Priority Health	BILLING POLICY No. 079
SEMIPRIVATE VS PRIVATE ROOM	
Date of origin: Mar. 18, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Semi-private and private hospital rooms refer to various levels of accommodation and privacy for patients in a hospital setting. A semi-private room is shared accommodation with another patient. A private room is not shared with another patient.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

We reimburse the same payment for routine hospital accommodations, regardless of the room type, unless certain specific circumstances exist. Under the following circumstances, we'll cover the private room charges:

- When it's medically necessary to isolate a patient to protect the patient's health or recovery for the wellbeing of other patients
- If a private room is the only available option and the hospital stay is medically necessary
- In cases where the facility exclusively offers private accommodations

We won't reimburse additional charges associated with a private room when requested by the member without a written order for medical necessity. In this case, the member would be responsible for covering the difference between the semi-private and private room rates.

We require the reporting of condition codes and value codes to identify the purpose of a private room verses semi-private room. The differential for a private room shouldn't exceed the difference between the standard charge for that accommodation and the typical semi-private rate at the time of admission.

Billing requirements should be followed as outlined below for reimbursement of medically necessary and non-medically necessary inpatient private room accommodations at hospitals, including critical access hospitals.

Coding specifics

Revenue codes*

- **0110**: Room and board – private room
- **0120**: Room and Board – semi-private room

*This may not be an all includes revenue code room and board list

Value codes

- **01**: Most common Semi-Private Rate - to provide for recording hospital's most common semi-private rate
- **02**: Hospital has no semi-private rooms - using this code requires $0.00 amount.

Condition codes

- **38**: Semi-private room not available
- **39**: Private room medically necessary

Medically necessary private room

- Revenue code 0110: Room and board – private room
- Condition code must be present:
  - **38**: Semi-private room not available OR
  - **39**: Private room medically necessary
- No comments are required.

Non-medically necessary private room

- Revenue code 0110: Room and board – private room
- Remarks should indicate the private room rate minus the semi-private room rate, displaying the private room differential (e.g., $500 - $400 = $100)
- No condition code or value code

Failure to include calculation in remarks for claims related to non-medically necessary private room rates will be denied.

Facilities with only private rooms

- Revenue code 0110: Room and board – private room
- Value code:
  - 02: Hospital has no semi-private rooms
  - This value code should have an amount of $0.00
- No comments are required

Place of service
21 – Facility

Documentation requirements
Medical necessity for a private room must be documented in the patient's medical record.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

Resources

- Medicare Benefit Policy Manual (CMS)
- Semiprivate vs Private Room (Molina Healthcare)

Related policies

- Billing policy 005: Condition codes (Priority Health)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made