Payment Policy: Inpatient Claim Billing/Coding Review

Reference Number: TX.CC.PI.04
Product Types: ALL
Effective Date: 04/01/2025
Last Review Date: 04/01/2025

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

Policy Overview

This policy provides clarification on the inpatient facility claim review process. It is the policy of the Company to comply with provisions set forth in federal and state guidelines. To comply with applicable regulatory and contractual provisions, the Company has the fiduciary obligation to review facility claims to verify accurate billing to facilitate accurate reimbursement on a prepay or post-pay basis.

Application
Inpatient facility provider claims

Inpatient Claim Review Procedures

1. The Company will review all inpatient hospital claims utilizing established criteria to determine eligibility for high-dollar review.
Claim referral criteria:

- Inpatient claims > $50,000 allowable charges; and/or
- Inpatient claims that qualify for DRG outlier

2. For claims meeting the above criteria, itemized bills are requested from the billing provider. Medical records may also be requested, if necessary to verify accurate billing, in addition to the itemized bill.

3. Itemized bill reviews are conducted on claims meeting the above criteria.

4. The following criteria is applied to verify accurate billing of the inpatient claim:

a. Inpatient claim complies with national standard and/or state specific billing requirements.
b. Inpatient claim billed charges must "reasonably and consistently" relate to underlying costs (CMS Provider Reimbursement Manual Section 2203).
c. Billed charges must constitute reimbursable benefits.
d. Billed charges must comply with Billing Guidelines of the Uniform Billing Editor.
e. The billed acuity level (rev code) complies with the underlying resource consumption threshold specified in the Uniform Billing Editor.

5. Claim details are reviewed to confirm that individually billed services and supplies are separately reimbursable.

a. The supply or service must be medically necessary, reasonable for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
b. The supply or service must be furnished at the direction of a physician (by distinct physician order).
c. Supplies that are generally available to all patients billed at the same underlying room and board acuity level and/or ordinarily furnished to patients during the course of a procedure, even though the equipment is rented by the hospital are not separately payable. The cost of these supply items is already included in the underlying charge for the room or procedure in which the services are delivered.
d. Supplies, items, pharmaceuticals, and services that are necessary or otherwise integral to the provision of a specific underlying service and/or the delivery of such underlying service(s) are not separately payable.
e. Items and supplies that may be purchased over the counter are not separately payable.
f. Supply fees billed daily or one time, which are unidentified and unsupported by medical records or documentation are not reimbursable.
g. Blood and blood product administration services are not separately reimbursable on inpatient Claims. Thawing/Pooling fees are not separately reimbursable.
h. Pharmacy charges will include the cost of the drugs prescribed by the physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel.
i. Advancements in laboratory testing technology allow a facility to obtain a wide variety of values/results from a single underlying blood sample and analysis. The costs incurred to analyze and obtain results from a blood sample will be reimbursed for each blood sample analysis performed. Multiple charges for results obtained from the same underlying blood sample analysis are not separately reimbursed.
j. Charges for the operating room includes the use of the operating room, the services of qualified professional and technical personnel, linen packs, basic instrument packs, basic packs, dressings, equipment, routine supplies such as sutures, gloves, dressings, sponges, prep kits, drapes, and surgical attire. Charges for instrument trays for any procedure are included in the cost of the procedure and are not separately reimbursable. The operating room charge shall include the cost of robotic technology and is not eligible for separate reimbursement.
k. Charges for reusable items, supplies and equipment are not separately payable, as the use of such reusable items, supplies and equipment does not result in an incremental cost
l. All charges are otherwise subject to review for confirmation that the amount billed for such supplies and services both reasonably and consistently relates back to its underlying (direct and indirect) costs.

m. Listing of supplies and equipment billed on an Inpatient claim that are not separately reimbursable include, but are not limited to:	
• Admission kits • Anesthesia supplies, including pharmaceuticals/gases when billed with anesthesia time charges • Any Linen • Bedpans/Urinals • Beds/Mattresses • Bili light • Bladder scans • Blood pressure cuffs and monitors • Breast milk/storage • Capital equipment • Cardiac monitors • Catheters (routine) • Cotton balls • CPR • CRRT • Dialysis supplies • Diapers • Disposable blood pressure cuffs • Disposable towels • Drapes • Dressing change trays/packs/kits • Dressings/Gauze/Sponges • Education/training • Enteral/Parenteral feeding supplies (tubing, bags, sets, etc.) • Experimental services • Facility personnel charges (lactation consultants, dietary consultants, transport fees, professional therapy functions (physical, occupational, and speech), etc.) • Foley/Straight catheters • Garter Belts • Gloves/Gowns/Drapes/Covers/Blankets • Handling fees • Heat light/Heating pad • Ice packs/Water bottles • Injections (vaccine administration) • Internal transports • Intubation/extubation • Investigational items • Irrigation solutions	• IV supplies (administration kits, arm boards, bottles, bags, catheters, pumps, tubing, extensions, angiocaths, sheaths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, etc.) • IV solutions used to dilute medications • Kerlix/Tegaderm/OpSite/Telfa • Kits/Packs • Lotion • Masks (including oxygen, CPAP, nasal cannulas/prongs, etc.) • Meal trays • Medication preparation • Monitoring (cardiac output, central venous pressure (CVP) lines, pulse oximetry, TCM, blood pressure monitoring, capnography, end tidal CO2, neurological status checks, pulmonary arterial pressure, Swanz-ganz lines/pressure readings, routine telemetry • Monitoring supplies (electrodes, cables, wires, etc.) • Nutritional supplements/additives • Odor eliminator/Room deodorizer • Operating room equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) • Operating Room Supplies (gowns, instrument trays, surgical packs, etc.) • Oral care kits and/or swabs (lemon glycerine swabs, flavored swabs, mouth care kits, toothettes, toothbrush, etc.) • Oximeter sensors/probes/covers • Oxygen unless utilized as an exclusive form of respiratory therapy • Oxygen sensors • Pacing cables/wires/probes • Patient transport • Perfusion supplies when billed with perfusionist time charges • Personal convenience items

m. Listing of supplies and equipment billed on an Inpatient claim that are not separately reimbursable include, but are not limited to:	
• Isolation supplies • Isolettes • IV infusions/IV push • IV line flushes and solutions • IV or PICC line insertions • Preparation or Set-up Charges • Pressure/Pump transducers • Razors • Rental Fees • Replacement batteries • Restraints • Resuscitation • Reusable items • Routine nursing services • RT assessment • Saline Solutions • SCD Sleeves/Compression sleeves/Ted hose • Separate nursing charges • Sharps containers • Shaving cream • Skin cleansers/preps • Skin temperature probes • Slippers • Soap • Socks • Specialty beds • Specimen collection devices, containers, and fees (venipuncture, phlebotomy, heel stick, etc.) • Sputum induction/Sputum trap • Stat charges • Stockings	• Point of Care monitoring and testing (bedside glucose, oximetry, fecal occult blood, etc.) • Portable charges • Preparation kits • Suction supplies (canisters, tubing, tips, catheters, liners, etc.) • Syringes/Needles/Lancets/Butterflies • Tape • Televisions • Thermometers/Temperature probes • Toilet tissue • Tongue depressors • Traction equipment • Transducer kits/packs • Tracheostomy care/Changing of cannulas • Underpads • Urometers/Leg Bags/Tubing • Video Systems • Wall suction • Wipes (baby, cleansing, etc.)

6. Facility billed charges are evaluated for cost-to-charge to confirm billed charges reasonably and consistently relate to the cost of providing the services.
   a. The amounts billed for implantable supply items are compared to the usual and customary provider billing data maintained in the ECRI Institute's database of medical/surgical supplies and implants. ECRI Institute is designated an Evidence-Based Practice Center by the U.S. Agency for Healthcare Research and Quality and listed as a federal Patient Safety Organization by the U.S. Department of Health and Human Services. In this database, hospitals populate with the amounts they actually pay for implantable devices.

   b. The amounts billed for pharmaceuticals are compared to Average Wholesale Price (AWP) of such pharmaceuticals that is provided by the website AMS, Medispan AWP or

ECRI Institute's database. These tools provide current AWP package pricing, Medicare Part B ASP and hospital APC/OPPS drug pricing information for FDA approved drug codes.

c. When an inpatient claim review identifies a significant "Cost-to-Charge Discrepancy," the Company will assign the allowable reimbursement to an amount that is 8 times the median amount the AMS database indicates that facilities pay for the same implantable supply item or 8 times the AWP price listed for the same pharmaceutical. This adjusted billed amount should allow for the provider to be reimbursed for the actual direct cost incurred to obtain the item, plus the indirect costs associated with the storage, maintenance and usage of item identified.

d. If a facility can provide documentation (i.e. invoices) demonstrating that it incurred a cost of greater than the allowed amount, the Company will review the documentation and respond as appropriate.

7. Correspondence is sent to the provider, listing all identified exceptions based on the review, and includes identification of overpayment if the review is completed on a post payment basis, and detail of disallowed charges if the review is applied on a prepayment basis. The provider correspondence describes the provider's right to appeal the claim review determination.

8. Response to claim appeals are provided within 30 days of receipt of the appeal. Ifany of the billing exceptions are remediated through provision of medical records, invoices, doctor orders, provider contracts, billing policies, or other clinical information, the claim review determination is withdrawn, and additional amounts paid (prepayment review) or overpayment determination withdrawn (post payment review).

9. Key Categories of Inpatient Billing Errors and Discrepancies

a. Billing errors - Charges not billed correctly (i.e. pharmaceutical and implant markups exceeding 8 times presumed cost, duplicate billing, data keying errors, inappropriate interval, component of a primary procedure, more than 24 hours of a daily therapy billed, etc.)
b. Experimental/Plan Language Benefit – Experimental or investigational drug or treatments that are not reimbursable.
c. Incorrect Bill Type – Charges were submitted on wrong bill type, such as HCFA 1500.
d. Incorrect Charges – The price of an item or the number of items billed were perceived to have a discrepancy.
   Insufficient Description – Service/item lacks enough detail to properly evaluate charge on its merit.
e. Level of care – Billed charges are not supported by the patient's acuity level.
f. Non-Covered – Service/item that is not covered by the Health Plan benefit.
g. Not Authorized – Service/item that is not authorized when authorization is required.
h. Quality of care issues – Never events and hospital acquired conditions

i. Unbundling – Charges for supplies and services that are considered routine, built into the cost of room & board and/or are an integral and necessary components of another procedure or service provided and are not separately billable on inpatient claims

Revision History	
04/01/25	New Policy developed for Texas Programs, incorporating information from CC.PI.04 Clean Claim Reviews, *CC.PI.06 Cost to Charge Adjustments on Clean Claim Reviews and CC.PI.10 Unbundling Adjustments on Clean Claim Reviews*

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations 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 plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This 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 payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This 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 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 policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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.

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.