



Inpatient Medical Review and Payment Policy

Policy

It is the policy of Fallon Community Health Plan (FCHP) 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 and InterQual, as well as FCHP internally-developed criteria, FCHP will determine the appropriateness of specific health care 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 FCHP Medical Director or delegated business associate who will make the final determination.

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

FCHP does not pay the facility for days that are not authorized. The contracted facility is liable for unauthorized days. When the member refuses treatment or discharge and the attending physician and the health plan agree that the resultant days are not medically necessary, the member is liable.

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, FCHP 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. Inpatient routine services in a hospital or skilled nursing facility generally are those services included 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 (ICUs). 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.

Definition

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.

Benefits application

Commercial

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

Senior Plan

- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®

Reimbursement

FCHP will reimburse at contracted rates for 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 Payment Policy entitled "Clinical Trials" for coverage issues pertaining to patient care services provided in conjunction with qualified clinical trials.

FCHP 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. FCHP'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 (DRGs) FCHP incorporates either of two Diagnosis Related Grouping (DRG) methodologies, depending on provider's contract. The most frequent DRG methodology used is that developed by the Centers for Medicare & Medicaid Services, known in the healthcare industry as "Medicare DRGs". FCHP also supports several versions of the All Payer Grouper, commonly referred to as "New York APGs", a frequently used DRG system for non-Medicare eligible populations.

Readmission policy for hospitals with DRG/Case Rate Reimbursement: For providers that are reimbursed by FCHP according to a DRG or similar case-rated 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.

Pre-admission diagnostic and non-diagnostic services related to the principal diagnosis that are provided within three calendar days of an inpatient admission are considered incidental to admission and included in the inpatient reimbursement. Pre-admission services may be subject to post-payment audits and retraction.

Any ambulatory procedures that result in an inpatient admission to the same facility are considered incidental to admission and included in the inpatient reimbursement.

Reimbursement for inpatient treatment and related services corresponds to the FCHP contracted rate for per diem, per case, DRG, and/or other arrangements, as applicable. The inpatient reimbursement rate is inclusive of all services supplied by the facility, including, but not limited to:

• Ancillary services	• Medications and supplies
• Anesthesia care	• Nursing care
• Appliances and equipment	• Radiology and imaging services
• Blood administration and glucometry	• Recovery room services
• Diagnostic services	• Therapeutic items (drugs and biologicals)

Referral/notification/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.

Charges for pre-admission services that occur within 3 calendar days of the admission should be submitted on the same claim as the inpatient services.

Place of service

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

Policy history

Origination date:	5/14/03
Previous revision date(s):	06/11/03, 05/12/04, 05/25/05, 06/07/06, 08/30/06, 12/6/06, 8/29/07, 01/1/09 – Clarify services included in inpatient reimbursement
Connection date & details:	07/1/09 – Updated description of DRG and case payment methodology and explanation of reimbursement for readmissions.

This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.