

## INPATIENT HOSPITAL ADMISSIONS

### Policy

AllWays Health Partners reimburses participating hospital facilities for the provision of medically necessary inpatient services.

### Policy Definition

Inpatient Hospital Admissions include items and services furnished to an inpatient, including room and board, nursing care and related services, diagnostic and therapeutic services and medical and surgical services.

### Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the AllWays Health Partners Payment Policy and by the provider's agreement with AllWays Health Partners. Member liability amounts may include, but are not limited to, copayments, deductible, and/or co-insurance, and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or authorization. Referral and authorization requirements can be located [here](#).

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

AllWays Health Partners reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to [Coding Provider Payment Guidelines](#) for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Admission status must be made via physician order and admission time begins at the time documented in the medical record as the time the patient has inpatient care begun. The time the order is written or the time a bed is held cannot be used as admission time.

If a patient transfers from the emergency room and/or observation status to inpatient status, separate reimbursement will not be made for emergency room charges or observation bed hours as the Room and Board charges represent a full 24-hour calendar day.

For MassHealth lines of business:

Please reference the link below for all of the payable DRG code sets:

<https://www.mass.gov/files/documents/2018/09/25/acute-hospital-ry19-chart-c-mh-drg-weights-and-mean-all-payer-lengths-of-stay.pdf>

### AllWays Health Partners Reimburses

- Inpatient acute medical admissions when notified within appropriate timeframes

### AllWays Health Partners Does Not Reimburse

- Claims that are reimbursed based on APR-DRG methodology are not eligible for interim billing or late charges
- Private rooms; only when prior authorized under medical necessity and will be reimbursed at the contractual semi-private room rate
- Experimental, investigational, and/or cosmetic services. Authorization for an admission to an inpatient setting does not supersede coverage limitations for experimental, investigational, and/or cosmetic services.
- Serious Reportable Events (SRE) as defined in AllWays Health Partners [Serious Reportable Events Payment Policy](#)

## Provider Payment Guidelines and Documentation

### Present on Admission (POA)

The POA indicator is required for all inpatient claims. Submit the POA indicator in accordance with the definitions published by CMS. The POA indicators will follow the diagnosis code in the appropriate 2300 HI segment.

| POA | Definition  |
|-----|---|
| Y   | Present at the time of inpatient admission  |
| N   | Not present at the time of admission  |
| U   | Documentation is insufficient to determine if condition is present on admission                                       |
| W   | Clinically undetermined; Provider is unable to clinically determine whether condition was present or not on admission |

### Serious Reportable Events & Provider Preventable Conditions

AllWays Health Partners does not reimburse for services associated with serious reportable events (SRE), “never events” and/or provider preventable conditions (PPC). To administer this policy, AllWays Health Partners recognizes, but is not limited to, the serious reportable events identified by the National Quality Forum and the CMS Medicare Hospital Acquired Conditions (HAC) and Present on Admission (POA) indicator reporting.

Please refer to AllWays Health Partners [Serious Reportable Events Payment Policy](#)

- Submit with the correct industry-standard codes
- Submit a Present on Admission (POA) indicator for each diagnosis code, when applicable
- Submit claims electronically using the 8371 ANSI Format with Bill Type 11 in the 2300 Loop CLM05-01 and CLM05-03

## **Diagnosis Related Group (DRG) Provider Billing Guidelines**

For DRG contracted hospitals, AllWays Health Partners uses All Patient Refined Diagnosis-Related Groups (APR-DRG) to administer the policy, incorporating the POA indicator into the DRG assignment.

DRG facilities contracted to use DRG payment methodology must submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment. AllWays Health Partners processes DRG claims through DRG software. If the submitted DRG and system-aligned DRG differ, the AllWays Health Partners assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient data, it will be rejected and returned.

*Please note:* AllWays Health Partners continues to require authorization for all inpatient services except routine newborn delivery.

## **Coding Elements**

The following discharge data elements are used for APR-DRG subclass assignment:

- ICD-CM diagnosis codes
- ICD-CM procedure codes
- Date of Birth
- Gender
- Birthweight (when applicable)
- Admit Date
- Discharge Date
- Status of Discharge
- Days on Mechanical Ventilator (value or ICD-10-CM code)

## **Maternity and Nursery Claims**

Submit claims for the delivery under the mother's AllWays Health Partners member ID and the nursery under the newborn's AllWays Health Partners member ID in order to receive two DRG payments.

*Please note:* Routine nursery charges are not reimbursed separately for AllWays Health Partners commercial line of business.

## **Transfer Claims**

AllWays Health Partners reimburses acute hospitals on a per diem basis under certain circumstances. Inpatient services delivered to members, who transfer among hospitals or among certain settings within a hospital, are reimbursed on a transfer per diem basis.

- 02 – Discharged/Transferred to another Short-Term General Hospital
- 05 – Discharged/Transferred to another Type of Institution

Transfers include any inpatient cases with a discharge status of a transfer to another short-term acute care facility (02 and 05).

The APR-DRG per diem conversion is calculated as follows:

- Base Rate \* APR-DRG weight/Network Average Length of Stay

The transfer per diem conversion is calculated as follows:

- Observed LOS for transfer case \* Calculated per diem conversion
  - Final payment is the lesser of per diem or acute reimbursement

## Related AllWays Health Partners Payment Guidelines

[Serious Reportable Events Payment Policy](#)

## References

[MassHealth Acute Inpatient Manual](#)

## Publication History

|   |                                  |
|---|----------------------------------|
| <b>Topic: Inpatient Hospital Admissions</b> | <b>Owner: Network Management</b> |
|---|----------------------------------|

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|-------------------------|---|
| <i>July 1, 2014</i>     | <i>Original documentation</i>   |
| <i>January 1, 2017</i>  | <i>Document restructure; added DRG billing guidelines, remove definitions</i> |
| <i>February 9, 2017</i> | <i>References updated</i>   |
| <i>April 3, 2017</i>    | <i>Added the MassHealth DRG link</i>  |
| <i>January 1, 2019</i>  | <i>Document restructure; codes, code descriptor and references updated</i>    |

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Payment policies are intended to assist providers in obtaining AllWays Health Partners ' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member’s benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

AllWays Health Partners includes AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company.