

Inpatient Hospital Services Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

- ☒ Fallon Medicare Plus
- ☒ MassHealth ACO
- ☒ NaviCare HMO SNP
- ☒ Summit Eldercare PACE
- ☒ Fallon Health Weinberg PACE
- ☒ Community Care

Policy

Fallon Health (FCHP, Fallon, the Plan) evaluates inpatient hospital services through utilization management review to determine medical necessity, authorization requirements and the appropriate level of care. Reimbursement is determined separately based upon the hospital's submitted claim(s), member eligibility and benefits, applicable billing and coding requirements, and the reimbursement methodology applicable to the claim.

Medical necessity criteria for level of care determinations to be considered for reimbursement include nationally recognized utilization review criteria, including but not limited to, CMS¹, InterQual as a general guide for clinicians, as well as Plan-internally developed criteria. Level of care determinations and reimbursement determinations are distinct processes. A determination that inpatient criteria were or were not met may affect coverage and payment but does not by itself change the hospital's billed level of care or reimbursement methodology.

When the information does not support medical necessity for the requested services, the Plan will initiate an authorization denial. Cases are reviewed with a Plan Medical Director or delegated business associate who will make the final determination.

Level of Care Determinations

The Plan evaluates inpatient hospital admissions upon medical necessity and appropriate acuity, pursuant to the clinical documentation presented upon review. Should acute inpatient level of care criteria not be met at the time of the utilization review, a lower level of care may be offered. If the hospital accepts the lower level of care determination, services may be reimbursed at the applicable contracted rates for observation, ambulatory surgery, emergency room or outpatient hospital services. The participating hospital must ensure the claim is billed with the correct place of service for the lower level of care.

- **Other Considerations.** For Plan members who discharge against medical advice (AMA) or expire during an observation level of care, the payment will not be adjusted to an acute inpatient level of care payment.
- Hospital medical records must document the attending physician's orders level of care and support the medical necessity for said level of care.

Level of Care Determinations are made in accordance with the Plan's utilization review program with Plan Medical Director or delegated vendor utilization review.

¹ Medicare Benefit Policy Manual, Chapter 1, Section 10 - Covered Inpatient Hospital Services Covered Under Part A; Quality Improvement Organization Manual, Chapter 4, Section 4110 - Admission/Discharge Review; and Medicare Program Integrity Manual, Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment.

If inpatient criteria are not met, services may be reimbursed at observation, ambulatory surgery, emergency room or outpatient level of care (if criteria for these levels of care are met and the claim is billed with the appropriate place of service code for that level of care).

All claims processing and reimbursement determinations are made in accordance with utilization management and plan medical director or delegated business associate review decisions. Decisions regarding level of care are made by Utilization Management and communicated via systematic notes and claim pends for Claims Department effectuation.

Unplanned Admissions

Urgent admissions do not require prior Plan authorization; however, participating hospitals are required to notify the Plan of admissions within one (1) business day of the admission or as specified in the participating hospital contract.

Preadmission Services

The Plan will not separately reimburse hospital services rendered as part of a pre-admission evaluation. Preadmission services are defined as those covered diagnostic and non-diagnostic services (including clinical diagnostic laboratory tests or other services) related to the principal diagnosis and provided on the same day or within three (3) days prior to a scheduled inpatient admission by the same hospital for the same member. Payment for preadmission Services is included in the participating hospital's contracted rates for inpatient level of care.

Preadmission services may be subject to post-payment audits and adjustment. Any ambulatory procedures that result in an inpatient admission to the same participating hospital are considered incidental to the inpatient admission and included in the reimbursement.

Same-day surgery and similar outpatient services related to the inpatient admission are not separately reimbursed.

Elective Admissions

Plan authorization is required for all elective admissions. Contracted hospitals are required to make best efforts to provide such notification of elective procedures seven (7) days in advance or at least 48 hours prior to the elective admission.

Medicare Inpatient–Only List Services

Should member be admitted for a procedure on the Medicare “Inpatient-Only” list, the service will not require a review if the procedure does not require Plan prior authorization.

- The Plan will, however, review the medical documentation and make an initial determination of whether a medically necessary Medicare “Inpatient-Only” procedure is documented in the medical record.
- If so, and if the other requisite elements for payment are present, then the Plan will deem a DRG to be appropriate, without regard to the expected or actual length of stay². If the Plan does not identify a Medicare “Inpatient-Only” procedure during the initial review, the admission will be assessed in accordance with the criteria.

MassHealth ACO and Community Care Members

Effective for inpatient admission notifications on or after January 1, 2026. Any provider notification of a request to continue inpatient level of care services (concurrent services) is to be reviewed against requested clinical documentation. If there is disagreement between the hospital and the Plan, a member adverse determination with applicable appeal rights will be issued. If the hospital and the Plan agree to a lower level of care (such as observation), the provider can formally withdraw the

² The “Inpatient-Only” procedure list is updated annually and published in the Hospital Outpatient Prospective Payment System (OPPS) Final Rule available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospital-OutpatientPPS/Hospital-Outpatient-Regulations-and-Notices>. To access the current years' Inpatient-Only list, click the link to the current years' regulation and then click the link to the “NFRM OPPS Addenda,” then open Addendum E.

request for Inpatient level of care. In such cases, the Plan will issue the formal dismissal notice to the member.

Authorization Determinations, Provider Appeals

Contracted hospitals may appeal denied authorizations through the Plan's provider appeal process. Fallon Medicare Plus and NaviCare members have appeal rights for adverse organizational determinations.

Claims submission is required for appeal eligibility. Appeal eligibility is based on a claim denial. If the hospital's appeal is determined that the denied inpatient level of care be upheld, the hospital may be able to submit a corrected claim at a lower level of care for payment.

Serious Reportable Events and Provider Preventable Conditions.

The Plan does not reimburse hospital services associated with serious reportable events (SRE), "never events" and/or provider preventable conditions (PPC). For additional information, please refer to the Plan's ***Serious Reportable Events and Provider Preventable Conditions Payment Policy***.

Balance Bill

Contracted hospitals may not balance bill members for any denial decision, whether it is partial stay or an entire stay, for days deemed not medically appropriate. Participating hospitals may not balance bill Plan members for unauthorized inpatient days. However, should the Plan member refuse hospital treatment or is discharged against medical advice, and the Plan with the Hospital Attending Physician agree that the inpatient days were not medically necessary, the Plan Member may be financially liable, provided all applicable regulatory requirements were followed.

Definitions

This policy applies to the payment of services rendered during an inpatient stay at contracted acute inpatient hospitals. Terms in quotations are defined within the respective section.

Reimbursement

Inpatient Hospital Services, for All Payment Methodologies

Inpatient hospital services are paid based upon Plan authorization for the billed inpatient days and the respective hospital's contracted reimbursement rates or applicable regulatory methodology (for example, Medicare Severity Diagnosis Related Groups (MS-DRG); MassHealth All Patient Refined Diagnosis Related Groups (APR-DRG)). Physician orders are to clearly identify inpatient or observation/outpatient status. The Plan's Medical Director or delegated business associate makes all denial of coverage decisions to the contracted hospital, whether it is partial stay or an entire stay.

The Plan does not reimburse for inpatient hospital services that were unauthorized, not medically necessary and/or experimental or investigational treatment. For further information pertaining to Clinical Trials coverage, refer to ***Clinical Trials Payment Policy***.

The Plan will not reimburse for services that have been deemed not appropriate by evaluation of the clinical criteria (including, but not limited to, InterQual, CMS, and other Plan-approved guidelines). Reimbursement for inpatient services is based on the review of clinical information and physician documentation. Physician orders are to clearly identify inpatient or observation / outpatient status. The Plan's Medical Director or delegated business associate makes all denial of coverage decisions to the contracted hospital, whether it is partial stay or an entire stay. Contracted hospitals may not balance bill members for any denial decision, whether it is partial stay or an entire stay, for days deemed not medically appropriate.

The Plan sets a rate of payment for alternative level of care to be applied when:

- The Plan and attending physician agree that the member meets alternative level of care criteria; and
- The Hospital agrees to payment at the rate set by the Plan.

Inpatient Readmission Policy

Payment for readmissions is included in the index admission payment in situations where review by Utilization Management has determined that the readmission is related clinically to the prior hospital inpatient admission.

If any active condition, or a complication of the condition / procedure / treatments, submitted as part of the DRG calculation of the index admission is the cause of the later admissions, then the subsequent admission fits a readmission per the policy. This condition may be any condition actively treated or arising during the prior admission from the same hospital for the same or related condition for which the member was treated or arising prior to the original discharge. The readmission determination is not based on the preventability of the readmission and applies to both preventable and non-preventable admissions. If it is determined that the member is being treated for the same or related condition as the original (index) admission, the reimbursement for the readmission may be denied.

- A "Readmission Chain" is defined as three or more admissions requested as DRG payment. A Readmission Chain can extend beyond the readmission time period, if the time between a discharge and subsequent readmission to the same inpatient hospital is within the readmission time period.
- An "Index Admission" is defined as the first admission \ length of stay in a cycle of multiple admissions.
- For example, a patient was admitted on the first of the month and was inpatient for four days. The patient was discharged on the fourth of the month. The patient was then readmitted six days later on the tenth of the month and remained inpatient for another four days, discharged on the fourteenth of the month. Patient returned to the hospital five days later (19th of the month) and was inpatient for another four days, with discharge on the twenty third of the month. While the third admission (19th of the month) is greater than seven (7) days from the index admit discharge, it was less than 7 days from the last discharge. This is an example for lines of business that have a 7-day readmission time period. For lines of business with a 30-day readmission time period, multiple admissions could extend beyond the 30 days if each admission was less than 30 days from the previous.
- If any active condition, or a complication of the condition/procedure/treatments, submitted as part of the DRG calculation of the index admission is the cause of the later admissions, then the subsequent admission fits a readmission per the Policy. This condition may be any condition actively treated or arising during the prior admission from the same hospital for the same or related condition for which the member was treated or arising prior to the original discharge. The readmission determination is not based on the preventability of the readmission and applies to both preventable and non-preventable admissions.

Readmission Criteria for Community Care and MassHealth ACO members

For hospitals that are reimbursed by the Plan according to a DRG or similar case-rated methodology for Community Care and MassHealth ACO plan members, the Plan will deny separate reimbursement for readmissions for inpatient services occurring within 7 days of discharge from the same hospital for the same or related condition for which the member was treated at the time of the original discharge. The readmission is for the same or similar condition as the prior admission as determined by Utilization Management review.

Readmissions for Fallon Medicare Plus, PACE and NaviCare members

- For hospitals that are reimbursed by the Plan according to a DRG or similar case-rated methodology for PACE plan members, the Plan will deny separate reimbursement for readmissions for inpatient services occurring within 30 days of discharge from the same hospital for the same or related condition for which the member was treated or arising prior to the original discharge. The readmission is for the same or similar condition as the prior admission as determined by Utilization Management review.

- Effective January 1, 2026, if the Plan receives a notification of readmission for inpatient services occurring within 30 days (or as otherwise specified in provider contracts), this will be reviewed as an organization determination, with applicable member appeal rights and notification (*CMS Final Rule CMS-4208-F*).

Readmission Review Exclusions

Effective for dates of service on or after 09/01/2022, the following are excluded from readmission review:

- Readmissions that are planned or expected for reasons such as cancer chemotherapy, or other similar repetitive treatments requiring acute inpatient level of care or for scheduled elective surgery;
- Readmissions due to high acuity chronic conditions and treatment for burns, sickle cell disease, or cystic fibrosis that require acute inpatient level of care;
- Readmissions due to stem cell transplants and/or complications;
- Obstetrical admissions; and
- Readmissions with a documented discharge status of left against medical advice · The documentation in the medical record should include the member discharged from the hospital "Against Medical Advice" (AMA), and that the hospital made an attempt to inform the patient of possible complications due to non-compliance and the possibility of readmission.

All-inclusive Reimbursement Rate

The inpatient reimbursement rate, regardless of payment methodology, is inclusive of all services supplied by the hospital, including, but not limited to:

- | | |
|-----------------------------------|---|
| • Ancillary services | • Medications and supplies |
| • Anesthesia care | • Nursing care and services |
| • Appliances and equipment | • Preadmission testing |
| • Bedside equipment | • Radiology and imaging services |
| • Blood administration | • Recovery room services |
| • Diagnostic services | • Therapeutic items (drugs and biologicals) |
| • Glucometry testing / monitoring | |

The Plan does not reimburse separately for routine services as described in *Chapter 22, Section 2202.6 of the CMS Provider Reimbursement Manual (Pub. 15-1)*. Inpatient routine services are inherent in the hospital daily service charge -- sometimes referred to as the "room and board" charge. Routine services are composed of two board components; (1) general routine services, and (2) special care units (SCUs), including coronary care units (CCUs) and intensive care units (ICUs). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, all equipment and supplies, and hospital services for which a separate charge is not customarily made. This applies to all payment methodologies and inpatient and outpatient levels of care.

The Plan does not reimburse separately for bedside nursing services or procedures performed during the inpatient stay as part of the room and board. Examples of nursing services which are components of room and board fees, include, but are not limited to, blood administration services, medication administration, IV hydration and IV medication administration, vaccine administration, dressing applications, therapies (including bedside respiratory therapies), glucometry testing/monitoring, catheterizations, tube feedings and irrigations, telemetry, and equipment monitoring services. These services are subsumed under the inpatient compensation paid to the hospital. This applies to all payment methodologies and inpatient and outpatient levels of care.

Intra-Hospital Transfers

Intra-hospital transfers from a medical or surgical unit to either a psychological or rehabilitation unit, or vice versa, require prior authorization unless restricted by regulation and must be billed separately according to the unit within which the inpatient care is provided. Payment will be made in accordance with the hospital's contracted reimbursement rates, a single case agreement (when necessary) or applicable regulatory methodology.

Inter-Hospital Transfers

The Plan reimburses such transfers based upon Plan authorization unless restricted by regulation (or notification for emergent cases) and medical necessity determination if the originating hospital cannot provide medically necessary care. Urgent/emergent inter-hospital transfers require Plan notification. Payment will be made in accordance with the hospital's contracted reimbursement rates, a single case agreement (when necessary) or applicable regulatory methodology.

Fallon Medicare Plus, NaviCare Member Eligibility Changes During Inpatient Admissions

The Plan will reimburse according to the product specific criteria below when a Plan member's eligibility updates either to or from a different insurance carrier.

- As per CMS guidelines, when the member was admitted to an inpatient hospital while enrolled with another insurer and whose enrollment with Fallon Health became effective prior to discharge, the other insurer (or original Medicare) is liable for all Part A charges for the entire inpatient admission. The only charges that Fallon Health would be responsible for are those incurred following the member's enrollment in Fallon Health that are unrelated to the inpatient admission.³
- As per CMS guidelines, when the member was admitted to an inpatient hospital while enrolled with the Plan, but whose enrollment ends prior to discharge, Fallon Health is liable for all Part A charges for the entire inpatient admission. The only charges that the other health plan, or Medicare, would be responsible for are those incurred following the member's disenrollment from Fallon Health that are unrelated to the inpatient admission. Enrollee cost-sharing for the inpatient hospital stay is based on the cost-sharing amounts as of the entry date into the hospital.⁴

Inpatient Admission Prior to Medicare Entitlement

Pre-entitlement is when a Medicare beneficiary is admitted as an inpatient to an acute care hospital prior to the beneficiary's Medicare entitlement effective date and is discharged after the Medicare Part A entitlement date. The inpatient admission is covered under Medicare Part A, and the entire stay is paid under the appropriate MS-DRG (*Medicare Claims Processing Manual, Chapter 3, Section 40*).

There are special billing guidelines to follow when the beneficiary becomes entitled to Part A benefits in the middle of an inpatient stay. The admission date on the claim will reflect the date of admission to the hospital, while the from/through dates will only reflect the actual entitlement through discharge (*MLN Matters Article SE1117*). Providers may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier threshold.

Note: Claims with a discharge date equal to the effective date of Medicare entitlement cannot be billed as pre-entitlement claims.

MassHealth ACO Transfer Per Diem Methodology

Inpatient services delivered to MassHealth ACO members who transfer among hospitals or among certain settings within a hospital are paid on a Transfer Per Diem basis.

³ 42 CFR § 422.318 - Special rules for coverage that begins or ends during an inpatient hospital stay.

⁴ Ibid.

The Adjudicated Payment Amount per Discharge (APAD) is a hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge (exclusive of any separate payment for LARC Devices or APAD Carve Out Drugs, if applicable,). This payment method also applies in certain other circumstances when the Plan is the responsible payer for only a portion of the acute hospital stay.

The Transfer Per Diem will equal the transferring hospital's total case payment amount, calculated by MassHealth using the APAD and, if applicable, outlier payment methodologies for the period for which the hospital is being paid on a transfer per diem basis, divided by the mean acute hospital all payer length of stay for the particular APR-DRG assigned. Transfer per diem payments are subject to the Total Transfer Case Payment Cap.

A Transfer Patient is any inpatient who meets any of the following criteria: (1) is transferred between Acute Hospitals; (2) is transferred between a DMH-Licensed Bed and a medical/surgical unit in an Acute Hospital; (3) is receiving Behavioral Health Services and whose enrollment status with the BH Contractor changes; (4) who becomes eligible for MassHealth after the date of admission and prior to the date of discharge, or is eligible for MassHealth on the date of admission but becomes ineligible prior to the date of discharge; (5) is a Member who exhausts other insurance benefits after the date of admission and prior to the date of discharge, or who becomes eligible for other insurance benefits after the date of admission and prior to the date of discharge; (6) who transfers, after the date of admission, from the PCC Plan, Primary Care ACO or non-managed care to an MCO, or from an MCO to the PCC Plan, Primary Care ACO or non-managed care; or (7) is admitted following an outpatient surgery or procedure at the Acute Hospital.

A Transferring Hospital is an Acute Hospital that is being paid on a Transfer Per Diem basis, pursuant to Section 5.B.3. Transfer Per Diem Payments (*in Notice of Final Agency Action, MassHealth: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services, available at: <https://www.mass.gov/lists/special-notice-for-acute-hospitals>*).

MassHealth ACO In State Hospital Transfer

A Hospital that transfers a patient to another Acute Hospital will be paid on a per diem basis (the "Transfer Per Diem basis"), capped at the Hospital's Total Transfer Payment Cap.

- Total Transfer Payment Cap is the Total Case Payment amount calculated by EOHS utilizing the APAD and, if applicable, Outlier Payment methodology(ies) set forth in Sections 5.B.1. Adjudicated Payment Amount per Discharge (APAD) and 5.B.2. Outlier Payments (*in Notice of Final Agency Action, MassHealth: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services, available at: <https://www.mass.gov/lists/special-notice-for-acute-hospitals>*) for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis under Section 5.B.3. Transfer Per Diem Payments (*in Notice of Final Agency Action, MassHealth: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services, available at: <https://www.mass.gov/lists/special-notice-for-acute-hospitals>*) for Inpatient Services provided to a Transfer Patient.

MassHealth ACO Out of State Hospital Transfer

- For MassHealth ACO members transferred to another acute hospital from an out-of-state acute hospital, the transferring out-of-state acute hospital will be paid at a transfer per diem rate ("Out-of-State Transfer Per Diem"), and no other payment methods will apply.
- The Hospital that is receiving the patient will be paid (a) on a per-discharge basis in accordance with the APAD, and, if applicable, Outlier Payment methodology(ies) specified in Section 5.B.1 and 5.B.2, if the patient is actually discharged from that Hospital; or (b) on a Transfer Per Diem basis, capped at the Hospital's Total Transfer Payment Cap, if the Hospital transfers the patient to another Acute Hospital or back to the Acute Hospital from which it received the patient.

The APAD is not paid for Administrative Days or for Inpatient Services that are paid on a per diem basis (for example, Transfer Per Diem), as described in the *Notice of Final Agency Action*,

MassHealth: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services, available at: <https://www.mass.gov/lists/special-notice-for-acute-hospitals>.

MassHealth ACO Enrollment Changes during Inpatient Admission

For MassHealth ACO members, when enrollment changes during an inpatient admission, Fallon Health covers the portion of the member's acute hospital stay during which they were enrolled as a member.

- (1) When the member's enrollment with Fallon Health becomes effective after the date of admission but prior to the date of discharge, or
- (2) When the member's enrollment with Fallon Health ends after the date of admission but prior to the date of discharge, Fallon Health will reimburse the covered portion of the acute hospital stay at the Transfer Per Diem rate, up to the Hospital's Total Transfer Payment Cap, or, if the member is at the Administrative Day (AD) level of care, at the AD per diem rate, in accordance with Section 5.B.6. Payments for Administrative Days (in *Notice of Final Agency Action, MassHealth: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services, available at: <https://www.mass.gov/lists/special-notice-for-acute-hospitals>*).

Maternity and Nursery Inpatient Services

- For Ob\Gyn services include delivery coding and coverage, refer to ***Obstetrics and Gynecology Payment Policy***.
- For Newborn services, including donor human milk and human milk derived products, coding and coverage, refer to the ***Newborn Services Payment Policy***.

Immediate Postpartum Long-Acting Reversible Contraception (LARC) Devices

LARC devices are defined as intrauterine devices and contraceptive implants and do not include the procedure itself. Effective November 1, 2021, acute inpatient hospitals may be paid separately for the LARC device if the LARC insertion occurs immediately post-labor and delivery during the same inpatient hospital labor and delivery stay, and all other requirements are met.

- Charges corresponding to the LARC device must be excluded from any facility claim that the hospital submits for the labor and delivery stay.
- The hospital must instead claim separate payment for the LARC device on a paper claim (CMS-1500 or UB-04 is acceptable). HCPCS codes and NDC Information (NDC Qualifier, NDC, NDC Unit of Measure and NDC Quantity) are required on the claim.
- The hospital must include a copy of the invoice for the LARC device from the manufacturer, supplier, distributor, or other similar party with the claim for the LARC device.

Claims for LARC devices submitted using the instructions above will pend for review and pricing by Fallon Health.

The LARC devices that are subject to these billing instructions include:

- J7296 Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg
- J7297 Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg
- J7298 Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg
- J7300 Intrauterine copper contraceptive
- J7301 Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg
- J7307 Etonogestrel (contraceptive) implant system, including implant and supplies (Nexplanon)

Professional and Ancillary Services

The Plan may reimburse covered professional and ancillary services provided during unauthorized inpatient days, for example observation level of care. These include physician charges, including charges from attending or consulting physicians of record and charges for ancillary services that are not included in the hospital payment. Reimbursement will be made in accordance with documented Utilization Management determinations and applicable pricing methodologies.

Drugs and Biologicals

Drugs and biologicals furnished and administered in the hospital for the care and treatment of inpatient members are covered when:

- The drug or biological is approved by the Food and Drug Administration (FDA) and used for an indication specified in the labeling. Use of an FDA approved drug or biological is covered if:
 - It was administered on or after the date of the FDA's approval;
 - It is medically necessary for the member; and
 - All other applicable requirements are met.

Drugs and biologicals which have not received final approval by the FDA are investigational and therefore not covered.

FDA-approved drugs may be used for indications other than those specified on the labeling (i.e., off-label) provided the drug or biological is recognized for the treatment of such indication in one of the standard reference compendia or in the medical literature.

When drugs and biologicals are eligible for separate reimbursement, a prior authorization request must be submitted and approved in advance (i.e., prior to administration) for drugs and biologicals that require prior authorization. This authorization request is separate from the inpatient hospital authorization request.

The Plan's reimbursement is for drugs and biologicals administered to a Plan member, is only up to the next incremental Level II HCPCS code unit. The Plan does not reimburse for drugs or biologicals that are not administered to Plan members including, but not limited to, those that are determined to be contaminated, wasted, or unused.

For additional information including MassHealth Acute Hospital Carve-Out Drug procedures, overall coding and authorization requirements, refer to ***Drugs and Biologicals Payment Policy***.

Referral/notification/prior authorization requirements

- Prior authorization is required for all elective admissions and authorization is required for continued stay in all acute care hospitals by the Plan or its delegated business associate. For elective admissions, hospitals are required to make best efforts to provide such notification of elective procedures 7 days in advance or at least 48 hours prior to the procedure/elective admission.
- Urgent admissions do not require prior authorization; however, hospitals are required to notify the Plan of admissions within one business day of the admission or as specified in the hospital contract.
- Prior authorization is required for intra-hospital transfers from a medical or surgical unit to either a psychological or rehabilitation unit, or vice versa.
- Prior authorization is required for all elective inter-hospital transfers. Urgent/emergent inter-hospital transfers do not require prior authorization however hospitals are required to notify the Plan within one business day of the admission or as specified in the hospital contract.

Billing/coding guidelines

Claims must comply with coding and billing standards. All claims are subject to retrospective review for coding and payment accuracy audit.

Medical records may be requested to complete such review from the contracted hospital.

Documentation must demonstrate and include level of care acuity, diagnoses and medical necessity for services rendered.

Inpatient Level of Care Coding and Clinical Validation

Fallon Health conducts DRG coding and clinical validation of inpatient claims to ensure accurate payment. Such validation activities include, but are not limited to, verification of diagnosis(es) and billed services against the requested medical record. Upon review, should the billed DRG with the validated DRG vary, the validated DRG will apply. The Hospital will be formally notified with afforded appeal rights.

Coding for hospital inpatient level of care services should be based on the member's actual clinical course, not on predictions of the clinical course or "rule out" diagnoses that are ultimately not substantiated in the clinical documentation as having occurred during the hospital stay.

To demonstrate the scope of such DRG Coding and Clinical Validation reviews, below are examples of clinical conditions:

- (1) **Sepsis.** Fallon Health applies the Sepsis III Criteria which state, "Sepsis should be defined as life-threatening organ dysfunction caused by a dysregulated host response to infection." While the Sequential Organ Failure Assessment (SOFA) score predicts who might develop sepsis, for post-service clinical validation of a sepsis DRG, Fallon Health's clinical validation process applies those same clinical elements as well as documentation that the values were life threatening and actions were taken for the extreme conditions due to the dysregulated host response to infection. Lactate level is only a factor when "Patients with septic shock can be clinically identified by a vasopressor requirement to maintain a mean arterial pressure of 65 mm Hg or greater and serum lactate level greater than 2 mmol/L (>18 mg/dL) in the absence of hypovolemia."
- (2) **Acute Kidney Failure.** This is a separate clinical condition from dehydration / pre-renal azotemia. The body's normal response to reduced flow to the kidney is to elevate the creatinine, so the kidney is not necessarily injured or failing when this occurs. Restoring euvolemia with fluids is the treatment of dehydration. Dialysis or norepinephrine + furosemide infusion would be the proven treatments.
- (3) **Acute Respiratory Failure** is different from acute respiratory distress or hypoxemia. Uses of nasal cannula oxygen is treating distress, while initiation of the use of an external device that the person does not use at home, such as CPAP, BiPAP, or intubation for documented poor oxygenation would be considered acute respiratory failure.
- (4) **Malnutrition.** None of the 34+ assessment tools that currently exist are entirely accepted or predictive for all outcomes, e.g.: length of stay, mortality and complications. However, two methods of nutritional assessment meet most requirements and have been validated for the adult, hospitalized population as non-invasive and time efficient. These methods are the Mini Nutritional Assessment Short-Form (MNA-SF), developed from and validated against the MNA Full Form (MNA-FF), and the Subjective Global Assessment (SGA). Both the MNA-FF and MNA-SF classify an excess number of patients as malnourished compared to other methods. The SGA does not exhibit this and may due to the fact that it does not rely on laboratory measures (e.g. serum albumin, prealbumin and lymphocyte count). These data may be useful in determining the severity of identified malnutrition, but are unreliable indicators of nutritional status - especially in older patients - due to the confounding effects that acute illness (e.g. inflammation and hydration) and age have on these parameters. In addition, the SGA is one of four assessment tools designed specifically to both provide nutritional assessment and predict outcomes. Fallon Health uses the SGA for the clinical validation review of malnutrition.

Place of service

This Policy applies to all services rendered by any inpatient hospital.

Policy history

Origination date:	5/14/03
Previous revision date(s):	06/11/03, 05/12/04, 05/25/05, 06/07/06, 08/30/06, 12/6/06, 8/29/07, 1/1/09, 7/1/09, 9/1/10, 1/1/12, 1/1/13, 9/1/13, 7/1/14, 3/1/15, 1/1/16.
<i>Connection</i> date & details:	March 2017 – Clarified language discussing routine and bedside nursing services. April 2018 – Annual review, no updates. April 2019 – Annual review, no updates. July 2019 – Updated the reimbursement section, clarified authorization for elective admissions. January 2021 – Revised DRG language; added information about coverage for drugs and biologicals, reimbursement for readmissions, plan members who change insurance during admissions, billing for MassHealth Carve-Out Drugs, and DRG coding and clinical validation. October 2021 – Added information about billing/coding for immediate postpartum long-acting reversible contraception (LARC) devices; added information about reimbursement for newborn hearing screening rendered in an inpatient setting. January 2022 – Updated billing/coding for immediate postpartum LARC devices to indicate that a UB-04 is acceptable. July 2022 – Reimbursement section updated to include list of readmissions excluded from readmission review effective for dates of service on or after 09/01/2022. January 2024 - Under Policy, updated coverage for inpatient admissions for Medicare Advantage plan members per Final Rule (CMS-4201-F); under Reimbursement, added new subsection for Inpatient admission prior to Medicare entitlement; also under Reimbursement, added new subsection for Transfer Per Diem for MassHealth ACO members. January 2026 – Under Policy, clarified the process for review of continuation of inpatient level of care (concurrent services) for effective January 1, 2026; under Reimbursement, clarified the readmission review process effective January 1, 2026, added new section for Donor human milk and donor human milk derived products for Community Care and MassHealth ACO members; under Billing/coding guidelines, removed section on Pharmaceutical waste, updated MassHealth Acute Hospital Carve-Out Drugs to reflect changes implemented by MassHealth effective April 1, 2025, clarified DRG coding and clinical validation. April 2026 – Under Reimbursement, All-inclusive payment rate, added: Effective July 1, 2026, outpatient services provided on the same day or within 3 days prior to an inpatient admission will be denied and not separately reimbursed. October 2026 – Renamed policy from Inpatient Medical Review and Payment Policy to Inpatient Hospital Services Payment Policy as a separate clinical criteria policy was created; updated the Policy and Reimbursement sections for regarding Level of Care and Readmissions payment conditions by product; updated

Referral/notification/prior authorization and Billing/coding guidelines by referencing related policies and clarifying notification periods.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.