510.1 HOSPITAL SERVICES OVERVIEW

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BACKGROUND

This chapter sets forth requirements of the West Virginia Bureau for Medical Services (BMS) regarding coverage, payment, and processing for Hospital Services provided to eligible Medicaid members by acute care, critical access, psychiatric, 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, 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 member's record. The fact that a provider has prescribed, recommended, or approved medical care, supplies/devices, or a service, does not 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 member'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 to the appropriate utilization management contractor (UMC) 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, Partial Hospitalization Services
- 510.3, Hospital Inpatient Services
- 510.4, Hospital Outpatient Services

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 Medicaid 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 West Virginia 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*.

510.1.3 Hospital Based Presumptive Eligibility

Hospital-Based Presumptive Eligibility (HBPE) was designed to identify and provide coverage for individuals who are likely eligible for Medicaid but are not enrolled. The Affordable Care Act gave hospitals the option to determine presumptive eligibility (PE) for certain Medicaid coverage groups. This is not an additional eligibility category; it is a method of determining temporary eligibility. A qualified hospital may elect to make presumptive eligibility determinations for populations whose eligibility is determined using the Modified Adjusted Gross Income (MAGI) methodology described in Chapter 10, Section 8 of the West Virginia Income Maintenance Manual. For additional information see *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: Consist 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 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 especially qualified in the diagnosis and treatment of conditions requiring these services and therapies.

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CHANGE LOG

SECTION	TITLE	EFFECTIVE DATE
Entire Chapter	Hospital Services Overview	January 1, 2024