Payment Policy: Not Medically Necessary Inpatient Professional Services

Reference Number: LA.PP.060
Product Types: Medicaid **Coding Implications**
Last Review Date: 08/2020 **Revision Log**

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Medical professional services performed in an inpatient facility location are only payable if the admission is determined to be medically necessary.

The purpose of this policy is to define payment criteria for medical professional services when the inpatient facility admission is denied as not medically necessary.

Application
Inpatient professional services
Inpatient Facility Claims
Participating and non-participating providers

Policy Description
All acute inpatient facility admissions require authorization. Louisiana Healthcare Connections uses written clinical support criteria to evaluate medical necessity, level of care, and/or clinical appropriateness. When the inpatient facility admission is denied as not medically necessary, the associated professional services are also not payable. Louisiana Healthcare Connections will not reimburse services which are not considered medically necessary.

Reimbursement
The health plan will utilize programmed claims logic to review inpatient professional claims and compare them to inpatient facility authorizations to draw a conclusion as to whether or not the professional services are payable.

In the event there is no matching inpatient authorization for the same member with dates of service included within the authorization date span, the professional claim will be denied with the following explanation code:

Explanation Code	Description
Exmg	NO AUTHORIZATION ON FILE FOR ASSOCIATED INPATIENT ADMISSION

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Definitions

EXmg – No authorization on file for associated inpatient admission

Inpatient Facility – For the purposes of this policy, a facility is defined as a Hospital, Skilled Nursing and other location and requires at least one overnight stay.

Inpatient Professional Services – Physician services rendered while a member has been admitted to an inpatient facility.

Member – A person insured or otherwise provided coverage.

Revision History	
08/15/2020	Converted corporate to local policy.
08/30/2022	Annual review; Updated copyright dates. Removed clinical and added payment policy in "Important Reminder" section

Important Reminder

This ~~clinical policy~~payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this ~~clinical policy~~payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this ~~clinical policy~~payment policy. This ~~clinical policy~~payment policy is consistent with standards of medical practice current at the time that this ~~clinical policy~~payment policy was approved.

The purpose of this ~~clinical policy~~payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This ~~clinical policy~~payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this ~~clinical policy~~payment policy. This ~~clinical policy~~payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this ~~clinical~~

~~policy~~payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this ~~clinical policy~~payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This ~~clinical policy~~payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This ~~clinical policy~~payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this ~~clinical policy~~payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This ~~clinical policy~~payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this ~~clinical policy~~payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_