



# *Hospital Inpatient Services*

*Hospitals that are paid under the  
Prospective Payment System*

*Medicaid and Other Medical  
Assistance Programs*

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# Covered Services

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## General Coverage Principles

Medicaid covers inpatient hospital services when they are medically necessary. This chapter provides covered services information that applies specifically to inpatient hospital services. Like all health care services received by Medicaid clients, these services must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information for Providers* manual.

### ***Hospital inpatient services (ARM 37.86.2801–2947)***

Inpatient hospital services are provided to Medicaid clients who are formally admitted as an inpatient and whose expected hospital stay is greater than 24 hours. Inpatient services must be ordered by a licensed physician or dentist and provided in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases. The institution must be currently licensed by the designated state licensing authority in the state where the institution is located, must meet the requirements for participation in Medicare as a hospital, and must have in effect a utilization review plan that meets the requirements of 42 CFR 482.30.

### ***Services for children (ARM 37.86.2201–2234)***

The Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all inpatient hospital services described in this manual. All applicable Passport to Health and prior authorization requirements apply.

### ***Importance of fee schedules***

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information for Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current ICD coding book. Take care to use the fee schedule and coding books that pertain to the date of service. Current fee schedules are available on the Provider Information [website](#) (see *Key Websites*).

## Physician Attestation and Acknowledgment (ARM 37.86.2904)

At the time a claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice:

*Notice to physicians: Medicaid payment to hospitals is based on all of each patient's diagnoses and the procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment or civil penalty under applicable federal laws.*

The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first client to the hospital. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. The provider may, at its discretion, add to the language of this statement the word *Medicare* so that two separate forms will not be required by the provider to comply with both State and Federal requirements.

## Utilization Reviews (42 CFR 456)

The Department or its contractor may at any time review paid claims, provider documentation for medical necessity, appropriate billing, etc. Providers must maintain documentation of medical necessity for services such as initial hospitalization, transfers and readmissions. For more information on provider requirements for maintaining documentation, see *Record keeping* in the *General Information for Providers* manual, *Provider Requirements* chapter. See also *Claims Review* in the *Introduction* chapter of this manual.

## Obtaining Resident Status (ARM 37.86.2921)

Providers must contact the Department to obtain hospital residence status prior to billing Medicaid (see *Key Contacts*). In order to qualify for residency status, a client must meet the following requirements:

- Use a ventilator for a continuous period of not less than 8 hours in a 24-hour period or require at least 10 hours of direct nursing care in a 24-hour period
- Must have been an inpatient in an acute care hospital for a minimum of 6 continuous months within the requesting facility.

It is the provider's responsibility to determine whether services could be provided in a skilled nursing care facility or by the home- and community-based waiver program. The provider must maintain written records of inquiries and responses

about the present and future availability of openings in nursing facilities and the home- and community-based waiver program. A redetermination of nursing facility or waiver availability must be made at least every 6 months.

## **Nursing Facility Placement**

Hospitalized Medicaid clients and Medicaid applicants being considered for nursing facility placement from the hospital shall be referred in a timely manner to the Department's designated review organization. This will allow preadmission screening to be accomplished before placement and payment is made on their behalf.

## **Coverage of Specific Services (ARM 37.86.2902)**

The following are coverage rules for specific inpatient hospital services. Inpatient hospital services included in the All Patient Refined Diagnosis-Related Group (APR-DRG) payment methodology include all routine services such as the following:

- Bed and board
- Nursing services and other related services
- Use of hospital facilities
- Medical social services
- Drugs, biologicals, supplies, appliances, and equipment furnished by the hospital for the care and treatment of inpatients
- Other diagnostic or therapeutic items or services provided in the hospital that are not specifically excluded (see *Noncovered Services* in this chapter) ARM 37.85.207.
- Outpatient services provided by the hospital facility the day of admission or the day before.

### ***Abortions (ARM 37.86.104)***

Abortions are covered when one of the following conditions are met:

- The client's life would be endangered if the fetus is carried to term.
- The pregnancy is the result of rape or incest.
- The abortion is determined by the attending physician to be medically necessary, even if the client's life is not endangered if the fetus is carried to term.

A completed *Medicaid Recipient/Physician Abortion Certification (MA-37)* form must be submitted with every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This form is the only form Medicaid accepts for abortion services.

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood, and explained to the client the prescribing information for mifepristone.

### ***Air transports***

Air transport providers must be registered with Medicaid as an ambulance provider. Claims for these services are billed on a CMS-1500 claim form. See the *Ambulance Services* manual available on the Provider Information website (see *Key Websites*).

### ***Chemical dependency treatment***

Chemical dependency services are limited. Providers must be approved by the Department before providing this service. Contact the Chemical Dependency Bureau for more information (see *Key Contacts*).

### ***Detoxification***

Detoxification services are covered for up to 7 days. More than 7 days may be covered if a hospital setting is required and the service has been authorized (see the *Passport* and/or *Prior Authorization* chapters in this manual). Services may also be covered if the Department or the Department's designated review organization determines that the client has a concomitant condition that must be treated in an inpatient hospital setting, and the detoxification treatment is a necessary adjunct to the treatment of the concomitant condition.

### ***Discharges***

A hospital's utilization review (UR) committee must comply with the Code of Federal Regulations 42 CFR 456.131 through 42 CFR 456.137 prior to notifying a Montana Medicaid client that he or she no longer needs medical care. The hospital is not required to obtain approval from Montana Medicaid at the client's discharge; however, a hospital's UR plan must provide written notice to Montana Medicaid if a client decides to stay in the hospital when it is not medically necessary (see *Hospital services beyond medical necessity* in the *Billing Procedures* chapter of this manual).

***Donor transplants***

Medicaid covers successful donor-related testing and services and organ acquisition services, which are bundled into the Medicaid client's transplant hospitalization, and are covered in this APR-DRG payment.

***Emergency department admissions***

Emergency medical services are those services required to evaluate, treat and stabilize an emergency medical condition.

***Mental health services***

Medicaid covers inpatient mental health services for Medicaid-enrolled clients when prior authorized (see the *Passport* and/or *Prior Authorization* chapters in this manual). Inpatient hospital services are not covered for adults enrolled in the Mental Health Service Plan (MHSP) but not covered for children enrolled in the Children's Mental Health Service Plan (CMHSP).

Providers should refer to the *Mental Health Manual* available on the Provider Information website (see *Key Websites*).

***Observation bed***

Clients in observation beds (admission of 72 hours or less) are considered outpatients and claims should be filed accordingly. See the *Hospital Outpatient Services* manual available on the Provider Information website.

***Out-of-state inpatient services (ARM 37.86.2801)***

Medicaid covers treatment in an out-of-state facility only when all of the following requirements are met:

- The client cannot be treated in state, and the provider contacts the prior authorization designated review organization (see *Key Contacts*) to determine if services are available in Montana before considering placement in an out-of-state facility.
- The provider received prior authorization for out-of-state services **before** the client is sent to an out-of-state hospital. See the *Passport* and/or *Prior Authorization* chapters in this manual for more information.

It is not the intent of the Montana Medicaid program to interfere or delay a transfer when a physician has determined a situation to be emergent. Prior authorization is not required in emergency situations. Emergency inpatient admissions must be authorized within 2 working days (Monday–Friday) of admission to an out-of-state hospital.

If a hospital that is located over 100 miles outside of the borders of Montana or a Center for Excellence hospital fails to obtain prior authorization before providing services to a Montana Medicaid client, retrospective authorization may be granted under the following circumstances only:

- The person to whom services were provided was determined by the Department to be retrospectively eligible for Montana Medicaid benefits;
- The hospital can document that the admission was an emergency admit for the purpose of stabilization or stabilization for transfer;
- The hospital must call for authorization within two working days (Monday–Friday) of the admission or knowledge of the client’s Medicaid eligibility;
- Interim claims equal to or greater than 30 days of continuous inpatient services at the same facility; or
- The hospital is retroactively enrolled as a Montana Medicaid provider, and the enrollment includes the dates of service for which authorization is requested; provided the hospital’s retroactive enrollment is completed, allowing time for the hospital to obtain prior authorization and to submit a clean claim within timely filing deadlines in accordance with ARM 37.85.406.

All out-of-state hospital services require prior authorization and may require Passport provider approval before services are provided.

### ***Readmissions***

All readmissions are subject to review for medical necessity of the initial as well as the subsequent hospitalization stays. Reimbursement cannot be made to a provider unless the service provided was medically necessary. Readmission may be reviewed on a retrospective basis to determine if additional payment for the case is warranted. If complications have arisen because of premature discharge and/or other treatment errors, then the APR-DRG payment for the first admission must be combined with the current admission before billing Medicaid. If the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the two admissions must be combined into one admission for payment purposes.

A client readmission occurring in an inpatient rehabilitation hospital three days prior to the date of discharge must be combined into one admission. Inpatient readmits within 24 hours must be combined if the same condition is coded.

### ***Same Day Readmission***

If a client is readmitted on the same day of discharge for the same condition, the entire stay must be billed as one admission.

If a client is readmitted on the same day of discharge for a separate condition, Medicaid may be billed for the new condition. The claim for the new condition and a letter of explanation including documentation for the separate condition must be sent directly to the Hospital Program Officer for review (see *Key Contacts*).

A client readmission occurring in an inpatient rehabilitation hospital three days prior to the date of discharge must be combined into one admission. Inpatient readmits within 24 hours must be combined if the same condition is coded.

Initial hospitalizations and readmissions are subject to review for medical necessity. Reimbursement cannot be made to a provider unless the service provided was medically necessary.

### ***Sterilization/Hysterectomy (ARM 37.86.104)***

#### **Elective Sterilization**

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when all of the following requirements are met:

1. Client must complete and sign the *Informed Consent to Sterilization* (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations (see *Appendix A: Forms* for the form and instructions). If this form is not properly completed, payment will be denied.

The 30-day waiting period may be waived for either of the following reasons:

- **Premature Delivery.** The *Informed Consent to Sterilization* must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
  - **Emergency Abdominal Surgery.** The *Informed Consent to Sterilization* form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.
2. Client must be at least 21 years of age when signing the form.
  3. Client must not have been declared *mentally incompetent* (see *Definitions*) by a Federal, State or local court, unless the client has been declared competent to specifically consent to sterilization.
  4. Client must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The client must be made aware of available alternatives of birth control and family planning.
- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or other substance which affects his/her awareness.

### **Medically Necessary Sterilization**

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and orchiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA-39). See *Appendix A: Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (Section B) or no life-threatening emergency (Section C) exists, the client and physician must sign and date Section A of this form prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). Also, for Section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the client (and representative, if any) was informed orally and in writing, prior to the

- surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when Sections B or C are used. Refer to *Appendix A: Forms* for more detailed instructions on completing the form.
- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
    - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
    - The reason for the hysterectomy was a life-threatening emergency.
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

### ***Transfers***

All diagnostic services are included in the APR-DRG payment. Diagnostic services that are performed at a second APR-DRG hospital, because the services are not available at the first hospital (e.g., a CT scan), are included in the first hospital's APR-DRG payment. This includes transportation to the second hospital and back to the first hospital. Arrangement for payment to the transportation provider and the second hospital where the services were actually performed must be between the first and second hospital and the transportation provider.

All transfers are subject to review for medical necessity. The initial hospitalization, all subsequent hospitalizations, and the medical necessity for the transfer itself may be reviewed. For information on billing and payment for transfers, see the *Billing Procedures* and the *How Payment Is Calculated* chapters in this manual.

### ***Transplants (ARM 37.86.4701–37.86.4706)***

Medicaid covers organ and tissue transplants that are medically necessary and not considered experimental or investigational. Organ transplants must be performed in a Medicare-certified facility. If Medicare has not designated a facility as being certified, the transplant must be performed by a program that is located in a hospital or parts of a hospital certified by the Organ Procurement and Transplantation Network (OPTN) for the specific organ being transplanted. A list of CMS-certified facilities can be accessed at the CMS website, <http://www.cms.hhs.gov>, and then search for “transplant program certification listing.”

Organ transplantation includes the transplant surgery and those activities directly related to the transplantation. These activities may include:

- Evaluation of the client as a potential transplant candidate
- Pre-transplant preparation including histocompatibility testing procedures
- Post-surgical hospitalization
- Outpatient care, including federal drug administration (FDA) approved medications deemed necessary for maintenance or because of resulting complications
- Associated medical expenses for the successful donor only. (These will be bundled into the Medicaid client's inpatient transplant hospitalization.)

These activities are covered by Medicaid as long as the client remains Medicaid-eligible and transplantation is prior approved. Services must comply with Medicare coverage guidelines for organ and tissue transplant services. If Medicare coverage guidelines are not available, the Department or the Department's designated review organization will review the requested transplant surgery to determine whether the surgery is experimental or investigational.

### **Noncovered Services (ARM 37.85.207 and 37.86.2902)**

The following medical and nonmedical services, except as otherwise specified in program-specific rules as a waiver service or an EPSDT service, are explicitly excluded from the Montana Medicaid program, except for those services specifically available, as listed in ARM 37.40.1406, 37.90.402, and Title 37, Chapter 34, Subchapter 9, to persons eligible for home- and community-based services; and except for those Medicare-covered services, as listed in ARM 37.83.812 to qualified Medicare beneficiaries for whom the Montana Medicaid program pays the Medicare premiums, deductible, and coinsurance.

- Chiropractic services
- Acupuncture
- Naturopathic services
- Dietician services (some services covered per ARM 37.86.3002)
- Physical therapy aide services
- Surgical technician services (technicians who are not physicians or mid-level practitioners)
- Nutritional services
- Masseur/Masseuse services
- Dietary supplements
- Homemaker services
- Home telephone service, remodeling of home, plumbing service, car repair, and/or modification of automobile

- Delivery services not provided in a licensed health care facility or nationally accredited birthing center unless as an emergency service
- Treatment services for infertility, including sterilization reversals
- Experimental services
- Bariatric services and surgery-related services (including bypass and revisions)
- Circumcisions not authorized by the Department as medically necessary
- Erectile dysfunction products, including but not limited to injections, devices, and oral medications used to treat impotence
- Sexual aids, including but not limited to devices, injections and oral medications
- Medical services furnished to Medicaid-eligible clients who are absent from the state including a child residing in another state for whom Montana makes adoption assistance or foster care maintenance payments are covered as in each program-specific rule and subject to the applicable conditions of those rules.
- Experimental services, services that do not comply with national standards of medical practice, non-FDA approved drugs, biologicals, and devices and clinical trials are excluded from coverage.
- Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of the Montana Medicaid program.

## Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

### ***Mental Health Services Plan (MHSP)***

This chapter does not apply to clients who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the *Mental Health* manual available on the Provider Information website (see *Key Websites*).

### ***Healthy Montana Kids (HMK)***

The information in this chapter does not apply to Healthy Montana Kids (HMK) clients. Hospital inpatient services for children with HMK coverage are covered by Blue Cross and Blue Shield of Montana (BCBSMT). For more information, contact BCBSMT at (877) 543-7669 (toll-free, follow menu) or (855) 258-3489 (toll-free, direct). Additional information regarding HMK is available on the HMK website (see *Key Websites*).

