Priority Health	BILLING POLICY No. 014
INPATIENT ONLY PROCEDURES	
Date of origin: Jan. 2024	**Review dates: 2/2025**

APPLIES TO

This policy applies to all Priority Health Medicare and Medicaid plans for both professional and facility claims, in and out of network.
For Priority Health commercial plans, follow the current authorization process for those inpatient only codes falling under InterQual criteria.

DEFINITION

This policy describes Priority Health's guidelines for inpatient only procedures reported in an outpatient setting.

POLICY SPECIFIC INFORMATION

General guidelines

The Centers for Medicare and Medicaid Services (CMS) inpatient only list is a listing of services that should only be performed in an inpatient setting due to the level of medical complexity.
Claims will be denied and returned to the provider when a procedure code with a status indicator of "C" (inpatient only) is reported in any place of service other than inpatient.

RESOURCES

- CMS's Medicare Claims Processing Manual
- CMS's Hospital Outpatient PPS

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 5, 2025	Added "Disclaimer" section