Claims and Payment Policy Inpatient Notification

Applicable To:
Medicare

Policy Number: CPP - 101

Original Effective Date:
Revised Date(s): N/A

BACKGROUND

The Health Plan is committed to ensuring its members receive high quality care in the most appropriate setting. To this end, The Health Plan initiates activities and processes when a member requires inpatient care. These include:

- Retrieval of clinical information from the facility;
- Eligibility and benefit determinations;
- Medical necessity and place of service treatment reviews; and
- Discharge planning to a more appropriate level or setting of care, including the early identification of medical and/or psychosocial needs for which the member may require additional care.

The Health Plans inpatient and discharge care manager's work with attending physicians, facility discharge planners, ancillary providers and community organizations to coordinate care and resources. A care manager may refer a member with identified complex discharge needs to a Health Plan outpatient care manager to ensure a smooth transition for the member.

POSITION STATEMENT

Providers are required to notify The Health Plan when its members receive care in any of the following settings:

- Acute Care Hospitals, including Critical Access Hospitals and Behavioral Health Hospitals
- Inpatient Rehabilitation Facilities
- Long-Term Acute Care Hospitals

- Skilled Nursing Facilities

Inpatient notification is accomplished by alerting The Health Plan by phone, fax or EDI 278 transaction. Participating providers can notify The Health Plan via its online provider portal, available at **https://provider.wellcare.com/Provider/Login**

The following notification time frames apply:

- Urgent and emergent admissions, including non-routine newborn care – By the next business day
- Elective inpatient admissions – By the next business day
- Observation stay – By the next business day

The level of inpatient care (e.g. medical, behavioral, telemetry, intensive, etc.) does not change the notification requirement.

Failure to notify The Health Plan timely may result in an administrative denial of the facility and/or professional claim.

Note: The requirement to obtain a prior authorization, if any, is *in addition to* the inpatient notification requirement. Please refer to the Health Plan Provider Manual for additional information about prior authorizations.

CODING & BILLING

Not Applicable

REFERENCES

Not Applicable

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP. The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT®, HCPCS©, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.

References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at **www.wellcare.com**.

'Ohana Health Plan,~ WellCare (Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)