BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Reimbursement Policy

Inpatient Hospital

Policy Number: 4.110
Version Number: 8
Version Effective Date: 11/01/2021

Product Applicability	☐ **All Plan⁺ Products**
Well Sense Health Plan ☐ Well Sense Health Plan	**Boston Medical Center HealthNet Plan** ☒ MassHealth MCO ☒ MassHealth ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses inpatient room and board and related ancillary care required during medically necessary acute care admissions. The Plan will not reimburse providers for services rendered in support of an admission if the primary reason for the admission is a service that is not covered, i.e., cosmetic surgery, investigational procedures, etc. The Plan will reimburse acute hospitals for covered inpatient services, based on the contractual terms within their Participating Provider Agreement and the terms of this policy. The terms of your contract may supersede specific sections of this policy only to the extent that the specific service is explicitly referenced within your provider contract. Otherwise this policy and the terms stated herein will be used in the adjudication of all applicable claims. Failure to follow the terms of this policy will result in claim denial or a delay in claim payment.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Definitions

Actual Acquisition Cost **-** the Hospital's invoice price for the drug, net of all on-or-off invoice reductions, discounts, rebates, charge backs and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the drug that was administered to the Member including any efficacy, outcome, or performance-based guarantees (or similar arrangements), whether received pre-or post-payment.

Performance-Based Guarantee - refers to any efficacy, outcome, or performance-based guarantee (or similar arrangement) from the drug manufacturer (or other party) to the hospital that applies to the treatment of the member with the carve-out drug in question, whether or not such an arrangement is required by the Plan.

Provider Reimbursement

Adjudicated Payment Amount per Discharge (APAD)

The Plan will reimburse hospitals for inpatient services utilizing the Executive Office of Health and Human Services (EOHHS) APAD reimbursement methodology. The reimbursement is a hospital-specific, all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge using the All Patient Refined-Diagnosis Related Group (APR-DRG) and Severity of Illness (SOI). The Plan will use EOHHS APR-DRG assigned weights and hospital rates. The admission date determines all inpatient reimbursement terms.

Outlier Reimbursement

A hospital is eligible for an outlier payment in addition to the APR-DRG reimbursement if the hospital's costs exceed the outlier threshold for that discharge.

Transfers of Care

When a hospital transfers a member to another acute care hospital for continued acute inpatient care, the Plan will reimburse the transferring hospital a transfer per diem rate, not to exceed the case APR-DRG rate including applicable outliers.

Member Enrollment & Eligibility Changes during an Inpatient Admission

The plan will prorate payments based on member's eligibility with the plan when an inpatient admission occurs prior to a member's effective date or if a member terminates from the Plan while receiving inpatient services. The hospital will be reimbursed at a per diem basis. The plan pays the lesser of the per diem rate, not to exceed the APR-DRG allowed amount, or hospital billed charges.

Postpartum Insertion of Long-Acting Reversible Contraception (LARC)

The Plan reimburses for LARC devices separately from the inpatient hospital payment when inserted immediately postpartum during the related labor and delivery inpatient stay in accordance with following guidelines:

- Costs, charges, and any other claims-based data corresponding to the LARC device must be excluded from any facility/institutional claim;

- Hospitals must submit claims for the LARC device on a professional claim even when the insertion is performed on an inpatient basis;
- Hospitals must include a copy of the invoice for the LARC device from the manufacturer, supplier, distributer, or other similar party;
- Hospitals must bill one of the HCPCS codes J7296, J7297, J7298, J7301, and J7307 and the corresponding National Drug Code (NDC) to ensure accurate payment;
- ICD-10 family planning code(s) must be included on the claim; and
- A LARC device refers specifically to intrauterine devices and contraceptive implants; it does not refer to the LARC procedure, itself.

For further guidance, see the Plan's reimbursement policy, *Family Planning, Sterilization, and Abortion Services, 4.115.*

APAD Carve-Out Drugs

The Plan will separately reimburse providers for Carve-Out drugs that are identified on the MassHealth Acute Hospital Carve-Out Drugs List published on the MassHealth website. The Plan reimburses for APAD Carve-Out Drugs separately from the inpatient hospital payment in accordance with following guidelines:

- Payment to Hospitals for APAD Carve-Out Drugs administered to members during an acute inpatient hospital visit will be the Hospital's "actual acquisition cost" of the Drug.
- Costs, charges, and any other claims-based data corresponding to the APAD Carve-Out Drug must be excluded from any facility/institutional claim; and
- Hospitals must submit claims for separate payment for APAD Carve-Out Drugs on a professional claim; and
- Hospitals must include the National Drug Code (NDC) and corresponding HCPCS for the drug, as well as the number of units administered to the member to ensure accurate payment; and
- Hospital must include the following as separate attachments to the claim for the APAD Carve-Out Drug:
    1. A statement of the Hospital's actual acquisition cost of the drug; and
    2. A copy of the invoice for the APAD Carve-Out Drug from the drug manufacturer, supplier, distributer, or other similar party; and
    3. Any other evidentiary documentation, if applicable.
- In the event that the hospital is a party to or a direct beneficiary of a performance-based guarantee from the drug manufacturer (or other party), and the terms of the performance-based guarantee allow the hospital to pay in full or in part for the carve-out drug only if certain conditions are met (e.g., the hospital is only required to pay for the drug if the member goes into remission), the hospital must not submit a claim to the Plan for the carve-out drug until the hospital actually makes the payment it will be required to make to the drug manufacturer or other party and must not submit any claim for the carve-out drug to the Plan in the event that it is not ultimately required to pay for the drug.

Other Services to Inpatients
Outpatient services rendered on the same date of an inpatient admission are included in the reimbursement for the inpatient admission.

Hospitals will not be reimbursed for outpatient services provided to any member that is concurrently an inpatient of any hospital. The hospital is responsible for payment to any other provider of services delivered to a member while an inpatient of that hospital.

For imaging services from freestanding and mobile imaging providers rendered in an outpatient setting, the technical component of all imaging services provided to any member that is concurrently an inpatient of any hospital and transported either within the hospital or outside of the hospital should be billed to the hospital. All imaging services rendered during a member's acute care hospital inpatient stay is included in the global all-inclusive inpatient compensation rates.

Admissions Following Outpatient Surgery or Procedure
For outpatient surgery that results in an inpatient admission the hospital will be paid the lesser of the transfer per diem rate, not to exceed the APR-DRG allowed amount, or the billed charges.

Administratively Necessary Days (AND)
Providers must use Revenue Code 0169 to report AND services. The AND services are reimbursed a per diem rate. Members that alternate between AND status and acute levels of care are not considered discharged, and as a result, only one APR-DRG will be reimbursed.

For any clinical criteria that must be met for a provider to be reimbursed reference the Plan's medical policy, *Administratively Necessary Days OCA 3.102*. Services described as AND are excluded under all commercial product benefit plans.

Inpatient Rehabilitation
Effective December 1, 2019, Acute Hospitals with a distinct rehabilitation unit are required to bill with the following taxonomy code if billing for rehabilitation services:

- 273Y00000X - Hospital-Rehabilitation Unit

Submission of claims with this taxonomy code will identify services that are rendered in the hospital Rehabilitation Unit.

Admission and Discharge Dates
The following section describes Plan rules applicable to the admission and/or discharge date:

- Admission status must be made via physician order. Neither the time the order is written nor the time a bed is reserved constitutes the start of an admission time. Admission time begins at the clock time documented in the nursing notes/flow sheets or progress notes as the time the patient is, in fact, placed in a bed for the purpose of initiating inpatient care.

- Reimbursement for an admission will be based on the payment methodology and rates of reimbursement in effect on the date of admission to the hospital.
- Reimbursement to a hospital for an admission does not include payment for the date of discharge.
- Admissions for members who leave against medical advice or who expire during an admission will be paid the eligible APR-DRG rate, where applicable.

Readmissions

Hospitals with a greater number of Potentially Preventable Readmission (PPR) will be subject to a percentage payment reduction per discharge.

The Plan may 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. Readmissions will be subject to review and payment may be retracted under certain circumstances, including but not limited to, premature discharge, nosocomial infections, medical necessity and complications related to SREs.

In the following cases, payment of readmission will not be retracted if it is determined that the readmission resulted from the following:

- Patient non-compliance
- Care provided at another facility

Service Limitations

The following services are not reimbursable:

- Private Rooms - unless required due to the treatment of an infectious disease that requires a private room, or for other circumstances approved as medically necessary the Plan will pay at the semi-private room rate.
- Convenience care items
- Delay Days – Inpatient days required due to hospital delays during discharge.
- Hospital Acquired Conditions/Serious Reportable Events – Any services rendered during an admission involving SREs will be removed from the APR-DRG grouping process.
- Experimental, Investigational, or Cosmetic services – including all supporting services even when those supporting services may be covered under other qualifying circumstances.
- Inpatient Nursing Services – these are considered inclusive to any room and board fee.
- Any inpatient services that are identified within a member's Evidence of Coverage as an excluded service.

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S.

Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

APR-DRG & Severity of Illness (SOI) Code Assignment

The Plan will use submitted claim information to group into the appropriate APR-DRG and Severity of Illness (SOI) code. This will be present on the hospital's Explanation of Payment. The first three digits represent the DRG. The last digit represents the SOI.

SOI	Description
1	Minor
2	Moderate
3	Major
4	Extreme

Example:
DRG: 191 - Cardiac Catheterization w Circ Disord Exc Ischemic Heart Disease
SOI: 2 – Moderate
APR-DRG: 1912

Newborn Billing

For Newborn billing guidelines refer to the Plan's reimbursement policy, *Newborn and Neonatal Intensive Care Unit (NICU) Services, 4.106.*

APR-DRG Coding Requirements

Providers must bill the Plan using industry standard coding conventions to avoid claim denials. For specific coding and claim field requirements, reference the Plan's Provider Manual and reimbursement policy, *General Billing and Coding Guidelines, 4.31.*

Late Charges and Interim Billing

Claims submitted for late charges and interim bills will be denied as global to the original claim payment. If the original claim was denied, the late charges will also be denied.

Hospital Acquired Conditions (HAC)/Present on Admission (POA)

The POA indicator is required for all inpatient claims. Diagnoses for hospital acquired conditions will not be included in the APR -DRG calculation. Compensation could vary, based on the recalculated DRG. For further information regarding hospital acquired conditions and claim reporting requirements, reference the Plan's reimbursement policy, *Provider Preventable Conditions and Serious Reportable Events, 4.610.*

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
09/23/2014	10/1/2014	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
09/18/2014	Retired Inpatient Hospital reimbursement policy for dates of admission prior to 10/1/14; New policy for dates of admission on or after 10/1/14	10/01/2014	Payment Policy Committee
10/30/2014	Added birth weight reporting requirements	10/30/2014	Payment Policy Committee
10/18/2016	New template, annual review, removed "or hospital billed charges" from transfer of care section, removed newborn billing guidelines and referenced Newborn/NICU services payment policy	01/01/2017	Payment Policy Committee
03/19/2019	New logo box, annual review, additional language for LARC device and Carve-Out drugs	04/01/2019	Payment Policy Committee
10/01/2019	Added section for Inpatient Rehabilitation unit to bill with specific taxonomy	12/01/2019	Payment Policy Committee
12/15/2020	Added language for APAD Carve-Out drugs	01/01/2021	Payment Policy Committee
10/19/2021	Annual Review	11/01/2021	Payment Policy Committee

Other Applicable Policies

Reimbursement Policies

- General Billing and Coding Guidelines, 4.31
- Provider Preventable Conditions and Serious Reportable Events, 4.610
- Outpatient Hospital, 4.17

- Newborn and Neonatal Intensive Care Unit (NICU) Services, 4.106

Medical Policy

- Administratively Necessary Days, OCA, 3.102

References

- 130 CMR 410.00: Outpatient Hospital Services
- 130 CMR 415.00: Acute Inpatient Hospital Services
- 244 CMR 4.00: Advanced Practice Registered Nursing
- Executive Office of Health and Human Services, Acute Hospital Request For Applications
- MassHealth Drug List (MHDL)
- MassHealth Acute Hospital Carve-Out Drugs List
- MassHealth Managed Care Entity Bulletin 42
- MassHealth Transmittal Letter ALL-225, February 2018
- MassHealth Transmittal Letter ALL-227, September 2018
- MassHealth Acute Hospitals Billing Instructions for Carve-Out Drugs
- MassHealth LARC Billing Instructions 0318
- Centers for Disease Control, Definitions for Nosocomial Infections
- CMS- Hospital Acquired Conditions (HAC) in Acute Inpatient Prospective Payment System (IPPS) Hospitals-Overview; ICN #901045
- CMS- Present on Admission (POA) Indicator reporting by Acute Inpatient Prospective Payment System (IPPS) Hospital; ICN # 901046
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage