



HOSPITAL SERVICES

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This provider manual outlines policy and claims submission guidelines for claims submitted to the North Dakota Health Enterprise MMIS.

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

COVERED HOSPITAL SERVICES

Covered hospital services are subject to the following requirements:

- Ambulance services are not payable to hospitals on UB-04 form and must be billed on a CMS 1500 claim form.
- Readmission to inpatient care on same day as discharge must be levied 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 reimbursements will be made for the mother and a newborn.
- Charges should reflect the usual and customary charge of the hospital. Only the patient due amount is subject to reimbursement by Medicaid.
- Miscellaneous codes need a description and report.

NON-COVERED HOSPITAL SERVICES

The following is a list of non-covered services that must be identified as non-covered if billed on a UB-04 claim form:

- Admission Kits
- Ambulance Charges
- Nursing – Outpatient
- Patient Convenience Items

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

Please refer to the Non-Covered Services guidelines for further information.

THIRD PARTY LIABILITY

Medicaid is considered a payer of last resort. Therefore, all third party liability must be utilized before Medicaid can be billed.

Medicare claims should be billed as follows:

- If the patient has Part A Medicare, charges for an inpatient stay must be billed entirely on a UB-04 claim form.
- If the patient has only Medicare Part B and incurs charges during an inpatient stay, the Part B charges must first be submitted to Medicare. The claim should then be submitted to Medicaid on a UB-04 claim form and include all charges for the inpatient stay. The UB-04 claim must include the Medicare Part B reimbursement amount.
- If the patient receives Medicare Part B services on an outpatient basis, all charges must be billed on a UB-04 claim form.

IN-STATE PROSPECTIVE PAYMENT SYSTEM HOSPITALS

INPATIENT SERVICES

Reimbursement to in-state acute prospective payment system (PPS) hospitals is based on All Patient Refined - Diagnosis Related Groups (APR-DRG) 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. Reimbursement for an acute hospital stay is based on these groups which are comprised of diagnosis and procedure codes reported by the provider.

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

3-DAY PAYMENT WINDOW

When a patient 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 patient by the hospital and/or facility that is owned/operated by the hospital. These services are not covered as separate services and must be included on the inpatient claim along with other related services.

OUTPATIENT SERVICES

The Outpatient Prospective Payment System (OPPS) applies to all hospital outpatient departments.

Each HCPCS code billed that is reimbursed under the OPPS which is assigned to an ambulatory payment classification (APC). A hospital may receive a number of APC reimbursements for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting.

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

IN-STATE CRITICAL ACCESS HOSPITALS

INPATIENT SERVICES

Reimbursement for inpatient services provided by in-state Critical Access Hospitals (CAH) is made on a per diem rate.

- Claims must be submitted with the appropriate bill type. The bill type frequency must coincide with the status code billed.
- Claims must be submitted each calendar month on a separate claim form.
- Room and board (revenue codes 100-219) 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 300-319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

OUTPATIENT SERVICES

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

ND Medicaid does not recognize Method II billing for CAH.

- Claims must be submitted with the appropriate bill type.
- 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 CMS-1500 claim form.
- Revenue codes 300-319, 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 a hospital that is located in the United States and is more than 50 miles from a North Dakota border.

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

The patient must obtain prior approval from ND Medicaid for out-of-state services.

- Claims must be submitted with the appropriate bill type. The bill type frequency must coincide with the status code billed.
- 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 100-219) should include the date of discharge or death.
- Revenue codes 300-319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

REHABILITATION FACILITIES

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

- Claims must be submitted with the appropriate bill type. The bill type frequency must coincide with the status code billed.
- 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 100-219) should include the date of discharge or death.

LONG TERM CARE HOSPITALS

Reimbursement for services provided by a Long Term Care Hospital (LTCH) is made based on a percentage of charges.

The patient must obtain prior approval from ND Medicaid for LTCH services.

- Claims must be submitted with the appropriate bill type. The bill type frequency must coincide with the status code billed.
- 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 100-219) should include the date of discharge or death.

PSYCHIATRIC HOSPITALS

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

ND Medicaid will cover inpatient psychiatric services for individuals under 21 years if the individual meets certificate of need criteria.

Inpatient psychiatric services are not covered for individuals 22-64.

- Claims must be submitted with the appropriate bill type. The bill type frequency must coincide with the status code billed.
- 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 100-219) should include the date of discharge or death.

KIDNEY DIALYSIS SERVICES

Kidney dialysis claims must be submitted to ND Medicaid using a *Bill Type 131* kidney dialysis units and *Bill Type 721* for freestanding kidney dialysis facilities.

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

Revenue Code **634**

Revenue Code **821**

Erythropoietin (OPE) < 10,000 units

Hemodialysis composite or other rate.

BILLING GUIDELINES

In-state and out-of-state hospitals must bill for services using the North Dakota Web Portal using the electronic claims submission web pages or Electronic Data Exchange transaction. The claim must include a valid National Provider Identification number (NPI) and taxonomy code.