HOSPITAL SERVICES

ND Medicaid covers inpatient and outpatient services provided by hospitals that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

COVERED HOSPITAL SERVICES

Covered hospital services are subject to the following:

- Ambulance services are not payable to hospitals on an institutional claim and must be billed on a professional claim.
- Readmission to inpatient care on same day as discharge must be combined as one inpatient stay except when readmission is unrelated to original inpatient stay diagnosis and treatments.
- Outpatient services provided on the day of discharge may not be separately billed and must be included on the inpatient claim.
- Separate payments will be made for the mother and the newborn. The newborn and mother's charges must be billed on separate claims for each member.
- Charges should reflect the usual and customary charge of the hospital. Only the patient's due amount is subject to payment by Medicaid.
- Miscellaneous codes need a description and supporting documentation.

NONCOVERED SERVICES

An inpatient stay that is less than 24 hours is not payable by ND Medicaid.

The following items are noncovered services and must be identified as noncovered if billed on an institutional claim:

- Admission Kits
- Ambulance Charges
- Barber/Beauty
- Biofeedback
- Books/Tapes
- Guest Tray
- Late Discharge
- Leave of Absence Room
- Lifeline
- Linen
- Non-Patient Room Rent
- Nursing – Outpatient
- Patient Convenience Items
- Postage
- Private Room
- Social Services
- Take Home Drugs
- Take Home Supplies
- Tax
- Technical Support Charges
- Telemetry in ICU
- TV/Telephone/Radio

Refer to the Noncovered Medicaid Services policy for further information.

BILLING GUIDELINES

ND Medicaid does not reimburse revenue codes 510-519 for hospital-based clinic services.

Claims for dual eligibles (Medicare and Medicaid) should be billed as follows:

- If the member has Part A Medicare, charges for an inpatient stay must be billed entirely on an institutional claim.
- If the member has only Medicare Part B and incurs charges during an inpatient stay, the Part B charges must first be submitted to Medicare. After Medicare processes, the charges should be submitted to ND Medicaid on an institutional claim and include all charges for the inpatient stay. The institutional claim must include the Medicare Part B payment amount.
- If the member receives Medicare Part B services on an outpatient basis, the charges must first be submitted to Medicare. After Medicare processes, the charges should be submitted to ND Medicaid and must be billed on an institutional claim.

Effective January 1, 2023, North Dakota Medicaid will require a valid HCPCS code for Revenue Code 0250 on all outpatient services. A NDC must also be submitted if the HCPCS code requires it.

« IN-STATE PROSPECTIVE PAYMENT SYSTEM HOSPITALS

INPATIENT SERVICES

Payment to In-state acute prospective payment system (PPS) hospitals is based on All Patient Refined – Diagnosis Related Groups (APR-DRG) version 39 for inpatient services. The APR-DRG system classifies patients into clinically consistent groups with similar length-of-stay (LOS) patterns and utilization of hospital resources.

Claims for services that will be reimbursed using APR-DRG cannot be submitted until the patient is discharged or transferred.

APR-DRG claims are paid based on the DRG relative weight times the hospital-specific rate. A capital payment will be included for all discharges. A cost outlier may be paid in addition to the base payment if the calculated cost based on covered charges exceeds the APR-DRG threshold.

- Cost Outlier for APR DRGs 580-640 (Newborns and Other Neonates)
  Covered charges * hospital IP CCR – (57,000 or 1.5 * DRG) * .80 = cost outlier
- Cost Outlier for all APR DRGs except 580-640
  Covered charges * hospital IP CCR – (60,000 or 2 * DRG) * .60 = cost outlier

3-Day Payment Window

When a member is admitted to a short-term acute care hospital, the hospital must review up to three days prior to the inpatient admission to see if any related outpatient services, diagnostic and non-diagnostic, were provided to the member by the hospital and/or facility that is owned/operated by the hospital. If there were related outpatient services in the 3-day window, they are not covered as separate services and must be included on the inpatient claim along with other related services.

OUTPATIENT SERVICES

The Enhanced Ambulatory Payment Grouping system (EAPG) applies to PPS hospital outpatient departments.

EAPGs are assigned to each line based on submitted claims information, including patient characteristics, ICD-10 codes, and CPT/HCPCS codes. The EAPG assignment for a given line may be affected by coding on other lines of service for the same claim. Packaging, consolidation, and discounting may be applied based on other services provided during the same visit. A visit is all related services provided to one patient in one service encounter; a claim may comprise multiple visits.

All outpatient services or visits occurring on the same day for a member must be billed on one claim.

EAPG claim lines are paid based on the EAPG relative weight times, the hospital-specific rate times, and any applicable discounting factors. **»**

IN-STATE CRITICAL ACCESS HOSPITALS

Inpatient Services

Payment for inpatient services provided by in-state critical access hospitals (CAH) is made on a per diem rate.

- Claims must be submitted each calendar month on a separate claim form.
- Room and board (Revenue Codes 0100-0219) will be reimbursed on a per diem basis. The number of units billed for room and board Revenue Codes should include the date of discharge or death.
- Revenue Codes 0300-0319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

Outpatient Services

Payment for outpatient services provided by a CAH is made on a percentage of charges.

ND Medicaid does not recognize Method II billing for CAH.

- Emergency room services should be billed as outpatient services on a separate claim form.
- Observation days and inpatient days cannot overlap.
- Physician services should be billed on a professional claim.
- Revenue Codes 0300-0319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

OUT OF STATE HOSPITALS

An out-of-state hospital is defined as one located in the United States and more than 50 miles from the North Dakota border.

Payment to out-of-state hospitals is based on a percentage of charges for both inpatient and outpatient services.

Out-of-state services require prior approval from ND Medicaid. See Out of State Services policy for additional information.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.
- Revenue Codes 0300-0319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

REHABILITATION FACILITIES

Payment for inpatient services provided by a rehabilitation facility is made on a per diem basis. Payment for outpatient rehabilitation services is made on a percentage of charges. Inpatient rehabilitation stays are subject to a limit of 30 days per stay «at a distinct rehabilitation unit» for patients 21 years of age and older.

- Claims must be submitted on a separate claim form each calendar month. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.

LONG-TERM CARE HOSPITALS

Payment for services provided by a long-term care hospital (LTCH) is made based on a percentage of charges.

LTCH services require prior approval from ND Medicaid.

- Claims must be submitted on a separate claim form each calendar month. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.

PSYCHIATRIC HOSPITALS

Payment for inpatient services provided by a psychiatric hospital is made on a per diem basis.

ND Medicaid will cover inpatient psychiatric services for members under 21 years of age if the member meets the certificate of need criteria.

Inpatient psychiatric services in a free-standing psychiatric hospital of more than 16 beds are noncovered for members ages 21 through 64.

- Claims must be submitted on a separate claim form each calendar month. All claims for a patient stay must be submitted at the same time.
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.

KIDNEY DIALYSIS SERVICES

Effective for service dates on or after March 1, 2021, HCPCS code A4657—Syringe, with or without needle, will not be paid separately and will be considered incidental to the dialysis service performed on that day.

Kidney dialysis claims must be submitted to ND Medicaid using the following Revenue *Codes* when billing for:

Revenue Code **0634**	Erythropoietin (OPE) < 10,000 units
Revenue Code **0771**	Vaccine Administration
Revenue Code **0821**	Hemodialysis Composite or Other Rate
Revenue Code **0831**	Peritonea/Composite or Other Rate
Revenue Code **0841**	CAPD/Composite or Other Rate
Revenue Code **0851**	CCPD/Composite or Other Rate