Inpatient Medical Review and Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

It is the policy of the Plan that only medically appropriate inpatient admissions that meet medical necessity criteria for inpatient level of care be reimbursed. Using nationally recognized utilization review criteria, including but not limited to, CMS[1], InterQual as a general guide for clinicians, as well as Plan-internally developed criteria, the Plan will determine the appropriateness of specific healthcare services to be rendered or already delivered. These services are authorized based on evaluation of the clinical information received from or documented by providers. When inadequate information is available to evaluate the appropriateness of a service or 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.

Inpatient admissions for Medicare Advantage and NaviCare members

Effective for inpatient admissions on or after January 1, 2024, the Plan will provide coverage by reimbursing (paying for) an inpatient admission:

- When based on consideration of complex medical factors documented in the medical record, the admitting physician expects the patient to require hospital care that crosses two-midnights (§ 412.3(d)(1), the ‘‘two midnight benchmark”);
    - The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.
    - If an unforeseen circumstance, such as a member's death or transfer, results in a shorter stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and payment for an inpatient hospital stay may be made.
- When the admitting physician does not expect the patient to require care that crosses two-midnights, but determines, based on complex medical factors documented in the medical record that inpatient care is nonetheless necessary (§ 412.3(d)(3), the ‘‘case-by-case exception’’); and
- When the inpatient admission is for a surgical procedure specified by Medicare as inpatient only (§ 412.3(d)(2), the “Inpatient-Only List”).

[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.

It is important to clarify that the 'two-midnight presumption'' (the presumption that all inpatient claims that cross two midnights following the inpatient admission order are ''presumed'' appropriate for payment does not apply to MA plans.

The Plan requires prior authorization for all elective inpatient admissions. Accurate clinical documentation in the medical record is important to the application of the two-midnight rule. The admitting physician is required to explicitly establish and document medical necessity, to ensure that payment is made only for medically necessary care.

When a plan member is being admitted for a procedure on the Medicare "Inpatient-Only" list, the plan will not conduct a medical review per se if the procedure itself does not require prior authorization. The Plan will, however, review the medical documentation and make an initial determination of whether a medically necessary" 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 stay.[2] If the Plan does not identify an "Inpatient-Only" procedure during the initial review, the admission will be assessed in accordance with the two-midnight rule as described above.

Inpatient admissions for PACE and Community Care members

For hospitals that are reimbursed by the Plan according to a DRG or similar case-rate methodology, inpatient hospital stays are generally payable if the admitting physician expects the plan member to require medically necessary hospital care spanning two or more midnights, and such reasonable expectation is supported by the medical record documentation. The statement of a physician expecting this is not sufficient – the medical record must show that at the two-midnight point, the member's medical condition, safety, or health would be significantly and directly threatened if care was provided in any less intensive setting (adapted from the Medicare two-midnight benchmark rule, Medicare Program Integrity Manual, Chapter 6, Section 6.5.2).

When an inpatient hospital admission that is medically necessary is interrupted by unforeseen circumstances beyond the two-midnight point, including but not limited to, unexpected death, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital, the DRG or case rate will be paid. When a member is admitted and the member's expected care past two midnights depends on how the member responds or depends on test results, then up until the two-midnight benchmark, the stay should be considered as Observation payment status. After the 2 midnight period has passed and the member's condition, treated using evidence based interventions, should still require services only available at an acute inpatient medical hospital the record will be reviewed to determine payment status of DRG vs Observation. Leaving AMA or expiring during an Observation payment status does not change it to a DRG payment.

When a plan member is being admitted for a procedure on the Medicare "Inpatient-Only" list, the plan will not conduct a medical review per se if the procedure itself does not require prior authorization. The Plan will, however, review the medical documentation and make an initial determination of whether a medically necessary" 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 or case-rate payment to be appropriate, without regard to the expected or actual length of stay.[3] If the Plan does not identify an "Inpatient-Only" procedure during the initial review, the admission will be assessed in accordance with the two-midnight rule as described above.

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[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/HospitalOutpatientPPS/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.

[3] 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 all payment methodologies

The Plan will pay for all authorized days during the course of an inpatient stay for eligible members. Payment is made at contracted rates and is based on the review of clinical information and physician documentation. Physician orders are to clearly identify inpatient or observation/outpatient status.

The Plan does not pay the hospital for days that are not authorized. The contracted hospital is liable for unauthorized days. When the member refuses treatment or discharge and the attending physician and the Plan agree that the resultant days are not medically necessary, the member may be liable.

Authorization determinations, provider appeals

Contracted hospitals must submit a claim and may access the Plan's provider appeals process in cases where there is disagreement about the Plan's authorization determination.

If the attending physician and the Plan disagree about the payment status requested, the Plan may offer, if medically appropriate, Observation status. If the attending physician declines the alternative payment status offered by the Plan, the physician and the hospital have the right to file a provider appeal once the claim is denied.

Professional services

- The Plan may pay for certain covered professional and ancillary services provided during unauthorized inpatient days. These are: Physician charges, including charges from attending or consulting physicians of record; and
- Charges for ancillary services that 1) are not included in contractual agreements with the skilled nursing facility or rehabilitation hospital where the service is provided; 2) are provided by an external vendor; and 3) are billed separately by that vendor.

Drugs and biologicals

Drugs and biologicals administered in the hospital, which are furnished by the hospital for the care and treatment of inpatients, are covered when:

1. The drug or biological represents a cost to the hospital rendering services to the plan member;
2. 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:
    a. It was administered on or after the date of the FDA's approval;
    b. It is medically necessary for the individual member; and
    c. 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

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for-Service-Payment/HospitalOutpatientPPS/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.

biologicals that are not administered to Plan members including, but not limited to, those that are determined to be contaminated, wasted, or unused.

Definitions

This policy applies to the payment of services rendered during an inpatient stay at contracted acute inpatient hospitals. The purpose is to ensure that sufficient clinical criteria have been met to assure medical appropriateness of the inpatient stay.

Reimbursement

The Plan will reimburse at contracted rates for inpatient services that have been deemed medically appropriate by the Plan and, as necessary, the Plan's Medical Director and/or delegated business associate. The Plan does not cover experimental/investigational services. See the Plan Payment Policy entitled "Clinical Trials" for coverage issues pertaining to patient care services provided in conjunction with qualified clinical trials.

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 payment status to be applied when:

- The Plan and attending physician agree that the member meets alternative payment status criteria; and
- The hospital agrees to payment at the rate set by the Plan.

Diagnosis Related Groups (DRGs): The Plan incorporates the CMS Diagnosis Related Grouping (DRG) methodology which was developed by the Centers for Medicare & Medicaid Services, known in the healthcare industry as "Medicare DRGs" and Adjudicated Payment Amount per Discharge (APAD) DRGs set by MassHealth.

Readmissions

For hospitals that are reimbursed by the Plan according to a DRG or similar case-rated methodology for commercial and MassHealth 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. This condition may be any condition actively treated or arising during the prior admission. A Readmission Chain is 3 or more admissions requested as DRG payment. A Readmission Chain can extend beyond 7 days, as long as the time between a discharge and subsequent Readmission to the same inpatient Hospital is within a 7-day time frame. An example is an index admit on the 1st of a month, which stayed for 4 days. Patient returned 6 days later on the 10th and stayed 4 days and subsequently returned 5 days later, on the 19th, and stayed 4 days. While the 19th is more than 7 days from the index admit discharge, it was less than 7 days from the last discharge.

For hospitals that are reimbursed by the Plan according to a DRG or similar case-rated methodology for Medicare/NaviCare/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. A Readmission Chain can extend beyond 30 days, as long as the time between a discharge and subsequent Readmission to the Same Inpatient Hospital is within a 30-day time frame.

The Plan will not authorize or reimburse services submitted as Observation when the services were requested for a DRG payment status and the DRG readmission would have been denied or

not separately reimbursed. This financial protection mechanism is in place to prevent paying for the management of a condition more than once in a short time period. 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. The readmission determination is not based on the preventability of the readmission.

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

- Readmissions that are for 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 medically necessary 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 show that the member signed out “Against Medical Advice”, and that the hospital made an attempt to inform the patient of possible complications due to non-compliance and the possibility of readmission.

Preadmission services

Preadmission diagnostic and non-diagnostic services related to the principal diagnosis that are provided within three calendar days of an inpatient admission are considered incidental to admission and included in the inpatient reimbursement. Preadmission services may be subject to post-payment audits and retraction.

Any ambulatory procedures that result in an inpatient admission to the same hospital are considered incidental to admission and included in the inpatient reimbursement.

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

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 in a hospital generally are to be included by the hospital in a 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, and the use of certain equipment and hospital services for which a separate charge is not customarily made.

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, 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.

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 and must be billed separately according to the unit within which the care is provided.

Inter-hospital transfers

Inter-hospital transfers are covered when medically necessary care is not available at the originating hospital. For example, when the plan member requires a medically necessary organ transplant that is not available at the originating hospital or when the plan member requires care that is not available at the originating hospital such as neonatal intensive care. Inter-hospital transfers for the preference or convenience of a plan member, plan member's family or the plan member's physician are not covered. Elective inter-hospital transfers require prior authorization. Urgent/emergent inter-hospitals transfers require notification.

Members who change insurance during admissions

The Plan will reimburse according to the product specific criteria below when a member changes from or to a different Insurance Payer.

For Medicare Advantage plan members (Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare HMO SNP), as per CMS guidelines, when the member was admitted to a Medicare 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.[4]

For Medicare Advantage plan members (Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare HMO SNP), as per CMS guidelines, when the member was admitted to a Medicare inpatient hospital while enrolled with Fallon Health 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.[5]

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.

[4] 42 CFR § 422.318 - Special rules for coverage that begins or ends during an inpatient hospital stay.
[5] Ibid.

Transfer Per Diem for MassHealth ACO members

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. 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.

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.

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-notices-for-acute-hospitals).

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 EOHHS 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-notices-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-notices-for-acute-hospitals) for Inpatient Services provided to a Transfer Patient.

For MassHealth 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 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,). 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-notices-for-acute-hospitals).

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-notices-for-acute-hospitals).

For commerical products payment is subject to Contract terms and potential ad hoc agreements when contract terms are not present.

Newborn hearing screening

When rendered in an inpatient setting, newborn hearing screening is not separately reimbursed.

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. 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.

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.

Billing/coding guidelines

Hospitals are expected to submit claims using industry standard forms or HIPAA industry electronic formats.

Charges for preadmission services that occur within three calendar days of the admission should be submitted on the same claim as the inpatient services.

Pharmaceutical Waste

- For multi-use vials of medication, bill only for the portion of the medication administered to the member; wasted pharmaceutical will not be reimbursed.
- The Plan does not require but will accept modifier JW (drug amount discarded/not administered to any patient) to identify drugs where the dosage contained in the single-use vial is greater than ordered and/or administered. The Plan will anticipate that hospitals will schedule patients in such a way as to maximize the use of a pharmaceutical and minimize

the waste. The Plan will reimburse for wasted pharmaceutical remaining within the last vial of single-use medication used in a single day in the event that the hospital documents within the patient's medical record the date, time, amount of pharmaceutical wasted, and signature of clinical staff wasting the medication. The Plan also anticipates that the hospital will utilize the most appropriately sized single-use vial or combination of single-use vials to deliver the ordered dose of medication in order to minimize waste.

The Plan reserves the right to audit to verify payment accuracy. Neither the Plan nor Plan members can be held financially responsible for any denied payments for pharmaceuticals that were not administered to the patient.

MassHealth Acute Hospital Carve-Out Drugs

Fallon Health requires hospitals to take the following actions with respect to drugs on the MassHealth Acute Hospital Carve-Out List for MassHealth ACO plan members:

1. Drugs and biologics on the MassHealth Acute Hospital Carve-Out Drugs List require prior authorization. The hospital must obtain prior authorization for the drug or biologic from Fallon Health or our designated pharmacy vendor – this prior authorization is separate from any prior authorization that may be required for the member's inpatient stay.
2. A drug or biologic designated by MassHealth as a carve-out drug must not be included on the hospital/institutional claim that the hospital submits for the plan member's inpatient stay.
3. The hospital must instead submit a separate claim for the carve-out drug on a hospital/institutional claim form (i.e., UB-04). (In other words, the drug should be the only item on the UB-04 claim.) The charge reported on the claim must be the "hospital's actual acquisition cost" for the drug.*
4. The claim for the carve-out drug must be reported with revenue code 0636 (Drugs requiring detailed coding), the HCPCS code for the drug, the National Drug Code (NDC) for the drug, and number of units administered.
5. The hospital must also include the following as separate attachments to the claim:
    a. A statement of the hospital's actual acquisition cost of the carve-out drug (as defined below) used to treat the member; and
    b. A copy of the invoice(s) for the carve-out drug from the drug manufacturer, supplier, distributor, or other similar party or agent; and
    c. Other additional documentation that the Plan deems necessary to evidence the hospital's actual acquisition cost of the carve-out drug.

* For purposes of this requirement, the "hospital's actual acquisition cost" of the carve-out drug is defined as follows:
"…*the hospital's invoice price for the drug, net of all on-or-off invoice reductions, discounts, rebates, charge backs and similar adjustments that the hospital has or will receive from the drug manufacturer or other party for the drug that was administered to the member including any efficacy, outcome, or performance-based guarantees (or similar arrangements), whether received pre-or post-payment*."

The MassHealth Acute Hospital Carve-out Drugs List is available at: https://masshealthdruglist.ehs.state.ma.us/MHDL/. This list may be updated from time to time.

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.

1. Charges corresponding to the LARC device must be excluded from any facility/institutional claim that the hospital submits for the labor and delivery stay.
2. 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.

3. 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)

DRG coding and clinical validation

Fallon Health conducts DRG coding and clinical validation of inpatient claims. The following may be helpful observations from our reviews:

It has been noted that hospitals may sometimes submit DRGs based soley on basic coding guidelines that are not necessarily supported once a clinical validation is done, as the billed diagnosis is not the most clinically accurate one. Coding for DRG stays 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 actually occurred during the hospital stay. For example, 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 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."

As another example, acute kidney failure 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.

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.

Malnutrition is another misunderstood term. 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, have been validated for the adult, hospitalized population and are 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 problem. This 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 01/1/09 – Clarify services included in inpatient reimbursement. 07/1/09 – Updated description of DRG and case payment methodology and explanation of reimbursement for readmissions. 09/01/2010 – Updated language in the Policy, Reimbursement and Billing/coding guidelines sections to address drug waste. 01/01/2012 - Added information to the reimbursement section about what services are included in the inpatient reimbursement rate. 01/01/2013 - Updated language discussing pharmaceutical waste in the Billing/coding guidelines. 09/01/2013 - Updated discussion about services included in the inpatient reimbursement rate to list glucometry separately. 07/01/2014 - Clarified discussion about drug waste. 03/01/2015 - Updated language to reflect Fallon Health rather than Fallon Community Health Plan. Update discussion of DRG/Case payment and readmissions. 01/01/2016 - Updated to new Plan template and clarified language discussing inpatient routine services. 09/01/2016 - Updated the policy and reimbursement sections
Connection 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 reimbursment 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. Revised 02/22/2024 to remove the attestation requirement under Inpatient admissions for Medicare Advantage and NaviCare members.

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.