moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM065
Policy Title:	Facility Guidelines, General Overview		
Section:	Facility-Specific	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☐ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

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Last Updated:	4/8/2024	Last Reviewed:	4/10/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		4/10/2024	

Reimbursement Guidelines

A. General

Moda Health follows industry standard guidelines for billing and payment for facilities as outlined in this policy. Billing guidelines may also be included in other posted Moda policies. Where an item is not specifically addressed, Moda Health follows CMS policy.

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail.

B. Claim Reviews

Moda Health may review any claim for appropriate coding, appropriate pricing, and payment per Medical and Reimbursement policies as posted. We will request any combination of documentation needed to support the billed services, including but not limited to:

- Invoices
- Medical records
- Itemized bill

All documentation requested must be provided within the 30 days required by the record request. If the requested documentation is not received within this time frame the claim will be denied for lack of needed records and payment will be re-considered once the documentation is received.

C. Inpatient Versus Outpatient Hospital Stays

1. Inpatient versus Outpatient Level of Care

   Moda Health uses Milliman Care Guidelines (MCG) to determine appropriate level of care. Select claims billed as inpatient with a DRG will be reviewed for level of care using the medical records. (See Level of Care Review, Moda Health [K])

2. Inpatient Hospital Claims

   a. Are submitted either in paper form or electronically on an institutional format (UB-04, CMS-1450).

   b. Are submitted with Type of Bill (TOB) code 11x.

   c. Must include the appropriate room and board revenue codes. (See below and Moda Health Policy RPM042.)

   d. The total units billed on the room and board revenue codes must match the length of stay calculated as discharge date less admit date.

   e. Exclude all professional components and ground/air ambulance.

      i. Professional components, including lab/pathology, radiology, anesthesia, emergency, etc., are to be submitted electronically on a Professional format form (CMS1500). (NUCC[1], Magnani[9], CMS[10])

      ii. Exception: Critical Access Hospitals (CAHs) which have elected Method II billing:

         1) May submit charges under revenue codes 096x – 098x for professional services by providers who have reassigned billing for their professional services to the CAH instead of submitting these services on a CMS1500 under the Medicare Physician Fee Schedule.

         2) For Outpatient claims, report the professional service with the appropriate HCPCS code and any modifiers needed. (CMS[20])

         3) The Method II Critical Access Hospital is responsible for communicating clearly with and obtaining a signed attestation & Form CMS-855R from each professional provider for whom they are billing on the facility claim (CMS1450 under revenue codes 096x – 098x). (CMS[20])

         4) If duplicate claims are received from both the CAH and the provider for professional services performed at a Critical Access Hospital, then the second claim processed will be denied.

            a) The Critical Access Hospital and the professional provider's billing office will need to determine together which claim was submitted in error.

            b) If the allowed (first) claim was submitted in error, a corrected claim with the charges redacted will need to be submitted before reimbursement can be made to the other billing office for the (second/duplicate) denied claim.

3. Outpatient Hospital Claims

   a. Include claims for Observation Services and other Outpatient Services.

b. Exclude all professional components and ground/air ambulance. (The exception for Method II CAH claims listed under Inpatient applies for Outpatient claims also.)

c. Are submitted either in paper form or electronically on an institutional format (UB-04, CMS-1450).

d. Are submitted with Type of Bill (TOB) code 13x.

D. Observation

1. Hospital observation is intended to allow a physician an opportunity to monitor and observe a patient and make a decision about on-going care.
2. Covered charges are to be correctly billed under revenue code 0762 with the appropriate observation HCPCS codes.
3. Applicable pre-authorization and notification requirements will apply.
4. Length of Observation stay.
   a. Moda Health reimburses for up to 48 hours of observation, if clinically appropriate.
   b. Observation stays billed beyond 48 hours will be reviewed for clinical level of care. See Level of Care Review (Moda [J]).
      i. Observation stays longer than 48 hours that do not meet clinical guidelines for inpatient level of care will be processed as observation and hours of observation care and charges after 48 will be denied per the CMS (Centers for Medicare and Medicaid Services) outpatient reimbursement terms.
      ii. MCG criteria are used to determine appropriate level of care.
      iii. Moda Health follows CMS guidelines regarding proper documentation of observation stays.
      iv. Additional requirements for Medicare Advantage claims:

      For Medicare Advantage claims, Moda Health follows the CMS guidelines for the *Medicare Outpatient Observation Notice* (MOON), form *CMS-10611,* for Medicare beneficiaries receiving outpatient observation care for more than 24 hours. All hospitals, including critical access hospitals, are required to begin providing this notice no later than March 8, 2017. (CMS [5, 6, 7, 8])
5. Correct billing of facility fees for observation stays.
   a. Hospitals are to report observation services using the following procedure codes: (CMS[16])
      i. G0378 *Hospital observation service, per hour.*
      ii. If applicable, G0379 *Direct admission of patient for hospital observation care* may be appropriate to report.
   b. Procedure codes 99234 – 99236 may not be reported by hospitals for observation facility fees. These codes are for reporting professional E/M services when the patient is in observation or inpatient hospital care and is admitted and discharged on the same calendar date. (CMS[17])

E. Special Care Unit Level of Care

2. Special care units include, but not limited to:
    a. Intensive Care Unit (ICU)
    b. Coronary Care Unit (CCU)
    c. Neonatal Intensive Care Unit (NICU)
    d. Pediatric Intensive Care Unit (PICU)
    e. Step-down Care Unit
3. Reviews of special care unit services are done for appropriate level of care and length of stay in the special care unit. See Level of Care Review (Moda [J]).
4. MCG criteria are used to determine appropriate level of care.
5. When the length of stay (LOS) in a special care unit extends beyond what is supported by the level of care criteria, the excess days will be reimbursed at the rate for the lower level of care.

F. Pre-admission Services

1. Reviews of Pre-admission services are done for conformity to policy and CMS guidelines.
2. Pre-admission service 3-day rule guidelines:
    a. Outpatient hospital services rendered three calendar days prior to or on the date of the inpatient admission are included in the inpatient claim reimbursement. These services are deemed to be inpatient hospital services, and are not eligible for separate reimbursement.
        i. This includes diagnostic services (including clinical diagnostic laboratory tests) provided to a patient by:
            1) The hospital.
            2) Any entity wholly owned or wholly operated by the hospital.
            3) Any other entity or provider under arrangements with the hospital (e.g. the admitting hospital owns the physician's practice performing the preadmission services.).
        ii. For example, if a Member is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient reimbursement. (CMS[2])
    b. The 3-day payment window policy does not apply when the admitting hospital is a Critical Access Hospital (CAH).
    c. The Emergency Room (ER) charges should be included on the inpatient claim, and no separate ER claim should be filed.
3. Pre-admission service 1-day rule guidelines:
    a. These hospitals are exempt from the 3-day rule but are subject to the 1-day rule, (including):
        i. Inpatient psychiatric hospitals and units.
        ii. Inpatient rehabilitation facilities and units.
        iii. Long-term care hospitals.

iv. Children's hospitals.
v. Cancer hospitals.

b. The 1-day payment window applies to the date of admission and the entire calendar day preceding the date of admission and will include the 24-hour period that immediately preceded the time of admission but may be longer than 24 hours. (CMS[3])

c. The 1-day payment window policy does not apply when the admitting hospital is a Critical Access Hospital (CAH).

d. The Emergency Room (ER) charges should be included on the inpatient claim, and no separate ER claim should be filed.

G. DRGs (Diagnosis Related Groups)

1. DRG Validation Reviews.

   DRG Validation Audits are conducted by Moda to confirm DRG assignment and accuracy of payment. DRG validation involves review of medical record documentation to determine correct coding on a claim submission and in accordance with industry coding standards as outlined by the Official Coding Guidelines, the applicable International Classification of Diseases (ICD) Coding Manual, Uniform Hospital Discharge Data Set (UHDDS), and/or Coding Clinics. (See Facility DRG Validation, Moda Health [M])

2. Ungroupable DRGs.

   MS DRG 998 and 999 are defined as ungroupable DRGs. Any claim which groups to an ungroupable DRG will be returned to the provider for correction of coding or claim errors.

3. DRG Methodology.
   a. The following charges and fees are included in the DRG reimbursement:
      i. Room and board, including services and supplies.
      ii. Late discharge.
      iii. Observational/outpatient.
      iv. Diagnostic laboratory services.
      v. Emergency or after-hours admission.
      vi. Medical transportation within the hospital.
      vii. Admission or utilization review paperwork.
      viii. Discharge (take home) prescription drugs.
      ix. Emergency room, if the patient is admitted.
      x. Pre-admission services three days prior to admission or one day prior to admission, as outlined above in section E.

   b. The majority of inpatient claims will be processed using DRG methodology.

   c. The following situations are subject to special rules, because the member's stay or the insurance coverage period is less than the time period covered by the DRG. Reimbursement may be less than, but will not exceed, the reimbursement under DRG methodology.
      i. Transfer patients. (Moda [E])
      ii. Hospitalization that begins before or ends after insurance is effective with Moda Health plan.

H. Hospital Readmission Claims Review (Group and Individual plans)

1. Commercial plan claims.

   All hospital readmissions from and to the same hospital/facility are considered a continuation of initial treatment.

   The two DRG hospital claims (identified using the assigned provider identifier) will be consolidated into one, combining all necessary codes, billed charges and the length of stay. The maximum allowable for Covered Services will be recalculated so that reimbursement is for a single, per case reimbursement.

   a. This readmission policy applies to the following but is not limited to:
      i. Emergent readmissions.
      ii. Psychiatric readmissions.
      iii. Clinically related readmissions.

   b. This readmission policy does not apply to the following:
      i. Critical Access Hospitals.
      ii. Readmission for unrelated condition.
      iii. Transfer from one acute care hospital to another.
      iv. Patient discharged from the hospital against medical advice.
      v. Readmission for the medical treatment of rehabilitation care.
      vi. Readmission for cancer chemotherapy or transfusion for chronic anemia.

2. Medicare Advantage and Medicaid claims.

   a. Our Medicare Advantage and Medicaid readmission policy aligns with CMS and includes readmission to the same hospital (using the assigned provider identifier) within 30 days of the initial admission.

   b. Hospital stays are subject to clinical review to determine if the readmission is related to or similar to the initial admission.

   c. Processing and Review.

      i. Readmissions occurring within 24 hours after discharge will be processed as a single claim.

      ii. Readmissions occurring within 2-30 days will be subject to clinical reviews. If the clinical review indicates that the readmission is for the same or similar condition, it may be considered a continuation of the initial admission for the purposes of reimbursement.

   d. Combining related DRG claims.

      When we receive DRG claims for both an initial and subsequent hospital stay, we combine the subsequent hospital stay with the initial claim within our system.

      i. When this occurs, we will send you a notification reflecting these changes and additional payment, if applicable.

      ii. Refunds will be requested when applicable.

   e. This readmission policy applies to the following but is not limited to:
      i. Emergent readmissions.

ii. Psychiatric readmissions.
iii. Clinically related readmissions.

f. This readmission policy does not apply to the following:
i. Critical Access Hospitals.
ii. Readmission for unrelated condition.
iii. Transfer from one acute care hospital to another.
iv. Patient discharged from the hospital against medical advice.
v. Readmission for the medical treatment of rehabilitation care.
vi. Readmission for cancer chemotherapy or transfusion for chronic anemia.

3. For more information, see Readmissions policy. (Moda [P])

I. Line Item Reviews

1. Select claims will be reviewed for consistency with industry standard billing guidelines and rules. These will be compared with CMS, industry standard, and Moda Health reimbursement policies.
2. These reviews most often include inpatient claims paying percent of charges or DRG. When the claim is paying DRG, the inpatient claim must have an outlier payment to qualify for a line by line audit.
3. Facilities will not be reimbursed nor allowed to retain reimbursement for services considered to be non-billable, non-reimbursable or not eligible for separate reimbursement. These charges are also not considered towards a DRG outlier payment (if applicable).

J. Coding Reviews

During the normal course of business, coding reviews may be done to determine accuracy and eligibility for payment. These reviews are conducted pre- and post-payment. (Moda [A])

K. Hospital Acquired Conditions and Never Events

Moda Health follows CMS Hospital Acquired Conditions (HAC) and Never Events policies.

4. For DRG reimbursed services, the DRG will be reduced after review when the HAC diagnosis is removed.
5. For other reimbursement methodologies, all services and supplies related to the HAC diagnosis will be removed prior to payment of the claim.
6. For Never Events all supplies and services for treatment of the Never Event will be removed from the claim prior to reimbursement.
7. For more information, see "Never Events, Adverse Events, Hospital-Acquired Conditions (HAC), and Serious Reportable Events (SRE)." (Moda [O])

L. Surgical Procedures Not Found on the Outpatient Fee Schedules

1. Surgical procedures not listed on the Outpatient Fee Schedule are individually reviewed for payment consideration when performed in a hospital outpatient setting or an Ambulatory Surgery Center (ASC).

2. Moda Health may also request medical records to:
    a. Help determine a reimbursement rate.
    b. Ensure that the procedure code reported accurately represents the surgery performed. (See sections H and I, above.)
3. If medical records are requested, we will make a determination regarding reimbursement once the documentation is received.

M. Maternity/Newborn Claims

Separate claims must be submitted for the mother and newborn services. Claims that reflect both maternity and newborn charges on the same claim form will be returned to the hospital and/or provider for correct billing.

N. Hospital-based Physician Services

1. Professional fees for covered services rendered to members by hospital-based physicians during a covered inpatient hospital stay, are not included in the hospital Maximum Allowable.
2. Professional services should be submitted on a Professional format form (CMS1500) or electronic equivalent. (NUCC[1], Magnani[9], CMS[10]) Charges submitted on institutional format forms (UB-04 CMS-1450) will be denied. (Moda [D])

    For Critical Access Hospitals this rule does not apply.

O. Interim Billing

1. Interim bills are defined by the following Type of Bill (TOB) codes:
    a. TOB 112 = Interim – First claim
    b. TOB 113 = Interim – Continuing claim
    c. TOB 114 = Interim – Last claim
2. The initial interim bill must have a patient status code of 30 (still patient) and be submitted with TOB code 112.
3. Processing.
    a. Effective April 12, 2018, Moda Health does not accept interim bills for out-of-network inpatient mental health or substance use disorder claims.
        i. The out-of-network facility is required to bill for the complete inpatient stay as one whole claim after the patient is discharged.
        ii. Interim bills will be denied, and the facility will need to resubmit after the patient is discharged. The denial code(s) will be:

Explanation code 70N	Interim Billing Declined. Resubmit claim with total billed charges with In-PT/Residential care is complete.
CARC 135	Interim bills cannot be processed.

        iii. Exception: Interim bills are accepted only for out-of-network claims on the few ASO employer groups that do not use CMS pricing methodology for out-of-network inpatient mental health or substance use disorder claims.
    b. For all other facility claims, Moda Health accepts interim bill TOB 112, 113, and 114.

c. The initial interim bill and all subsequent interim bills submitted will be held and combined when the final claim is received, and a single claim reimbursement will be made.

P. Type of Bill (TOB) Codes

1. In order to be processed correctly and promptly, all elements on the claim must be completed accurately.
2. The Type of Bill (TOB) code submitted must be consistent with and appropriate for the facility submitting the claim.
3. Medicare defines the valid and appropriate TOB codes for each type of facility. (CMS[21])
4. Critical Access Hospitals (CAH), Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) have specifically designated TOB codes for use.
5. Effective May 1, 2023, if a claim is identified with an incorrect TOB for one of these special facility types, the entire claim will be denied to provider responsibility, and a corrected claim will be required.

Q. Ambulance Services

1. Ambulance claims are required to follow the CMS coding guidelines.
2. Ambulance services provide by hospital-based equipment are not to be billed on the inpatient hospital claim with the inpatient services.
   a. All ambulance services are to be billed as outpatient on a CMS1500 form or electronic equivalent.
   b. Ambulance services billed on inpatient claims will be denied.

R. Late Charges

1. Late charges are defined as TOB code 115.
2. Late submissions are accepted if submitted within timely filing limits. If that requirement is met, we will review them for consideration.
3. If the review determines the late charges are appropriate, all charges for this inpatient episode of care will be combined, and a payment determination will be made on the total charges. Additional reimbursement will be issued, if applicable.

S. Hospital Corrected Billings and/or Adjustments

1. Corrected claims must be submitted using TOB code with a frequency code of "7" *Replacement of Prior Claim* as the final digit.
2. Corrected claims must be submitted within timely filing requirements to be accepted for consideration and processing.
3. All claims must contain all pertinent information including all applicable ICD diagnosis and procedure codes, present on admission (POA) flags and discharge status.

4. Charges included on previously submitted claims, whether billed as interim or complete claims, must be included on the corrected claim, since this is a complete replacement of any and all previously submitted claim(s).
5. Itemizations or records may be requested to re-adjudicate the corrected claim.

T. Revenue Codes

1. According to the Uniform Billing Editor, "The revenue codes for "Other" (ending with 0XX9) are assigned at the state level for local billing needs." (Whitehead & Magnani [4])
2. Moda Health considers revenue codes for "Other" (ending with 0XX9) to be unlisted revenue codes, which are generally not accepted by Moda Health. Instead, a more specific revenue code ending in "1," "2," "3," "4," "5," "6," "7," or "8" which applies should be used, or the general revenue code (ending with "0," e.g., 0XX0) may be used when there is no CMS requirement to use a more specific revenue code. (Moda [Q])

U. Freestanding Ambulatory Surgery Centers (ASCs)

1. Services included in ASC facility fees.

   The maximum allowable includes, but is not limited to, the following (Noridian[15]):

   a. Nursing services, services furnished by technical personnel, and other related services.
   b. Drugs and biologicals for which separate payment is not made under the OPPS, surgical dressings, supplies, splints, casts, appliances, and equipment.
   c. Administrative, recordkeeping, and housekeeping items and services.
   d. Blood, blood plasma, and platelets, with the exception of those to which the blood deductible applies.
   e. Materials for anesthesia.
   f. Intraocular lenses.
   g. Implantable devices, with the exception of those devices with pass-through status under the OPPS.
   h. Radiology services for which payment is packaged under the OPPS.

2. Services not included in the ASC facility fee.

   These items should be billed separately from the facility fee with appropriate Healthcare Common Procedure Coding System (HCPCS) or CPT coding:

   a. Ambulance services.
   b. Custom braces (e.g., leg, arm, back and neck).
   c. Services furnished by an independent laboratory.
   d. Physician or other individually contracted provider services, including anesthesia.
   e. The sale, lease or rental of durable medical equipment to ASC patients for use in their homes.
   f. Prosthetic devices defined as those items that are permanent replacements to existing body parts, including artificial legs, arms and eyes. Invoices are to be submitted upon request. Shipping and handling are not separately reimbursed.

V. Laboratory Tests

Point of Care (POC) testing is not eligible to be reported as a laboratory test (CPT). This includes but is not limited to:

- Glucometers
- Blood gases
- Ionized calcium
- Urine dipsticks
- Hemoglobin & hematocrit
- Lactate
- And others

These POC tests may not be billed as lab tests under revenue code(s) 0300-0319, etc.

W. Emergency Services

1. Emergency Department facility fees are to be correctly billed under revenue codes 0450, 0451, 0452, 0456 (Emergency Room).
2. Emergency Department professional fees are to be correctly billed on a CMS1500 claim form or electronic equivalent, using POS 23 Emergency Room – Hospital. Professional claims will be reimbursed according to the applicable professional fee schedule.
3. The patient's medical record documentation for diagnosis and treatment in the Emergency Department (ED) must indicate the presenting symptoms, diagnoses and treatment plan and a written order(s) by the provider. All contents of medical records are to be clearly documented.
4. Medical records and itemized bills may be requested for review to support the billed services and level of care.

X. Outpatient Hospital Multiple Fee Reductions

For information on multiple fee reductions on outpatient hospital claims, see "Modifier 51 – Multiple Procedure Fee Reductions" sections A & D.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AARC	=	American Association of Respiratory Care
AHA	=	American Hospital Association
AMA	=	American Medical Association
ASC	=	Ambulatory Surgery Center
ASO	=	Administrative Services Only
CAH, CAHs	=	Critical Access Hospital(s)

Acronym or Abbreviation		Definition
CCI	=	Correct Coding Initiative (see “NCCI”)
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
ED	=	Emergency Department (also known as/see also ER)
ER	=	Emergency Room (also known as/see also ED)
FAH	=	Federation of American Hospitals
HAC	=	Hospital Acquired Condition
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as “hick picks”)
HFMA	=	Healthcare Financial Management Association
HIPAA	=	Health Insurance Portability and Accountability Act
ICD	=	International Classification of Diseases
ICD-10	=	International Classification of Diseases, Tenth Edition
ICD-10-CM	=	International Classification of Diseases, Tenth Edition, Clinical Modification
ICD-10-PCS	=	International Classification of Diseases, Tenth Edition, Procedure Coding System
MCG	=	Milliman Care Guidelines
MOON	=	Medicare Outpatient Observation Notice
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
NUCC	=	National Uniform Claim Committee
OPPS	=	Outpatient Prospective Payment System
PICU	=	Pediatric Intensive Care Unit
POA	=	Present on Admission
RPM	=	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
RVU	=	Relative Value Unit
TOB	=	Type of Bill
UB	=	Uniform Bill
UHDDS	=	Uniform Hospital Discharge Data Set

Definition of Terms

Term	Definition
Advanced practice provider (APP)	'Advanced Practice Provider' is a general title used to describe individuals who have completed the advanced education and training that qualifies them to (1) manage medical problems and (2) prescribe and manage treatments within the scope of their training. Some specific types of APPs include clinical nurse specialists, nurse practitioners, and physician assistants. This term is approximately equivalent to the Medicare term Non-physician practitioner (NPP).
Clinical Staff	A person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but does not individually report that professional service. (AMA[18])
Emergency Department	• Type A emergency department: must meet regulatory requirements and be open 24 hours/day and 7 days/week and submit codes 99281-99285 for ED facility fees. Type B emergency department: must meet regulatory requirements but is not open 24 hours/day and 7 days/week and submit codes G0380-G0384 for ED facility fees. (CMS[14])
Emergency Medical Condition	• Member is in serious jeopardy of their health or their unborn child, or • Has serious body function or impairment, or Has serious dysfunction of any bodily organ or part. (CMS[13])
Emergency Services	Services needed to stabilize an emergency medical condition (CMS[13])
Inpatient	A person who has been admitted by a physician order to an inpatient hospital bed for purposes of receiving inpatient services.
Inpatient Hospital	A facility which provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services to patients admitted by a physician order to an inpatient bed for care for a variety of medical conditions.
Level of Care	The intensity of effort required to diagnose, treat, preserve or maintain an individual's physical or emotional status. (CMI[12])
Non-physician Practitioner	A Medicare term which Medicare defines as: Health care providers who practice either in collaboration with or under the supervision of a physician, including physician assistants, nurse practitioners, and clinical nurse specialists, are referred to as non-physician practitioners (NPPs). (CMS[19]) This term is approximately equivalent to the non-Medicare term Advanced Practice Provider (APP).
Outpatient	A person with health problems who visits the hospital for diagnosis or treatment, but does not at this time need to be admitted to an inpatient bed for care.

Term	Definition
Outpatient Hospital	A portion of the hospital that treats patients with health problems who visit the hospital for diagnosis or treatment, but do not at this time need to be admitted to an inpatient bed for care.
Pre-Admission Testing	Includes any service related to a patient's planned inpatient admission or same day surgery that is performed on the day of, or within the 72-hour period prior to the day of, a patient's planned inpatient admission or same day surgery service. Pre-Admission Testing services are considered related to an inpatient admission or same day surgery if the outpatient principal diagnosis is similar to, or the same as, the inpatient or same day surgery diagnosis.
Qualified Health Care Professional	A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulations (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. (AMA[18])
Wholly Operated	An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. 42 CFR §412.2 (CMS[11])
Wholly Owned	An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. 42 CFR §412.2 (CMS[11])

Type of Bill codes:

Code	Code Description
112	Interim – First claim
113	Interim – Continuing claim
114	Interim – Last claim
115	Late charges
117	Replacement of Prior Claim (used for corrected claims)

Coding Guidelines & Sources – (Key quotes, not all-inclusive)

"The 1500 Health Insurance Claim Form (1500 Claim Form) answers the needs of many health care payers. It is the basic paper claim form prescribed by many payers for claims submitted by physicians, other providers, and suppliers, and in some cases, for ambulance services." (NUCC[1])

"Professional Component. … Services to individual patients must be specially billed by the physician or, with the physician's authorization, by the hospital, partnership, corporation, or other organization of physicians.…

Billing the Professional Component. … All facilities, except all-inclusive rate hospitals and CAHs, must bill the physician's professional services on a CMS-1500 form or its electronic equivalent. Services must be identified with a HCPCS or CPT code and a date of service. An ICD-9-CM diagnosis code that relates to the service rendered must be on the claim." (Magnani[9])

"It is necessary to distinguish between the medical and surgical services rendered by a physician to an individual patient, which are paid under Part B, and provider services (including a physician's services for the provider) which are paid under Part A. This is necessary because the payments are made from different trust funds, A/B MACs (A) and (B) are involved in handling the claims, and the method of determining the payments for Part A benefits differs from the Part B payment calculation.…

A. The Professional Component

The professional component of a provider-based physician's services pertains to that part of the physician's activities that is directly related to the medical care of the individual patient. It represents remuneration for the identifiable medical services by the physician that contribute to the diagnosis of the patient's condition or to his treatment. These services are covered under Part B. Claims for professional services are processed by the A/B MAC (B) and are paid, where applicable, under the fee schedule."

(CMS[10])

"The MOON must be delivered to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or CAH must provide the MOON no later than 36 hours after observation services as an outpatient begin."

(CMS[5])

"Hospitals and Critical Access Hospitals (CAHs) are required to provide written and verbal explanation to Original Medicare and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours.

The process for delivery of this standardized notice (Form CMS-10611), the Medicare Outpatient Observation Notice (MOON), can be found in §400 of Chapter 30 of the Medicare Claims Processing Manual." (CMS[8])

Cross References

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.

B. "Clinical Editing." Moda Health Reimbursement Policy Manual, RPM002.

C. "Additional Practice Expense Items During a Public Health Emergency (PHE) – CPT 99072." Moda Health Reimbursement Policy Manual, RPM074.

D. "Clinic Services In the Hospital Outpatient Setting – Commercial." Moda Health Reimbursement Policy Manual, RPM061.

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Background Information

Facility billing guidelines are developed by a group of national, industry-standard sources such as CMS, the NUBC, and the member-organizations that make up the NUBC (including AHA, CMS, FAH, HFMA, NUCC, and others), and any other applicable specialty organizations (e.g., AARC, etc.).

This policy is intended to provide a general overview of basic Facility Guidelines used and applied by Moda Health. It is not intended to be a complete, detailed, and exhaustive summary of each and every facility billing guideline and regulation used. Some of these topics will also have a separate, focused reimbursement policy document which will cover the subject in greater detail. Refer to the listing of related reimbursement policies in the Cross References section.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member’s medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member’s medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member’s medical benefit plan, the member’s medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider’s agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
4/10/2024	Clarification/Update: Section B: Added clarification re: how claims are handled if records not returned timely. Sections R.2 & S.2: Clarification added that timely filing requirements apply. Section S.1: Clarification of the frequency code for corrected claims. Section X: Added. Cross References: Added one entry. Reordered entries C-X by Title & updated footnotes to match new order. Hyperlinks updated.
2/8/2023	Clarification/Update: Section C.2.e & C.3.b: Clarifies Method II CAH exception for revenue codes 0960 – 0989 and how duplicate professional charges on CMS1500 claims will be handled. Section P: Added for correct TOB for Critical Access Hospital (CAH), Rural Health Center (RHC) and Federally Qualified Health Centers (FQHC). Subject to TAC 28. Definition of Terms: 4 entries added. References & Resources: 4 entries added.
12/14/2022	Clarification/Update: Section D.5: Clarification of correct codes for hospitals to use for billing observation services with 2 related footnote sources added.
11/9/2022	Clarification/Update: Change to new header; includes Idaho. Section I: Clarification of DRG outlier line item reviews added. Cross References: Hyperlinks added.
5/11/2022	Clarification/update. Added information about special care unit LOS reviews. These have been occurring (concurrent, pre-pay, post-pay) but were not previously mentioned in the policy. Policy History: Added. Entries prior to 2022 omitted (in archive storage).
4/10/2019	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
10/12/2009	Original Effective Date (with or without formal documentation). Policy based on CMS and industry standard facility billing guidelines.