



ADMINISTRATIVE RULES OF MONTANA



37.86.2801 ALL HOSPITAL REIMBURSEMENT, GENERAL

- (1) Reimbursement for inpatient hospital services is set forth in ARM 37.86.2806, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, 37.86.2928, 37.86.2943, and 37.86.2947. Reimbursement for outpatient hospital services is set forth in ARM 37.86.3005, 37.86.3006, 37.86.3007, 37.86.3009, 37.86.3014, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3022, 37.86.3025, 37.86.3037, and 37.86.3109. Cost of hospital services will be determined for inpatient and outpatient care separately. Administratively necessary days are not a benefit of the Montana Medicaid program.
- (2) The department may require providers of inpatient or outpatient hospital services to obtain authorization from the department or its designated review organization either prior to provision of services, prior to admission, or prior to payment.
- (3) Medicaid reimbursement shall not be made or shall be reduced unless the provider has obtained authorization from the department or its designated review organization prior to providing any of the following services:
 - (a) inpatient psychiatric services provided in an acute care psychiatric hospital, acute care general hospital or a distinct part psychiatric unit of an acute care general hospital, and outpatient partial hospitalization as required by ARM 37.88.101:
 - (i) if prior authorization is not obtained, the claim will be denied;
 - (ii) Medicare crossover claims do not need prior authorization; and
 - (iii) third party liability claims must be prior authorized.
 - (b) services related to transplantations covered under ARM 37.86.4701 and 37.86.4705:
 - (i) if prior authorization is not obtained, the claim will be denied;
 - (ii) Medicare crossover claims must be prior authorized; and
 - (iii) third party liability claims must be prior authorized.
 - (c) any other services for specific diagnosis or procedures that require all Medicaid providers to obtain prior authorization:
 - (i) if prior authorization is not obtained, the claim will be denied;
 - (ii) Medicare crossover claims must be prior authorized; and
 - (iii) third party liability claims must be prior authorized.

- (d) inpatient services in facilities designated as a Center of Excellence and all out-of-state facilities:
 - (i) if prior authorization is not obtained, reimbursement of the inpatient claim will be 50% of the amount calculated in (1); except in claims subject to (3)(a), (b), and (c) will be denied;
 - (ii) Medicare inpatient crossover claims do not need prior authorization except claims subject to (3)(b) and (c); and
 - (iii) inpatient third party liability claims must be prior authorized:
 - (A) if prior authorization is not obtained, reimbursement of the inpatient third party liability claim will be 50% of the amount calculated in (1); except claims subject to (3)(a), (b), and (c) will be denied.
- (4) Upon request, the department may grant retroactive authorization for the provision of the hospital's services when:
 - (a) the person to whom services were provided was determined by the department to be retroactively eligible for Montana Medicaid benefits including hospital benefits;
 - (b) the hospital can document that at the time of admission it did not know, or have any basis to assume, that the client was Montana Medicaid eligible;
 - (c) the hospital can document that the admission was medically necessary for purposes of emergency stabilization or stabilization for transfer;
 - (d) interim claims in a PPS hospital equal to or greater than 30 days of continuous inpatient services at the same facility; or
 - (e) the hospital is retroactively enrolled as a Montana Medicaid provider, and the enrollment includes the dates of service for which authorization is requested provided the hospital's retroactive enrollment is completed allowing time for the hospital to obtain prior authorization and to submit a clean claim within timely filing deadlines in accordance with ARM 37.85.406.
- (5) For purposes of (4)(a), (b), and (c) the hospital must call for authorization within three working days (Monday through Friday) of the admission or the date it gained knowledge of the client's Medicaid eligibility and must meet the requirements for timely filing as specified in ARM 37.85.406:
 - (a) the basis for the request must be documented in the client's hospital record; and
 - (b) providers seeking retroactive authorization for adult mental health claims must submit their requests in writing.
- (6) The department or its designated review organization may approve a request for prior authorization when the service is medically necessary under any of the following conditions:
 - (a) the client travels to another state because the department finds the required inpatient services are not available in Montana, or it is determined by the department that it is general practice for clients in a particular locality to use inpatient resources in a border hospital, or an in-state qualified provider who could normally render the inpatient service but does not think they can adequately treat the client;

- (b) there is a medical emergency and the recipient's health would be endangered if the client were required to travel to Montana to obtain the medical services;
 - (c) the client, or the client's representative, can demonstrate to the satisfaction of the department that medical services represent the least costly service and all other viable alternatives have been exhausted per medical standards of care; or
 - (d) the client is a child residing in another state for whom Montana makes adoption assistance or foster care maintenance payments.
- (7) Medicaid reimbursement for early elective delivery and nonmedically necessary cesarean sections will not be made unless the hospital submitting the claim meets the following requirements:
- (a) Effective July 1, 2014, a hospital submitting claims for deliveries must have a hard stop policy regarding early elective deliveries and nonmedically necessary cesarean sections that complies with the requirements in ARM 37.86.2902(9).
 - (b) Effective October 1, 2014, hospital claims for inductions and cesarean sections must meet the following coding requirements:
 - (i) current ICD inpatient procedure codes must be used on all inpatient hospital claims; and
 - (ii) claims for inductions or cesarean sections must have one of the following condition codes:
 - (A) Condition Code 81—cesarean section or induction performed at less than 39 weeks for medical necessity;
 - (B) Condition Code 82—cesarean section or induction performed at less than 39 weeks gestation elective; or
 - (C) Condition Code 83—cesarean section or induction performed at 39 weeks gestation or greater.
 - (iii) The department will begin accepting these coding changes as of July 1, 2014.
 - (c) Beginning October 1, 2014, the department will reduce reimbursement to hospitals that perform early elective inductions or cesarean sections prior to 39 weeks and 0/7 days gestation, or nonmedically necessary cesarean sections at any gestation:
 - (i) a 33% reduction in PPS reimbursement; or
 - (ii) cost-based hospital interim reimbursement will be reduced 33% and the total claim payment will not be eligible for final reimbursement through cost settlement as provided in ARM 37.86.2806.
- (8) All hospitals must use current ICD procedure codes for inpatient claims and current CPT codes for outpatient claims, including Medicare crossover claims.

Authorizing statute(s): 2-4-201, 53-2-201, 53-6-113, MCA

Implementing statute(s): 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

History: NEW, 1983 MAR p. 756, Eff. 7/1/83; EMERG, AMD, 1985 MAR p. 1160, Eff. 8/16/85; AMD, 1987 MAR p. 1658, Eff. 10/1/87; AMD, 1991 MAR p. 1027, Eff. 7/1/91; AMD, 1992 MAR p. 1496, Eff. 7/17/92; AMD, 1993 MAR p. 1520, Eff. 7/16/93; AMD, 1994 MAR p. 1732, Eff. 7/1/94; AMD, 1995 MAR p. 1162, Eff. 7/1/95; AMD, 1996 MAR p. 459, Eff. 2/9/96; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1388, Eff. 6/18/99; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2001 MAR p. 27, Eff. 1/12/01; EMERG, AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 1991, Eff. 8/1/02; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05; AMD, 2006 MAR p. 3078, Eff. 1/1/07; AMD, 2008 MAR p. 1983, Eff. 10/1/08; AMD, 2010 MAR p. 1534, Eff. 7/1/10; AMD, 2011 MAR p. 1391, Eff. 7/29/11; AMD, 2014 MAR p. 1415, Eff. 7/1/14.