Applicable To:

- ☑ Medicare
- ☑ Medicaid – excluding Nebraska, Arizona, Missouri, and Kentucky
- ☑ Children's Medical Services Health Plan (CMS Health Plan)

Claims and Payment Policy: Inpatient Hospital Short Stays Reviews

Policy Number: CPP- 147

Original Effective Date: 1/1/2020
Revised Effective Date(s):

BACKGROUND

As defined by CMS, medical review is the collection of information and clinical review of medical records to ensure that payments are made only for services that meet all Medicare coverage, coding, and medical necessity requirements. This definition may differ across state Medicaid programs, but the intent is similar. The goal of WellCare's medical review program is to increase the payment accuracy of Medicare and Medicaid claims. State-specific definitions and requirements may vary.

As stated in the CMS Internet-Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual (PIM), Chapter 6, § 6.5.2, "Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care provided was [sic] provided in a less intensive setting." Additionally, the Code of Federal Regulations, in Title 42 § 412.46(b) states the following with respect to Medicare: "A physician order has no presumptive weight….A physician's order will be evaluated in the context of the evidence in the medical record."

For purposes of determining the appropriateness of payments for inpatient admissions, WellCare may conduct post-payment reviews of medical records for Inpatient Prospective Payment System (IPPS) hospitals, Critical Access Hospitals (CAH), Inpatient Psychiatric Facilities (IPF) and Long Term Care Hospitals (LTCH), as appropriate. These retrospective post-pay reviews, which can occur for admissions of two days or less, may be performed based on WellCare's data analysis and its prioritized medical review strategies.

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POSITION STATEMENT

WellCare may, at its discretion, to perform post-pay retrospective reviews of hospital admissions, including admissions of two days or less, at both participating and non-participating facilities.

Should WellCare identify an admission to review, WellCare or its designee will request service-specific information from the provider. This information may include, but is not limited to, complete medical records, itemized bills, and consent forms. The provider should allow access to its records, or supply copies of records to support the charges billed. To uphold payment of the inpatient DRG, the medical record must demonstrate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the member for the duration of the stay. WellCare retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, the medical necessity of services, and correct coding and billing practices.

For more information about WellCare's retrospective review process, please reference the Claims and Payment Policy entitled *Pre-Payment and Post-Payment Review.*

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

CODING & BILLING

N/A

REFERENCES

1. CMS Internet-Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual (PIM), Chapter 6, § 6.5.2
2. Code of Federal Regulations, Title 42 § 412.46(b)

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a

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number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
12/30/2019	• Approved by RGC