PAYMENT REIMBURSEMENT POLICY

Title: PRP-22 Inpatient Only Procedures

Category: PHP_PAYMENT REIMBURSEMENT (PR)

Effective Date: 11/01/2023

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1. Guidelines:

This policy applies to all network and non-network physicians and other qualified health care professionals, including but not limited to the percentage of charge contract physicians and other qualified health care professionals. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. PHP may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid for through CMS but are covered by the Plan to support covered benefits available through one of the Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms will take precedence if there is a conflict between this policy and the provider contract.

2. Description:

The purpose of this reimbursement policy is to provide billing and reimbursement guidelines regarding Inpatient Only Procedures (IOP). Due to the complexity of some procedures, there is a medical need for post-operative recovery and monitoring of at least 24 hours of inpatient care. Therefore, it is considered not appropriate to perform these services in an outpatient facility setting.

3. Policy:

This policy applies to inpatient-only services (IOP) reported on facility and professional claims. IOP is not payable when performed in the Outpatient setting.

4. Coding and Billing:

The Plan follows the Centers for Medicare and Medicaid Services (CMS) guidelines regarding Inpatient Only Procedures reimbursement. Inpatient-only procedures (IOP) are not payable when performed and billing in the Outpatient setting. The Plan code edit applications will identify these codes on claims when billed with an outpatient Place of Service or outpatient Type of Bill.

5. Documentation Requirements:

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for the admission of the patient as an inpatient. The order for an inpatient admission must be on file in the medical record along with documentation that supports the need for this level of care. In general, inpatient orders are placed for a patient expected to require services and a level of care that crosses two midnights.

Exemptions

The Plan understands the decision to admit a patient as an inpatient is made by the physician with consideration of numerous factors, including the patient's medical history, immediate medical needs, the types of facilities available to provide medically necessary services, the

hospital's by-laws and admissions policies, and the appropriateness of treatment in each setting.

In instances where an otherwise covered inpatient procedure on the IOP list is going to be performed in an outpatient setting, a written request for consideration of coverage in this setting as an exemption may be submitted for review by our medical resource management department. Please submit these requests using the prior authorization form. The form should be submitted at least two weeks prior to the date of surgery and indicate clearly that the request is for consideration of an IOP procedure to be performed in an outpatient setting. The physician's office that is responsible for scheduling the procedure should submit this request along with supporting documentation for consideration.

6. Verification of Compliance:

Claims are subject to audit, prepayment, and post-payment to validate compliance with the terms and conditions of this policy.

7. Terms & Definitions:

Exemption: Approved one-time allotment of coverage

Inpatient Admission: Formal admission to an acute care facility under a doctor's order of inpatient-level care that is expected to span at least two midnights.

Outpatient Services: Medical or surgical care that doesn't generally require more than one day (24 hours) of care. However, in some instances, a patient without an inpatient order may remain in observation care for longer than 24 hours. This includes emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor hasn't written an order to admit you to a hospital as an inpatient.

Place of Service: Place of Service Codes are two-digit codes placed on healthcare professional claims to indicate the setting in which a service was provided.

Type of Bill: This four-digit alphanumeric code provides three specific pieces of information after a leading zero. CMS ignores the leading zero. This three-digit alphanumeric code gives three specific pieces of information

- First Digit = Leading zero. Ignored by CMS
- Second Digit = Type of facility
- Third Digit = Type of care
- Fourth Digit = Sequence of this bill in this episode of care. Referred to as a "frequency" code

8. References, Citations, Resources & Associated Documents:

Current Procedural Terminology (CPT)

9. Centers for Medicare and Medicaid Services, final rule 2022 and other publications and services - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

10. Revision History:
Original Effective Date: 01/01/2023

Next Revision Date: 11/01/2024

10. Document Evaluation Panel:

Revision Date	Reason for Revision
8/23	Annual review
