Inpatient Hospital Payment Policy

Policy Statement

Inpatient care refers to any medical service that requires admission into a hospital. This policy documents Neighborhood Health Plan of Rhode Island's coverage and reimbursement requirements for inpatient facility services.

Scope

This policy applies to:

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- InterQual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Reimbursement Requirements

Compensation for inpatient treatment and related services is based on the applicable network contracted rate (e.g., diagnosis-related group [DRG]). Refer to your current contract for details regarding inpatient reimbursement provisions as your contract may supercede this policy. The inpatient reimbursement rate 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
- Labortory services
- Medication and supplies
- Nursing care
- Operating room services
- Pathology services
- Preadmission testing*
- Radiology/Imaging services
- Recovery room services
- Therapeutic items (drugs and biologicals)

*Note: The above services, including routine preadmission testing performed prior to an admission are considered covered services but not reimbursed separately.

Payment Methodology

Neighborhood reimburses professional inpatient claims Fee-For-Service for all lines of business. Reimbursement of institutional claims varies by line of business:

- **Medicaid** plans are paid in accordance to their contracted terms.
- **INTEGRITY and Commercial** plans are paid according to the CMS Inpatient Prospective Payment System (PPS) Medicare Severity Diagnosis Related Groups (MS-DRG).

    - **Outpatient Pre-diagnostic Services Prior to Admission**

      Outpatient and pre-diagnostic services provided up to three (3) days prior to an inpatient episode of care, including the day of member admission, are considered part of the MS-DRG payment.

Eligibility changes during an Inpatient Stay – Facility Reimbursement

Medicaid

If the member has another insurer at the time of admission and becomes eligible with Neighborhood Health Plan during the stay, then the other insurer would be responsible for the entirety of the members stay.

When a member terminates during an inpatient admission, Neighborhood Health Plan will reimburse until the management of the member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.[1]

- If a member does not transition care, Neighborhood will reimburse through the end of the admission.

If a member does not have coverage prior to becoming a Neighborhood Health Plan member, Neighborhood will compensate for covered days based on member eligibility at a per diem rate; subject to provider contractual agreements.

- Providers need to bill according to when the member was eligible. Example: Member is admitted on 6/24, became eligible with Neighborhood Health Plan on 7/1 discharged on 7/6. Claim should be billed with statement from/through dates according to when the member became eligible.

INTEGRITY/Commercial

Neighborhood Health Plan currently uses the Medicare MS-DRG as established by CMS to assign an MS-DRG to an inpatient claim. Refer to the CMS website for additional information.[2]

If a member has another insurer at the time of admission and becomes eligible with Neighborhood Health Plan during the stay, then the other insurer would be responsible for the entirety of the members stay.

When the member terminates during an inpatient admission, Neighborhood Health Plan will reimburse until the management of the member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.[3] Commercial will also follow this payment methodology.

- If a member does not transition care, Neighborhood will reimburse through the end of the admission.

If the member does not have coverage prior to becoming a Neighborhood Health Plan member, providers would need to bill with a statement from and through date according to when the member was enrolled. However, the admission date should reflect the actual date the member was admitted.

Providers need to bill according to when the member was eligible. Example: Member is admitted on 6/24, became eligible with Neighborhood Health Plan on 7/1 discharged on 7/6. Claim should be billed with statement from/through dates according to when the member became eligible.

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[1] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-04/NHPRI%20Full%20Contract%20Managed%20Care%20Amendment%206_03302022_wj.pdf

[2] https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/ms-drg-classifications-and-software

[3] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-11/ricontract03012020_0.pdf

Inpatient Only Procedures

Neighborhood Health Plan will follow CMS guidance for inpatient only procedures. Medicare has established a list of procedures that it believes can only be safely performed in the inpatient setting. These services have OPPS status indicator "C" in OPPS Addendum B and are listed together in Addendum E of each year's OPPS/ASC final rule.

https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html

Benefit Exclusions

The following services are excluded from coverage under this policy:

- Services considered payable as outpatient service;
- Post hospital SNF care, furnished by a hospital or a critical access hospital that has a swing-bed approval;
- Nursing facility services that may be furnished as a Medicaid service in a swing- bed hospital that has an approval to furnish nursing facility services.
- Hospital inpatient stays must be at least 24 hours. Members whose stay is less than 24 hours must be billed as outpatients.

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines. Please refer to the Provider Manual on our website for required fields on a UB-04 submission.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
09/18/2024	Annual Review Date. No content changes.
08/01/2023	Policy Create Date.