REIMBURSEMENT GUIDELINES – Inpatient Hospital

Product Applicability

☐ All Plan* Products

Boston Medical Center HealthNet Plan*
☐ MassHealth
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Commonwealth Care
☒ Commonwealth Choice/Employer Choice

Well Sense Health Plan*
☐ New Hampshire Medicaid

Effective Date: 10/01/2014
Policy Number: 4.110

This policy is intended to serve as a general guide for reimbursement. Please refer to the MassHealth Member Handbook, BMC HealthNet Plan Qualified Health Plans, including ConnectorCare, the Commonwealth Care or Commercial Evidence of Coverage (EOC), Schedule of Benefits (SOB) and your provider contract for specific terms of coverage and reimbursement. Unless otherwise specified in writing, reimbursement will be made at the lesser of the billed charges, or the contractual schedule of payments. Use of this policy does not guarantee payment.

Prior-authorization
Please refer to the Plan’s Prior Authorization Requirements Matrix at www.bmchp.org.

Policy Statement
The Plan reimburses covered services based on the provider’s contractual rates with the Plan and the terms of reimbursement identified within this policy.

Covered Services
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 Reimbursement is based on member benefits and eligibility, medical necessity review, where applicable, coordination of benefits, adherence to Plan policies, clinical coding criteria, and the BMC HealthNet Plan agreement with the rendering or dispensing provider. Plan policies may be amended at BMC HealthNet Plan’s discretion. All Plan policies are developed in accordance with state, federal and accrediting organization guidelines and requirements, including NCQA.
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.

**Provider Reimbursement**
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.

**Adjudicated Payment Amount per Discharge (APAD)**
Effective for dates of admission on or after October 1, 2014, 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 the lesser of a transfer per diem rate, not to exceed the case APR-DRG rate including applicable outliers, or hospital billed charges.

**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.

**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. 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 Administratively Necessary Days medical policy, policy number OCA: 3.102. AND services are excluded under all commercial product benefit plans.

**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 (AMA) 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 Exclusions

- 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 last digit represents the SOI.

SOI
1-Minor  2-Moderate  3-Major  4-Extreme

Ex APR-DRG 1912

191-Cardiac Catheterization w Circ Disord Exc Ischemic Heart Disease
2-Moderate
Birth Weight – Newborn Inpatient Claims
Birth weight is needed for correct claims processing and accurate reimbursement of newborn inpatient claims and should always be submitted in accordance with industry standards on the UB04 claim form. Claims submitted without the birth weight will be denied.

Newborn Billing
MassHealth Members
Newborns will be assigned a temporary member ID number.

**Routine**: Claims for the newborn and mother should be billed under their individual member ID numbers. Routine rev codes 0170-Newborn Nursery; 0171-Newborn Level1

**Non Routine/Sick Newborn Charges**: Claims for the newborn and mother should be billed under their individual member ID numbers. 0172-Newborn Level 2(Continuing); 0173-Newborn Level3 (Intermediate); 0174 Newborn Level 4(Intensive); 0179 Nursery

BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Members - Effective for dates of service on or after October 1, 2014

**Routine**: if the newborn is not enrolled in BMC HealthNet Plan, charges for the mother and routine well newborn services must be submitted on separate claims under the mother’s member ID number. When a delivery involves multiple births, separate claims must be submitted for each newborn under the mother’s member ID number. Routine rev codes 0170-Newborn Nursery; 0171-Newborn Level1

*If newborn’s own ID is available, routine well newborn charges must be submitted under the newborn’s own member ID number.*

**Non Routine/Sick Newborn**: The charges for the mother and non-routine/sick newborn services must be submitted on separate claims. The newborn claim must be submitted under the newborn’s own member ID number. When a delivery involves multiple births, separate claims must be submitted for each newborn under the newborn’s own member ID. Non routine rev codes 0172-Newborn Level 2 (Continuing); 0173-Newborn Level3 (Intermediate); 0174 Newborn Level 4(Intensive); 0179 Nursery

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 the General Billing and Coding Guidelines reimbursement policy, policy number 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 Hospital Acquired Conditions, Provider Preventable Conditions and Serious Reportable Events reimbursement policy, policy number 4.610.

**References**

**Legal and Regulatory References**

- 130 CMR 410 – Outpatient Hospital
- 114.1 CMR 36.00 – Acute Care Hospital
- 244 CMR 4.00 – Nurses in the Expanded Role
- CDC Definitions for Nosocomial Infections [http://www.cms.gov/HospitalAcqCond/01_Overview.asp#TopOfPage](http://www.cms.gov/HospitalAcqCond/01_Overview.asp#TopOfPage)
- Centers for Medicare & Medicaid Services Hospital Acquired Conditions/Present on Admission
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Evidence of Coverage, Form No. BMCHP-CC-8
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan
- Evidence of Coverage, Form No. BMCHP CChoice-1
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage
- Executive Office of Health and Human Services, Rate Year 2015, Acute Hospital Request for Applications

**Other References**

N/A

In addition to the above regulations, any bulletin, transmittal letter, or notification otherwise changing this reference is herein incorporated as a reference.

**Related Policies**

General Billing and Coding Guidelines reimbursement policy, policy number 4.31

Hospital Acquired Conditions, Provider Preventable Conditions and Serious Reportable Events reimbursement policy, policy number 4.610

Outpatient Hospital reimbursement policy, policy number 4.17
Administratively Necessary Days medical policy, policy number OCA: 3.102

**Policy History and Approval Dates**

**Review Dates/Revisions**

**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

**10/30/2014** – Added birth weight reporting requirements

**Approval Dates**

**Original Effective Date:** 10/01/2014

**Original Internal Approval:** 09/23/2014

**Original Regulatory Approval:** N/A