

Inpatient Hospital Admissions

Policy

Mass General Brigham Health Plan reimburses participating hospital facilities for the provision of medically necessary inpatient services.

Policy Definition

Inpatient Hospital Admissions include items and services furnished to an inpatient, including room and board, nursing care and related services, diagnostic and therapeutic services and medical and surgical services.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include, but are not limited to, copayments, deductible, and/or co-insurance, and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or authorization. Referral and authorization requirements can be located [here](#).

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global

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allowance, are not eligible for separate reimbursement. Please refer to [Coding Provider Payment Guidelines](#) for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Admission status must be made via physician order and admission time begins at the time documented in the medical record as the time the patient has inpatient care begun. The time the order is written or the time a bed is held cannot be used as admission time.

If a patient transfers from the emergency room and/or observation status to inpatient status, separate reimbursement will not be made for emergency room charges or observation bed hours as the Room and Board charges represent a full 24-hour calendar day.

For MassHealth line of business:

Please reference the link below for all of the payable DRG code sets:

[Special notices for acute hospitals](#)

Mass General Brigham Health Plan Reimburses

- Inpatient acute medical admissions when notified within appropriate timeframes

Mass General Brigham Health Plan Does *Not* Reimburse

- Claims that are reimbursed based on APR-DRG and MS-DRG methodology are not eligible for interim billing or late charges
- Private rooms; only when prior authorized under medical necessity and will be reimbursed at the contractual semi-private room rate
- Experimental, investigational, and/or cosmetic services. Authorization for an admission to an inpatient setting does not supersede coverage limitations for experimental, investigational, and/or cosmetic services.
- Serious Reportable Events (SRE) as defined in Mass General Brigham Health Plan [Serious Reportable Events Payment Policy](#)

Provider Payment Guidelines and Documentation

Present on Admission (POA)

The POA indicator is required for all inpatient claims. Submit the POA indicator in accordance with the definitions published by CMS. The POA indicators will follow the diagnosis code in the appropriate 2300 HI segment.

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POA	Definition
Y	Present at the time of inpatient admission
N	Not present at the time of admission
U	Documentation is insufficient to determine if condition is present on admission
W	Clinically undetermined; Provider is unable to clinically determine whether condition was present or not on admission

Serious Reportable Events & Provider Preventable Conditions

Mass General Brigham Health Plan does not reimburse for services associated with serious reportable events (SRE), “never events” and/or provider preventable conditions (PPC). To administer this policy, Mass General Brigham Health Plan recognizes, but is not limited to, the serious reportable events identified by the National Quality Forum and the CMS Medicare Hospital Acquired Conditions (HAC) and Present on Admission (POA) indicator reporting.

Please refer to Mass General Brigham Health Plan’s [Serious Reportable Events Payment Policy](#)

- Submit with the correct industry-standard codes
- Submit a Present on Admission (POA) indicator for each diagnosis code, when applicable
- Submit claims electronically using the 8371 ANSI Format with Bill Type 111 in the 2300 Loop CLM05-01 and CLM05-03

Diagnosis Related Group (DRG) Provider Billing Guidelines

For DRG contracted hospitals, Mass General Brigham Health Plan uses All Patient Refined Diagnosis-Related Groups (APR-DRG) for Commercial and Medicaid members, and Medicare Severity Diagnosis-Related Groups (MS-DRG), which incorporates the POA indicator into the DRG assignment.

DRG facilities contracted to use DRG payment methodology must submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment. Mass General Brigham Health Plan processes DRG claims through DRG software. If the submitted DRG and system-aligned DRG differ, the Mass General Brigham Health Plan assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient data, it will be rejected and returned.

Please note: Mass General Brigham Health Plan continues to require authorization for all inpatient services except routine newborn delivery.

Coding Elements

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The following discharge data elements are used for APR-DRG and MS-DRG subclass assignment:

- ICD-CM diagnosis codes
- ICD-CM procedure codes
- Date of Birth
- Gender
- Birthweight (when applicable)
- Admit Date
- Discharge Date
- Status of Discharge
- Days on Mechanical Ventilator (value or ICD-10-CM code)

Maternity and Nursery Claims

Submit claims for the delivery under the mother's Mass General Brigham Health Plan member ID and the nursery under the newborn's Mass General Brigham Health Plan member ID in order to receive two DRG payments.

Please note: Routine nursery charges are not reimbursed separately for Mass General Brigham Health Plan commercial line of business.

Transfer Claims

Mass General Brigham Health Plan reimburses acute hospitals on a per diem basis under certain circumstances. Inpatient services delivered to members, who transfer among hospitals or among certain settings within a hospital, are reimbursed on a transfer per diem basis.

02 – Discharged/Transferred to another Short-Term General Hospital

05 – Discharged/Transferred to another Type of Institution

Transfers include any inpatient cases with a discharge status of a transfer to another short-term acute care facility (02 and 05).

The APR-DRG per diem conversion is calculated as follows:

- Base Rate * APR-DRG weight/Network Average Length of Stay

The MS-DRG per diem conversion is calculated as follows:

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- Base Rate * MS-DRG weight/Geometric Mean Length of Stay

The transfer per diem conversion is calculated as follows:

- Observed LOS for transfer case * Calculated per diem conversion
 - Final payment is the lesser of per diem or acute reimbursement

Related Mass General Brigham Health Plan Payment Guidelines

[Acute Hospital Care at Home](#)

[Serious Reportable Events Payment Policy](#)

References

[Acute Inpatient Hospital Manual for MassHealth Providers | Mass.gov](#)
[Medicare Claims Processing Manual, Chapter 3 - Inpatient Hospital Billing](#)
[MLN6922507 - Medicare Payment Systems - September 2022 \(cms.gov\)](#)

Publication History

Topic: Inpatient Hospital Admissions	Owner: Network Management
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July 1, 2014	<i>Original documentation</i>
January 1, 2017	<i>Document restructure; added DRG billing guidelines, remove definitions</i>
February 9, 2017	<i>References updated</i>
April 3, 2017	<i>Added the MassHealth DRG link</i>
January 1, 2019	<i>Document restructure; codes, code descriptor and references updated</i>
January 1, 2023	<i>Document rebrand, incorporated MS-DRG's for Medicare Advantage</i>

Provider Payment Guidelines

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers' contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.