BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Reimbursement Policy

Inpatient Hospital

Policy Number: SCO 4.110
Version Number: 3
Version Effective Date: 04/01/2021

Product Applicability

☐ **All Plan[+] Products**

Well Sense Health Plan
☐ New Hampshire Medicaid
☐ NH Health Protection Program

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 covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy. The Plan covers 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.

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.

Inpatient Reimbursement

The Plan reimburses hospitals for inpatient services utilizing Medicare Severity-Diagnosis Related Groups (MS-DRG). The reimbursement is a hospital-specific, all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge. The Plan will use Medicare MS-DRG assigned weights and hospital rates. The discharge date determines all inpatient reimbursement terms.

Admission and Discharge Dates

The following section describes the Plan rules applicable to payment on the 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 member 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 discharge to the facility.
- Reimbursement to a facility for an admission does not include payment for the date of discharge.
- Admissions for members who leave against medical advice (AMA) or who expire during an admission will be paid the eligible MS-DRG payment rate, where applicable.

Outliers

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

Transfer of Care

A hospital which transfers a member to another hospital for continued inpatient hospital services will be reimbursed based upon a per diem rate. The payment is twice the per diem rate for the first day of the stay and the per diem rate for every following day up to the full MS-DRG amount. If the stay is less than one day, one day is paid.

The receiving hospital which does not transfer a member to another hospital shall be paid the full DRG rate.

When a transfer case results in treatment in the second hospital under a DRG different than the DRG in the transferring hospital, the transferring hospital may be paid an outlier payment. An exception to this applies to MS-DRG 789. This DRG assumes that the member will be transferred, since a transfer is part of the definition. In this case, the hospital that transfers a member is paid the full amount of the DRG rate.

Members who leave against medical advice, but are admitted to another inpatient hospital on the same day as they left, will be treated as transfers and the transfer payment policy will apply.

Readmissions

Hospitals may place a member on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Only one bill is submitted and one payment made.

When a member is discharged or transferred from an acute care hospital, and is readmitted to the same acute care hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall combine the original and subsequent stay onto a single claim. Services rendered by other entities during a combined stay must be paid by the acute care hospital.

When an member is discharged/transferred from an acute care hospital and is readmitted to the same acute care hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals shall report condition code B4 on the claim that contains an admission date equal to the prior admission's discharge date.

The Plan may 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. 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 Provider Preventable Conditions.

Hospital Outpatient Services with Related Inpatient Care

Admission of more than one day will be paid according to the following terms:

- Outpatient hospital diagnostic services rendered within 3 calendar days prior to inpatient admission, with a calendar day beginning at 12:00 AM and ending at 11:59 PM, shall be inclusive of the inpatient payment and not be billed separately.
- Related non-diagnostic outpatient hospital services, except for ambulance to an admitting hospital and maintenance renal dialysis, provided by the admitting hospital to the member during the 3 days immediately preceding and including the date of the admission are included in the inpatient payment and are not to be billed separately. Unrelated non-diagnostic hospital outpatient services are reported with condition code 51.
- When a member transfers from observation to inpatient status, the hours of observation and other services provided during an observation stay will be included in the inpatient payment rate. Observation services should not be billed separately from the inpatient claim.

Other Services to Inpatients

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 and ambulance services rendered during a member's acute care hospital inpatient stay are included in the all-inclusive inpatient compensation rates.

Plan Enrollment Changes During an Admission

When a member is eligible with the Plan on the date of admission as a hospital inpatient and their eligibility changes during the same inpatient stay, the Plan will reimburse the hospital for the full inpatient stay.

When an member is eligible with Original Medicare or another plan on the date of admission as a hospital inpatient and their eligibility changes during the same inpatient stay to the Plan, Original Medicare or the other plan is responsible for the reimbursement to the hospital for the full inpatient stay.

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.

Split Claim Billing

All related services must be reported on one claim. Subsequent related claims received after the initial claim will be denied. The initial claim must be resubmitted as a replacement claim.

Late Charges and Interim Billing

Claims submitted for late charges and interim bills will be denied. 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 DRG calculation. Compensation could vary, based on the recalculated DRG. For further information regarding hospital acquired conditions and claim reporting requirements, reference the Hospital Acquired Conditions, Provider Preventable Conditions and Serious Reportable Events reimbursement policy.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
08/17/2015	01/01/2016	Payment Policy	SCO Product Subgroup

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
08/19/2018	Annual Review	10/01/2018	Payment Policy Committee
03/16/2021	Annual review, no changes	04/01/2021	Payment Policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, SCO 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, SCO 4.108
- Outpatient Hospital, SCO 4.17

References

- Medicare Claims Processing Manual 100-04, Chapter 3 Inpatient Hospital Billing

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.