510.3 HOSPITAL INPATIENT SERVICES

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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 inpatient hospital services provided to eligible West Virginia Medicaid members by acute care, critical access, psychiatric, and medical rehabilitation hospitals and any distinct part units therein.

POLICY

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. 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. 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 appropriate Utilization Management Contractor (UMC) in accordance with the procedures and admission criteria utilized by the appropriate UMC and approved by the BMS. Additionally, admissions must be based upon the written order of a physician enrolled in West Virginia Medicaid and licensed in the state in which the physician is located, and authorized to admit patients to the facility in which the service is rendered. See Centers for Medicare and Medicaid Services (CMS) 42 CFR Part 424 subpart B and 42 CFR 412.3 for further details on physician requirements.

510.3.1 Acute Care and Critical Access

Acute care is defined as short-term treatment or health care provided to a patient for a severe injury or episode of illness, or during recovery from surgery. The presence of Critical Access Hospitals in rural areas are a safety net for the provision of acute care. Critical Access Hospital is a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (CMS). The rural facilities provide short-term inpatient and limited outpatient hospital services to patients more than 35 miles from another hospital, have 25 or fewer acute care inpatient beds, maintain an annual average length of stay of 96 hours or less for acute care patients, and provide 24 hours a day, seven days a week emergency care service.

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

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 part of the inpatient services and are to be billed on one claim.

510.3.2 Organ Transplant Services

West Virginia Medicaid covers specific types of organ transplants performed in hospitals certified for participation in Title XVIII, Medicare, for the specific transplant procedure. Procedures may be performed out of state only when the authorized transplant cannot be performed in West Virginia because the service is not available or due to capacity limitations, the transplant cannot be performed in the necessary time period.

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; and
- The transplant is likely to prolong life and restore a range of physical and social function.

Criteria applicable to transplant services and facilities in West Virginia also apply to out-of-state transplant services and facilities.

Prior authorization is required for all transplants by the appropriate UMC. The following types of transplants are covered with prior authorization, if medically necessary:

- Heart transplant
- Bone marrow transplant
- Liver transplant
- Kidney transplant
- Pancreas/kidney transplant
- Lung transplant – single and double
- Heart/lung transplant
- Small intestine transplant
- Cornea transplant

The transplant of two organs during the same surgical procedure are not covered 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 Center for Organ Recovery and Education (CORE) 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 recipient's identification (ID) number.

510.3.3 Psychiatric Inpatient Facilities

A member admitted to a psychiatric distinct part unit must have a mental health diagnosis as the primary admission diagnosis consistent with the current Diagnosis and Statistical Manual (DSM) diagnosis for documentation purposes and the current International Classification of Diseases (ICD) diagnosis for billing purposes. If, however, 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 DRG. In these instances, the patient must be discharged from the distinct part unit when medically necessary and readmitted as an acute care medical admission followed by a medical necessity review and certification by the appropriate UMC. These psychiatric admissions will be subject to audit and cost settlement.

Medicaid also reimburses Psychiatric Residential Treatment Facilities (PRTFs) for members under 21. For further information see *Chapter 531, Psychiatric Residential Treatment Facility Services*.

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 in this setting must be billed separately under the practitioner's provider number if not included in the facility's invoice. Outpatient services may also be rendered in this setting, refer to *Chapter 521, Behavioral Health Outpatient Services*.

510.3.3.2 Inpatient Adult Psychiatric Services

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

- When rendered to Medicaid eligible adults age 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 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

An inpatient rehabilitation facility is a facility licensed to provide intensive rehabilitative services. An inpatient rehabilitation facility will be able to provide more intensive rehabilitation than a skilled nursing facility or home-based rehabilitation service.

Services covered in this setting are for medical inpatient rehabilitation services for Medicaid eligible individuals provided in a facility which meets certification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). 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. All services require prior authorization by the appropriate UMC.

510.3.5 Service Limits for Inpatient Services

Medicaid coverage places limits on certain categories of facilities with regard to admission review procedures, medical need, and age 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 appropriate UMC. Services that require prior authorization are identified on the appropriate UMC website.

General requirements by category of providers 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 appropriate 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 appropriate UMC.
4. Inpatient medical rehabilitation facility admissions are subject to both admission and continued stay review by the appropriate UMC.
5. The BMS will consider for reimbursement all emergency health care services that out-of-state providers furnish to West Virginia Medicaid members. The circumstances must be documented clearly as a medical emergency, and the services must be medically necessary. The provider must maintain complete documentation in the emergency room records and submit the information with the claim for reimbursement to both justify and document the emergency.
6. If a Medicaid member is deemed ineligible, due to age, income, etc., the inpatient services they are currently receiving will continue to be reimbursable by Medicaid as long as the medical necessity guidelines are being met according to the appropriate UMC.

510.3.5.2 Hospital Readmissions

All clinically related hospital admissions occurring within a 30-day period may be subject to review. Readmissions will be denied when any of the following are determined:

- A medical readmission for a continuation or recurrence of a previous admission or closely related condition (e.g., readmission for diabetes following initial admission for diabetes)
- A medical complication related to an acute medical complication related to care during the previous admission (e.g., patient discharged with urinary catheter readmitted for treatment of a urinary tract infection)
- An unplanned readmission for surgical procedure to address a continuation or recurrence of a problem causing the previous admission (e.g., readmitted for appendectomy following a previous admission for abdominal pain with fever)
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the previous admission (e.g., readmission for drainage of a post-operative wound abscess following an admission for bowel resection)
- A patient leaves against medical advice (AMA) and returns the same day to the same hospital (this would be considered part of the original admission).

Hospital readmission review determination as described above is specifically to determine if the readmission is clinically related and is not an assessment of medical necessity or appropriateness of setting. In the absence of information to determine the appropriateness of the readmission, clinically related readmissions within a thirty-day period will be automatically denied and the provider will need to submit medical documentation to support the need for payment.

510.3.5.3 Inpatient Non-Covered Services

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

- Admissions which are not authorized by the appropriate UMC in accordance with Medicaid policy in effect as of the date of service.
- Admissions other than emergency to out-of-network facilities for services which are available in-network.
- Admissions for experimental or investigational procedures.
- Admissions and/or continued stays which are strictly for patient convenience and not related to the care and treatment of a patient.
- 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

Emergency room services are medical services provided to an eligible member after the sudden onset of a medical condition with severe symptoms, including severe pain, so that the absence of immediate

medical attention could reasonably be expected to result in placing the patient's health in jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
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 and observation services which result in an inpatient admission are deemed to be part of the admission and not billed separately. Please see *Chapter 510, Policy 510.4 Hospital Outpatient Services*.

The BMS will consider for reimbursement all emergency health care services that out-of-state providers furnish to WV Medicaid members. The circumstances must be documented clearly as a medical emergency, and the services must be medically necessary. The provider must maintain complete documentation in the emergency room records and submit the information with the claim for reimbursement to both justify and document the emergency.

510.3.8 Hospital Transfers

The 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. The BMS pays transfer cases on a graduated per diem basis up to the full DRG payment amount.

All sending hospitals receive a graduated per diem amount based upon the DRG to which the case is assigned for that 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 DRG's related to the transfer or death of a neonate or diagnosis of burns, 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 may be eligible for Medicaid only for treatment of emergency medical conditions. For further information, refer to *Chapter 400, Member Eligibility.*

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 the PPCs, except as provided above.

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 is the responsibility of the original facility, not the Medicaid member or Non-Emergency Medical Transportation (NEMT) broker. 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/Newborn Related Services

A newborn child whose mother is Medicaid eligible at the time of the child's birth is eligible for Medicaid services for up to one year from the date of birth. The service must be billed with the newborn's Medicaid identification number and not with the mother's identification number.

For managed care members, the managed care entity the mother was enrolled in at the time of birth is responsible for claims incurred by a newborn up to two months after birth. See *Chapter 519, Practitioner Services, Policy 519.19 Women's Health Services* for information about coverage of maternity related services.

510.3.13 Long-Term Acute Care Hospitals

Long-Term Acute Care Hospitals (LTACs) furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple care or chronic conditions, that need hospital-level care for relatively extended periods. To qualify as an LTAC for West Virginia Medicaid payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average stay greater than 25 days. Many of the patients in an LTAC are transferred there from an intensive or critical care unit. An LTAC generally provides services such as respiratory therapy, head trauma treatment, and pain management. They do not provide services that are basically custodial (i.e. help with feeding or dressing).

West Virginia Medicaid reimburses for an LTAC hospital stay when medically appropriate, with Prior Approval.

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.

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). Standards for the coverage of organ transplant services is referenced in attachment 3.1.E.

CHANGE LOG

SECTION	TITLE	EFFECTIVE DATE
Entire Chapter	Entire Chapter: Hospital Inpatient Services Section 510.3.5.2: Added language: Hospital Readmissions Section 510.3.13: New benefit: Long-Term Acute Care Hospitals	January 1, 2024