Hospital Network Update
October 2024

Hospital Observation

McLaren Health Plan is implementing a Hospital Observation Payment Policy, effective 1/1/2025. The policy outlines observation level of care reimbursement and authorization requirements. The policy is included with this update for your review and can be found in our Provider Manual at https://www.mclarenhealthplan.org/mclaren-health-plan/provider-communications.

UPDATE: Emergency Department Facility E & M Coding Policy

McLaren Health Plan previously sent a communication to Hospitals in May 2024 regarding the Emergency Department Facility E & M Coding Policy. McLaren Health Plan is revising the information previously sent. The revised policy, effective 1/1/25 is as follows:

SCOPE
LOB = Medicaid
Claim Type = Institutional, Outpatient
Service = ED visits

POLICY
Beginning with claims submitted on 1/1/2025, McLaren Health Plan will implement Optum EDC Analyzer and deny facility ED claims where the level of service billed is not supported by the claim information submitted. Providers should rebill facility claims within 90 days with the appropriate level of service for payment.

McLaren Health Plan will use the following factors in considering appropriate levels of service:

1. Presenting problems – as defined by the ICD-10 reason for visit diagnosis;
2. Diagnostic services performed – based on the intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e. lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound); and,
3. Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes

Applicable codes to be evaluated include:

99282	G0381	ED Level 2
99283	G0382	ED Level 3
99284	G0383	ED Level 4
99285	G0384	ED Level 5

Claims for the following may be excluded from a denial:

1. Patients who were admitted from the ED or transferred to another health care setting (Skilled Nursing Facility, Long Term Care Hospital, etc.)
2. Critical care patients (99291, 99292)
3. Patients under 2 years of age

4. Certain diagnoses that when treated in the ED most often necessitate a greater than average usage, such as significant nursing time
5. Patients who have expired in the ED

OTHER
Internal denial code – C679: Information submitted does not support this ED level of service. Please rebill with the appropriate ED level of service.

Remittance CARC code – 150: Payer deems the information submitted does not support this level of service.

Remittance RARC code – M26: The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.

If you have any questions, please contact your Provider Relations Representative at 888-327-0761 (TTY: 711) for assistance.

McLaren Health Plan thanks you for the quality care you deliver!

Hospital Observation Payment Policy

Line of Business: McLaren Health Plan Medicaid
Effective Date: 1/1/2025

This policy applies to observation services provided at a facility. If there is a conflict between this policy and applicable federal or state laws, regulations or regulatory requirements, the applicable laws or regulations will control. Further, if there is a conflict between this policy and a provider contract, the provider contract will govern. Note – coverage may be mandated by MDHHS or CMS.

Providers are required to submit accurate claims and documentation for all services performed.

Providers must submit claims using valid code combinations required by applicable law. Claims should be coded appropriately according to industry standard coding guidelines. All claims are subject to claims edits and may be subject to further reviews by McLaren or contracted third parties. Providers are expected to promptly work with McLaren and any third parties to provide any requested information related to a claim submission.

Definition

- **Observation Care:** a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or if the patient is able to be discharged from the hospital. Observation services are commonly ordered for a patient who presents to the Emergency Department (ED) and who then require a significant period of treatment or monitoring to make a decision concerning their admission or discharge. Observation services generally do not last more than 72 hours.

Policy

1. **Authorization Requirements**
   - Observation stays do not require authorization.
   - Hospital observation stays are those hospital services that are generally 48 hours or less in nature.
   - Observation Care must be medically necessary.
   - Observation services may be appropriate when the member does not meet an inpatient level of care and meets an observation level of care.

2. **Authorization Required for Request for Inpatient Level of Care**
   - A request for admission that meets inpatient criteria but could be treated in an observation setting will be considered an observation stay. Updated clinical information may be submitted by the facility at 48 hours.
   - All inpatient stays require prior authorization from McLaren.
   - Obtaining authorization does not guarantee payment.

3. **Authorization Review**
   - All requests for inpatient authorizations will be reviewed against McLaren's clinical criteria for inpatient level of care.
   - McLaren uses nationally recognized criteria for its clinical criteria, including but not limited to, InterQual to determine the appropriate level of care. Guidelines are not a substitute for clinical judgment. McLaren's Chief Medical Officer or his/her designee may refer to guideline criteria in

reaching the determination but are not required to adhere to any single published criteria.

- Facilities must provide sufficient clinical information for McLaren to make an appropriate medical necessity determination.
- Facilities must supply documentation to support the claim submitted. This information includes but is not limited to complete medical charts, itemized bills and consent forms.
- **Authorization approval does not guarantee payment (see below for the 48 hour rule)
- McLaren has the right to review, audit or otherwise deny claims based on benefit limitations and exclusions, eligibility, correct coding. billing practices and McLaren payment policies.

4. 48 Hour Rule

- **Less than 48 Hours**
  - McLaren will reimburse medically necessary observation services less than 48 hours without an authorization.
  - McLaren will reimburse inpatient stays less than 48 hours for the exclusions listed below.
  - For purposes of calculating the 48 hours, the time starts at the time a patient is placed in a bed for the purpose of initiating observation care. Observation services should continue to be billed as an observation service.
  - Authorization is not a guarantee of payment.
  - Facilities may timely rebill at an observation level of care.
  - Inpatient stays billed and paid that are less than 48 hours are subject to retrospective reviews.

- **48 Hours or More**
  - If the facility received an approved authorization, based on medically necessity review, for an inpatient stay, the claim will be approved at the inpatient level of care for payment purposes.
  - McLaren reserves the right to review and/or deny the claim for other valid purposes (ineligible member, not medically necessary, etc.).

- **Exclusions to the 48 Hour Rule**
  - If an authorization request is submitted to McLaren at an inpatient level of care, for a stay less than 48 hours, but McLaren determines that it meets the following exclusions and approves the authorization request, it will pay at the inpatient level:
    - Deliveries – APR DRGs 540-5404, 5411-5414, 5421-5424, 560-5604
    - Neonatal Services – APR DRGs 580-62641
    - Nursery/Newborns – APR DRGs 630-64041
    - ICU Revenue Codes: 0200-0209
    - Discharge Status of 20 (patient expired)
    - Diagnosis codes Z37-Z37.7, Z38-Z38.8 (births)
    - MSA Bulletin 15-32 Inpatient and Outpatient Hospital ICD-10 Short Stay Reimbursement.
    - CMS Inpatient Only Code

Audit

McLaren or a third party may audit or otherwise review all paid inpatient hospital claims to ensure the integrity of the paid claims. This includes, but is not limited to coding validation, payment accuracy, compliance with regulations, policies, and contractual requirements. These reviews include clinical claim reviews and payment analytics.