for persons under 21 years of age. If the person was receiving such services prior to his twenty-first birthday and he continues without interruption to require and receive such services, the services are covered to his twenty-second birthday. Such inpatient services are subject to the limitations specified in (2) and (3) above.

(6)

Inpatient hospital services, in an institution for tuberculosis or in the tuberculosis service of a general hospital, are covered for persons 65 years of age or older.

(7)

Inpatient general hospital services for persons under 65 years of age with a primary diagnosis of mental illness or tuberculosis are covered. Such inpatient services are subject to the limitations specified in (2), 3, 5 and (6) above.

(b)

Following delivery, an early discharge follow up visit for the mother and newborn, within 48 hours of discharge, is covered without authorization when the decision to discharge the mother and newborn before the time periods specified in subsection (a)(1)(A) is made by the treating physician in consultation with the mother. When discussing early discharge with the mother, the treating physician shall disclose the availability of an early discharge follow up visit. If early discharge is determined appropriate, the treating physician and mother shall determine, based on factors such as the transportation needs of the family and environmental and social risks, whether the postdischarge visit shall occur at home, in the treating physician's office, or the plan's facility. The early discharge follow up visit shall:(1) Be prescribed by the treating physician. (2) Be with licensed health care providers whose scopes of practice include postpartum care and/or newborn care. (3) Include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments.

(1)

Be prescribed by the treating physician.

(2)

Be with licensed health care providers whose scopes of practice include postpartum care and/or newborn care.

(3)

Include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments.

(c)

The following inpatient hospital services are not covered:(1) Services in an institution for mental illness for persons 21 through 64 years of age except as specified in (a)(5) above. (2) Services in an institution for tuberculosis for persons under 65 years of age. (3) Inpatient hospital services provided by a hospital which has been designated as noncontracting in accordance with section 51541(c) except for the following: (A) Emergency services and subsequent inpatient services, in accordance with section 51541(c)(6)(A), until the patient's condition meets the definition of stable for transport, as defined in section 51110(c). (B) Services to a beneficiary who is an inpatient and whose condition meets the definition of stable for transport as defined in section 51110(c) providing the following conditions are met:1. A hospital designated as contracting with capacity to provide the necessary care is unavailable and this finding has been appropriately justified, and 2. The patient, whose condition is stable, continues to require acute level of care, and 3. Discharge of the patient, whose condition is stable, from acute level of care would be life threatening or could result in permanent impairment. (C) Services to a beneficiary who is eligible for Medicare benefits providing the conditions of section 51005 have been met. (D) Services to a Medicare Part A crossover patient subsequent to the exhaustion of Medicare inpatient benefits as along as the beneficiary is in a life threatening or emergency situation which could result in permanent impairment, until the patient's condition meets the definition of stable for transport, as defined in section 51110(c). (E) Services to beneficiaries where the travel time from a beneficiary's home to a contract hospital, exceeds the normal practice for the community or 30 minutes, whichever is greater, and the noncontracting hospital providing services is closer to the beneficiary's home than a contracting hospital. (F) Services to a beneficiary when retroactive authorization has been granted in accordance with section

51003(b).

(1)

Services in an institution for mental illness for persons 21 through 64 years of age except as specified in (a)(5) above.

(2)

Services in an institution for tuberculosis for persons under 65 years of age.

(3)

Inpatient hospital services provided by a hospital which has been designated as noncontracting in accordance with section 51541(c) except for the following: (A) Emergency services and subsequent inpatient services, in accordance with section 51541(c)(6)(A), until the patient's condition meets the definition of stable for transport, as defined in section 51110(c). (B) Services to a beneficiary who is an inpatient and whose condition meets the definition of stable for transport as defined in section 51110(c) providing the following conditions are met:1. A hospital designated as contracting with capacity to provide the necessary care is unavailable and this finding has been appropriately justified, and 2. The patient, whose condition is stable, continues to require acute level of care, and 3. Discharge of the patient, whose condition is stable, from acute level of care would be life threatening or could result in permanent impairment. (C) Services to a beneficiary who is eligible for Medicare benefits providing the conditions of section 51005 have been met. (D) Services to a Medicare Part A crossover patient subsequent to the exhaustion of Medicare inpatient benefits as along as the beneficiary is in a life threatening or emergency situation which could result in permanent impairment, until the patient's condition meets the definition of stable for transport, as defined in section 51110(c). (E) Services to beneficiaries where the travel time from a beneficiary's home to a contract hospital, exceeds the normal practice for the community or 30 minutes, whichever is greater, and the

noncontracting hospital providing services is closer to the beneficiary's home than a contracting hospital. (F) Services to a beneficiary when retroactive authorization has been granted in accordance with section 51003(b).

(A)

Emergency services and subsequent inpatient services, in accordance with section 51541(c)(6)(A), until the patient's condition meets the definition of stable for transport, as defined in section 51110(c).

(B)

Services to a beneficiary who is an inpatient and whose condition meets the definition of stable for transport as defined in section 51110(c) providing the following conditions are met:1. A hospital designated as contracting with capacity to provide the necessary care is unavailable and this finding has been appropriately justified, and 2. The patient, whose condition is stable, continues to require acute level of care, and 3. Discharge of the patient, whose condition is stable, from acute level of care would be life threatening or could result in permanent impairment.

1.

A hospital designated as contracting with capacity to provide the necessary care is unavailable and this finding has been appropriately justified, and

2.

The patient, whose condition is stable, continues to require acute level of care, and

3.

Discharge of the patient, whose condition is stable, from acute level of care would be life threatening or could result in permanent impairment.

(C)

Services to a beneficiary who is eligible for Medicare benefits providing the conditions of section 51005 have been met.

(D)

Services to a Medicare Part A crossover patient subsequent to the exhaustion of Medicare inpatient benefits as along as the beneficiary is in a life threatening or emergency situation which could result in permanent impairment, until the patient's condition meets the definition of stable for transport, as defined in section 51110(c).

(E)

Services to beneficiaries where the travel time from a beneficiary's home to a contract hospital, exceeds the normal practice for the community or 30 minutes, whichever is greater, and the noncontracting hospital providing services is closer to the beneficiary's home than a contracting hospital.

(F)

Services to a beneficiary when retroactive authorization has been granted in accordance with section 51003(b).

(d)

There shall also be a periodic medical review (not less than annually) of all beneficiaries in mental hospitals by a Medical Review Team as defined in section 50009.2.