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 CAH must meet criteria established in Federal legislation as well as criteria required by the state. For CAH criteria, review *Minnesota Rural Hospital Flexibility Program and Critical Access Hospital Information* on the Minnesota Department of Health (MDH) website.

Allowable Base Year Operating Cost: A hospital's base year inpatient hospital cost per admission or per day that is adjusted for case mix and excludes property costs.

Base Year: A hospital's fiscal year from which cost and statistical data are used to establish rates.

Case Mix: A hospital's distribution of admissions among the diagnostic categories.

Day Outlier: An admission where the length of stay exceeds the geometric mean length of stay for neonate and burn diagnostic categories by one standard deviation and all other diagnostic categories by two standard deviations.

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 Care: Emergency department care must:
1. Be provided in a hospital with a designated emergency department; and
2. 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.
1. The member 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.
2. The situation is not considered an emergency if the member contacts the medical professional and is not given an appointment for the same day of the call.
3. Prescheduled services are not considered an emergency.
4. 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, and meets one of the following criteria:
1. Receives room, board, and professional services in the institution for a 24-hour period or longer
2. 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

Inpatient Hospital Costs: A hospital's base year inpatient hospital service costs determined under the cost finding methods of Medicare that includes direct and indirect medical education, without regard to adjustments in payments by Medicare.

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

Local Trade Area Hospital: A hospital with 20 or more Medical Assistance (Medicaid) admissions in the base year that is located in a state other than Minnesota but in a county contiguous to Minnesota and located in a metropolitan statistical area, as determined by Medicare, for the October 1 prior to the most current re-based rate year.

Low-Volume Local Trade Area Hospital: A metropolitan statistical area hospital located outside Minnesota in a county contiguous to Minnesota that has less than 20 Medical Assistance (Medicaid) admissions in the base year.

Operating Costs: Inpatient hospital costs excluding property costs.

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 as follows:
1. By or under the direction of a physician or dentist
2. 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 member. IMCare 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.

Property Costs: Inpatient hospital costs, including depreciation, interest, rents and leases, property taxes, and property insurance.

Rate Year: A calendar year from January 1 through December 31.

Trim Point: That number of inpatient days beyond which an admission is a day outlier.

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 IMCare members are eligible. Refer to *Benefits* section for coverage determination.

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, and injectable 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.

Delivering Provider Services

IMCare encourages delivering providers to review the MN–ITS Evidence-Based Hospitals list.

Coverage Limitations

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

1. Requests for authorization. Refer to Chapter 5, Service Authorization.
2. Service Authorization identification (ID) required for all hospital admissions except for normal deliveries (vaginal or Cesarean sections). Refer to Chapter 13, Inpatient Hospital Notification and Authorization.
3. Consent forms/statements of acknowledgment for hysterectomies, voluntary sterilizations, and therapeutic abortions. Refer to Chapter 10, Reproductive Health – Obstetrics and Gynecology.

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 member's physical or mental disability is such that it is not in the best interest of the member 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 member at one clinic site. Refer to Chapter 4, Billing Policy, for additional information regarding claims submission.

When a member is admitted to a hospital as an inpatient and inpatient Service Authorization is denied and/or the member does not meet inpatient criteria (see Chapter 13, Inpatient Hospital Notification and Authorization, for more information), services provided in the hospital may be covered by IMCare when billed as outpatient

hospital services if the following apply:
1. The member was in the hospital for less than 48 hours (total); up to 72 hours with documentation
2. The stay has not been billed as an inpatient stay
3. The admission hour and discharge hour are indicated on the claim. Code "99" (hour unknown) is not acceptable.

Claims must include the reason for *unscheduled* outpatient visits. Please note the following:
1. An unscheduled outpatient visit is defined as type of bill (TOB) 013X or 085X with type of admission 1, 2, or 5 and revenue codes 045X, 0516, 0526, or 0762
2. Outpatient claims must include the ***International Classification of Diseases, 10th Revision, Clinical Modification*** (ICD-10-CM) code describing the patient's stated reason or condition (such as follow-up or pregnancy in labor)
3. The reason for visit is not required for all *scheduled* outpatient encounters. It may be reported for scheduled visits, such as encounters for ancillary tests, when the data provides additional information to support medical necessity.

If a member is admitted to the hospital as an inpatient from an outpatient department of the hospital (e.g., emergency department, Ambulatory Surgical Center [ASC], 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.

Hydration, Infusion, Drug Injections, and Chemotherapy Administration

Initial Codes: 96360, 96365, 96374, 96409, 96413

1. **96360**: Initial hydration up to one hour
2. **96374**: Initial intravenous (IV) drug push
3. **96365**: Initial IV infusion up to one hour
4. **96409**: Initial chemotherapy IV drug push
5. **96413**: Initial chemotherapy IV infusion up to one hour

Service delivery does not drive coding selection. Report the one initial code with the highest level of service provided during that visit or day regardless of the time administered during the visit. After selection of the initial code, report all additional related services provided with add-on, subsequent, or concurrent codes.

1. Add-on, subsequent, and concurrent codes: 96361, 96366-96379, 96411, 96415 – 96549
2. 96368: Concurrent infusions, only reportable once per encounter.

Modifier 59: Reporting of modifier 59 is only appropriate when the member has return visit(s) on the same day or if there is more than one IV site (multiple IV lines running into a single IV site do not qualify as multiple sites). Documentation is required.

96523-(IV irrigation): Code 96523 is not reportable if an injection, infusion, or Evaluation and Management (E/M) is provided on the same day.

Cardiac Rehabilitation (93798, 93799)

Cardiac rehabilitation is described by the United States 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 atherosclerotic process, and enhance the psychosocial and vocational status of selected patients." IMCare follows Medicare criteria for cardiac rehabilitation services.

1. Cardiac rehabilitation services are the aftercare for myocardial infarction, coronary bypass surgery, stable angina, and other similar diagnoses.
2. Cardiac rehabilitation services are for the following additional indications: heart valve replacement, angioplasty, heart or heart-lung transplant, and congestive heart failure.
3. Cardiac rehabilitation services include a recovery program primarily consisting of monitored exercise or exercise therapy with patient instruction and diagnostic testing services.
4. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. IMCare follows the Centers for Medicare & Medicaid Services (CMS) for services furnished in the hospital or CAH or in an on-campus outpatient department of the hospital or CAH.

Outpatient hospitals and physician-directed clinics that have a Medicare-approved cardiac rehabilitation program may provide cardiac rehabilitation services to IMCare 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 member 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. IMCare 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 as follows:

1. 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.
2. Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG
3. For the convenience of the patient, patient's family, or provider

All hospitals and critical access hospitals (CAHs) are required to provide written notification and an oral explanation to individuals receiving observation services as outpatients for more than 24 hours using the Medicare Outpatient Observation Notice (MOON), which is a standardized notice.

Observation Billing Policy

1. Bill the facility component of observation services on the 837I claim form or electronic equivalent using revenue code 762. A procedure code is not required with revenue code 762.
2. Bill observation services separately from surgical services.
3. When observation services continue from one day to the next (over midnight), bill the beginning observation service date.
4. When observation services are provided on two consecutive days, interrupted by a discharge, bill two distinct line items, each reflecting the specific service dates.
5. When observation services are provided on two consecutive days but separate months, bill the beginning observation service date.
6. 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.
7. Bill fetal monitoring using revenue code 762.
8. 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.
9. Any observation services over 72 hours that are denied need to be Appealed with supporting information for consideration of any additional payment.

Direct Admission to Observation Status

1. Use code G0379.
2. Hospitals may bill for members who are directly admitted to observation. G0379 is reportable once per observation stay.
3. A direct admission occurs when a physician in the community refers the member to the hospital for observation, bypassing the clinic or emergency department.

Prolonged Intravenous (IV) 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:
1. Blood
2. Blood products
3. Biologicals
4. Chemotherapy agents
5. Other drugs that require prolonged infusion
6. 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 emergency department, ASC, or outpatient specialty clinic and, as such, is part of the Ambulatory Payment Classification (APC) payment. Bill pulse oximetry separately only when an E/M visit is the only other service provided.

Mental Health Partial Hospitalization

Mental health out of network partial hospitalization is a covered service for adults and adolescents if the hospital has received IMCare approval for its partial hospitalization program. Notify IMCare when a member starts his/her mental health partial hospitalization out of network. Bill mental health partial hospitalization using one of the following Healthcare Common Procedure Coding System (HCPCS) codes:
1. H0035 – Mental health partial hospitalization, adult
2. H0035 with modifier HA – Mental health partial hospitalization, adolescent

One unit equals one hour. Refer to Chapter 16, Mental Health Services.

Billing Instructions for Outpatient Claims

1. Bill outpatient hospital claims using TOB 13X or 14X.
2. CAHs must use TOB 14X for referenced or referred diagnostic services.

3. Bill outpatient authorized services on a separate claim from non-authorized services.
4. Bill covered and non-covered services on the same claim.
5. When more than one clinic visit (distinctly separate E/M service) is provided, bill with condition code G0 on the same or separate claim.
6. Identify the place of service (POS) with either 19 (Off-Campus Outpatient Hospital) or 22 (On-Campus Outpatient Hospital)

See the *Minnesota Critical Access Hospitals (CAH)* section for billing instructions for CAHs.

Copay Billing Policies

Copays apply to some services provided to Medical Assistance (Medicaid) members. Copay guidelines are listed in Chapter 2, Health Care Programs and Services.

Note: The non-emergency visit to hospital-based emergency department copay will be deducted from the outpatient hospital facility claim. IMCare 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. IMCare 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:

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

Non-Ambulatory Payment Classification (APC) Facilities

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

1. Community Mental Health Centers (CMHCs)
2. Hospice
3. Comprehensive Outpatient Rehabilitation Facilities (CORFs)
4. CAHs
5. Federally Qualified Health Centers (FQHCs)
6. Rural Health Clinics (RHCs)
7. Non-surgical Indian Health Service (IHS)
8. Freestanding 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 services provided by the same hospital on two separate patient care units by two medical services are billed as one continuous admission. This includes patients transferred between acute general medical/surgical services to or from general psychiatric services.

Inpatient admission for detoxification is not covered under IMCare 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. The medical records of members admitted for detoxification are subject to retrospective review by the medical review team. Inpatient

medical detoxification and/or treatment of sequelae resulting from drug or alcohol ingestion are billed as any other acute inpatient admission.

Inpatient-Only Procedures

Dually Eligible Medicare and Medicaid Members

The Centers for Medicare & Medicaid Services (CMS)-identified inpatient-only procedures provided to members who are dually eligible for Medicare and Medicaid must be provided in an inpatient setting for IMCare to pay the coinsurance and deductible amount. IMCare will not make payment if the inpatient only procedure is performed in an outpatient setting for a dually eligible Medicare/Medicaid member.

Medicaid-Only Members

IMCare identifies procedures that should be performed only in an outpatient setting. IMCare follows Medicare guidelines for payment for inpatient-only procedures and pays for these procedures only on inpatient claims.

Medicaid Members with Third Party Liability (TPL)

Providers must follow the POS rule of the primary payer. IMCare will not make payment if the POS rule of the primary payer is not followed.

Point of Origin of Admission Code

Effective for hospital admissions on and after July 1, 2010, Point of Origin of Admission code 7 (emergency department) is no longer a valid code for hospital admissions.

There is no specific replacement Point of Origin of Admission code. Providers are advised to use the most appropriate code instead, keeping in mind that UB-04 Form Locator 15 now is defined as Point of Origin (where the patient came from before presenting to the facility), and is no longer used to report the Source of Admission.

Example: When a patient presents to the emergency department and subsequently is admitted as an inpatient, the Point of Origin code would be 1 if the patient came from home or any other non-health care facility location.

Present on Admission (POA) Indicator

The POA indicator is now required for all inpatient claims. POA is defined as "present at the time the order for inpatient admission occurs." Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA.

MN Stat 256.969, subd. 3b, indicates that the State will no longer pay for services related to a hospital-acquired condition. IMCare adopted this MHCP guideline and requires the POA indicator on all inpatient claims for all hospital provider types (acute care and critical access). We will use this indicator to identify services related to a hospital-acquired condition.

Per Minnesota Law, you are not to bill the member for any payment disallowed due to this ruling.

The POA indicator is assigned to principal and secondary diagnoses and the external cause of the injury codes. CMS does **not** require a POA indicator for the external cause of injury code unless it is being reported as an "other diagnosis."

Birth Weight requirement

Hospitals must include value code 54 (Newborn Birthweight in Grams) on all claims for babies under 29 days at time of admission. This is regardless of whether the baby was born inside or outside the hospital, and whether the newborn was transferred to or from the hospital. If an ICD-10 diagnosis code indicating birth weight is reported on the claim, the birth weight must correlate to the weight reported with value code 54.

Covered Days

Covered Days are reported with value code 80.

Effective for discharges on or after October 1, 2015, value code 80 is required to indicate covered days, which is equivalent to accommodation days. If the value code is not listed, the claim will be rejected.

Non-Covered Inpatient Hospital Services

The following inpatient hospital services are not covered:
1. Leave days
2. Leaves of absence
3. Reserve beds

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 837I claim format must be the date and hour outpatient services began. Code "99" (hour unknown) is not acceptable. Outpatient includes services provided in the emergency department, ambulatory surgery, radiology, and observation status whether or not a bed was used.

Fee-for-Service (FFS) and Managed Care Organization (MCO) Transition During Inpatient Hospital Stay

Effective June 1, 2016, if a member changes health plans or changes from fee-for-service (FFS) to a health plan while he/she is in the hospital, the effective date of the health plan enrollment is no longer dependent on inpatient admit or discharge dates.

The previous health plan or FFS in effect at the time of admission remains financially responsible for the inpatient hospital services for that hospital stay and any related professional and ancillary services until discharge from the hospital.

The new health plan will be responsible for the services that are not related to the inpatient hospital stay beginning on the effective date of the enrollment. The same policy applies when a member changes from a health plan to FFS.

If a member's IMCare coverage changes from FFS to managed care during a hospital stay, bill FFS for the entire stay.

If a member's coverage changes from IMCare to FFS during a hospital stay, bill IMCare for the entire stay.

Inpatient Admission Following Outpatient Services for Discharge Date Prior to October 1, 2015

If a member is admitted as an inpatient immediately following outpatient services (e.g., emergency department, ambulatory surgery, radiology, or observation status) at the same hospital, submit information in the following fields using these guidelines:

1. Statement Covers Period
   a. Report the "From" date using the date outpatient services began
   b. Report the "Through" date using the date service ended for the period reflected on the bill
2. Covered Days/Non-Covered Days
   a. "Covered Days" includes both inpatient and outpatient service dates, whether or not a bed was used
   b. Do not count the day of discharge unless the patient is still a patient
   c. Report "Non-Covered Days" as the number of days of care not covered (e.g., leave of absence days)
   d. "Covered Days" plus "Non-Covered Days" must equal the "Statement Covers Period"
3. Admission Date:
   a. Report the actual admission date
   b. Admission date can be before or after the "From" date
4. Procedure Codes: Use ICD-9-CM procedure code(s) for the date service was rendered

Inpatient Admission Following Outpatient Services—for Discharge Date on or after October 1, 2015

Include outpatient services provided immediately before an inpatient admission on the inpatient claim regardless of discharge date. **Please note that the definition of covered days changed as of October 1, 2015.**

Covered days are equivalent to the room and board days. Report covered days with value code 80 regardless of the date of discharge. Outpatient services were and continue to be included on the inpatient claim when outpatient services occur prior to admission.

Use the following information to report inpatient admission following outpatient services date for discharge date on or after October 1 2015:

1. Outpatient days are no longer included in the covered days when the admitting hospital delivers outpatient services immediately prior to the inpatient admission.
2. Covered Days/Non-Covered Days
   a. Include outpatient services on the inpatient claim when outpatient services occur prior to admission.
   b. Do not count the day of discharge.
   c. Do not include the outpatient days in the covered days count.
   d. Covered days are equivalent to room and board days.
3. Admission Date: Report the actual admission date.
4. Procedure codes: Use ICD-10-CM procedure codes for the date service was rendered

Outpatient Services Treated as Inpatient Services

All services other than ambulance and maintenance renal dialysis services provided by the hospital (or an entity wholly owned or wholly operated by the hospital) and provided on the same date of the inpatient admission are deemed related to the admission and are not separately billable. Also, services provided on the first, second, and third calendar days preceding the date of admission are related to the admission, and thus must be billed with the inpatient stay, unless the hospital attests to specific non-diagnostic services as being unrelated to the inpatient hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the admission) by adding a condition code 51 to the separately billed outpatient non-diagnostic services claim. Effective April 1, 2011, providers may submit outpatient claims with condition code 51. Refer to Chapter 11, Laboratory/Pathology, Radiology, and Diagnostic Services, regarding billing of diagnostic services. All diagnostic services provided to a IMCare member on the date of the member's inpatient admission and during the three calendar days immediately preceding the date of admission would continue to be

required to be included on the bill for the inpatient stay.

Preventive Screenings

Screening services when provided to hospital inpatients should be billed using 12X TOB and will be paid at outpatient payment methodology.

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 and Patient Status Code 30, still an inpatient. If one or more interim payments have already been made, the original claim number of the claim being replaced must be entered in the Original Reference Number field of the claim format.

Deliveries and Births

Submit separate claims for a mother and her newborn. Newborns 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 provider NPI number. Service Authorization must be sought for rehabilitation admissions when out of network. If a member is transferred between acute inpatient care and inpatient rehabilitation, each rehabilitation admission requires a different Service Authorization number, unless the rehabilitation admissions are to be combined.

If the admissions to a Medicare-designated rehabilitation unit are not issued separate Service Authorization 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 Service Authorization numbers or do not meet criteria for separate payment (refer to Chapter 13, Inpatient Hospital Notification and Authorization), 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 is readmitted to the inpatient rehabilitation unit a few days later.

1. 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 IMCare provider ID number; and
2. If the medical review/utilization management team did not issue a new Service Authorization 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 with its own Service Authorization number and the hospital's NPI.

Same Day Transfers

When a member is transferred from one facility to another facility before midnight of the same day, the condition code of 40 must be assigned to the claim or the claim will be denied.

The original provider must bill as follows:

1. Indicate "0" in Covered Days;
2. Insert condition code 40 to indicate the member was transferred from one participating provider to another before midnight on the day of admission; **and**
3. Ensure that the admission date and statement "from" and "through" dates are the same.

Respite Care
Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time for Medicare beneficiaries.

The total number of general inpatient care days and inpatient respite care days may not exceed 20 percent of the total days provided to a hospice recipient.

Incarcerated Members

When an incarcerated member is covered by other health insurance, the health care provider must bill that insurance before submitting the bill to the appropriate county or Department of Corrections (DOC) for reimbursement. If the member is enrolled in IMCare, claims for inpatient services should be submitted to the Minnesota Department of Human Services (DHS). This includes services provided in the following:
1. 21 – Inpatient Hospitals
2. 51 – Inpatient Psychology Facility
3. 61 – Inpatient Rehabilitation Facility

The claim will deny. Call the Minnesota Health Care Programs (MHCP) Provider Call Center at **1-651-431-2700** or **1-800-366-5411** to report claims that denied because the member was enrolled in IMCare for the date of service. MHCP will replace and pay the claims through Fee-for-Service (FFS). IMCare will not pay for inpatient services while the member was incarcerated. Providers should contact the appropriate county jail or correctional facility regarding how to bill for any outpatient services that were provided.

Medicare Exhausted Benefits for Members with Dual Eligibility (Non-IMCare Classic [HMO SNP] Members)
If a IMCare member has dual eligibility with Medicare and exhausts Medicare benefits during an admission, the hospital can be paid the greater of the Medicare payment, including deductible and coinsurance (Medicare beneficiary responsibility is paid by IMCare), or the payment less Medicare payment including deductible and coinsurance.

Do the following when Medicare Part A benefits are exhausted:
1. Submit the inpatient charges to IMCare as primary
2. Follow the Electronic Claim Attachments instructions in Chapter 4, Billing Policy
3. Attach the Medicare's (Part A and Part B) explanation of benefits (EOB) for date of service(s) (DOS)
4. Write "Medicare Part A Benefits Exhausted" on top of Medicare EOBs

Spenddown
When members have a spenddown satisfaction date, inpatient claims must be submitted using the first date of eligibility (the spenddown satisfaction date) as the "from" date. The date of admission must contain the date of the member's admission to the inpatient hospital.

Inpatient Certified Registered Nurse Anesthetist (CRNA)
A hospital must remove Certified Registered Nurse Anesthetist (CRNA) costs from inpatient rates and have separate payment made for CRNA services. Inpatient CRNA services are not separately billable for hospitals that choose to retain CRNA costs in their inpatient rates.

Bill separately on the 837P for enrolled CRNA services provided in an inpatient hospital setting by any of the following:
1. A CRNA who is independent or employed by a physician
2. A CRNA employed by a hospital
3. An entity or group not enrolled as a hospital that is billing CRNA services
4. A critical access hospital (CAH) that does not qualify for the CRNA billing exemption under Medicare Part

Minnesota Critical Access Hospitals (CAHs)

Critical Access Hospitals(CAHs) are paid at a rate that is designated by CMS and based on each hospital separately. Payment for outpatient, emergency, and ambulatory surgery hospital services provided by a CAH as designated under MN Stat. sec. 144.1483 are made on a reasonable cost basis under the cost finding and allowable costs determined under the Medicare program according to MN Stat. 256B.75(b). Every fiscal year the rates change for the providers, but these rates can also change quarterly or monthly as well.

It is the provider's responsibility to submit CAH rates to IMCare and update IMCare with any changes to the rates **prior to the submission of claims** for that rate period. Once IMCare receives the updated rates, please allow up to 30 days for programming of the rates to be completed. **We do not reprocess claims received prior to the date the change is made in our system**.

Please mail or fax all CAH rate updates and changes to:

IMCare
1219 SouthEast 2nd Ave
Grand Rapids, MN 55744

Fax: **1- 218-327-5545**

IMCare requires all CAH providers to fax or mail CAH rates for claims processing on an annual basis. IMCare follows up with contracted CAH providers on a quarterly basis to verify their current CAH rate.

IMCare will process all CAH claims with the current rates on file at IMCare at the time the claim is received, regardless of participating or non-participating provider status with the IMCare provider network. If the current rates on file were received more than one year ago, claims will deny. Providers must send updated rates and resubmit the claim to be considered for reimbursement.

CAH Outpatient Interim Payment

For CAH outpatient services, valid TOBs 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 IMCare.
Requirements for HCPCS procedure coding and revenue code reporting follow Medicare guidelines.

The following revenue codes require a HCPCS code: 0250, 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 IMCare contract, generally at the most recent interim inpatient payment rates for your facility. If a member is admitted to a CAH as an inpatient from an outpatient department of the hospital (e.g., emergency department, ASC, 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 IMCare 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-04 format (paper or electronic) instead of

the CMS-1500 format (also known as Option Method II) must bill IMCare 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, or 98X. Payment will be up to 100 percent of the IMCare 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 facility's contracted rate, or up to 100 percent of the IMCare 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 IMCare on a reasonable cost basis. Bill cost-based CRNA services in the UB-04 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 IMCare fee schedule. Bill in the 837P format using the appropriate HCPCS code(s). Refer to *Enrolled CRNA – Employee Billing* in Chapter 7, Anesthesia Services.

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

CAH and Exhausted Medicare Benefits

If a CAH submits an IMCare inpatient claim because a member 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 the Outpatient Prospective Payment System (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 IMCare fee schedule using TOB 341. Medicare-eligible home health episodes of care should be billed using the Home Health Prospective Payment System (HH PPS) billing guidelines as prescribed by CMS.

CAH and Chemical Dependency (CD) Services

Outpatient hospital services billed by a CAH must use TOB 85X.

CAH and Ambulance Services

Ambulance services provided by a CAH or an entity that is owned and operated by a CAH are paid based on the reasonable cost basis.

Hospital In-Reach Service Coordination (IRSC)

Overview

IMCare covers hospital in-reach service coordination (IRSC) to reduce instances of emergency department

(ED) and other non-medically necessary health care utilization. Hospital IRSC brings together health care and community-based services for IMCare members for up to 60 days after hospital discharge. It includes helping the member navigate and coordinate services to address mental and chemical health; housing; transportation; employment; peer support services; and other health, social, and economic needs. Hospital IRSC also connects the member with existing covered services available to him/her, such as targeted or waiver case management or care coordination in a Health Care Home (HCH).

Eligible Providers

Hospitals may employ or contract with the following individual providers to provide hospital IRSC:

1. Clinical Nurse Specialist – Mental Health (CNS-MH)
2. Licensed Independent Clinical Social Worker (LICSW)
3. Licensed Marriage and Family Therapist (LMFT)
4. Licensed Professional Clinical Counselor (LPCC)
5. Licensed Psychologist (LP)
6. Mental health rehabilitative professional
7. Nurse practitioner (NP)
8. Physician
9. Physician assistant (PA)

Hospitals may also employ or contract for IRSC with a coordinator who is not one of the above-named provider types. This contracted coordinator must be supervised by one of the providers listed above and have, at minimum, a bachelor's degree in social work, public health, corrections, or a related field.

Enrolled Community-Based Providers

MHCP-enrolled community-based providers need to sign and submit to MHCP a Community-based Providers for In-Reach Service Coordination (IRSC) – Applicant Assurance Statement (DHS-3898) so their records indicate they are IRSC program participants.

In-Reach Service Coordinators

Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field.

Eligible Members

Before performing the assessment, IMCare recommends that providers determine if the member is already receiving services that would make him/her ineligible for participation in in-reach care coordination.

Members receiving the following services are not eligible to participate:

1. Health care home services
2. Mental Health Targeted Case Management (MH-TCM) services
3. Health care delivery system (HCDS) demonstration project services

IRSC is available to members of any age with three or more emergency department visits in the previous four consecutive months.

The qualifying emergency department services and inpatient stays are not limited to a single hospital. Clinicians may use the Minnesota Information Transfer System (MN–ITS) Health Information Request (HIR) User Guide clinical tool to access a more complete medical history for IMCare members. The HIR User Guide clinical tool can help prevent duplication of services. If multiple providers deliver IRSC one or more days during a 60-day service period, IMCare will reimburse all providers for the initial assessment; however, only the provider whose

claim is filed first with IMCare will be reimbursed for the follow-up continuing service.

Reimbursement Period

The 60-day service reimbursement period begins on either of the following:
1. On the date of the initial assessment for members identified in the emergency department
2. On the date of discharge from the hospital for members identified during hospitalization

Members enrolled in the following IMCare programs are eligible for hospital IRSC services:

BB FF JJ	MinnesotaCare
LL	MinnesotaCare Child
MA	Medical Assistance (Medicaid)
NM	State-funded Medical Assistance (Medicaid)

Covered Services
IMCare covers hospital IRSC performed through a hospital ED. Covered services include coordination and navigation services and services rendered to connect eligible members with existing IMCare-covered services and community-based services and resources available.

The provider must perform an initial assessment of the member to evaluate the following:
1. Mental and chemical health needs
2. Housing needs
3. Transportation needs
4. Employment needs
5. Peer support services needs
6. Other health, social, and economic needs, including an assessment of other services that the member may be eligible for or receiving, such as targeted or waiver case management or care coordination in an HCH

Follow-up services after the initial assessment include navigation and coordination services to help the member access a continuum of services to reduce frequency of visits to a hospital ED for non-medically necessary health care utilization. These services may address the member's needs determined in the initial assessment. Services may be provided in the member's living environment or by phone.

Hospital IRSC:
1. May be provided for up to 60 days after the discharge date of the ED visit or inpatient hospital admitting event that results from an ED visit;
2. Is limited to two non-overlapping 60-day periods per calendar year, if there are a minimum of three ED visits or inpatient admitting events that resulted from an ED visit; and
3. Is limited to a total of 80 hours across one or both 60-day periods.

Non-Covered Services

The following services are not covered under hospital IRSC:
1. Services over 80 hours within a calendar year
2. More than two non-overlapping 60-day occurrences within a calendar year
3. Other existing covered services (for example, transportation, housing, mental health services, and chemical health services)

Billing

1. Use the electronic 837P Professional claim format.
2. Use procedure code T1016 with modifier U2 for the initial hospital IRSC assessment.
3. Use procedure code T1016 with modifier U2 and TS for follow-up hospital IRSC services.
4. Services are billable in 15-minute unit increments.
5. Use the hospital NPI as the billing provider.
6. Report the NPI of the treating professional; if the services are provided by an in-reach service coordinator, report the NPI of the supervising professional as the treating provider.

Legal References

MN Stat. sec. 144.1483 – Rural Health Initiatives
MN Stat. sec. 144.50 – Hospitals, Licenses; Definitions
MN Stat. sec. 256B.0625, subd. 1 – Covered Services: Inpatient hospital services
MN Stat. sec. 256B.0625, subd. 4 – Covered Services: Outpatient and physician-directed clinic services
MN Stat. sec. 256B.32 – Facility Fee Payment
MN Stat. sec. 256B.75(b) – Hospital Outpatient Reimbursement
MN Stat. sec. 256L.03, subd. 3 – Covered Health Services: Inpatient hospital services
MN Stat. sec. 256.9685 – Establishment of Inpatient Hospital Payment System
MN Stat. sec. 256.9686 – Definitions
MN Stat. sec. 256.969 – Payment Rates
MN Stat 256.969, subd. 3b – Nonpayment for hospital-acquired conditions and for certain treatments
MN Stat. sec. 256.9695 – Appeals of Rates; Prohibited Practices for Hospitals; Transition Rates
MN Rules part 9505.0300 – Inpatient Hospital Services
MN Rules parts 9505.0501 – 9505.0540 – Hospital Admissions Certification
MN Rules part 9500.1105, subp. 1. A. (2) – Basis of Payment for Inpatient Hospital Services: Reporting requirements
Title 42 Code of Federal Regulations (CFR) Part 440.10 – Inpatient hospital services, other than services in an institution for mental diseases
42 CFR 440.20 – Outpatient hospital services and rural health clinic services