



# *Hospital Inpatient Services*

*Hospitals that are paid under the  
Prospective Payment System*

*Medicaid and Other Medical  
Assistance Programs*

*This publication supersedes all previous Hospital Inpatient Services handbooks. Published by the Montana Department of Public Health & Human Services, July 2005.*

*Updated December 2010, October 2011, April 2012, April 2013, July 2013, and January 2014.*

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**My NPI:**

the same payment are the services that were provided at the second hospital and transportation to the second hospital and back to the first hospital. Arrangement for payment to the transportation provider and the second hospital must be arranged between the first and second hospital and the transportation provider.

All transfers are subject to review for medical necessity. Initial hospitalizations, subsequent hospitalizations, and transfers may be reviewed for medical necessity. Reimbursement cannot be made to a provider unless the service provided was medically necessary.

The patient status code (FL 17 of the UB-04 paper claim form) should contain the appropriate discharge status code. The following discharge status codes are valid for Montana Medicaid.

<b>Discharge Status Codes</b>			
<b>Status Code</b>	<b>Description</b>	<b>Status Code</b>	<b>Description</b>
01	Discharged to home or self-care (routine discharge)	40	Expired (death) at home
02	Discharge/Transfer to another short-term general hospital for inpatient care	41	Expired in a medical facility (e.g., hospital, SNF, ICF, or free standing hospice)
03	Discharge/Transfer to skilled nursing facility (SNF)	42	Expired – place unknown
04	Discharge/Transfer to an intermediate care facility (ICF)	43	Discharge/Transfer to Federal hospital
05	Discharge/Transfer to another type of institution for inpatient care	50	Hospice – home
06	Discharge/Transfer to home under care of organized home health service organization	51	Discharge/Transfer to hospice medical facility
07	Left against medical advice or discontinued care	61	Discharge/Transfer within this institution to hospital-based Medicare-approved swing bed
08	Discharge/Transfer to home under care of a Home IV provider	62	Discharge/Transfer to another rehabilitation facility including rehabilitation distinct part units of a hospital
09	Admitted as an inpatient to this hospital	63	Discharge/Transfer to a long-term care hospital
20	Expired (death)	64	Discharge/Transfer to nursing facility certified under Medicaid, but not Medicare
30	Still a patient (Neonate providers discharge status code for interim billing.)	65	Discharge/Transfer to a psychiatric hospital or psychiatric distinct part unit of a hospital



When a member is moved from an acute care bed to a distinct part rehabilitation unit bed, it is considered a transfer.

## Bundled Services

Services that are included in the APR-DRG payment are considered bundled and include the following:

- Services provided on the day of admission or on the day preceding admission.
- All routine services. (See Coverage of Specific Services in the Covered Services chapter of this manual.)
- All diagnostic services (e.g., radiology). This includes diagnostic services that are performed at a second hospital because the services are not available at the first hospital (e.g., CT scan) as well as transportation between the two hospitals. See the Transfers section in this chapter.
- Donor/Harvesting.
- All ancillary services provided by the hospital or performed by another entity under contract with the hospital (e.g., hospital has a contractual agreement with an enrolled independent laboratory).

## Split/Interim Billing

Some inpatient hospital services necessitate the use of split or interim bills for Medicaid reimbursement. In general, providers cannot split bill APR-DRG claims, except in a few cases:

- When Medicare lifetime reserve days have been exhausted, inpatient claims must be submitted to the Department for review. (See Key Contacts.) Documentation of exhaustion must be attached to the claim.
- ***For members classified as hospital residents.*** Claims for members approved and classified as *hospital residents* may be interim billed on a monthly basis after the first 180 days. These claims must be sent to the Department with a letter of explanation for manual pricing. (See Key Contacts.) The Department may approve the special billing and forward the claim to the claims processing contractor for processing with pricing instructions. Before billing for residents, the provider must obtain resident status for the member. (See the Obtaining Resident Status section in the Covered Services chapter of this manual.)
- Hospitals subject to the inpatient hospital prospective payment reimbursement method may only interim bill when the member has been a patient in the same facility at least 30 days, is Medicaid-eligible for a minimum of these 30 days, and has received prior authorization, in which case the hospital may bill every 30 days. Interim claims are paid by a per diem amount multiplied by the number of covered Medicaid eligible days. Upon patient discharge, the interim claims will be voided or credited by the hospital and the hospital must bill a single admit through a discharge claim which will be paid by APR-DRG.
- The Department will not accept late charges (Type of bill = 115). Instead, hospitals are instructed to adjust earlier claims if appropriate.