

Chapter 14

Hospital Services

Hospital services include inpatient and outpatient services provided in a facility qualified to participate in Medicare. Hospital services must be medically necessary and provided by or under the supervision of a physician, dentist, or other provider having medical staff privileges in the hospital.

Definitions

Minnesota Critical Access Hospital (CAH): A facility designated as a Critical Access Hospital must meet criteria established in federal legislation as well as criteria required by the state. For critical access hospital criteria review [Minnesota Rural Hospital Flexibility Program and Critical Access Hospital Information](http://www.health.state.mn.us/divs/chs/rhpc/cah/index.html) on the Minnesota Department of Health (MDH) Web site at <http://www.health.state.mn.us/divs/chs/rhpc/cah/index.html>.

Diagnostic Related Groups (DRGs): An inpatient classification scheme, which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital, to establish prospective payment rates.

Emergency Department (ED) Care: Emergency department care must:

- Be provided in a hospital with a designated emergency department; and
- Reflect direct patient care, including active patient assessment, monitoring, and treatment by hospital medical personnel such as physicians, nurses, or lab and x-ray technicians.

Medical records must document the emergency diagnosis and the extent of direct patient care.

Emergency department care does not include unattended waiting time.

Emergency department care/emergency services are covered for a medical emergency. This means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; continuation of severe pain; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death. Labor and delivery is a medical emergency, if it meets this definition.

- The recipient must be seen by the medical professional on the same day that the member contacted the medical professional in order for the situation to be considered an emergency.
- The situation is not considered an emergency if the recipient contacts the medical professional and is not given an appointment for the same day of the call.
- Prescheduled services are not considered an emergency.
- Services provided as follow-up to initial emergency care are not considered emergency services.

Inpatient: A patient who has been admitted to a medical institution as an inpatient, as recommended by a physician or dentist, who:

- Receives room, board, and professional services in the institution for a 24-hour period or longer; or

- Is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged, or is transferred to another facility and does not actually stay in the institution for 24 hours.

Institution for Mental Disease (IMD): A facility with 17 or more beds that is primarily engaged in providing diagnosis, treatments, or care of persons with mental diseases, including medical attention, nursing care, and related services. Adults under age 65 who are patients in an IMD are not eligible for MA unless they are under age 21 at the time of admission.

Outpatient: A patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

Outpatient Hospital Services: Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided:

- To outpatients;
- By or under the direction of a physician or dentist;
- By an institution that is licensed or formally approved as a hospital by an officially designated authority for state standard-setting and meets the requirements for participation in Medicare as a hospital.

Outpatient Observation Status: Observation status is care received in a hospital facility that is not dependent on location, medical department, or whether a patient bed is assigned to the recipient. PrimeWest Health uses Medicare criteria for billing observation status.

Outpatient observation services are paid for up to 48 hours. Observation services will be considered for unusual circumstances up to 72 hours with documentation.

Patient: An individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

UB-92: The federal claim form for billing hospital services.

Eligible Providers

An eligible facility, meeting the definition of and licensed as a hospital, qualified to participate in Medicare, including a hospital that is part of the Federal Indian Health Service (IHS), designated by the federal government to provide acute care.

Eligible Members

All PrimeWest Health System members are eligible to receive inpatient and outpatient hospital services, except GAMC Hospital Only (GHO) recipients who are eligible only for inpatient services.

Additional Services

Professional services (e.g., anesthesiologist, physician) are covered in addition to outpatient or inpatient hospital services. Other services, such as lab, radiology, supplies, injectible drugs, may be separately covered services when outpatient hospital services are provided. Refer to the specific service chapters of this manual for coverage and billing policy.

Coverage Limitations

Services provided to an outpatient or inpatient, are subject to the same requirements that apply to other providers, including:

- Requests for authorization (refer to [Authorization](#), ch. 5);
- As of January 1, 2006, transplant prior authorization requests must be submitted to PrimeWest Health System Medical Administration by the physician's office rather than the transplant facility. The transplant facility can request verification of prior authorization approval prior to the surgery by contacting the physician or by calling the PrimeWest Health System Provider Call Center at 866-431-0802.
- Service authorization ID required for all hospital admissions (refer to [Inpatient Hospital Authorization](#), ch. 13).
- Consent forms/statements of acknowledgment for hysterectomies, voluntary sterilizations, and therapeutic abortions (refer to [Reproductive Health](#), ch. 10).

Covered Outpatient Hospital Services

An outpatient hospital clinic is a **non-emergency** service providing diagnostic, preventive, curative and rehabilitative services on a **scheduled** basis.

In medically indicated situations when the recipient's physical or mental disability is such that it is not in the best interest of the recipient to be physically moved to multiple outpatient hospital clinic sites, the outpatient hospital facility may bill a specialty clinic facility fee for each distinctly different specialty clinic service that is brought to the recipient at one clinic site.

PrimeWest Health follows the guidelines for claim completion are in the UB-92 claim form instructions and the State UB- 92 Manual.

When a recipient is admitted to a hospital as an inpatient and IHA is denied and/or the recipient does not meet inpatient criteria, services provided in the hospital may be PrimeWest Health covered when billed as outpatient hospital services if:

- The recipient was in the hospital for less than 48 hours (total), up to 72 hours with documentation;
- The stay has not been billed as an inpatient stay; and
- The admission hour and discharge hour are indicated on the claim. Code "99" (hour unknown) is not acceptable.

If a recipient is admitted to the hospital as an inpatient from an outpatient department of the hospital (e.g., emergency department, ambulatory surgical center, observation status whether or not a bed is used), charges from the outpatient services must be included in the inpatient hospital stay. Submit the date of admission as the date outpatient services began.

Cardiac Rehabilitation (93798, 93799)

Cardiac Rehabilitation is described by the U.S. Public Health Service as consisting of “comprehensive, long-term programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling.” It further states that these programs “are designed to limit the physiological and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse the athero sclerotic process, and enhance the psychosocial and vocational status of selected patients.” PrimeWest Health follows Medicare criteria for cardiac rehabilitation services.

- Cardiac rehabilitation services are the aftercare for myocardial infarction, coronary bypass surgery, stable angina, and other similar diagnoses.
- Cardiac rehabilitation services are for the following additional indications: heart valve replacement, angioplasty, heart or heart-lung transplant and congestive heart failure.
- Cardiac rehabilitation services include a recovery program primarily consisting of monitored exercise or exercise therapy with patient instruction and diagnostic testing services.
- A physician must be in the exercise area and immediately available for an emergency at all times the exercise program is being conducted. Services of non-physician personnel must be furnished under the direct on-site supervision of a physician.

Outpatient hospitals and physician directed clinics that have a Medicare approved cardiac rehabilitation program may provide cardiac rehabilitation services to PrimeWest Health members.

A cardiac rehabilitation program is 36 sessions. It is the provider’s responsibility to request authorization for additional sessions when more than 36 sessions will be provided.

Outpatient Observation Services

Covered outpatient observation services are reasonable and necessary to treat or diagnose a recipient, and are independent of other procedures (e.g., E/M procedure code is not required in addition to observation for payment of observation). Observation services are covered for up to 48 hours. PrimeWest Health will consider observation services for up to 72 hours for unusual circumstances when submitted with additional documentation.

Outpatient observation services are not covered when they are provided:

- In addition to a surgical procedure, unless the observation is monitoring or treatment beyond the community standard for the surgical procedure. Bill the unusual observation service with modifier “22,” and include an explanation of the unusual circumstances.
- Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.
- For the convenience of the patient, patient’s family or provider.

Observation Billing Policy

- Bill the facility component of observation services on the UB-92 or electronic equivalent

using revenue code 762. A procedure code is not required with revenue code 762.

- Bill observation services separately from surgical services.
- When observation services continue from one day to the next (over midnight), bill the beginning observation service date.
- When observation services are provided on two consecutive days, interrupted by a discharge, bill two distinct line items, each reflecting the specific service dates.
- When observation services are provided on two consecutive days but separate months, bill the beginning observation service date.
- For observation, one hour equals one unit. Round fractions of time less than 30 minutes down. Round fractions of time greater than 30 minutes up.
- Bill fetal monitoring using revenue code 762.
- G0244 is a covered service with diagnoses of chest pain, asthma or congestive heart failure. G0244 will not be paid in addition to another observation service.

Prolonged Intravenous Therapy

Prolonged IV therapy begins when the IV needle is in place, continues through the administration, and ends when the insertion site care is complete.

The following are billable in addition to the prolonged IV therapy:

- Blood;
- Blood products;
- Biologicals;
- Chemotherapy agents;
- Other drugs that require prolonged infusion; and
- Specialty catheters not routinely supplied.

Blood Transfusions

Blood transfusions require the actual number of units provided related to the specific product or procedure. Multiple units are not reported when the number of units included in the code description is multiple and the number of units used is equal to or below the unit measurement of the code (this is reported as one unit).

Pulse Oximetry

Pulse oximetry is considered part of the ED, ASC, or outpatient specialty clinic, and as such, is part of the APC payment. Bill pulse oximetry separately only when an E/M visit is the only other service provided.

Mental Health Partial Hospitalization (H0035)

Mental health partial hospitalization is a covered service for adults and adolescents if the hospital has received DHS approval for its partial hospitalization program (refer to [Mental Health Services](#), ch. 16).

Bill mental health partial hospitalization using HCPCS codes:

- H0035 - Mental health partial hospitalization, adult; or
- H0035 with modifier HA - Mental health partial hospitalization, adolescent.

One unit equals one hour.

UB-92 Billing Instructions for Outpatient Claims

Refer to the State UB-92 Manual for complete information.

- Bill outpatient hospital claims using type of bill (TOB) 13X or 14X.
- Critical access hospitals must use TOB 14X for referenced or referred diagnostic services.
- When attaching an Explanation of Medicare Benefits (EOMB), circle the recipient name related to the claim submitted on the EOMB.
- Bill outpatient authorized services on a separate claim from non-authorized services.
- Bill covered and non-covered services on the same claim.
- When more than one clinic visit (distinctly separate E/M service) is provided, bill with condition code G0 on the same or separate UB-92 claims (paper or electronic).

See the [CAH section](#) for billing instructions for critical access hospitals.

Copay Billing Policies

Effective October 1, 2003, copays apply to some services provided to MA and GAMC recipients. Copay guidelines are listed in [Health Care Programs & Services Chapter 2](#). Additional information is available in [Eyeglass & Vision Care Services Chapter 20](#).

Note: The non-emergency visit to a hospital-based emergency department copay will be deducted from the outpatient hospital facility claim. PrimeWest Health will use the type of admission in conjunction with the revenue code to determine whether or not the visit was considered an emergency visit or a non-emergency visit. PrimeWest Health will consider a type of admission equal to “1” in conjunction with revenue code 45X to be an emergency.

Non-covered Outpatient Hospital Services

The following outpatient hospital services are not covered and are ineligible for payment:

- Services provided by an employee of the hospital, such as an intern or a resident;
- Services lasting 24 hours or more, except for observation status;
- Detoxification that is not medically necessary to treat an emergency; and
- Outpatient hospital services that immediately precede an inpatient hospital admission.

Non-APC Facilities

The following facilities **are not subject** to the APC payment methodology:

- Community Mental Health Centers (CMHCs);
- Hospice;
- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Critical Access Hospitals (CAHs);
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs);
- Non-surgical Indian Health Services (IHS); and
- Free Standing Ambulatory Surgery Centers (ASCs).

Urgent Care facilities must follow Medicare guidelines for the facility charge.

Covered Inpatient Hospital Services

Inpatient hospital services are covered if determined medically necessary. Inpatient admission for detoxification is not covered under PrimeWest Health unless it is required for medical treatment. Inpatient hospitalization may be medically necessary due to conditions resulting from withdrawal or conditions occurring in addition to withdrawal and the conditions require constant availability of a physician and registered nurse and/or complex medical equipment found only in an inpatient hospital setting.

Inpatient Only Procedures

Dually Eligible Medicare and Medicaid Recipients

The CMS-identified inpatient only procedures provided to recipients who are dually eligible for Medicare and Medicaid must be provided in an inpatient setting for PrimeWest Health to pay the coinsurance and deductible amount. PrimeWest Health will not make payment if the inpatient only procedure is performed in an outpatient setting for a dually eligible Medicare/Medicaid recipient.

Medicaid Only Recipients

Providers may choose the appropriate place of service for patients who are eligible for Medicaid only.

Medicaid Recipients with TPL

Providers must follow the place of service rule of the primary payer. PrimeWest Health will not make payment if the place of service rule of the primary payer is not followed.

Non-covered Inpatient Hospital Services

The following inpatient hospital services are not covered:

- Leave days, leaves of absence, and reserve beds; and
- Inpatient chemical dependency treatment (covered under CCDTF and administered at the county or tribal level).

Inpatient Billing

Inpatient Admission Following Outpatient Services

If a member is admitted as an inpatient directly following outpatient hospital services (e.g., emergency department, ambulatory surgery, observation status whether or not a bed was used), the date and hour of the inpatient admission documented on the UB-92 inpatient bill must be the date and hour outpatient services began. Code “99” (hour unknown) is not acceptable.

Interim Billing

Inpatient hospital billing cannot be submitted until the member is discharged. However, for lengths of stay over 30 days, hospitals may submit replacement claims each month after the initial bill incorporating the previously billed/paid stay. Interim bills must include the Discharge Hour 99 (FL 21) and Patient Status Code 30 (FL 22), still an inpatient. If one or more interim payments have already been made, FL 37 must include the payer claim number (PCN) of the claim being replaced.

Deliveries and Births

Submit separate claims for a mother and her newborn. Newborns born on or after 10/1/04, whose mother is enrolled in a health plan at the time of birth will be retroactively enrolled in the same health plan for the birth month, unless the newborn meets an exclusion.

Rehabilitation

Submit separate claims for members with admissions to a Medicare designated rehabilitation unit, using the PrimeWest Health rehabilitation provider ID number. IHA must be sought for rehabilitation admissions. If a member is transferred between acute inpatient care and inpatient rehabilitation, each rehabilitation admission requires a different IHA number, unless the rehabilitation admissions are to be combined.

If the admissions to a Medicare designated rehabilitation unit are not issued separate IHA numbers by the medical review agent, indicate the days in the acute inpatient setting as leave of absence days. Similarly, if the admissions to acute inpatient are not issued separate IHA numbers or do not meet criteria for separate payment (refer to [Inpatient Hospital Authorization](#), ch. 13), indicate the days in the rehabilitation setting as leave of absence days.

For example, a member is admitted to an acute inpatient hospital, transferred to the rehabilitation unit, readmitted into the acute inpatient hospital, and a few days later is readmitted to the inpatient rehabilitation unit.

- If the admissions meet criteria for two acute inpatient payments, the provider must bill separate claims for each acute inpatient hospitalization with each hospital’s PrimeWest Health

provider ID number; and

- If the medical review agent did not issue a new IHA number for the second admission to the inpatient rehabilitation unit, the provider must submit one claim for both inpatient rehabilitation hospitalizations, indicating dates of the second acute inpatient hospitalization as leave days (refer to the State UB-92 Manual for the leave of absence span code), with its own IHA number, and with the hospital’s inpatient rehabilitation PrimeWest Health provider ID number.

Inpatient CRNA

A hospital may choose to remove CRNA costs from inpatient rates and have separate payment made for CRNA services. PrimeWest Health must be notified, in writing, of the hospital’s decision to remove CRNA costs from its inpatient rates.

Inpatient CRNA services are not separately billable for hospitals that choose to retain CRNA costs in their inpatient rates.

Enter	CMS-1500
The hospital PrimeWest Health provider ID number, where the CRNA services were performed.	In Box 33
The PrimeWest Health provider ID number of the CRNA, who performed the service,	In Box 24K
The 7-digit base hospital provider ID number, where the CRNA services were performed, with the suffix “00” added,	In Box 17a
The CRNA or physician’s PrimeWest Health provider ID number,	In Box 33
The PrimeWest Health provider ID number of the CRNA (who performed the service).	In Box 24K
The base hospital PrimeWest Health provider ID number (where the CRNA services were performed).	In Box 17a

MinnesotaCare

If a MinnesotaCare enrollee’s \$10,000 inpatient hospital limit has been reached, the enrollee is responsible for the balance of the hospital bill, unless the enrollee is eligible for MA. If eligible for MA, the hospital must bill DHS.

PrimeWest Health eligibility beginning after the date of inpatient admission

If a recipient's PrimeWest Health eligibility begins during an inpatient hospitalization, use the following instructions to complete the UB-92 for payment to be made:

- Admission Date is the actual date of hospital admission.
- From/To Date is the date eligibility began through the discharge date or final billing date.
- Remove all procedure codes that occurred before eligibility began.
- Remove all revenue codes and charges that were incurred before the eligibility date.
- If eligibility began on the day of hospital discharge, follow these 4 steps, submit a paper claim that includes a cover letter explaining that only charges for the last day of service can be paid, and mail it to the Claims Department at PrimeWest Health.

Minnesota Critical Access Hospital (CAH)

Payment for outpatient, emergency and ambulatory surgery hospital services provided by a CAH as designated under MS [144.1483](#) are made on a reasonable cost basis under the cost finding and allowable costs determined under the Medicare program according to MS [256B.75\(b\)](#).

CAH Outpatient Interim Payment

Unless your PrimeWest Health contract states otherwise, interim payment for outpatient services provided by a CAH will be at the Medicare interim payment rate under Part B expressed as a percentage to be applied to covered charges subject to legislative decreases and increases. The intent of the interim payment is to approximate the actual cost as nearly as possible to minimize the retroactive adjustment to be made on the basis of actual costs. Settlements to the interim rates are not performed or provided for at this time.

For CAH outpatient services, valid types of bills (TOB) are 851, 852, 853, 854, and 857. TOB 131 is not valid for CAH outpatient billing unless the CAH has been directed to use these codes by PrimeWest Health. Requirements for HCPCS procedure coding and revenue code reporting follow Medicare guidelines.

The following revenue codes require a HCPCS code: 0260; 0274; 0300 - 0369; 0400 - 0449; 0460 - 0499; 0530 - 0549; 0610 - 0619; 0636; 0730 - 0759; 0771; 0920 - 0929; 0940; 0942; 96X; 97X; and 98X.

CAH Inpatient Payment

Payment for inpatient hospital is made according to the terms in your PrimeWest Health contract, generally at the most recent interim inpatient payment rates for your facility. If a recipient is admitted to a CAH as an inpatient from an outpatient department of the hospital (e.g., emergency department, ambulatory surgical center, observation status whether or not a bed is used), charges from the outpatient services must be included in the inpatient hospital stay. The date of admission submitted is the date outpatient services began.

CAH and Professional Services

A CAH must bill for outpatient professional services according to Medicare.

Unless instructed by PrimeWest Health to bill all professional services on the CMS-1500 form, a CAH that has elected under Medicare to bill for outpatient professional services in the UB-92 format (paper or electronic) instead of the CMS-1500 format (also known as Option Method II) must bill PrimeWest Health accordingly. The CAH must list the professional services along with the appropriate HCPCS code(s) (physician or other practitioner) and one of the following revenue codes: 96X, 97X, and 98X. Payment will be up to 100% of the PrimeWest Health System physician fee schedule allowable before applicable reductions or adjustments.

A CAH that uses the standard method with billing to the Medicare Carrier must continue to bill on the CMS-1500 format. Payment will be at the facilities contracted rate, or up to 100% of the PrimeWest Health physician fee schedule allowable before applicable reductions or adjustments.

CAH and CRNA Services

CAHs will be paid for outpatient CRNA services according to Medicare.

A CAH that has applied and qualified for the CRNA billing exemption under Medicare Part B will be paid for such services by PrimeWest Health on a reasonable cost basis. Bill cost-based CRNA services in the UB-92 format (paper or electronic) using revenue code 0379 and no HCPCS procedure code.

A CAH that does not qualify for the CRNA billing exemption under Medicare Part B will be paid according to the PrimeWest Health fee schedule. Bill in the CMS-1500 format (paper or electronic) using the appropriate HCPCS code(s). Refer to Outpatient CRNA Billing in [Anesthesia Services](#), ch. 7.

It is noted that the Medicare CRNA payment method may be different from the method elected by a CAH for inpatient services under PrimeWest Health. That is, a CAH may have elected to remove CRNA costs from its PrimeWest Health inpatient rates under Minnesota Rules [9500.1105](#), subp. 1 A (2) and have separate payment under the PrimeWest Health fee schedule.

CAH and Exhausted Medicare Benefits

If a CAH submits a PrimeWest Health inpatient claim because a recipient has exhausted Medicare Part A benefits but has billed Medicare Part B, use TOB 13X to submit Medicare Part B payment rather than 85X. The Part B services will be paid as a Medicare crossover under OPPS and offset against CMS inpatient payment.

CAH and Home Health Services

Medicaid-covered home health services provided by a CAH are not paid based on a reasonable cost basis. Home health services continue to be paid under the PrimeWest Health fee schedule using TOB 341. Medicare-eligible home health episodes of care should be billed using the HH PPS billing guidelines as prescribed by CMS.

CAH and CD Services

Outpatient hospital services billed by a CAH under the Consolidated Chemical Dependency Treatment Fund (CCDTF) must use TOB 85X. Payment will be according to CCDTF rates and not based on the reasonable cost basis.

CAH and Ambulance Services

Ambulance services provided by a CAH or an entity that is owned and operated by a CAH are not paid based on the reasonable cost basis. Ambulance services continue to be paid under the PrimeWest Health fee schedule.

Legal References

MS [144.1483](#)

MS [144.50](#)

MS [256B.0625](#), subd. 1; subd. 4

MS [256B.32](#)

MS [256D.03](#), subd. 4

MS [256L.03](#), subd. 3

MS [256.9685](#); [256.9686](#); [256.969](#); [256.9695](#)

Minnesota Rules [9500.1090 to 9500.1140](#); [9505.0300](#); [9505.0500 to 9505.0540](#)

42 CFR 440.10

42 CFR 440.20