PAYMENT POLICY STATEMENT: MEDICARE ADVANTAGE

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
05/17/2016	05/17/2017	05/17/2016

Policy Name	Policy Number
Hospital and Skilled Nursing Facility Admission Diagnostic Procedures	PY-0060

Policy Type		
☐ Medical	☐ Administrative	☒ Payment

Payment Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Payment Policies.

In addition to this Policy, payment of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

A. SUBJECT

Hospital and Skilled Nursing Facility Admission Diagnostic Procedures

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be determined based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

C. DEFINITIONS

- Diagnostic procedures, are procedures such as chest X-rays, urinalysis, etc. provided to patients upon admission to a hospital or skilled nursing facility.

D. POLICY

I. CareSource will reimburse providers for a diagnostic procedure performed as part of the admitting procedure to a hospital or skilled nursing facility when it is reasonable and necessary as follows:
   A. The test is specifically ordered by the admitting physician (or a hospital or skilled nursing facility staff physician having responsibility for the patient where there is no admitting physician): i.e., it is not furnished under the standing orders of a physician for his patients;
   B. The test is medically necessary for the diagnosis or treatment of the individual patient's condition; and
   C. The test does not unnecessarily duplicate the same test performed on an outpatient basis prior to admission or performed in connection with a recent hospital or skilled nursing facility admission.

II. If required, providers must submit their prior authorization number their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS.

For Medicare Plan members, reference the Applicable National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Compliance with NCDs and LCDs is required where applicable.

CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to:
https://www.cms.gov/Medicare/Medicare.html

AUTHORIZATION PERIOD

If applicable, reimbursement is dependent upon products and services frequency, duration and timeframe set forth by CMS.

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued: 05/17/2016
Date Reviewed: 05/17/2016
Date Revised:

G. REFERENCES

1. Centers for Medicare & Medicaid. (2016, May). Retrieved May 12, 2016, from https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=196&ncdver=1&bc=AgAAQAAAAAAA&

The Payment Policy Statement detailed above has received due consideration as defined in the Payment Policy Statement and is approved.