

# Inpatient Medical Review and Payment Policy

## Policy

It is the policy of the 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 Plan-internally developed criteria, the Plan 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, the Plan will initiate an authorization denial. Cases are reviewed with a Plan Medical Director or delegated business associate who will make the final determination.

The Plan will pay for all authorized days during the course of an inpatient stay for eligible members. Payment is made at contracted rates and is based on the review of clinical information and physician documentation. Physician orders are to clearly identify inpatient or observation/outpatient status.

The Plan 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 Plan's provider appeals process in cases where there is disagreement about the 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 Plan 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 Plan's alternative level of care rate.

The 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.

The Plan does not reimburse separately for routine services as described in section 2202.6 of the CMS Provider Manual. Inpatient routine services in a hospital or skilled nursing facility generally are to be 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.

The Plan does not reimburse separately for bedside nursing services or procedures performed during the inpatient stay as part of the room and board. Examples of nursing services which are components of room and board fees include, but are not limited to, blood administration services, medication administration, IV hydration and IV medication administration, vaccine administration, dressing applications, therapies, glucometry testing/monitoring, catheterizations, tube feedings and irrigations, telemetry, and equipment monitoring services. These services are subsumed under the inpatient compensation paid to the facility.

When drugs are eligible for separate reimbursement, the Plan reimburses the provision of covered FDA-approved non-self-administered drugs when given in an inpatient setting. The Plan's reimbursement is for pharmaceuticals which are administered to a Plan member, only up to the next incremental Level II HCPCS code unit. The Plan anticipates that the provider will utilize the most appropriately sized single-use vial or combination of single-use vials to deliver the ordered dose of medication and minimize waste.

The Plan does not reimburse for drugs that are not administered to Plan members including, but not limited to, those that are determined to be contaminated, wasted, or unused.

Specific contract terms will apply.

## Definitions

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.

## Reimbursement

The Plan will reimburse at contracted rates for inpatient services that have been deemed medically appropriate by the Plan and, as necessary, the Plan's Medical Director and/or delegated business associate. The Plan does not cover experimental/investigational services. See the Plan Payment Policy entitled "Clinical Trials" for coverage issues pertaining to patient care services provided in conjunction with qualified clinical trials.

The Plan will not reimburse for services that have been deemed not appropriate by evaluation of the clinical criteria (InterQual, CMS, and other Plan-approved guidelines). Reimbursement for inpatient services is based on the review of clinical information and physician documentation. Physician orders are to clearly identify inpatient or observation/outpatient status. The 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 Plan sets a rate of payment for alternative level of care to be applied when:

- The 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 Plan.

**Diagnosis Related Groups (DRGs):** The Plan incorporates the CMS Diagnosis Related Grouping (DRG) methodology which was developed by the Centers for Medicare & Medicaid Services, known in the healthcare industry as "Medicare DRGs."

**Readmission policy for hospitals with DRG/Case Rate Reimbursement:** For providers that are reimbursed by the Plan according to a DRG or similar case-rated methodology for Commercial plan and MassHealth enrolled members, the Plan will deny reimbursement for readmission for inpatient services occurring within 7 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. For providers that are reimbursed by the Plan according to a DRG or similar case-rated methodology for Medicare plan members, the Plan will deny reimbursement for readmission for inpatient services occurring within 30 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. The Plan will not authorize or reimburse services submitted as Observation when the services meet the inpatient level of care and an inpatient readmission would have been denied.

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.

The inpatient reimbursement rate, regardless of payment methodology, is inclusive of all services supplied by the facility, including, but not limited to:

- Ancillary services
- Anesthesia care
- Appliances and equipment
- Bedside equipment
- Blood administration
- Diagnostic services
- Glucometry testing/monitoring
- Medications and supplies
- Nursing care and services
- Preadmission testing
- Radiology and imaging services
- Recovery room services
- Therapeutic items (drugs and biologicals)

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When drugs are eligible for separate reimbursement, the Plan reimburses the provision of covered FDA-approved non-self-administered drugs when given in an inpatient setting. The Plan's reimbursement is for pharmaceuticals which are administered to a Plan member, only up to the next incremental Level II HCPCS code unit.

The Plan does not reimburse for drugs that are not administered to Plan members including, but not limited to, those that are determined to be contaminated, wasted, or unused.

Reimbursement will be made in accordance with contracted rates.

Intra-hospital transfers from a medical/surgical unit to either a psychological or rehabilitation unit, or vice versa, must be billed separately according to the unit within which the care is provided

## **Referral/notification/prior authorization requirements**

Prior authorization is required for all elective admissions and authorization is required for continued stay in all acute care facilities by the Plan or its delegated business associate. Urgent admissions do not require prior authorization; however, facilities are required to notify the Plan of admissions within one business day of the admission or as specified in the provider contract.

For elective admissions facilities are required to make best efforts to provide such notification of elective procedures 7 days in advance or at least 48 hours prior to the procedure/elective admission.

## 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 three calendar days of the admission should be submitted on the same claim as the inpatient services.

### Pharmaceutical Waste:

- For multi-use vials of medication, bill only for the portion of the medication administered to the member; wasted pharmaceutical will not be reimbursed.
- The Plan does not require but will accept modifier JW (drug amount discarded/not administered to any patient) to identify drugs where the dosage contained in the single-use vial is greater than ordered and/or administered. The Plan will anticipate that providers will schedule patients in such a way as to maximize the use of a pharmaceutical and minimize the waste. The Plan will reimburse for wasted pharmaceutical remaining within the last vial of single-use medication used in a single day in the event that the provider documents within the patient's medical record the date, time, amount of pharmaceutical wasted, and signature of clinical staff wasting the medication. The Plan also anticipates that the provider will utilize the most appropriately sized single-use vial or combination of single-use vials to deliver the ordered dose of medication in order to minimize waste.

The Plan reserves the right to audit to verify payment accuracy. Neither the Plan nor Plan members can be held financially responsible for any denied payments for pharmaceuticals that were not administered to the patient.

## 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. 07/1/09 – Updated description of DRG and case payment methodology and explanation of reimbursement for readmissions. 09/01/2010 – Updated language in the Policy, Reimbursement and Billing/coding guidelines sections to address drug waste. 01/01/2012 - Added information to the reimbursement section about what services are included in the inpatient reimbursement rate. 01/01/2013 - Updated language discussing pharmaceutical waste in the Billing/coding guidelines. 09/01/2013 - Updated discussion about services included in the inpatient reimbursement rate to list glucometry separately. 07/01/2014 - Clarified discussion about drug waste. 03/01/2015 - Updated language to reflect Fallon Health rather than Fallon Community Health Plan. Update discussion of DRG/Case payment and readmissions. 01/01/2016 - Updated to new Plan template and clarified language discussing inpatient routine services. 09/01/2016 - Updated the policy and reimbursement sections
Connection date & details:	March 2017 – Clarified language discussing routine and bedside nursing services.

April 2018 – Annual review, no updates.

April 2019 – Annual review, no updates.

July 2019 – Updated the reimbursement section, clarified authorization for elective admissions.

*The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. 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. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*