



inpatient medical review and payment policy

description of procedure/service

This policy applies to the payment of services rendered during an inpatient stay at contracted acute hospitals and at long term acute care, acute rehabilitation, and skilled nursing facilities. The purpose is to ensure that sufficient clinical criteria have been met to assure medical appropriateness of the inpatient stay.

policy

It is the policy of Fallon Community Health Plan that only medically appropriate inpatient admissions that meet medical necessity criteria for inpatient level of care be reimbursed. Using nationally recognized utilization review criteria, such as CMS, InterQual, as well as FCHP developed internal criteria, FCHP will determine the appropriateness of specific healthcare services to be rendered or already delivered. These services are authorized based on evaluation of the clinical information received from or documented by providers. When inadequate information is available to evaluate the appropriateness of a service or the information does not support medical necessity for inpatient level of care, FCHP will initiate an authorization denial. Cases are reviewed with a Fallon Community Health Plan Medical Director or delegated business associate who will make the final determination.

Fallon Community Health Plan will pay for all authorized days during the course of an inpatient stay for eligible members. Payment is made at contracted rates.

Fallon Community Health Plan does not pay the facility for days that are not authorized. The contracted facility is liable for unauthorized days except when the member refuses treatment or discharge and the attending physician and the health plan agree that the resultant days are not medically necessary. In the case of a non-contracted facility, the member is liable for unauthorized days when not approved for medical necessity.

Contracted facilities may access the health plan's provider appeals process in cases where there is disagreement about the health plan's decision to authorize or not authorize payment.

In cases in which the health plan and the attending physician agree that the member does not meet level of care criteria, the facility may agree to payment at an alternative level of care rate as a substitute for a day that would otherwise be unauthorized. If the facility agrees to such an arrangement and there is a contracted alternative level of care rate available, the day will be authorized for payment at the health plan's alternative level of care rate.

The health plan may pay for certain covered professional and ancillary services provided during unauthorized inpatient days. These are:

- Physician charges, including charges from attending or consulting physicians of record; and
- Charges for ancillary services that 1) are not included in contractual agreements with the skilled nursing or rehabilitation facility where the service is provided; 2) are provided by an external vendor; and 3) are billed separately by that vendor.

FCHP does not reimburse separately for routine services as described in the CMS Federal Provider Manual Publication 15, Section 2022.6:

Routine Services.--Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge—sometimes referred to as the “room and board” charge. Routine services are composed of two board components; (1) general routine services, and (2) special care units (SCUs), including coronary care units (CCUs) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Specific contract terms will apply.

benefits application

- FCHP Direct Care/FCHP Select Care
- FCHP Independent Care
- FCHP Flex Care Direct/Select
- Fallon Senior Plan™
- FCHP MassHealth
- Major Medical
- Bill At Home/Direct Enrollment
- Fallon Preferred Care
- Fallon Senior Preferred Care

coverage and reimbursement criteria

Fallon Community Health Plan will reimburse at contracted rates for all inpatient services that have been deemed medically appropriate by FCHP and, as necessary, the Plan’s Medical Director and/or delegated business associate. FCHP does not cover experimental/investigational services. See, however, FCHP Medical Payment Policy entitled “Clinical Trials for the Treatment of Cancer” for coverage issues pertaining to patient care services provided in conjunction with qualified clinical trials for the treatment of cancer.

Fallon Community Health Plan will not reimburse for services that have been deemed not appropriate by evaluation of the clinical criteria (InterQual, CMS and other FCHP approved guidelines). Reimbursement for inpatient services is based on the review of clinical information. Fallon Community Health Plan’s Medical Director or delegated business associate makes all denial decisions to the contracted facility, whether it is partial stay or an entire stay. Contracted facilities may not balance bill members for any denial decision, whether it is partial stay or an entire stay, for days deemed not medically appropriate.

The health plan sets a rate of payment for alternative level of care to be applied when:

- The health plan and attending physician agree that the member meets alternative level of care criteria; and
- The facility agrees to payment at the rate set by the health plan.

Diagnosis - Related Groups (DRG) - Fallon Community Health Plan incorporates the Diagnosis Related Grouping (DRG) methodology, devised by the Centers for Medicare & Medicaid Services (CMS), when processing inpatient claims.

For providers that are reimbursed by FCHP according to a DRG methodology, FCHP will deny reimbursement for readmission for inpatient services occurring within seven days of discharge from the same facility for the same or related condition for which the member was treated at the time of the original discharge

preauthorization requirements

Preauthorization is required for all elective admissions and authorization is required for continued stay in all acute care facilities by FCHP or its delegated business associate. Urgent admissions do not require preauthorization, however, facilities are required to notify FCHP of admissions within 24 business hours of the admission or as specified in the provider contract.

billing/coding guidelines

Providers are expected to submit claims using industry standard forms or HIPAA industry electronic formats.

place of service

This policy applies to all services rendered at any inpatient facility.

policy implementation

Policy number:	ADM0009
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