



510.1 HOSPITAL SERVICES OVERVIEW

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DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

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POLICY METADATA

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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 Hospital Services provided to eligible WV Medicaid members by acute care, critical access, psychiatric and medical rehabilitation hospitals and any distinct part units therein.

Inpatient and outpatient hospital services, including tests furnished by participating hospitals, are covered only when ordered by a licensed medical practitioner for the care and treatment indicated in the management of illness, injury, or maternity care, or for the purpose of determining the existence of an illness or disease. All Medicaid covered items and services must be medically necessary. The physician's order and appropriate documentation of medical necessity must be on file in the patient's record. The fact that a provider has prescribed, recommended, or approved medical care, supplies/devices, or a service, does not in itself make such care, supplies/devices or services medically necessary or a covered service. For definition of medically necessary, refer to [Chapter 200, Definitions and Acronyms](#). For reimbursement information refer to [Chapter 600, Reimbursement Methodologies](#).

There must be documentation in the patient's record for all services billed to the West Virginia Medicaid Program, which substantiates the medical necessity for covered items or services. For Medicaid covered services or items requiring prior authorizations, the physician's order and documentation must be submitted prior to the provision of the service.

This chapter outlines or describes the allowable services which may be rendered within each of the categories of hospital providers: acute care, critical access, psychiatric, and medical rehabilitation.

The following policies are included in Chapter 510, Hospital Services:

- 510.1 Hospital Services Overview
- 510.2 Hospital Based Presumptive Eligibility (HBPE) Services
- 510.3 Hospital Inpatient Services
- 510.4 Hospital Outpatient Services
- 510.5 Partial Hospitalization Services

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POLICY

510.1.1 PROVIDER PARTICIPATION

Hospitals must be licensed in the state of West Virginia or the state in which they provide services and be qualified to participate in the Medicare Program. Refer to [Chapter 300, Provider Participation Requirements](#) for enrollment requirements for Hospital providers.

510.1.2 MEMBER ELIGIBILITY

Reimbursement for medically necessary Hospital Services is available for all WV Medicaid-eligible members, subject to the conditions and limitations applicable to these services. Additional information on member eligibility is located in [Chapter 400, Member Eligibility](#).

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Critical Access Hospital (CAH): Critical Access Hospital is defined in the Code of Federal Regulations at [CFR 42, Chapter 4, Section 400.202](#), as “a facility designated by the Centers for Medicare and Medicaid Services as meeting the applicable requirements of [Section 1820 of the Act](#) and [of Subpart F of Part 485](#) of this chapter. Characteristics of critical access hospitals include:

- Special reimbursement status, consisting of 100 percent cost reimbursement as determined by Medicare fiscal intermediary Number of beds: Except as permitted for CAHs having swing bed agreements (with Medicare) under [42 CFR 485.645](#), the CAH maintains no more than 15 inpatient beds.
- Length of stay. The CAH provides acute inpatient care for a period that does not exceed an average of 96 hours per patient annually.

Distinct Part Unit: A psychiatric or rehabilitation unit within an acute care hospital that specializes in the delivery of inpatient psychiatric or rehabilitation services. The unit must be reimbursed as a distinct unit as a sub provider on the Medicare cost report.

Hospital: Any institution, place, building, or agency in which an accommodation of five (5) or more beds, including beds that may be a part of a specialty unit, is maintained, furnished, or offered for patient care and treatment.

Psychiatric Hospital: to be licensed as a psychiatric hospital, a hospital shall be devoted exclusively to the care of psychiatric patients; have professional personnel especially qualified in the diagnosis and treatment of psychiatric disorders; have adequate facilities for the protection of the patients and staff; meet the requirements for a general hospital; and be in compliance with requirements at [42 CFR. 482.61](#) and [42 CFR 482.62](#).

Rehabilitation Hospital: to be licensed as a rehabilitation hospital a hospital shall be devoted exclusively to the care of patients requiring rehabilitation services and therapies; and have professional personnel



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especially qualified in the diagnosis and treatment of conditions requiring these services and therapies.

CHANGE LOG

| REPLACE | TITLE | CHANGE DATE | EFFECTIVE DATE |
|----------------|-------|-------------|----------------|
| Entire Chapter | | | TBD |

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