



510.3 HOSPITAL INPATIENT SERVICES

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BACKGROUND

This chapter sets forth requirements of the West Virginia (WV) Bureau for Medical Services (BMS) regarding coverage, payment and processing for inpatient Hospital Services provided to eligible WV Medicaid members by acute care, critical access, psychiatric and medical rehabilitation hospitals and any distinct part units therein.

POLICY

An inpatient admission is defined as a Medicaid eligible member who has been admitted to an inpatient facility for bed occupancy for purposes of receiving inpatient hospital facility services. Inpatient care is covered under the Medicaid Program when it is reasonable and medically necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body part. The services must be consistent with the diagnosis or treatment of the patient's condition, and must be rendered in accordance with current standards of medical practice to be considered medically necessary. Inpatient care which does not contribute to the treatment of an illness or injury, or to improve the functioning of a malformed body part, is not covered. Nursing and other related services, such as use of hospital facilities, medical and social services, and transportation furnished by the hospital during an inpatient stay are included in the rate of reimbursement. Covered services are limited to those admissions which are certified by the BMS' Utilization Management Contractor (UMC) in accordance with the procedures and admission criteria utilized by the UMC and approved by BMS. Additionally, admissions must be based upon the written order of a physician enrolled in WV Medicaid who is licensed in the practice of medicine in the state in which the physician is located, and authorized to admit patients to the facility in which the service is rendered.

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This category of hospital services includes both acute care and critical access hospitals.

The WV Medicaid Program reimburses hospitals for medically necessary inpatient services provided to eligible members within coverage limitations in effect on the date of service. Coverage and benefit limitations may be revised periodically as necessary due to changes in State and Federal regulations, fiscal constraints, or WV Medicaid policies.

Covered inpatient services include acute care admissions and critical access admissions, as well as admissions to Medicare certified psychiatric and medical rehabilitation inpatient distinct part units. Services rendered in the distinct part psychiatric unit are covered for both children and adults. Coverage for services rendered in the rehabilitation inpatient distinct part unit is limited to children under age 21.

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Any move to or from a distinct part unit to or from a medical/general unit within the same hospital is treated as a separate admission and requires prior authorization.

A member admitted to a psychiatric distinct part unit must have a mental health diagnosis as the primary diagnosis consistent with a Diagnosis and Statistical Manual (DSM) diagnosis for documentation purposes and an International Classification of Diseases (ICD) diagnosis for billing purposes. If during the inpatient stay in the distinct part unit, the treatment emphasis changes to a physical health diagnosis or condition, the hospital cannot bill the distinct part rate but must bill the appropriate Diagnosis Related Group (DRG). In these instances the patient must be discharged from the distinct part unit if medically necessary and appropriate and following medical necessity review and certification by the BMS' UMC, readmitted as an acute care medical admission.

Inpatient services are primarily for treatment indicated in the management of acute or chronic illness, injury, impairment, or for maternity care. The member's hospital records and the hospital's utilization review process must document that the care and services rendered were medically necessary; that the services rendered could only be provided on an inpatient basis (i.e. could not be provided on an outpatient basis or in a lower level of care facility); and that the services rendered were necessary for each day of inpatient care billed to Medicaid.

All inpatient and outpatient services provided within 72 hours of the hospital admission are considered to be part of the inpatient services and are to be billed on one claim.

510.3.2 ORGAN TRANSPLANT SERVICES

WV Medicaid covers certain types of organ transplants performed in a Medicare-approved transplant facility.

Organ transplant services are covered when generally considered safe, effective, and medically necessary when no alternative medical treatment recognized by the medical community is available. The intended transplant must be performed to manage a disease consistent with recognized standards in the medical community. Investigational, research, or experimental procedures are not covered.

The criteria for transplantation are based on the critical medical need of the member and a maximum likelihood of successful clinical outcome. All other medical and surgical therapies that might be expected to affect short-and long-term survival must have been tried or considered. At a minimum, the transplantation criteria include the following:

- Current medical therapy has failed and the member has failed to respond to appropriate therapeutic management
- The member is not in an irreversible terminal state
- The transplant is likely to prolong life and restore a range of physical and social function.

Prior authorization is required for all transplants. BMS' UMC reviews requests for prior authorization. The following types of transplants are covered with prior authorization, and if medically necessary:

- Heart Transplant
- Bone Marrow Transplant

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- Adult Liver Transplant
- Pediatric Liver Transplant
- Kidney Transplant
- Pancreas/Kidney Transplant
- Lung Transplant – single and double
- Heart/Lung Transplant
- Small Intestine Transplant
- Cornea

Transplants are not covered when two of them are performed together, except under the following circumstances:

- If the primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process
- If the damage to the second organ will compromise the outcome of the transplant of the primary organ, multiple organ transplantation may be considered.

Reimbursement for the hospital admission in which the transplant is performed is standard DRG reimbursement with a maximum of \$75,000. Additionally, the hospital will be reimbursed the standard acquisition cost invoiced by CORE (Center for Organ Recovery and Education) for each category of organ. Additional transportation cost associated with the organ acquisition is also reimbursed if not provided by the hospital in which the transplant is performed. Donor cost, if not reimbursed by the donor's insurance, may be reimbursed by the Medicaid Program under the Medicaid eligible member's ID number.

510.3.3 PSYCHIATRIC INPATIENT FACILITIES

Members who are admitted to psychiatric distinct part units must have an admission diagnosis of a mental illness. If however, during the course of the stay, treatment changes from psychiatric care to physical care, the hospital shall bill the appropriate DRG in addition to billing for psychiatric services provided in the distinct unit. These psychiatric admissions will be subject to audit and cost settlement.

Medicaid also reimburses for Psychiatric Residential Treatment Facilities for members under 21. For further information see [Chapter 531, Policy 531.1, Psychiatric Residential Treatment Facility](#).

510.3.3.1 Inpatient Psychiatric Facility Acute Care Under 21

Services rendered in this setting include inpatient acute care psychiatric services for individuals under 21 (Professional services rendered to members who are admitted to a psychiatric facility for members under 21 must be billed separately under the practitioner's provider number. Those charges are not included in the facility's invoice). Outpatient services may also be rendered in this setting, refer to [Chapter 510, Policy 510.4 Hospital Outpatient Services](#).

If the Medicaid member is in the Physician Assured Access System (PAAS) Program, primary care provider (PCP) referrals are not required.

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510.3.3.2 Inpatient Adult Psychiatric Services

Medicaid program coverage for inpatient psychiatric services rendered to adults is limited as follows:

- When rendered to Medicaid eligible adults 21 and over in Medicare certified distinct part psychiatric units of acute care general hospitals when such individuals are admitted following medical necessity review and admission certification by the BMS' UMC.
- For those individuals 65 and over who are both Medicare and Medicaid eligible, the Medicaid program provides coverage of coinsurance and deductible payments for individuals admitted to facilities designated as institutes for mental disease (IMD). Psychiatric facilities classified as IMD are defined in federal regulation at [42 CFR 435.1009](#). In general, this designation includes all Joint Commission accredited psychiatric inpatient facilities.

510.3.4 INPATIENT MEDICAL REHABILITATION FACILITY

Services covered in this setting are for medical inpatient rehabilitation services for Medicaid eligible individuals under 21, and general medical outpatient services provided in a facility which meets certification requirements of the Office of Health Facility, Licensure and Certification (OHFLAC). Medicaid covers inpatient rehabilitation services in facilities that are certified by Medicare as rehabilitation hospitals or distinct rehabilitation units of a general acute care hospital.

510.3.5 SERVICE LIMITS FOR INPATIENT SERVICES

Medicaid coverage places limits on certain categories of facilities with regard to admission review procedures and characteristics of members they may serve. The following sections outline those limitations and program exclusions.

510.3.5.1 Prior Authorization Requirements for Inpatient Services

All inpatient admissions, with the exception of those related to labor and delivery, are subject to medical necessity review and certification of admission by the BMS' UMC. Services that require prior authorization are identified on the BMS' [UMC website](#). Services for prior authorization must be requested via the BMS' [UMC web-based portal](#).

General requirements by category of provider are as follows:

1. Admissions to general and critical access acute care facilities are subject to medical necessity review and preadmission certification. The retrospective authorization is available by the BMS' UMC in the following circumstances:
 - procedure/service denied by the member's primary payer, providing all requirements for the primary payer has been followed including the appeals process; or,
 - retroactive West Virginia Medicaid eligibility.Retrospective review must be requested within 12 months of discharge date
2. Admissions to Medicare certified distinct part psychiatric and rehabilitation units of acute care facilities are subject to both preadmission and continued stay review.
3. Psychiatric inpatient facility admissions are subject to admission and continued stay review by the BMS' UMC.

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4. Inpatient Medical Rehabilitation Facility admissions are subject to both admission and continued stay review by the BMS' UMC. Members who are inpatients, upon reaching the age of 21, may continue to receive services through age 21, as long as they continue to meet medical necessity criteria for continued stay.

510.3.5.2 Inpatient Non-Covered Services

The following inpatient services are excluded from coverage by the West Virginia Medicaid Program:

1. Admissions which are not authorized by the BMS' UMC in accordance with Medicaid program policy in effect as of the date of service.
2. Admissions other than emergency to out-of-network facilities for services which are available in-network
3. Admissions for experimental or investigational procedures
4. Admissions and/or continued stays which are strictly for patient convenience and not related to the care and treatment of a patient
5. Inpatient psychiatric or medical rehabilitation facility admissions of individuals age 21 or over
6. Inpatient admission for services which could be performed in an outpatient or other lower level setting

510.3.6 OBSERVATION SERVICES

Outpatient observation is the medically necessary extended services provided to a patient whose condition requires additional care, including use of a bed and monitoring by hospital nurses and staff. Coverage of observation may not exceed 48 hours. All inpatient and outpatient services, including observation services, provided within 72 hours of the hospital admission are considered to be part of the inpatient services and are to be billed on one claim.

For further details see [Chapter 510, Policy 510.4 Hospital Outpatient Services](#).

510.3.7 EMERGENCY ROOM SERVICES

All inpatient and outpatient services, including emergency room services, provided within 72 hours of the hospital admission are considered to be part of the inpatient services and are to be billed on one claim.

Charges for the emergency room services, observation services which result in an inpatient admission are deemed to be part of the admission and not separately billable.

For further details see [Chapter 510, Policy 510.4 Hospital Outpatient Services](#).

510.3.8 HOSPITAL TRANSFERS

BMS makes a distinction in its prospective payment system between cases that are discharged after a full course of treatment and cases that are transferred between two acute care facilities. Transfer cases are defined as those cases that are transferred between two acute care facilities for continuation of care.

West Virginia Medicaid pays for transfer cases similarly to Medicare. BMS pays transfer cases on a graduated per diem basis up to the full DRG payment amount.

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All sending hospitals receive a graduated per diem amount based upon the DRG to which the case is assigned for the sending hospital's phase of the treatment. The final discharging hospital receives a full DRG payment amount based upon the DRG to which the case was assigned for the final discharging hospital's phase of the treatment.

Transfer cases are eligible for high cost outlier payments and indirect teaching adjustments in addition to their graduated per diem payments. Each phase of the hospitalization is assigned a DRG based upon the principal diagnosis and surgical procedures performed during that phase.

Cases assigned to the two DRG's specific to transfer cases for neonates that died or were transferred, and burn cases that are transferred, receive the full DRG payment.

510.3.9 NON-CITIZEN EMERGENCY SERVICES

Illegal or ineligible non-citizens who meet the residence and other Medicaid policy eligibility criteria are eligible for Medicaid only for treatment of emergency medical conditions. For further information refer to Chapter 18 of the [Income Maintenance Manual](#).

510.3.10 HOSPITAL-ACQUIRED CONDITIONS

All hospitals must identify and report to BMS all Provider Preventable Conditions (PPCs), as defined in the federal Medicaid regulation, [42 CFR §447.26](#). However, hospital providers are prohibited from submitting claims for payment of these conditions except as permitted in [42 CFR §447.26](#), when the PPC for a particular patient existed prior to the initiation of treatment for that patient by that hospital provider, as noted by use of the Present on Admission indicator. The DRG payment calculations automatically ensure that providers will not be compensated for these conditions. Hospital providers who are not reimbursed using DRGs must report all PPCs on claims and bill zero charges for these PPCs, except as provided above.

See CMS.gov coding guidelines related to provider preventable conditions for more information:
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf>

510.3.11 INTERFACILITY TRANSPORTS VIA AMBULANCE

Ambulance transportation from one hospital to a different hospital must be for specialized care that is not available at the sending facility. In addition, the patient's current medical condition must meet the medical necessity criteria established in [Chapter 524, Transportation Services](#).

Reimbursement for same day, round trip transportation by ambulance for services not available at sending facility is the responsibility of the sending facility, not the Medicaid member or Program. The hospital or Medicaid member requesting ambulance transport is responsible for reimbursing the ambulance agency if the reason for transport does not meet the criteria listed above.

510.3.12 MATERNITY RELATED SERVICES

See [Chapter 300, Member Eligibility](#) for special considerations related to newborn eligibility.

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See [Chapter 519, Policy 519.19, Women's Health Services, Maternity Section](#) for information about coverage of maternity related services

REFERENCES

West Virginia State Plan references hospital services at sections [3.1-A\(1\)](#), [3.1-B\(1\)](#), [supplement 2 to attachments 3.1-A and 3.1-B\(1\)](#).

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in [Chapter 510, Policy 510.1 Hospital Services Overview](#) also apply to this policy.

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			TBD